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Results from the Truven/Brandeis Analytic Services Contract

Presentation to the Green Mountain Care Board

July 30, 2015

Changing Policy Environment – Consistently Valuable Information

- So many policy options
  - Single payer?
  - All payer?
  - ACO?
  - Bundled payments?
  - Capitation?
- How to evaluate the effect of change?
  - Reliably
  - Affordably
  - Continuously
- Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)

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Goal for this Presentation

- Provide an overview of accomplishments from this project
- Highlight changes in Vermont healthcare, 2008-2012
  - Overall trends –
    - 2012 level of spending/enrollment
    - 2008-2012 average annual growth rates
  - Focus on selected aspects of the overall trend
  - Identify tools and methods that we developed in this contract that can be used as new data become available
- Suggest future enhancements to and uses of VHCURES data

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Truven/Brandeis Analytic Contract Has Multiple Tasks

- Data assembly and management
- Populations for analyses
- Health Accounts
- Special studies
  - Health spending drivers (decomposition) –
    - Commercial,
    - Medicaid,
    - Medicare
  - Market Analysis
  - Episodes of care
- All of these findings are based on VHCURES – We focus on 2012 because the 2013 Medicare data arrived too late for inclusion in this contract.
- Commitment to transparency – all the code necessary to generate similar results from updated data are delivered

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What did we learn about 2008-2012?

- By payer type:
  - Commercial population declined but spending per enrollee grew rapidly
    - Much of the growth was in hospital outpatient care
    - Much of the growth was in price – special study
    - Spending was in line with national norms
  - Medicaid
    - Rapid growth in eligibility
    - Spending per full benefit enrollee was flat
    - Vermont is more generous than many states
  - Medicare
    - Vermont residents appear healthier than other parts of the country
    - Hospital outpatient spending is a big driver
- By region:
  - Regional differences are modest but real
  - Burlington is big, a little healthier than average with a faster-than-most growth rate in spending – especially for commercial insurance

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VHCURES Vermont Covered Lives*, 2012 (N)

2012	Vermont Population	VHCURES	VHCURES Commercial	VHCURES Medicaid	VHCURES Medicare
All	626,011	562,474	307,256	144,227	110,992
Male	308,778	270,381	151,724	67,282	51,376
Female	317,233	292,093	155,532	76,945	59,616
Age					
<18	123,951	112,683	52,911	59,660	113
18-64	403,616	324,649	228,525	75,636	20,488
65+	98,444	125,142	25,821	8,930	90,391

*Covered lives are calculated by payer and equal the number of enrolled months divided by 12.

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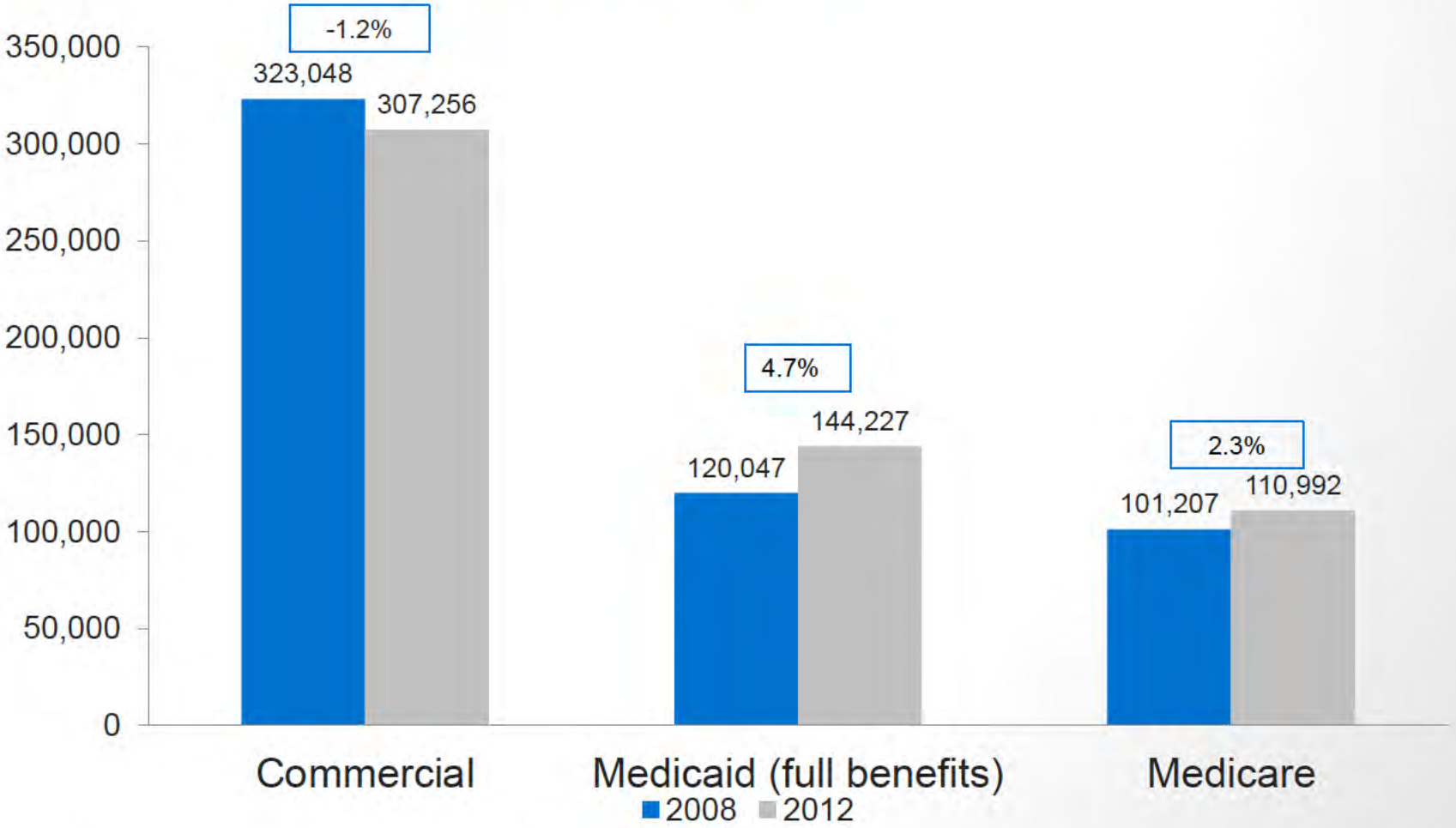
Enrollment* by Payer, 2008-2012



*Comprehensive medical enrollment weighted by months of insurance coverage. Enrollment is calculated by reporting payer. Medicare Advantage enrollees are counted in the commercial claims only and dual Medicare/Medicaid eligibles are included in both the Medicaid enrollment counts and in the Medicare enrollment counts. Prescription drug coverage (not shown) is measured separately. Average annual growth shown in the box.

