

Sustainable Healthcare Expenditures Workgroup
Meeting Minutes
October 20th, 2014

Welcome and Introductions

Committee members present:

Denise Honzel, Chair – Oregon Business Council
Kraig Anderson – Moda Health
Dean Andretta [phone] – Willamette Valley Community Health
William Ely [phone] – Kaiser Permanente
James Gajewski, MD – Oregon Medical Association
Glenn Johnson [phone] – PeaceHealth
Jesse Ellis O’Brien – OSPIRG
Greg Van Pelt [phone] – Oregon Health Leadership Council
Kelvin Wursten – Cambia Health Solutions

Not attending:

Peter Davidson – PacificSource Health Plans
Jon Hersen – Legacy Health
Meg Niemi – SEIU Local 49
William Olson – Providence Health & Services

Oregon Health Authority: Lori Coyner, Stacy DeLong, Veronica Guerra, Jonah Kushner, Jeff Winkley
Oregon Insurance Division: Gayle Woods
OHSU: John McConnell, PhD

Welcome & goals

Chair Denise Honzel convened the meeting and welcomed the group. Attendees introduced themselves and the agenda was reviewed.

Lori Coyner reminded members of the functions and tasks of the workgroup. Reiterated the letter from the Governor to the OHPB with areas of focus, one of which to examine total health care expenditures for the State. First step in this examination is to establish a methodology with the preference of utilizing existing data sources. Past meetings there had been discussion around whether to focus on cost to provide care vs. spending and after looking at the charge of the committee the methodology should be built around spending, as this is where much of existing data resides and to that end the workgroup has engaged Dr. John McConnell to create some preliminary estimates on expenditures with the existing data sources and then look to identify any data gaps instead of building a new data infrastructure from the ground up for this effort which would take considerable resources.

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Welcome & goals continued

Committee questions and discussion included:

- Is there another committee who is going to take the SHEW methodology and look to utilize it in some way? Answer: that has not been established at this time. The charge of the SHEW is to come up with a methodology and report it to the OHPB in December 2014. OHPB would then have to make decisions on what the next steps should be.

Update of the APAC Technical Advisory Group (TAG)

Jonah Kushner presented an update of the work of the APAC TAG, which will be a data source for calculating statewide expenditures. Presentation slides can be viewed here:

<http://www.oregon.gov/oha/srgdocs/APAC%20TAG%20Update%20for%20SHEW.pdf>

Committee questions and discussion included:

- What are the proposed 4 critical new fields looking to add to APAC?
 - Combine market segment and exchange field
 - ID plan identifier
 - Network flag – inside or outside
 - Plan medal tier – gold, silver, bronze
- Need to be clear in how the APAC data will be used, i.e. will it be used for rate review or overall appropriateness of rates? This would be a concern, for example with quality assurance issues of the data. Answer: One goal of the OID is to use the data for Oregon specific information regarding actuary value and also developing trend information instead of basing on national data. There can be direct comparisons with what is calculated in APAC versus what the carriers calculate themselves and utilize the TAG to investigate variability and other data integrity issues and to engage stakeholders to further effectiveness of the information.
- There is a concern of whether the acuity of a diagnosis can be accurately captured with all claims databases. Also issues on how to handle patients with multiple diagnoses that are beyond primary, 2nd or 3rd which also may not reflect accurately care of patient that was required by practitioners and in addition different requirements for different carriers can affect data collection efforts.
- What is TAGs current level of comfort with the data or how far along percentage-wise? Answer: don't really have a good sense at this point without a complete set of numbers to compare. Focal point currently is with building all of the appropriate fields that will be most useful going forward and validation efforts. Milliman has implemented a robust first level of validation and given insight on national trends in fields as well. TAG will provide these results with potential issues back to carriers when this process is complete.

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- Concern that much of the work that will be done will be based on FFS claims but ignores the fact of other patient care work that goes on that is not reflected on a claim, specifically with an integrated insurance-provider organization. Need to figure out the best way to work around this reality as this data set will look very different from other carriers. Answer: this will be part of the review process and should be addressed.
- Question regarding review dates for rate filings. Answer: 2015 review process will be the same as in the past but with the addition of having APAC as a comparison for testing.
- Concern with trending of data, if not going back and retrieving past year's information, trends won't be useful or meaningful for next few years.
- Question regarding of the proposed fields to add to APAC which will directly address the health expenditure calculation? Answer: There are cost and spending fields, but are not in the immediate critical adds, the workgroup will be updated on the progress as it occurs.
- Committee requested a link to the TAG website that will have the updated information and access to the proposed new data fields and timelines. This will be emailed to the group and is provided here:
<http://www.oregon.gov/oha/Pages/apac-tag.aspx>

Update of health care expenditure methodology

Dr. John McConnell presented an update of the expenditure methodology that he and his OHSU Center for Health Systems Effectiveness team has been formulating. Presentation slides can be viewed here: <http://www.oregon.gov/oha/srgdocs/SHEW%20methodology%20update.pdf>

Committee questions and discussion included:

