HEALTHCARE COST
CONTAINMENT COMMITTEE

165 Capitol Ave
HARTORD, CONNECTICUT
06106-1775
Telephone (860) 702-3480
Facsimile (860) 702-3556

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

HEALTHCARE COST CONTAINMENT COMMITTEE MEETING MINUTES
January 13, 2025

Meeting Called to Order by **Josh Wojcik**

Attendance:

Labor	State Comptroller Administrative Staff
Carl Chisem – CEUI	
Dan Livingston – SEBAC	Thomas Woodruff
	Presenters
	Bernie Slowik – OSC
	Rae-Ellen Roy – OSC
Management	Betsy Nosal -OSC
Gregory Messner	
Karen Nolen	
	Consultants
Dept. of Insurance	Terry DeMattie, Segal
Paul Lombardo	

Public Comment:

No Public Comment

Financials:

Our expected balances for the end of the year show that the active health appropriation is holding steady with a surplus of about $33 million. The active health FAD accounts indicate a combined balance of approximately $102 million. However, this is not where we want to be regarding the overall IBNR balance. Therefore, we will implement an IBNR adjustment for the upcoming year.

Additionally, we need to build up the retiree health appropriation. This value has been updated to incorporate the anticipated reimbursement amounts for Medicare premiums charged to our retirees and the updated Medicare Advantage premium rates from Aetna, effective January 1st. We expect to close the year with a deficit of around $34 million, which nearly offsets the surplus in the active health appropriation. We will address this adjustment within the year through the FAC or otherwise.

Regarding the retiree health, OPEB FAD accounts show a combined surplus balance of approximately $229.5 million. This indicates a very healthy balance with the proper reserves in place.

Partnership:

As of the beginning of the year, Partnership 2.0 has 167 groups enrolled, comprising just over 25,000 employees and over 60,000 members. Next week, we will hold quarterly partnership update meetings with an adjusted rate projection. These meetings are scheduled for Tuesday, the 21st, at 2:00 PM and Friday, the 24th, at 9:00 AM.

We are also excited to announce the launch of a new member-facing website for Partnership, which will be available on carecompass.com. The current website will continue to be used by HR and for new group inquiries. The website launch will coincide with the quarterly update meetings, where it will be part of the content discussed.

There are still five groups remaining under Partnership 1.0, with a total of 2,500 employees and 3,500 members.

High-Level Utilization:

The situation remains consistent with what we've seen over the past few months, though some of our line items are, unfortunately, moving in the wrong direction. We continue to see significant trends in inpatient facilities, which we discussed last month. However, we have not identified many actionable items in that category.

We are certainly noticing increases in high-cost claimants; overall, utilization is rising. Additionally, we have seen a significant uptick in utilization on the pharmacy side. We are currently reviewing this situation and will propose some strategies to the committee to slow this trend without significantly impacting our members.

As we move forward, we will discuss these proposals further. Other areas, such as outpatient and professional services, are trending upwards, but to a lesser extent than pharmacy and inpatient services. Overall, we are seeing a trend of an increase of 0.7%.

Communications Update:

We continue communicating monthly with all our plan members through our chronic education and well-being seminars. Additionally, if any of our point solutions or other vendors host a seminar or webinar, they are included in this monthly communication. In December, we conducted a special email campaign focused on stress and emotional health, which we traditionally do around the holidays.

We are also working on a Mental and Emotional Health Care Compass page that will launch soon. This page will provide various resources for our plan members, as we recognize the importance of unique care options based on the growing need and interest.

Two key sliders are featured on the benefits portal from December to January. The first is the Provider of Distinction program. This slider is prominently placed at the top of the Quantum Health Benefits Portal for quick access to current programs.

The second slider highlights our Healthy Living Programs page, which is relatively new to Care Compass. This summary page enables our plan members to view programs related to diabetes care and orthopedic care, which just launched on January 1st through our new partnership with Hinge and Upswing. This partnership offers unique virtual opportunities for care.

This page also contains our Chronic Well-Being and HEP or Distinctions programs, along with resources for emotional health, which will be available soon. This makes it easier for our plan members to find the care and programs we have in place.

Lastly, I want to mention our Benefit Spotlight series held in the fall. It included information on the Quantum Health Benefits Portal, the Cigna Dental lookup tools, and the OHIP program for those receiving related letters or communications. The DPP Diabetes Program was also featured.