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Two Views of Spending

- Allowed Amount
  - Payers can drive trends through their reimbursement policies – a key is setting the allowed payment amount on standard claim form
  - Includes payments by the insurer as well as out-of-pocket expenses
  - Secondary payers with coordination of benefits claims react to allowed amount and are not separately included in this view
- Health Accounts
  - Uses the paid amounts on claims
  - Includes secondary claims to capture all payments
- Per member per year (PMPY) results in this presentation use the Allowed Amount view

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Total Spending in Vermont, 2012 ($ millions)

2012	Health Accounts	Allowed Amount
Payer		
Commercial	1,435	1,591
Medicaid	1,135	1,101
Medicare	976	1,027
Provider		
Hospital	1,557	1,559
Physician	805	858
Rx	523	595
Other	661	708
Total	3,546	3,719
Average Growth 2008-2012	4.5%	4.0%

Health Accounts calculations are based on insurance payments as reported by primary and secondary payers. The column labeled Allowed Amount is the amount as reported by the primary payer.

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Populations for Analysis

- Identified five referral regions based on care seeking patterns in both the hospital discharge data (VUHDDS) and VHCURES

- Regions are:
    1. Greater Burlington (Burlington, Middlebury, St. Albans)
    2. Barre/Morrisville
    3. St. Johnsbury/Newport
    4. Upper Valley (White River Junction, Randolph, Brattleboro, Springfield)
    5. Rutland/Bennington

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Total Spending across Regions, 2012 ($ millions and %s)

2012	Vermont Total	RR1 Burlington	RR2 Barre	RR3 St. Jnbury/ Newport	RR4 Upper Valley	RR5 Rutland
Payer						
Commercial	$1,591	40.9%	14.1%	7.7%	20.8%	16.5%
Medicaid	1,101	35.5%	15.9%	10.4%	18.9%	19.3%
Medicare	1,027	32.5%	13.5%	10.0%	22.5%	21.6%
Provider						
Hospital	1,559	34.8%	14.1%	9.4%	22.7%	18.9%
Physician	858	42.2%	14.0%	8.7%	18.2%	17.0%
Rx	594	37.2%	13.6%	9.2%	21.0%	19.1%
Other	708	35.3%	16.6%	8.9%	19.0%	20.2%
Total	3,719	37.0%	14.5%	9.1%	20.7%	18.7%

Note: Calculations are allowed amount as reported by the primary payer only. Region is based on residence of the patient not location of provider.

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Trends in Per Member Per Year (PMPY) Spending 2008-2012

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PMPY Spending across Regions, 2012 ($)

2012	Vermont Total	RR1 Burlington	RR2 Barre	RR3 St. Jnbury/ Newport	RR4 Upper Valley	RR5 Rutland
Payer						
Commercial	5,178	4,996	4,789	5,425	5,456	5,593
Medicaid*	7,554	7,885	8,148	6,633	7,041	7,620
Medicare	9,251	9,083	8,663	8,865	9,206	10,224
Provider						
Hospital	2,770	2,509	2,614	2,877	3,082	3,067
Physician	1,525	1,675	1,425	1,454	1,358	1,512
Rx	1,042	1,012	944	1,045	1,069	1,160
Other	1,254	1,153	1,389	1,232	1,166	1,479
Total	6,591	6,348	6,373	6,607	6,675	7,217

*Medicaid PMPY excludes expenditures from limited benefit plans

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PMPY Average Percent Change Across Regions, 2008-12 (%)

% Change in PMPY Spending	Vermont Total	RR1 Burlington	RR2 Barre	RR3 St. Jnbury/ Newport	RR4 Upper Valley	RR5 Rutland
Payer						
Commercial	4.5%	4.4%	4.3%	4.5%	4.9%	4.3%
Medicaid*	0.7%	1.1%	0.0%	1.1%	1.4%	0.0%
Medicare	1.6%	1.4%	1.1%	1.6%	1.5%	2.6%
Provider						
Hospital	4.2%	4.2%	4.5%	3.4%	4.3%	4.6%
Physician	1.7%	2.9%	-2.0%	1.0%	2.5%	1.6%
Rx	3.4%	4.5%	2.8%	3.7%	2.4%	2.9%
Other	2.7%	1.5%	6.1%	2.6%	3.5%	1.9%
Total	3.2%	3.4%	2.9%	2.8%	3.4%	3.1%

*Medicaid PMPY excludes expenditures from limited benefit plans

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Profiling Regions by Socio-demographics and Risk, 2012

Resident region	Total Pop*	Percent greater than 65 years old*	Percent of Households Below Poverty Rate*	Average risk#	PMPY Spending per risk unit 1.0
RR1 Burlington	253,430	11.8%	11.2%	0.932	$5,162
RR2 Barre, Morrisville	89,464	14.6%	10.3%	0.966	$5,125
RR3 St Johnsbury, Newport	54,935	16.9%	15.7%	1.031	$4,958
RR4 Upper Valley	123,867	16.7%	11.9%	1.027	$5,174
RR5 Rutland, Bennington	102,414	17.4%	12.5%	1.136	$4,959
Totals	625,579	14.6%	11.8%	1.000	$5,101

Source: * = Census Bureau, # = VHCURES based estimates

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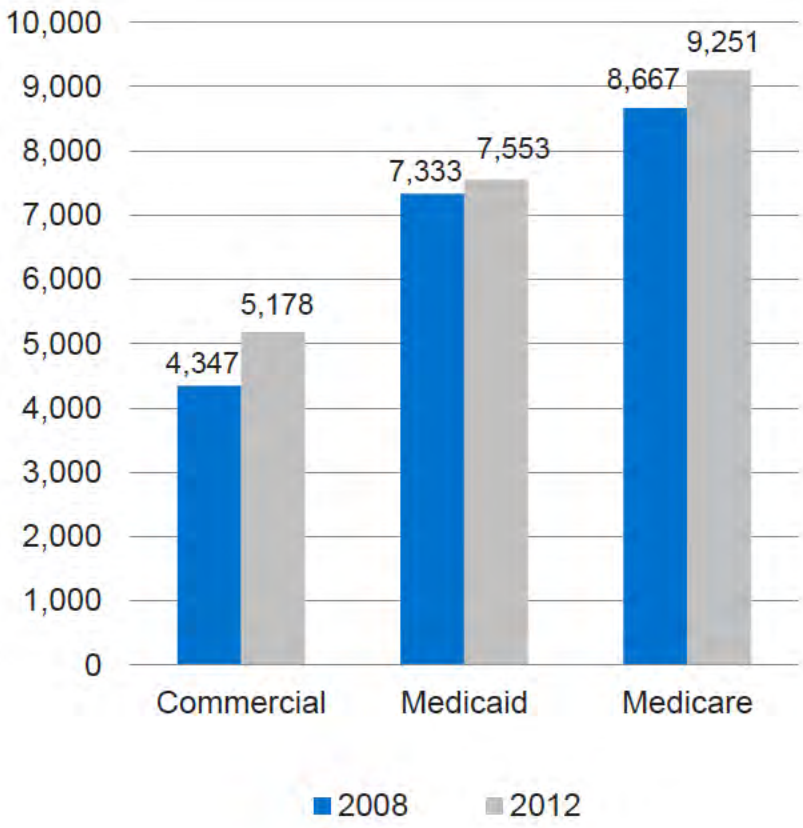
Vermont PMPY by Payer, 2008-2012