- Cost versus acuity is where some may have an issue given one site can provide the same service at a lower cost than another depending on their delivery structure, i.e. private physician's office versus a hospital setting. Answer: The first run through on the calculation is a global cost and not a comparison of costs between provider entities. SHEW, at this juncture won't be involved in looking at provider level costs. Furthermore, the focus is on what is the overall spending on health care as opposed to provider costs. It is this spending aspect that SHEW is defining as expenditure that will be looking to measure.
- Question – are behavioral health claims are included in the data? Answer: behavioral health is and substance abuse claims however are not.
- Need to consider the source of the data, which would be APAC fed with a Medicaid fee schedule, which is not going to include or be representative of the actual cost related resources in patient care for those organizations such as Kaiser, not using FFS model. The data results could look strange and distort the overall picture. How this methodology is looking to mitigate this is with the re-pricing/standardizing based on the other claims in the system for those encounters that are captured by having \$0 attached to them.

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- The re-pricing strategy could be effective depending on how the expenditure numbers are used. If this is for rate review and rate filings then there would be concerns about non adjusted numbers or those that are different than individual carrier's numbers. Answer: this number won't be utilized in rate review and the group is charged with looking at total spend whereas the rate review is concerned with carrier level PMPMs. The idea is to have a methodology that can be tracked over time to identify trends. And at this juncture looking to have a plan to get to a total spend number with gaps identified that can be brought forth and worked through. Once this has been established take that to build a trend over time. Another interesting aspect that this methodology can also be useful in uncovering variations in utilization and variations in price. The changes in spending can be tracked back to those factors. In addition we also can also look at the different market segments and how they are affecting the total spend, for instance the impact of the new Medicaid enrollees with recent expansion.
- May see some glitches in data patterns with changes in CMS in regards to coding and global reimbursements and other Medicare/Medicaid rule changes that are currently under way and upcoming. Need to keep in mind these changes when tracking trends if different rules applied at different times and what that affect may have been on the data.
- Question - how are claims defined? Does this include deductibles and other patient out of pocket expenses? Answer – total spend would be a combination of health plan and patient portions together.
- Question – will we have a continuity of baseline that will be acknowledged or built into the model and will information be reliable year over year so that each year we are not changing how we are counting the spend, no longer comparing apples to apples. Answer – Ideally will be able to identify these changes and with transparency identify and acknowledge all changes that may occur to the process.
- It was expressed that the group is moving in the right direction in getting to a total spend PMPM and incorporating multiple sources including uninsured is valuable. Uninsured will be critical as this population decreases so will be interesting to see this impact on total expenditures.
- Question – how will pharmacy expense of by the uninsured be captured if they are paying cash? Answer – this will be difficult to pin down exactly, but estimations can be made through examining other data models and plugging in an amount.
- Question – how will be defining the Oregon population given there are those who live in bordering states that have Oregon employer paid insurance and/or receive care in Oregon. Or vice versa, Oregonians travelling to other states for care. Answer – John and Lori will investigate further and get back to the group. The key will be consistent. The group had consensus that it should be Oregon resident based.
- Question – Are we looking at in the claims allowed amount or paid amount? Answer – can see allowed (insurance + patient out of pocket), paid and out of pocket. For global spend, the thinking is to look at allowed. Can track both paid and allowed and see where the differences are, where the trends are going.
- Question – Does the spend calculation include administrative expenses? Answer – it does not, but that can be something that is added on. Possibly look at some methodologies for next meeting or be sure to include as a caveat as missing data.

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- Question – Is there any differential in above the line or below the line? Answer – that distinction was not made. Below the line would mean not allowed and therefore no spend? Non-covered claims? John will take a look and report back to the group.
- Question – how are capitated patients handled? Those should still generate an encounter claim so carriers should be submitting that data as well. For Medicaid, it is in carriers' best interest to submit these claims for their rate review so should be generating them.
- Question – how do we account for those insurance products where commercial members are balanced billed or referenced based pricing or if member wants to pay more than the allowed amount? Given the purpose of the group and what the group is trying to get is that what is collected may not be as important as what is spent. Too difficult to track down what all patients actually paid in its entirety. So the allowable amount may be good enough to get to the most important information. Cost burden on the consumer will still be captured. There are many other complexities to consider with paid given reinsurance, Medicare, subsidies, etc. Consensus is to use allowed for the expenditure but follow the other paid and billed aspects to see trends.

Wrap up and next steps

Next meeting is 11/7, 10:30am-12:30pm

- OHA Actuarial Services Unit will review John's numbers. Possibly have Milliman look at commercial PMPM.
- John will look to have updated Medicaid numbers and commercial numbers for the group.
- Follow up on those issues/questions that were brought forward:
 - Oregon resident/ boundary issues
 - Administrative costs
 - Below the line or unallowed claims
 - Allowed vs. paid vs. billed amounts – see what data is available that can be trended
 - Look for a comparator for reasonableness when the total spend number has been calculated. Oregon Business Council is using EcoNW to compare Oregon health care spending with other states, which may help as well, Denise will look to provide this information.

For more information on this workgroup, please visit <http://www.oregon.gov/oha/Pages/srg.aspx>