Attendance during our live events was encouraging, and we've noticed a great interest in on-demand viewing, with substantial viewership continuing even up to January 9th. The Quantum Benefits video is on demand, and the Cigna Dental information is available on our Benefits Enrollment page. When new employees receive their welcome emails, they will find links to these resources, including our benefits enrollment page on Care Compass. They can also access the diabetes resources from the diabetes page. Overall, we are committed to helping everyone find the care they need.

Upswing Analysis:

The program was fully implemented in January 2023. To conduct the analysis, we needed a group of participants with 12 months of experience before their participation date. We selected members who enrolled between January and May of 2023, allowing us to account for their 12 months of

prior experience plus an additional three months of run-out, as this analysis was conducted on an incurred basis.

From this, we identified 113 members with the required 12 months of experience, both pre- and post-participation. Of those 113 members, we established statistical cohorts for 111.

To evaluate the participants against a cohort, we developed a methodology to identify what we call "statistical twins." This involved analyzing each participant's age, gender, total MSK spend in the previous year, the first three diagnosis codes received from Upswing, whether they had a diagnosis of obesity, and whether they were on GLP-1 medication, as these factors can significantly impact MSK spending.

Through this process, we were able to create cohorts for 111 members. To provide some context, there could be hundreds or even thousands of individuals in a cohort for each participant, lending us strong credibility concerning the non-participating group, representing 99% of those with MSK spending. However, the credibility of the Upswing participant group is less robust. Therefore, the results we present should be regarded as indications of the plan's performance rather than definitive endorsements or criticisms of the program.

We will highlight some key findings, illustrated through graphs, that will clarify some of our credibility issues. Initially, we observed a lower trend in MSK-related spending for participants, particularly a significant decrease in outpatient costs. I will elaborate on the credibility channels when we reach that graph. Notably, no surgeries were reported among program participants, which is a significant finding, even within this small group.

Additionally, medical-related pharmacy spending decreased significantly by 42% for participants, while it increased for non-participants. It's important to note that no one is immune to rising prescription drug costs; participants experienced a 17.7% increase compared to a 23.5% increase for non-participants.

One of the key points we will discuss in an upcoming exhibit is the comparison of opioid-related pain medications to non-opioid pain medications. The results are favorable for the Upswing program, showing greater utilization of non-opioid medications compared to opioids during the evaluation period.

Here is the breakdown of medical claims for participants and non-participants, presented on a PMPM basis. On the right, we have the claims specifically related to MSK conditions.

The starting PMPM for participants was $891, while for non-participants, it was $1,094. This indicates that the individuals who participated in the program had a lower risk than those who did not. Therefore, it is crucial to encourage more high-cost individuals to join the program to improve overall outcomes. The significant difference in PMPM values highlights the credibility challenge caused by the relatively small number of participants.

After applying statistical twin matching, we see the MSK-related claims. The starting PMPM figures are much closer, so we utilize this methodology. Analyzing the trends from the baseline

period to the measurement period, we see a negative trend for participants and a significant positive trend for non-participants. Although we cannot definitively conclude that the program is achieving its intended goals, this evidence suggests it may be moving in the right direction.

Next, we can examine the credibility issues by place of service. The PMPM for inpatient services shows that for non-participants, it is $29, while it was $0 for participants during the baseline period. This means that the 111 participants had no inpatient admissions in that period. To illustrate how a few cases can skew data, just one admission in the baseline period would have raised the PMPM for participants to around $29-$30. Although this shows a significant gap between $29 and $0, it reflects just one admission.

The credibility problem is notable for inpatient services. While the issue is less severe for other services, it still exists. The decrease in participant claims is primarily due to the absence of emergency room visits in the measurement period. However, if the numbers were generally credible, it would only take four ER visits to align the trend more closely with that of non-participants. This indicates that the results are very sensitive to the experiences of just a few individuals.

Part of the observed changes can be attributed to the program itself, while some may be due to the characteristics of the participants. You can see a considerable amount of professional service utilization. The graphs show similar trends, with slight participant favorability, underscoring our credibility challenges. The inpatient graph shows how just one or two admissions could influence the results.

There is favorable information regarding opioid and non-opioid utilization. During the baseline period, opioid use among the participants in the Upswing program was very low compared to non-participants. This suggests that individuals who choose to enter the upswing program may be more health-conscious than those who do not participate. However, it also indicates some bias in the program that needs to be addressed through increased member participation.

