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
November 12, 2024

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:

The balance in the active appropriation stands at $33.2 million, an increase from our last review.

There was a $24.4 million FAC reduction. I hadn't realized that this amount had already been deducted from the appropriation value provided to me, which led to a double count of that

discount. The good news, however, is that we now have a surplus of $33.2 million in that account.

We are seeing an increase in claims in the active health FAD accounts. It's still too early to determine whether this is a long-term trend or a one-time payment spike. Nevertheless, the total balance in those accounts remains healthy at approximately $119 million.

On the other hand, the retiree appropriation account shows a deficit of about $34.7 million, primarily due to the increase in the MAPD premium, which will take effect on January 1st. We are optimistic that potential renewals won't be as severe as initially anticipated, but current indications suggest otherwise. The renewal for 2025 is in, and it is higher than we had previously expected and reported, contributing to the $34.7 million deficit.

Conversely, the OPEB FAD accounts, which act like checking accounts, are expected to show a surplus of approximately $232.9 million by the end of the year, exceeding our initial expectations. We continue to draw down this amount to alleviate the overall impact on premium deductions.

Question: What are the 2025 rates?

Answer: The PMPM rate for all is $337.24, consistent across the board.

Partnership:

As of November 1st, we have 168 groups enrolled in Partnership 2.0, totaling just over 25,000 employees and more than 60,000 members at the end of October. Final rate letters regarding the re-rate of the Medicare Advantage plan have been sent to the existing group leads. Additionally, invitations for the quarterly partnership meetings have been sent to our current group contacts. These meetings are scheduled for next week on the 18th at 9:00 AM and the 21st at 3:00 PM. We plan to provide an early rate range projection for the 2025 renewal during these meetings.

As for Partnership 1.0, we currently have five groups enrolled with 2,500 employees and 3,500 members.

High-Level Utilization:

Looking at our utilization dashboard, we can see a significant increase in our reported metrics, with a 6.9% year-over-year increase.

The two main drivers behind this trend are a high volume of pharmacy usage, which we hope will decrease as the year progresses, and, more concerningly, inpatient facility usage. As we highlighted last month, we committed to conducting a deeper analysis of inpatient facility utilization. We have started this process but need further investigation to understand the situation.

We will not present additional items on this topic this month, but we aim to provide more insights by next month. Initial findings indicate that utilization primarily drives the increase, and the

numbers are extraordinary. We want to conduct a more thorough investigation to understand better what is happening in this area. We will continue monitoring the inpatient facility usage and provide a more in-depth analysis next month.

HEP Compliance Update 2024

Here are the 2024 HEP compliance numbers.

State Compliance:
- Total household compliance: 59.1%
- Non-compliance: 40.9%
- Total participant compliance: 73.7%
- Non-compliance: 26.3%

When we compare the numbers from May to November 4th, we see a significant increase, indicating that we're progressing.

Partnership Compliance:
- Total household compliance: 55%
- Non-compliance: 45%
- Total participant compliance: 70.7%
- Non-compliance: 29.3%

Similarly, there has been a noticeable increase in partnership compliance numbers from May to November 4th.

Specific Compliance Requirements for 2024:
- Preventive screening: 93%
- Dental: 83%
- Cholesterol screening: 93%
- Breast cancer screening: 94%
- Cervical cancer screening: 89.4%
- Colorectal cancer screening: 88.5%
- Chronic condition education: 70.6%

The most significant improvement has been in chronic condition education compliance, which saw a 34% increase from September to November 4th. This rise can largely be attributed to effective communications from Betsy and her team, particularly the distribution of chronic condition letters.

To address compliance for 2024, the care coordinators at Quantum are conducting outreach specifically for members who need to be more compliant with their chronic care condition education. Additionally, care coordinators review compliance during calls with members, even if the call was not originally about compliance.

We are observing trends where members are reaching out to check their compliance status and inquire about the chronic condition education bonus.

Looking ahead to the 2025 compliance year, we plan to revamp the HEP portal for a more user-friendly experience. My team and I are also working on automating the HEP reinstatement process to eliminate the need for manual processing. From August to October, we successfully processed approximately 1,139 reinstatements manually, a significant achievement.

The projected go-live date for the 2025 HEP requirements is February 1st, and we're collaborating with Quantum to ensure a smooth implementation.