- **Commercial has largest increase from 2008 to 2012**
- **Medicaid spending flat**
- **Medicare has a slight increase**

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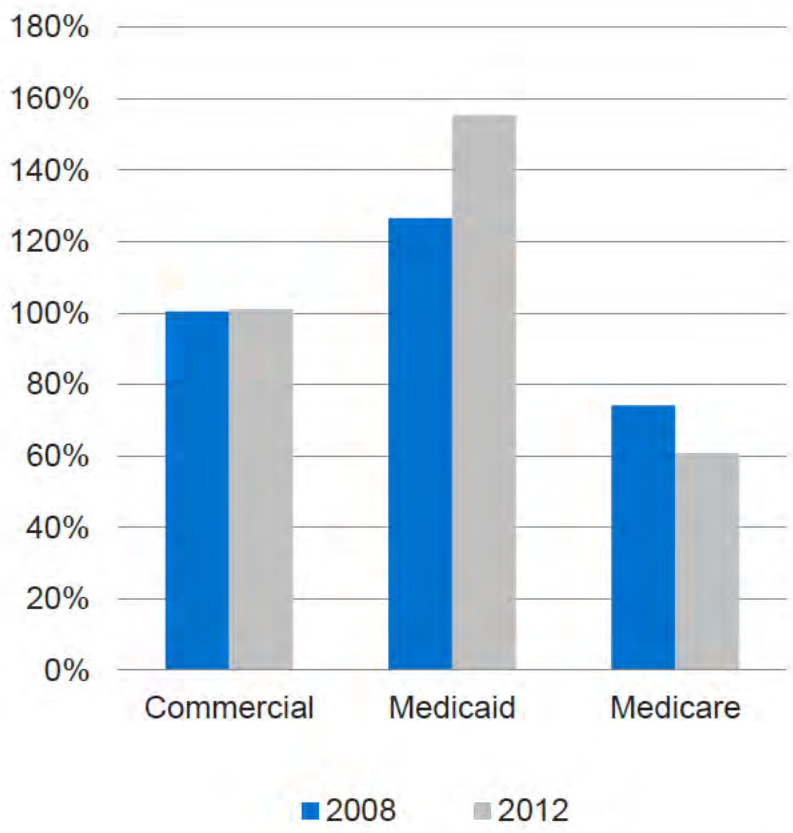
Vermont PMPY Compared to MarketScan* – 2008-2012



- **Commercial remains virtually at national average**
- **Medicaid spending is higher than comparison states and increases in 2012**
- **Medicare is less costly than national total in 2008 and decreases in 2012**

*The Truven Health MarketScan data system has nationwide enrollment and claims data for commercial, Medicaid and Medicare populations.

Kaiser Family Foundation 2012 US Medicaid Full Benefits PMPY= $6,502 – not shown in graph.

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How Do The Parts Of The Project Fit Together?

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Special Studies Purpose

- Explain above high level trends
- Focus was informed by discussions with GMCB and staff based on health care reform long term goals
- Designed to provide building blocks to support population-based health system and payment reform
- Recommendations for using VHCURES to support moving toward all payer
- Examples of research
  - Revisiting regional markets useful for reforms (e.g., ACO)
  - Measuring price variation with standardized metrics across payers, markets, and providers, necessary for designing reforms
  - Identify drivers of health spending necessary for any cost containment efforts
  - Provide interactive tool for simulations highlighting savings potential

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Special Studies Overview

- Goals:
  - Present a detailed picture of the Vermont healthcare landscape and trends
  - Monitor reform and support policy decisions
- Profiling regions and populations:
  - Basis for addressing population health risk in analytic groupings
- Decomposition studies:
  - How much spending growth is price, how much quantity or case mix?
  - How does this differ by payer and population and level of care?
- Market analysis dashboard:
  - What are patterns of care across regions in Vermont, and the cost impact?
  - Where are the higher cost services and providers, and what appropriate cost efficiencies can be achieved?
- Cross-payer analyses
  - Within each study; shows differences in levels of spending per service, and differences in patterns
  - Recommendations for using VHCURES to support moving toward all payer

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Vermont Health Spending Drivers (Decomposition), 2008-2012

- Goal: Monitor trends in price and utilization for each payer and region. Understand price differences, adjusting for other factors
- Overview of findings
  - Price drives health spending growth, more than offset utilization decreases
  - Medicaid inpatient price most rapid due to reimbursement changes - still below commercial and Medicare
  - Medicare inpatient pure price grew less than 2% annually, commercial over 4%
  - Commercial hospitalization price levels and growth greater for out-of-state care (DH and others)
  - For outpatient facility care, price and utilization services grew fastest (commercial and Medicaid)