The trend for opioids is similar for both participants and non-participants. However, when we examine the trend for non-opioids, we see that the PMPM cost is decreasing for non-participants while it is increasing for participants. This could be interpreted as positive information, indicating that the Upswing program is effectively ensuring that participants are getting adequate pain management without immediately resorting to opioids. Instead, they seem to be utilizing non-opioid medications first. Despite some concerns about credibility, there are still positive takeaways from this information.

In the data, the green represents the participants, indicating a negative trend, while the red signifies a positive trend. Notably, even in the positive trend, there are instances of good news.

For example, in the outpatient category, urgent care increased from $0.23 for participants to $0.72, a 205% change. In contrast, emergency room visits decreased from $13 to $0.

While the numbers may be small, they suggest a positive development. Specifically, the upswing program shows an increase in non-opioid medication utilization, alongside a rise in urgent care visits, juxtaposed with a decrease in emergency room usage.

The most significant takeaway from this analysis concerns surgeries. Participants in the upswing program had no surgeries during the evaluation period. This could mean they didn't require surgeries or experienced declining knee, hip, and shoulder surgeries. There was a 100% negative trend in surgeries for this group compared to participants with significantly higher trends.

In conclusion, the upswing program appears to be having the desired impact. However, to validate these findings, we need to encourage significantly more participation in the program.

Question: It appears that all this is claims data. Do we have any? Does the program survey its participants? Do we have any data on how the numbers are feeling or doing? Is there anything else related to that?

Answer: I can provide insights based on our office's general informational surveys. We ask about various point solutions and specifically about participation in specific programs.

We have received feedback indicating significant improvements over time regarding Upswing. Our most recent survey showed a marked increase in recognition of Upswing and a higher participation rate than earlier years.

Additionally, Upswing conducts internal surveys, and we have received many favorable responses. As Dave mentioned, those who have participated in the program have engaged with a representative who has genuinely helped them, leading to positive experiences.

I will follow up with Upswing to gather any formal survey results I can share.

SNF PA process update:

We've recently received some concerns regarding Medicare Advantage plans, particularly our plan's PA process and utilization management for skilled nursing facilities. In response, we have collaborated with Aetna to enhance the process, making it less cumbersome and more user-friendly for our members.

Aetna has introduced what we're calling the Utilization Management Optimization Plan. This initiative involves a significant update known as the "One Nurse Model." In a typical scenario, when a patient is hospitalized, they are assigned a nurse case manager who oversees their care and makes authorization decisions during their stay. Once the patient transitions to a rehab facility for skilled nursing care, a new nurse reviews their rehabilitation progress.

With the One-Nurse Model, a single nurse will be assigned to each patient throughout their hospital stay and their time at the rehab facility. This nurse will have a comprehensive understanding of the patient's condition and care requirements, which will help address any gaps in knowledge during the transition between care settings.

Moreover, Aetna has placed nurses directly on-site at these facilities for members admitted to Yale facilities. Any patient transitioning from inpatient care at a Yale facility to a skilled nursing facility will automatically receive approval for their prior authorization without additional review.

Additionally, Aetna will have nursing support available at select more extensive skilled nursing facilities to ensure face-to-face engagement with members, caregivers, and families. This engagement will help clarify the approval process, ongoing care, and eventual discharge procedures. The ultimate goals are to improve member outcomes, reduce the volume of appeals, and enhance the overall experience for both members and their caregivers.

Although I don't have a complete list of the skilled nursing facilities involved yet, we will soon provide that information and a rollout schedule.

Regarding denial audits, we will review a sample of 20 denial cases that were later overturned each month. These findings will be discussed with leadership and presented to our office for potential action plans. We aim to identify patterns in the reasons for denial, whether they relate to provider education in hospitals, skilled nursing facilities, or our members themselves. Understanding these patterns will help us address any issues effectively.

Furthermore, we are implementing a Post-Acute Automation Process for SNF admissions and continued stays. This process will enable real-time decision-making through a digital tool that answers selected questions, allowing automatic medical necessity reviews and approvals. This improvement will expedite processes and eliminate the need for time-consuming phone calls.

Skilled nursing facilities will be trained on these new processes in the coming months. Overall, we intend to reduce denials, increase education, and enhance the approval rate to ensure that cases referred for skilled nursing care genuinely require it.

Question: Could you please clarify if decision automation applies only to approvals while denials are not automated?

Answer: You are correct. The automated process is solely for approvals. There are no automatic denials. If an automatic review triggers any denial, it will be sent to a medical director for a human review and interaction. This denial will then be thoroughly examined and discussed with the facility.

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

Motion to Adjourn was made by Dan Livingston, seconded by Gregory Messner.

Meeting was adjourned.