

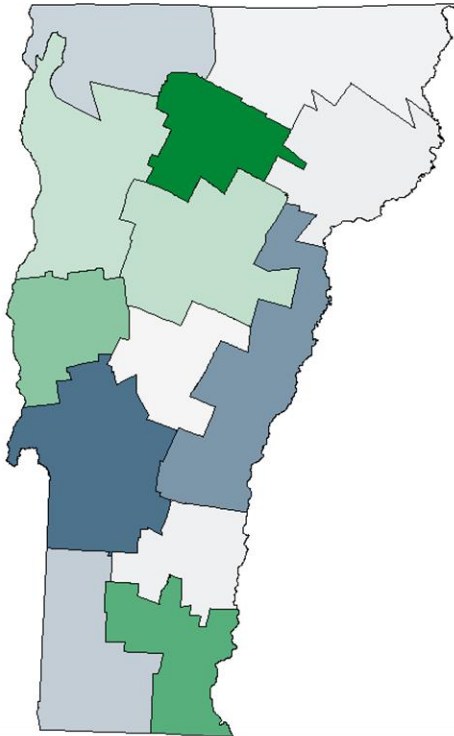
Office Visits Over Time

2012 - 2016

Green Mountain Care Board Meeting

September 12, 2018

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Background

- Are outpatient visit utilization rates changing over time?
- Are the lengths of visits changing?
- How are prices changing over time (insurance paid and member responsibility)?
- Do observed changes differ based on the type of payer?

Background

- ❑ Evaluation and management code for office or other outpatient visits
 - CPT Codes: 99201 – 99205 (new patients)
99211 – 99215 (established patients)
G0463 (Medicare patients, beginning in 2014)

- ❑ Decomposed into three (3) main components
 - Utilization (office visits per member)
 - Price (insurer paid and member responsibility)
 - Intensity (typical visit length)

- ❑ Payer Type
 - Medicare
 - Medicaid
 - Medicare Advantage
 - Fully Insured
 - Self - Funded