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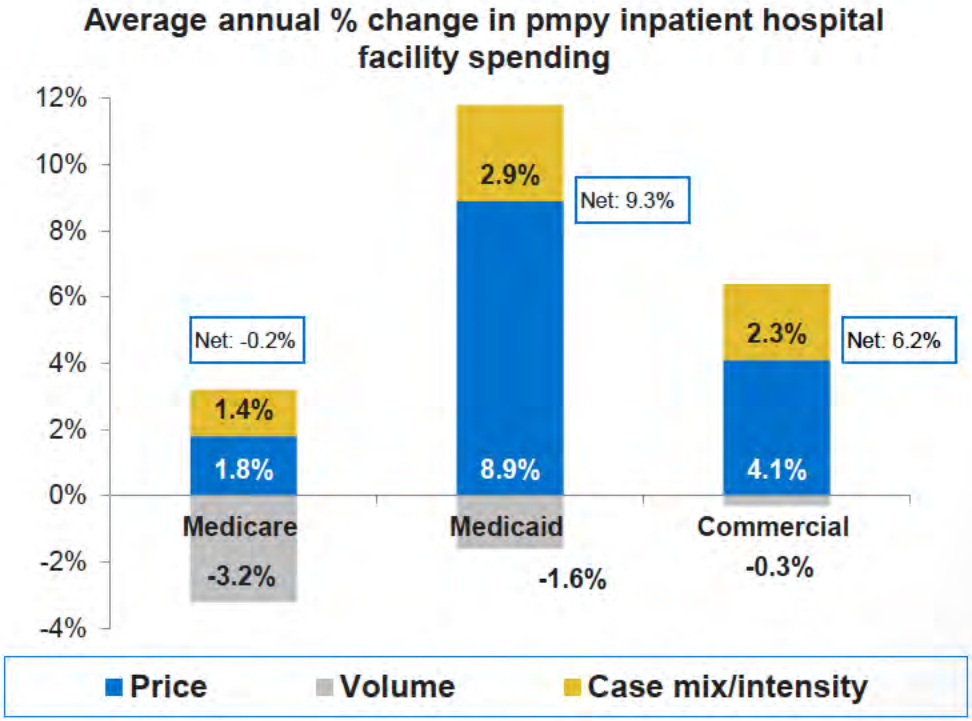
Hospital inpatient facility care: how much spending growth is price, how much quantity and how much case mix?



- Price drives spending growth; Medicare slowest
- Decrease in hospitalization rates for all payers, made up by price
- Changing reimbursement in Medicaid increased overall price per admission

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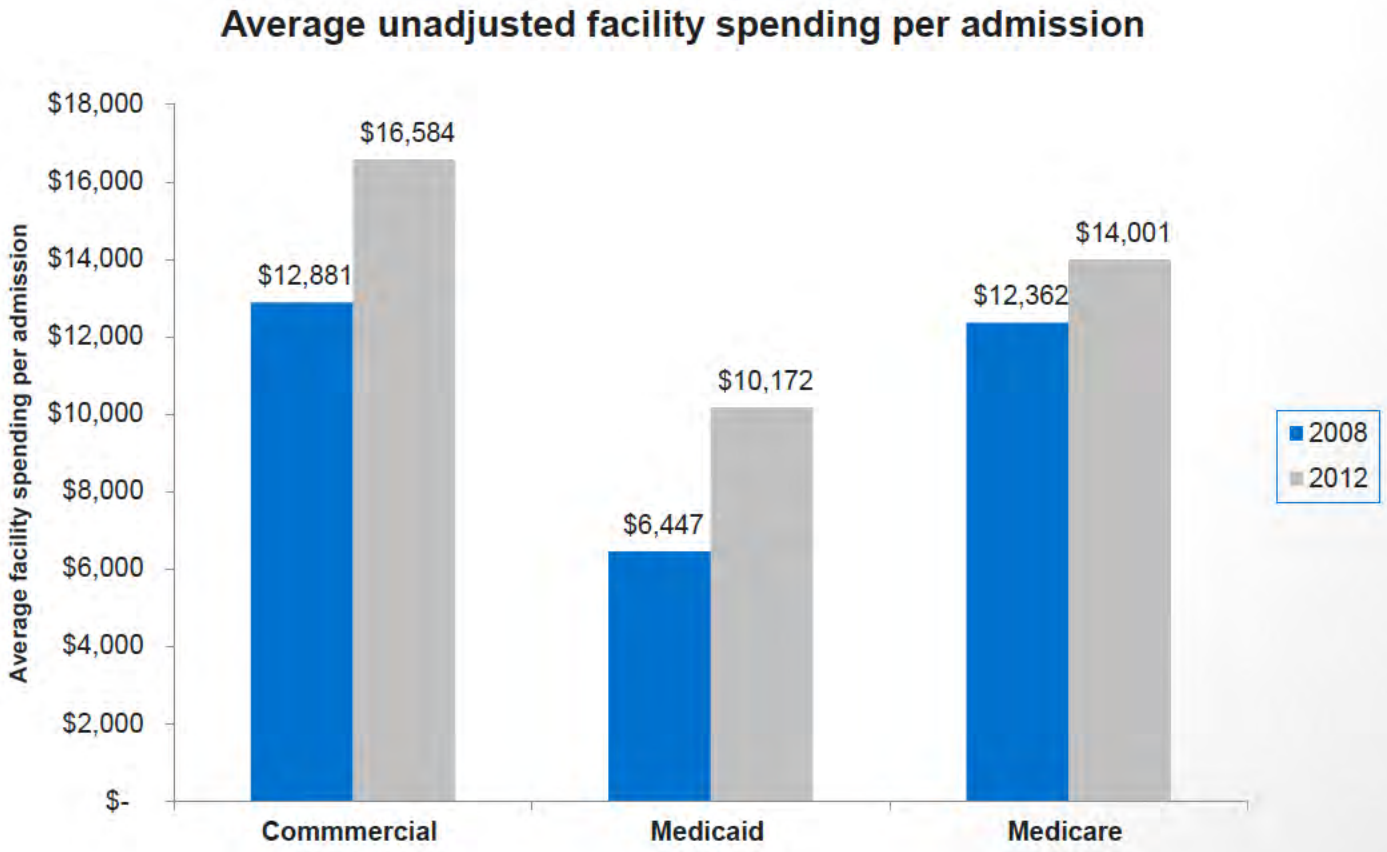
Inpatient hospital care spending and growth per-admission: how does it differ by payer?



Also see market analysis

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Understanding cross-payer differences in inpatient care: How does price level and growth differ, after adjusting for resource use?