Communications Update:

Here's a high-level overview of our communications activities in October and what's coming in November.

We sent out five key communications, which are detailed in the chart. One important takeaway is that our email open rates indicate which topics are important to employees. Thankfully, employees are remaining subscribed to our Care Compass email distribution by selecting what content they find relevant and engaging.

We recently had an open enrollment period for flexible spending accounts, which showed a significant increase in interest, reaching an average open rate of 23%. The initial email sent out achieved an impressive open rate of nearly 48%. This demonstrates that our employees are eager to learn about their flexible spending options, which is further reflected in the click-through rates, indicating that they not only opened the emails but also explored the benefits in detail.

Another highlight from this month is our reminder regarding the HEP program. Although we typically maintain a clear separation between our Care Compass emails and the HEP program administered by Quantum, we aimed to assist by addressing the needs and confusion we heard from employees. The email we sent out was effective and generated substantial interest.

We are on track for a successful compliance year in 2024. Additionally, we launched a benefits spotlight series. We showcased the Quantum Health portal in September with a demonstration, followed by a Cigna spotlight in October. This event was a quick 30-minute session highlighting their registered site and lookup tool. Looking ahead to November, we will focus on diabetes awareness month with a spotlight on our diabetes programs, including the diabetes prevention program with Wellspark and the diabetes reversal and management program with Virta.

Registration for these events has been encouraging. Even though this is our first time holding these spotlights, we saw approximately 50% registration turnout, and the on-demand option has allowed employees to watch the replay.

In our November portals, we will continue to reflect on current events. We have incorporated a HEP slider, A provider of Distinction slider and a Diabetes Awareness Month slider that make it easier for employees to access these benefits with one click once they open their benefits portal.

Quantum Performance:

This overview focuses on Quantum's performance from August 1, 2023, to July 31, 2024, encompassing a full year of data.

Regarding engagement and clinical outreach, we achieved a member engagement rate of 62%, above the industry average. Furthermore, 99% of high-cost claimants and 99% of the eligible population for clinical outreach were actively engaged with Quantum Health.

Looking at how Quantum delivers value, we increased HEP program compliance among members by 16% and by 22% at the household level. Quantum Health managed 92% of total claims dollars, indicating that we significantly impacted member care. Additionally, 79% of high-cost claimants received real-time interventions, which I will elaborate on later. The overall member NPS stands at 72, again above our industry benchmark.

When we break down the data by cost and prevalence, we find that the highest claims expenditures are associated with cancer, mental health, and gastrointestinal issues. It's no surprise that members are effectively utilizing preventative health encounters with primary care physicians. Mental health conditions, along with musculoskeletal issues, rank among the top concerns for our members.

We analyzed some information regarding state and partnership engagement. This analysis focuses on the state plan and the members who are involved. On average, members engaged with us about three to three and a half times. During these interactions, we discussed various topics; each time a member calls, multiple subjects are addressed.

One of Quantum's strengths is our commitment to having meaningful conversations rather than rushing members off the phone. We prioritize allowing members to discuss as many topics as they want and delve deeply into those discussions. Our average engagement with providers will be explored further in the presentation. The member satisfaction score with the state stands at 71.

We are examining how members are connecting with Quantum. Members prefer to call in, as phone interactions yield the highest engagement. This aligns with the data shown in the blue box under the digital experience, which indicates members logging into their portal to explore various topics.

We identified the top three areas of interest for members when using the member portal: checking their claims, finding a provider, and reviewing their benefits. These are the primary concerns driving member self-service activity on the portal.

The partnership plan shows trends similar to those observed in the states, particularly regarding average member engagement and discussion topics. However, the partnership plan's core metrics are somewhat higher than those of the states.

When examining member interactions with the partnership, it's evident that many members prefer to contact customer service for assistance rather than navigating the digital portal. This

aligns with trends observed in the states regarding member preferences for handling claims, finding providers, and understanding benefits.

A closer look at member engagement reveals that a significant portion of calls to the customer service team concerns medical plans. Specifically, 74% of members calling in have questions about their medical plans, while only 2% inquire about pharmacy services. Additionally, examining the benefits ecosystem, which encompasses all inquiries, we find that nearly 50% of calling members have Quantum-related questions.

While the primary reason for these calls may vary, many members also ask about the HEP program. On the right-hand side of our analysis, we detail members' top five questions regarding their benefits.