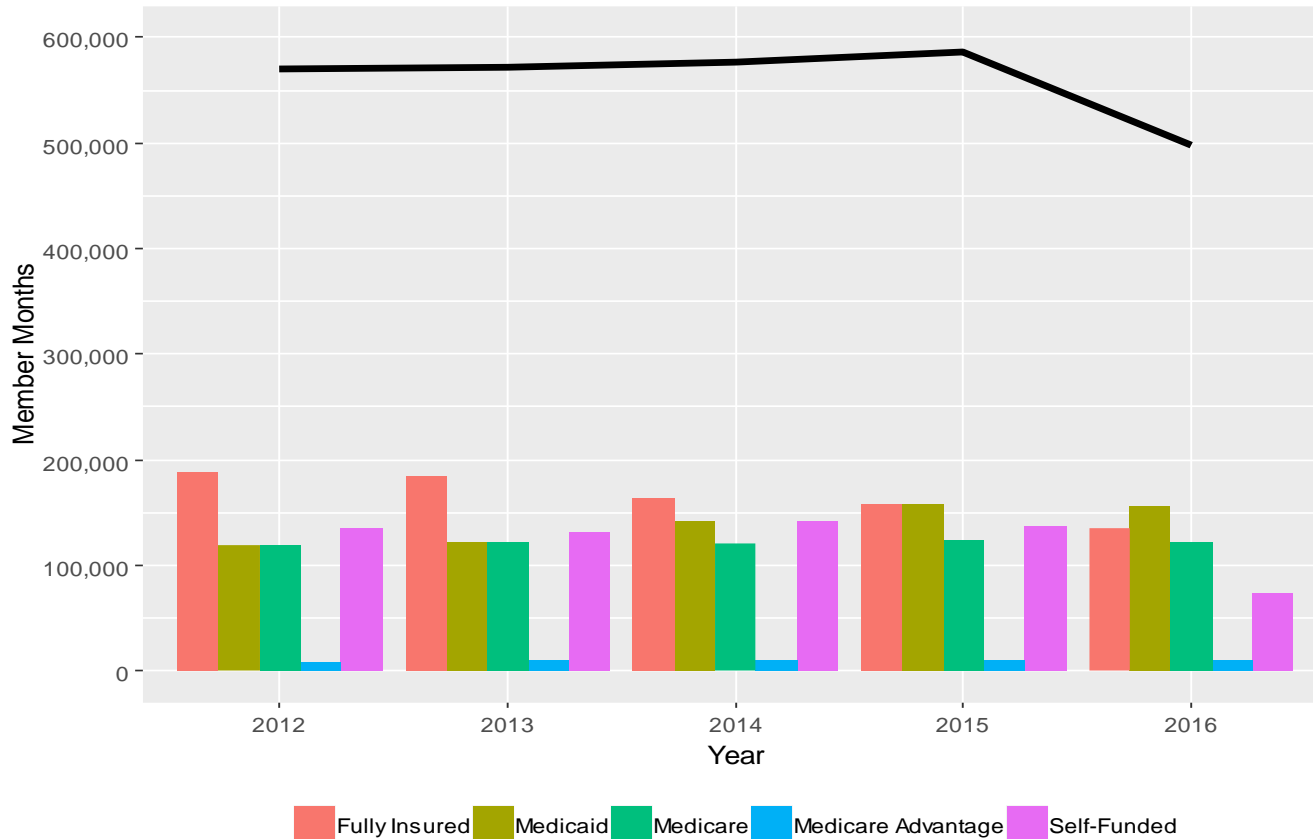
Background - Population

☐ Average membership in VHCURES

Payer	Year				
	2012	2013	2014	2015	2016
Medicare	118,781	121,787	120,522	123,966	122,591
Medicare Advantage	8,797	9,655	9,404	9,775	10,361
Medicaid	118,555	122,726	141,262	157,767	155,204
Fully Insured	188,453	185,439	164,450	157,776	134,634
Self - Funded	135,652	131,654	140,798	136,291	74,453
Total	570,238	571,261	576,436	585,575	497,243

Background - Population

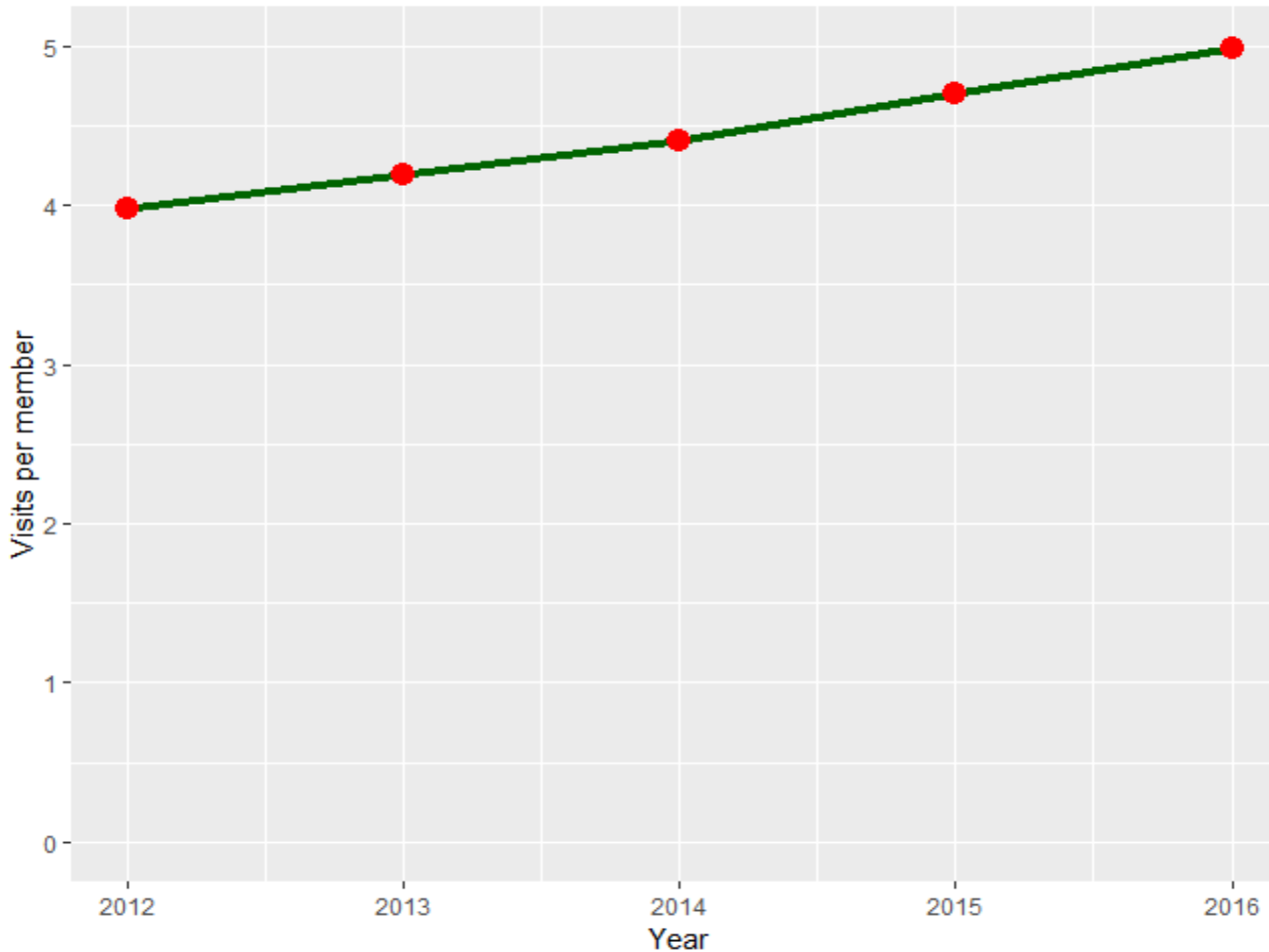
☐ Average membership in VHCURES



- Slight increase in total population from 2012 to 2015, with most members having Fully Insured Plans or Medicaid.
- Decline in total population was observed in 2016 due to the *Gobeille* decision (about 46% of members with Self - Funded plans no longer submit claims).