	$ per DRG resource weight unit					
Payer	2008	2009	2010	2011	2012	Average annual growth
Commercial	$10,561	$11,547	$12,106	$12,256	**$12,419**	4.1%
Medicaid	$5,723	$6,822	$7,530	$8,079	**$8,039**	8.9%
Medicare	$8,297	$8,403	$8,735	$8,901	**$8,861**	1.7%

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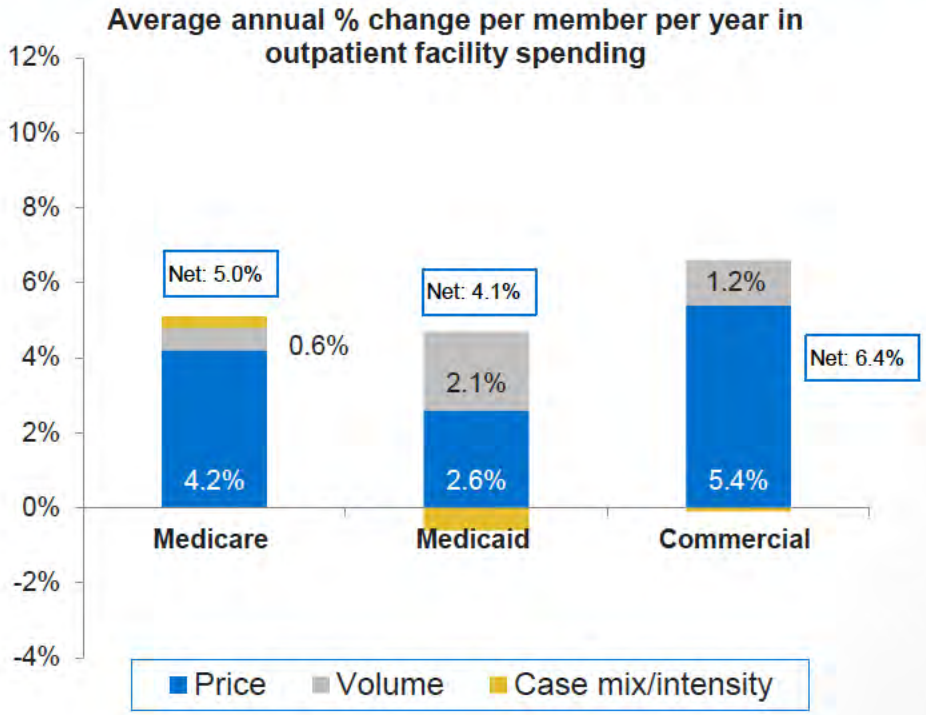
Outpatient facility care: how much spending growth is price, how much quantity and how much case mix?



- Price drives spending growth; Medicaid slowest price growth
- Volume per member per year is increasing
- Units less easily compared across payer

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Understanding price variation key to all payer reform: Market analysis dashboard will facilitate study of price variation

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Market analysis

- Goal: understanding nature and extent of price variation
  - Interactive tool to examine market patterns by region, and opportunities for savings
- Data: VHCURES 2011 all payers
  - 81 high cost high priority DRGs
  - Acute and post acute spending
- Examples of policy questions
  - How much hospital inpatient care (and what type) is provided locally, and how much out of region and state?
  - What are the cost implications?
  - Are patients seeking care out of area care at higher cost sicker?
  - Are there opportunities for savings in travel or cost?

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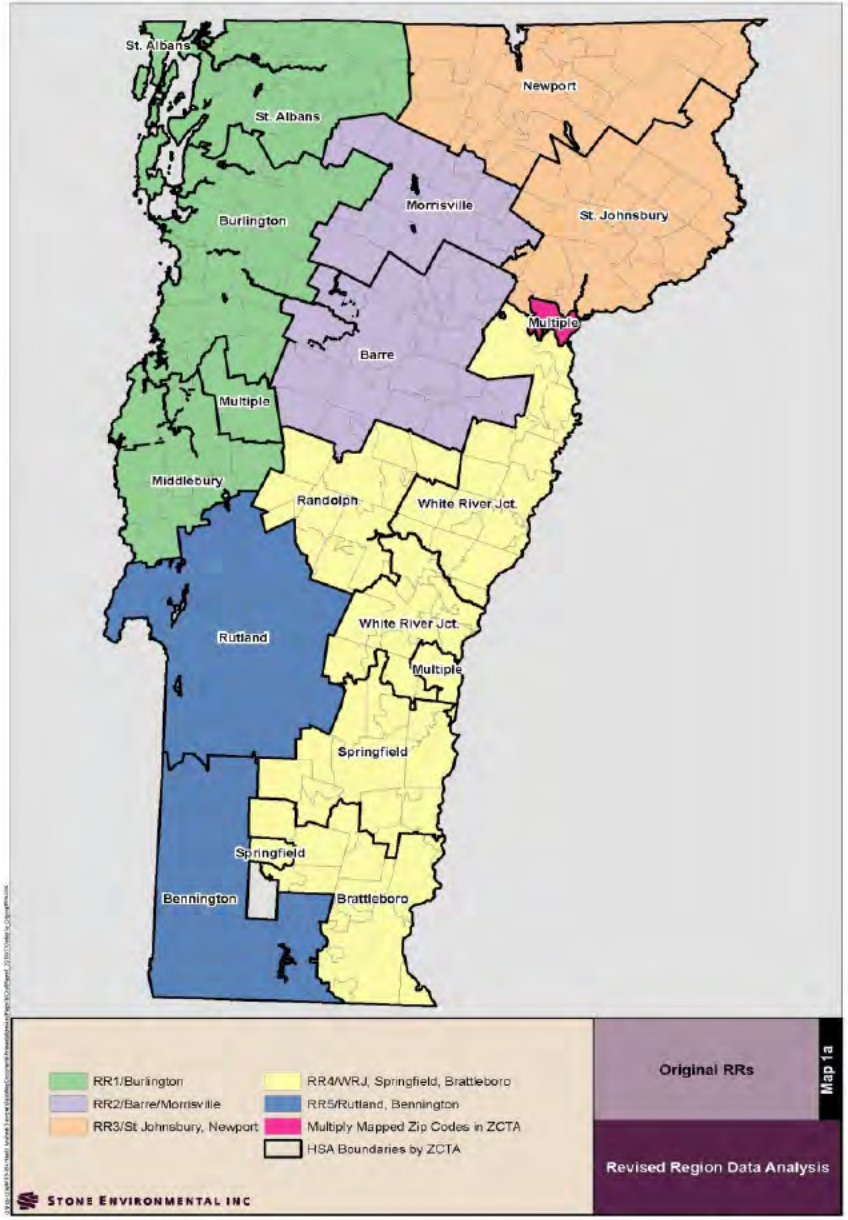
Market analysis population regions



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Market Analysis Report: Overview of findings

- Most patients seek inpatient care within local area
- Out-of-area and out-of-state spending not always associated with higher risk
- There is considerable excess spending that is not accounted for by differences in patient risk profiles.
  - The opportunities (high cost DRGs) differ by payer
  - Medicaid has the lowest amount of excess spending
- Potential savings inpatient acute care - $25 million/year
  - Maternity care without complications: $1.2 million annually
- Use dashboard to further assess differences across payer by DRG, to inform a model by which the price variation across payers are reduced

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Market analysis example of origin – destination matrix