In terms of referrals, Flyte emerges as the most discussed topic. We aim to gather information on referral progress and success rates. We've found that 67% of members referred by Quantum engage with Flyte. Quantum tracks this engagement through a questionnaire that is completed when members enter the program. With Upswing Health, 65% of members referred from Quantum show engagement with Upswing, tracked by whether they clicked from the member portal to Upswing.

However, data regarding Virta Health is less reliable since participation in that questionnaire is optional, and many members refrain from responding.

Hot topics for call-in members include challenges with submitting claims to the Anthem portal and ensuring that lab services at New Haven Hospital are correctly covered. Members also frequently mention claims processing errors through Anthem. These are the primary subjects driving member inquiries.

This report analyzes member utilization and the process by which providers request and receive authorizations. We processed just under 2,000 authorizations, with 90% approved overall. Of these, 3% were for out-of-network services, typically for items unavailable within the network.

Cancer treatments, pulmonary testing, and gastroenterology services are the most frequently approved authorizations. In contrast, denials primarily involve chronic conditions, particularly cardiac issues and pulmonary testing. Additionally, some authorizations were denied for calcium scoring, deemed not medically necessary.

When we examined the appeals process, we found that approvals were granted mainly after we received additional information from the providers. Initially, these providers needed to submit the necessary clinical documentation, and it was only during the appeals process that they could provide it.

We will look at the real-time intercept data. This approach is central to Quantum’s philosophy; when members call in, we aim to engage them early in their healthcare journey. This early engagement is critical as it helps members make informed decisions to improve their healthcare outcomes and remain within network services.

In the last analysis, we engaged over 25,000 members through this real-time intercept strategy, focusing on the 50 days leading up to a claims trigger month, which occurs when we receive $1,000 in claims.

The top diagnoses where we were impacted ranged from cancer to cardiac issues. The average number of engagements per member was found to be between 3 and 3.7. We also tracked the authorizations we assisted with and recorded provider interactions, crucial to ensuring effective care.

This data shows how our members utilized their benefits before the trigger month, including services like emergency room visits, urgent care, and outpatient surgeries. It indicates our effectiveness in guiding members along their healthcare journey and redirecting them to the appropriate level of care.

This is a case study involving a member from the State of Connecticut. We will call her Jess, though that is not her real name. Jess was diagnosed with breast cancer in November. The diagnosis occurred after Quantum Health facilitated a provider's call for authorization and clarification regarding surgery benefits. This highlights the importance of Quantum Health's role in handling such calls.

During the real-time care coordination process in November, Jess interacted with the Care Coordinator nurse, who contacted her upon referral. The nurse introduced herself, outlined her role, and helped Jess understand her benefits. She provided resources related to cancer management and financial assistance and developed a treatment plan tailored for Jess. The nurse also scheduled regular follow-up communications to stay in touch.

After Jess had her MRI, it was determined that the cancer was stage one, with four affected areas. As a result, the provider recommended a double mastectomy. The Care Coordinator assisted Jess by ensuring her providers were in-network, outlining her co-pay amounts, and clarifying her benefits. This effort made Jess feel confident about any out-of-pocket costs she might face. It reassured her that all necessary authorizations were in place for her upcoming surgery, enabling her to focus solely on her treatment plan.

Following Jess's discharge from inpatient care, the Care Coordinator made a post-discharge call. This is standard practice for our nursing team to ensure members understand their after-visit summaries and discharge instructions. They also perform medication reconciliation and confirm that the member has the necessary support at home after leaving the hospital.

Before the initial claims were submitted, Jess thanked the nursing team for their support. She mentioned in a note that a book the nurse sent her, aimed at helping her navigate her cancer journey, was very thoughtful. She thanked them, saying everything was going well and appreciating their support during this challenging time. This reflects our commitment not only to the member but also to their entire family.

We'll review the utilization trends for the members and how Quantum Health can help impact those. In 2023, data showed over 94% compliance in appropriate utilization. Approximately 87% of members-maintained relationships with their primary care physicians, and in-network claims reached 99%. While there was an increase in urgent care visits compared to emergency room usage, it is more appropriate for members to utilize urgent care services. However, Quantum's involvement still allows for improvement in managing these trends. Telehealth usage also stands at 2%, offering another avenue for members to receive care efficiently.