Origin _RR	Destination – number of admissions – all payers, high priority conditions, 2011								
	In-RR1	In-RR2	In-RR3	In-RR4	In-RR5	DH	NH-MA-NY	Other	All
RR1:Burlington	**89%**	2%	0%	3%	1%	1%	1%	2%	100%
RR2:Barre	21%	**56%**	1%	10%	1%	8%	1%	2%	100%
RR3:St. J/New	5%	4%	**59%**	3%	0%	17%	10%	1%	100%
RR4:WRJ	2%	2%	0%	**46%**	3%	34%	11%	2%	100%
RR5:Rutland	8%	0%	0%	8%	**69%**	7%	6%	2%	100%
All RR regions	37%	9%	6%	14%	15%	12%	5%	2%	100%

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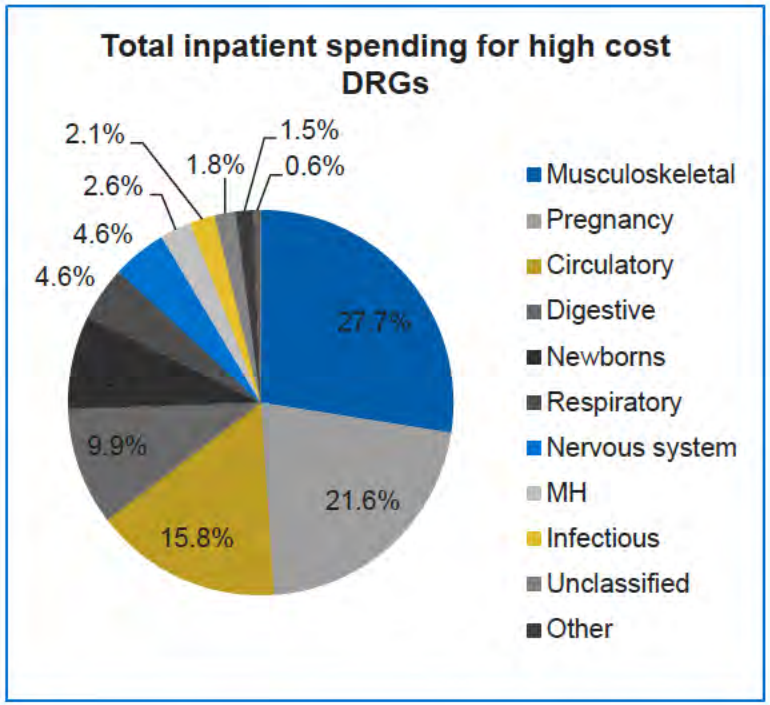
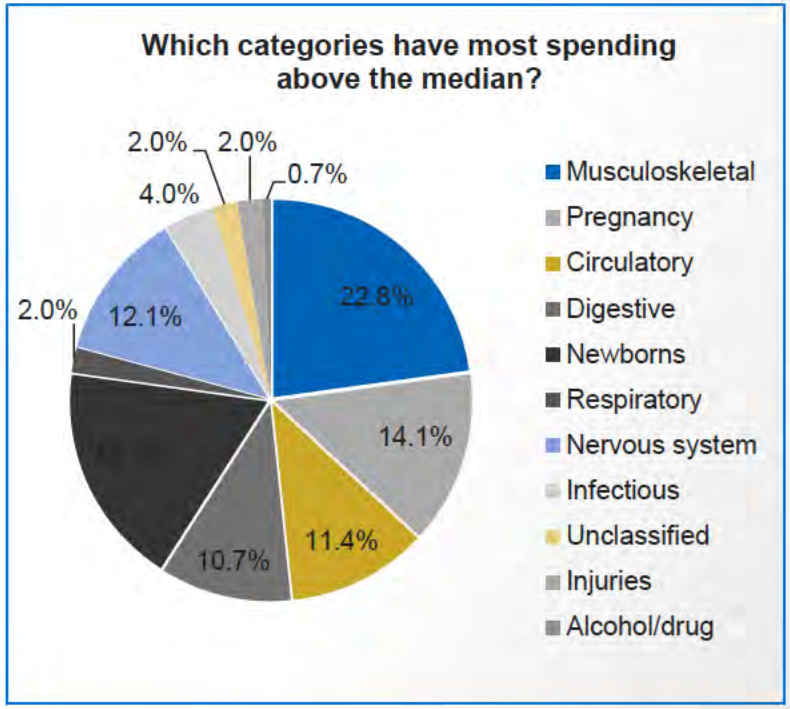
Market analysis – overview of variation in commercial spending by major diagnostic category and opportunity for savings





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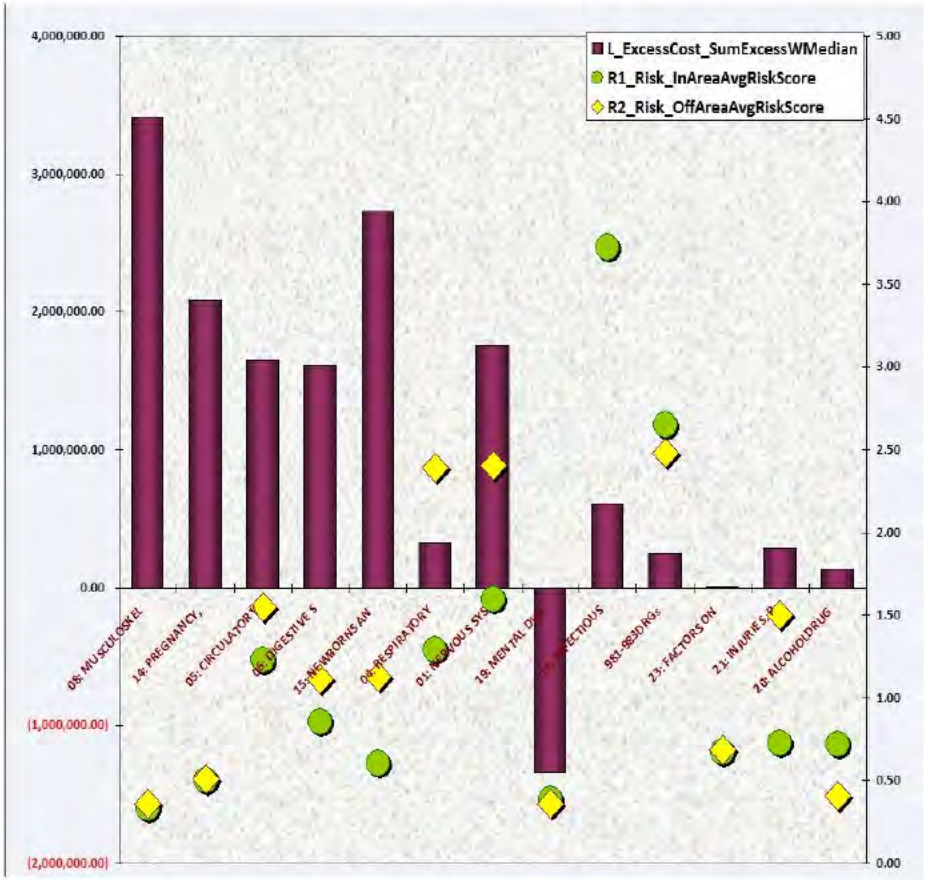
Market analysis example: Are commercially insured patients seeking out-of-area and out-of-state care sicker, justifying travel and spending?



Yellow diamond higher = out-of-area patients are sicker

- Total higher-than-average amount greatest for musculoskeletal, newborns, least for mental disease
- Individuals leaving local area for service are often no sicker than patients staying in local area

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Dashboard example: Spending variation for DRG 470 (Major joint replacement without major complications)

Payer	Number of admissions	Total acute spending on DRG*	Total deviation from dominant provider (UVMMC) median
Commercial	711	$24.1 million	$4.1 million
Medicaid	145	$2.5 million	$20,000
Medicare	1157	$25.8 million	$1.8 million
Total all payers	2013	$52.4 million	$5.9 million

- Medicaid has few admissions, and little savings opportunity
- The greatest (+) deviation from median is commercial
- Can be analyzed by hospital and region (where is there most deviation from median), and by risk adjustment

*DRG has been standardized across time periods and payer

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Methodological contributions in using VHCURES to address policy questions (1)

- Populations
  - Testing of local markets for monitoring, and applying risk measures for reform
  - Link with census data for social determinants mapping
- Risk adjustment
  - Use of accepted techniques to risk adjust populations across payer
  - Risk adjustment across payers specific to hospital admissions
  - Observed vs expected for inpatient services
- Inpatient care
  - Measure of acute vs post-acute spending
  - Identify choice/ no choice admission types
  - Meaningful units for measuring resource use across payer
- Outpatient care
  - Understanding how Medicaid categories of service can be used (GHCA)
  - Standard “revenue code”-based measures across payer

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Methodological contributions in using VHCURES to address policy questions (2)

- Episodes
  - Method tested to change unit of analysis from patients and services to episodes across service type for attributing providers
  - Used VHCURES to test approach (applied consistent metrics to Medicaid and commercial)
- "What if" interactive tool (dashboard)
- **All payer building blocks: Using VHCURES to understand meaningful differences in population risk, price and utilization across payers**

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Next steps for using VHCURES for analytics

- Design regular reporting templates for monitoring and posting
  - Create dynamic dashboard more available to non-VHCURES users
  - These templates should take advantage of the more timely data you get from Commercial payers and Medicaid
- Plan for prioritizing special studies
- Updating / addressing VHCURES limitations
- Continue to develop sub-markets to understand patterns (eg., mhsa)
- Leverage decomposition work to simulate cross-payer pricing in meaningful units

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Summary

- The results of this contract provide insight into aspects of Vermont's history. We did focus on 2008-2012 and it is 2015.
- VHCURES is an ongoing data collection effort and our contract provides a set of tools that you can apply to the new data, including procedures to:
  - Examine spending trends by payer, provider, and setting
  - Examine the healthcare landscape in parts of the state that are big enough to generate reliable results but homogeneous enough to track separately
  - Analyze the influence of changes in price, utilization and intensity on spending trends
  - Analyze the potential impact of changing patient care seeking behavior
- CMS may improve the timeliness of the Medicare data which is essential to understanding the situation of Vermont providers. But even without more timely CMS data, many of the procedures we have shared could be used with the more timely commercial and Medicaid data to good effect.

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Recommendations

- All health policy questions are about some combination of access, cost, or quality –
  - VHCURES can provide information on all of these dimensions.
  - Our work focused mostly on cost but the information is organized to support work in each of these dimensions.
  - There is much more to be done looking at social determinants of health and ways to maximize the impact of public dollars being spent. The referral regions provide a good framework for that work.
- As you think about all-payer policy options it will remain critical to understand the individual dynamics of commercial, Medicaid, and Medicare. Their interactions can be addressed through simulation analyses and other techniques.

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Appendix -- Task Overview

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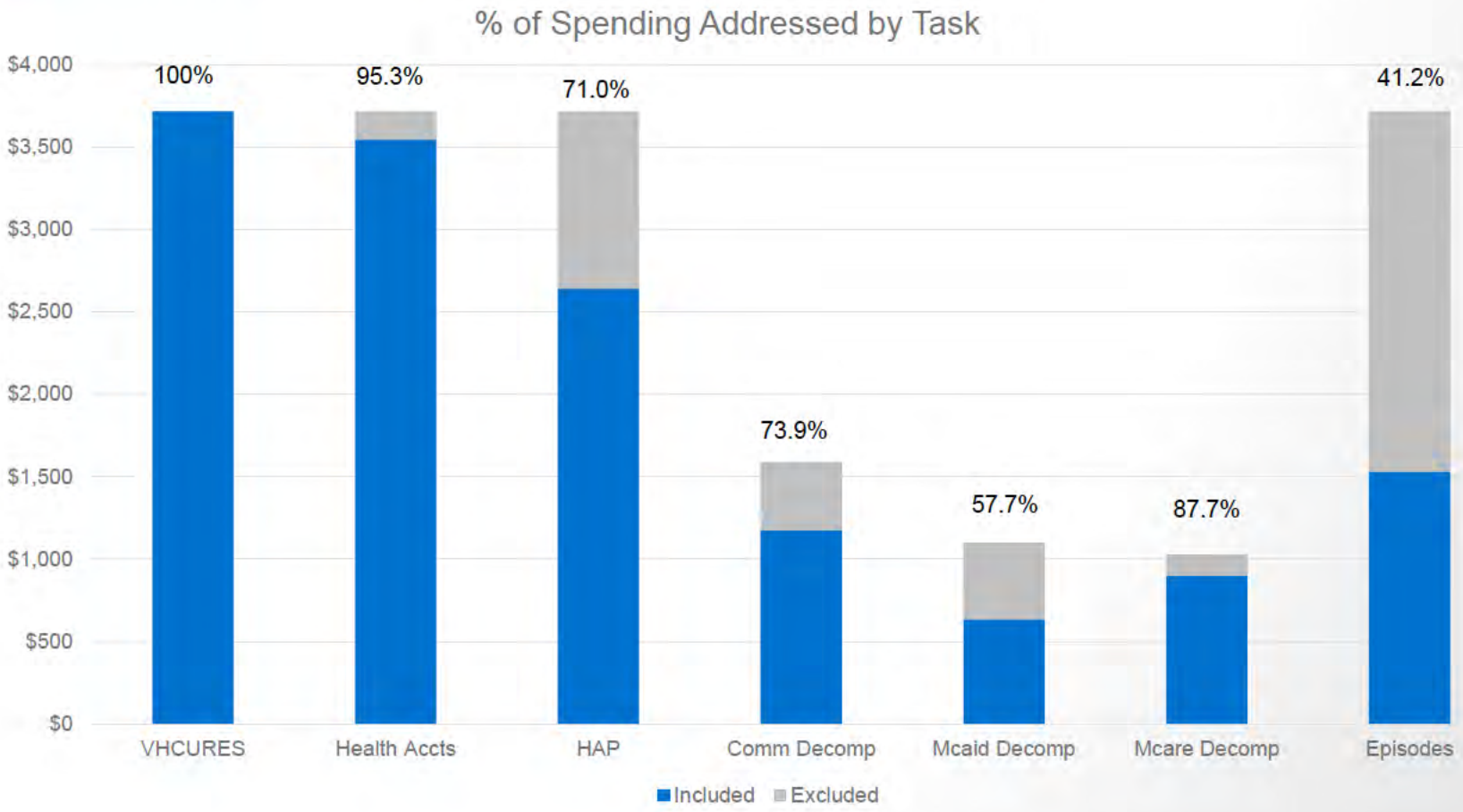
Special Studies Narrow the Question to get a Reliable Answer: Total Spending Compared to Task Coverage, 2012 ($millions)