Additionally, reviewing wasteful utilization is essential. The data reflects our ongoing efforts to lower inpatient days, representing how long members stay in hospitals. We conduct utilization reviews, monitoring transitions from inpatient care to suitable step-down facilities.

This presentation takes a deeper dive into the prevalence of specific health issues among your members. As we discussed earlier, mental health is one of the top areas where members are utilizing their benefits, with diagnoses such as depression and mood disorders, as well as anxiety disorders being the most common.

87% of your members engage with primary care providers (PCPs) in primary care utilization. The data from Quantum Health shows a positive trend in increasing PCP designations quarter over quarter. This insight underscores the importance of primary care utilization to ensure members access the appropriate specialists, which helps keep healthcare costs manageable by providing a central point of care.

Frequent ER visits are often not the best option for care. If a member visits the ER for the same condition three times within three months, we reach out to see what's going on and how we might redirect their care. We apply a similar approach if they visit the ER six times for different conditions within six months. Our goal is to reduce these frequent utilizers.

Let's look at the cost drivers. Certain conditions are significant contributors to overall healthcare costs. Cancer is consistently identified as a primary cost driver across our business. Other significant factors include health status encounters, which involve members receiving preventive exams from their primary care physicians, and mental health, which is also a key contributor. Cancer and mental health issues have shown to be consistent cost drivers across our member population.

Finally, we analyze chronic condition support. The top portion of this slide illustrates care gap closures among your members. For instance, members with asthma have a care adherence rate of 85.3%, surpassing the benchmark of 82.3%. This is a strong indicator of the effectiveness of your chronic condition programs and shows that members are actively engaging in their care plans.

In the lower section of the slide, we display how engaged members diagnosed with chronic conditions are with Quantum Health, particularly those who also have a primary care physician.

When examining clinical interventions, we can observe two distinct areas of information. We have 14,000 members eligible for clinical outreach. This group consists of individuals diagnosed

as at risk within a high-risk healthcare journey. Our population includes more than 100,000 members, but not all require clinical engagement.

Among those eligible for clinical outreach, 96% have overall engagement, while 37% are engaged clinically, slightly below our overall book of business.

We see members being admitted to the hospital and how we assist them in managing their care. We also have pre-admission conversations, where we reach out to those members. We successfully contacted 100% of this membership and engaged 59%. These pre-admission conversations ensure that members understand the reason for their hospital visit, adhere to their medications, and have coordinated safety plans for their discharge. Note that these pre-admission conversations specifically pertain to musculoskeletal surgeries, though they can also apply to outpatient procedures.

In the middle column, we discuss utilization management, which involves reviewing patients currently admitted to the hospital. We aim to ensure they remain hospitalized only as long as necessary. Nurses conduct reviews to assess the situation and recommend appropriate discharge, including transitioning to a step-down facility. Through this process, we were able to prevent 166 unnecessary inpatient days.

Lastly, we examine post-discharge conversations for any hospitalized member. We conducted a follow-up call and engaged 41% of these members.

Reducing readmission rates is crucial for keeping members out of the hospital. Our readmission rate within 30 days of discharge is 8.9%, lower than the Connecticut and national averages.

I want to highlight our collaboration with Nuvance and Yale New Haven Hospital. We are effectively sharing data related to high-risk members to enhance their engagement.

Although our partnership is newly established, it has already demonstrated promising results. We are proactively reaching out to members who may have yet to respond to previous phone calls or letters sent by Quantum by sharing relevant data. This approach aims to improve member engagement and increase their understanding of the NPS.

Currently, the Net Promoter Score for providers contacting Quantum is 86.

Question: In your comparatives, for instance, are you comparing July to July for the 16% increase in HEP compliance among members?

Answer: We have been reviewing the HEP program from the previous year, which is assessed based on the annual year rather than the benefit year. Therefore, if I'm not mistaken, we will be comparing data from January 2022 to December 2023 against that of 2024.

The 16% and 22% increases reflect the compliance rates for 2023 at this time last year, compared to the compliance rates for 2024 at this time this year. We are looking at where we stood with 2023 compliance for October last year.

Question: What's an AI-assisted provider call?

Answer: An AI-assisted provider called. This occurs when a provider contacts us to verify that authorization is on file without speaking to a care coordinator. They want to check the authorization.

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

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

The meeting was adjourned.