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Task 1 – Analytic File Creation and Reporting

Title:	Analytic File Creation / Allowed Amount Quarterly Reports
Goal:	To change the VHCURES relational database into an analytic file which would easily allow comparison of people and providers over time for subsequent analyses.
Input:	VHCURES commercial, Medicaid, Medicare (medical and rx)
Criteria:	Exclude non-Vermont residents Exclude denied claims Exclude secondary payer claims Exclude behavioral health plan enrollees from commercial Exclude limited benefit plan enrollees and expenses from Medicaid Exclude Medicare Advantage enrollees from Medicare
2008 Total Expenditures:	$3,172 million
2012 Total Expenditures:	$3,719 million
Deliverables:	Truven VHCURES analytic research data files PMPY Reports by payer and service site

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Task 2 – Health Analysis Populations

Title: Health Analysis Populations

Goal: To construct and evaluate the geographic areas (health referral regions) to best define discrete regions for purposes of healthcare analyses.

Input: VHUDDS
Truven VHCURES analytic research data files (medical only)

Criteria: Age < 65 (commercial, Medicaid) and >65 (Medicare)
Exclude dual Medicare / Medicaid eligibles

2008 Total Expenditures: $1,471 million

2012 Total Expenditures: $2,641 million

Deliverables: Crosswalk from zipcode to revised health referral region
HAP-1 report proposing revised regions using inpatient claims
HAP-2 report evaluating proposed regions with APCD

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Task 3 – Health Accounts

Title: State Health Accounts

Goal: Assess the total expenditures spent on health care using the standard health accounts methodology for comparison to international, national and state benchmarks

Input: Truven VHCURES analytic research data files (medical and rx)

Inclusion: Include secondary payers
Include limited benefit plan expenditures from Medicaid
Include Medicare Advantage in Medicare

2008 Total Expenditures: $2,973 million

2012 Total Expenditures: $3,546 million

Deliverables: Truven Health Accounts workbooks
Health accounts report

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Task 4 – Episodes of Care

Title:	Episodes of Care
Goal:	Assess the healthcare experience using episodes of care for commercial and Medicaid population.
Input:	Truven VHCURES analytic research data files for Medicaid and commercial claims (medical only)
Criteria:	Require claims and enrollment during month (VHCURES) Exclude dual Medicare / Medicaid eligibles
2008 Total Expenditures:	$1,509 million
2012 Total Expenditures:	$1,532 million
Deliverables:	Episodes of care report

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Task 5 – Decomposition of Health Expense 2008-2012

Title: Decomposition of Health Expense 2008-2012

Goal: To evaluate the drivers of inpatient and outpatient medical spending. Specifically, were changes in price from 2008 to 2012 due to a rise in the complexity of services provided, a sicker population or price increases.

Input: Truven VHCURES analytic research data files (medical only)

Criteria: Age < 65 (commercial, Medicaid) and >65 (Medicare)
Exclude dual Medicare / Medicaid eligibles
Exclude GHCA from Medicaid expenditures (professional services)

2008 Total Expenditures: $2,281 million
$1,041 commercial, $487 Medicaid, $761 Medicare

2012 Total Expenditures: $2,711million
$1,175 commercial, $635 Medicaid, $901 Medicare

Deliverables: Commercial 2008-2012 decomposition report
Medicaid 2008-2012 decomposition report
Medicare 2008-2012 decomposition report

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Task 6 – Market Analysis 2011

Title:	Market Analysis of Health Spending
Goal:	Interactive tool to examine market patterns, utilization and spending by region, and opportunities for savings in the inpatient setting
Input:	Truven VHCURES analytic research data files (medical only)
Criteria:	Age < 65 (commercial, Medicaid) and >65 (Medicare) Exclude dual Medicare / Medicaid eligibles Inpatient services only
2011 Total Expenditures:	$524 million $159 commercial, $265 Medicaid, $101 Medicare
Deliverables:	Market Analysis I Report Market Analysis II Excel Analytic Tool Market Analysis II Report

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Health care spending growth patterns: comparing across payers

	Average annual change in:					
Service	Price	Quantity	Mix / intensity	Price / resident	Enrollment	Annual total program spend
Commercial						
Inpatient	4.1%	-0.3%	2.3%	6.2%	-1.7%	4.3%
Outpatient facility	5.4%	1.2%	-0.1%	6.4%	-1.7%	4.6%
Professional	2.9%	0.6%	-0.2%	2.2%	-1.7%	0.5%
Medicaid (non-duals)						
Inpatient	8.9%	-1.6%	2.9%	10.2%	5.0%	15.8%
Outpatient facility	2.6%	2.1%	-0.6%	4.1%	5.0%	9.3%
Professional*	-1.1%	1.2%	0.1%	0.2%	5.0%	5.2%
Medicare (includes duals)						
Inpatient	1.8%	-3.2%	1.4%	-0.2%	2.3%	2.1%
Outpatient facility	4.2%	0.6%	0.3%	5.0%	2.3%	7.4%
Professional	1.6%	-1.2%	0.8%	1.2%	2.3%	3.4%

* Medicaid analysis excludes government health care activities, limiting interpretation of professional services

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