Office visits (2012 - 2016)

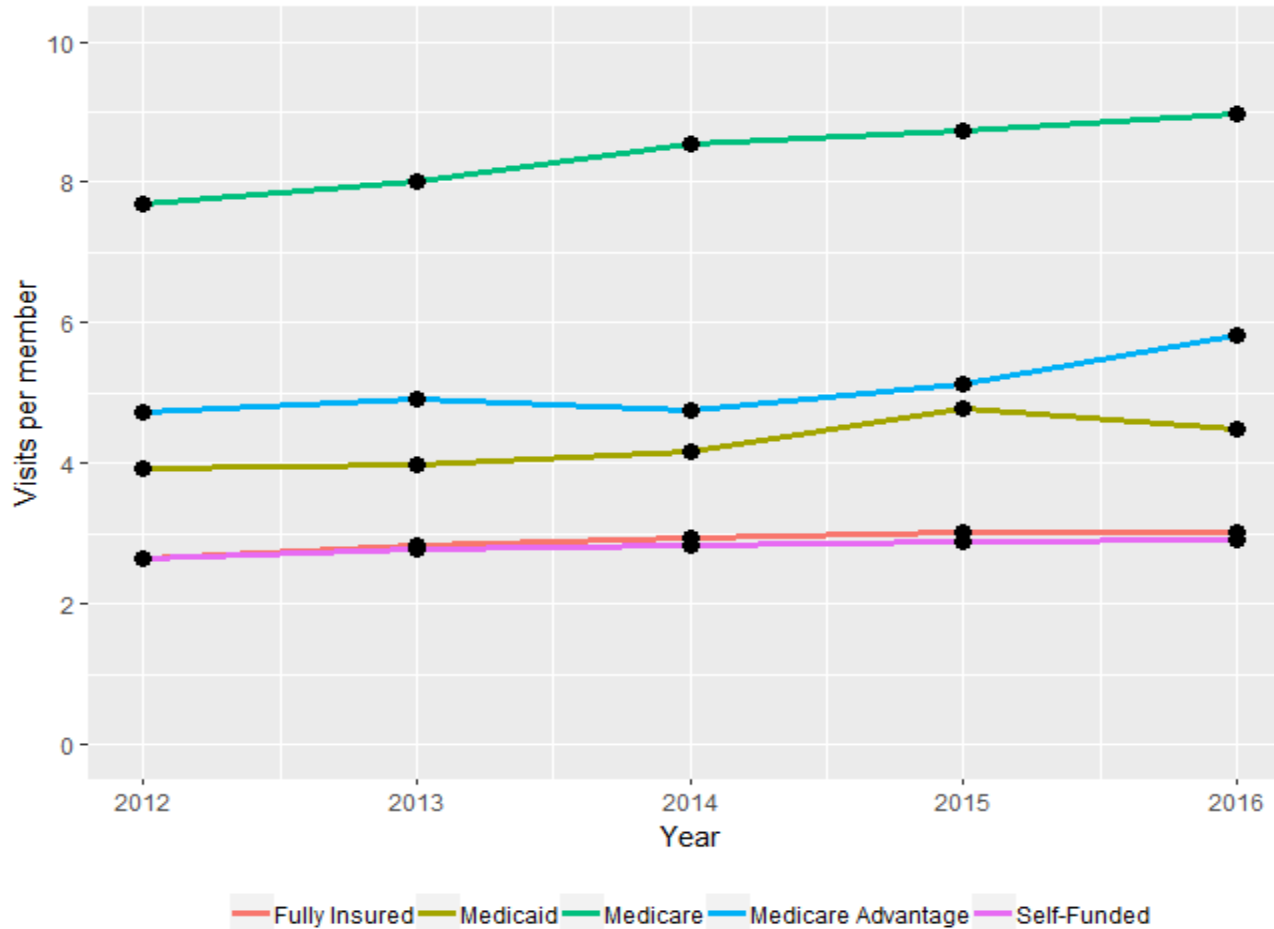
☐ Total office visits per member per year over time



Total office visits over time increased from 4 visits per member each year to 5 visits per member by 2016.

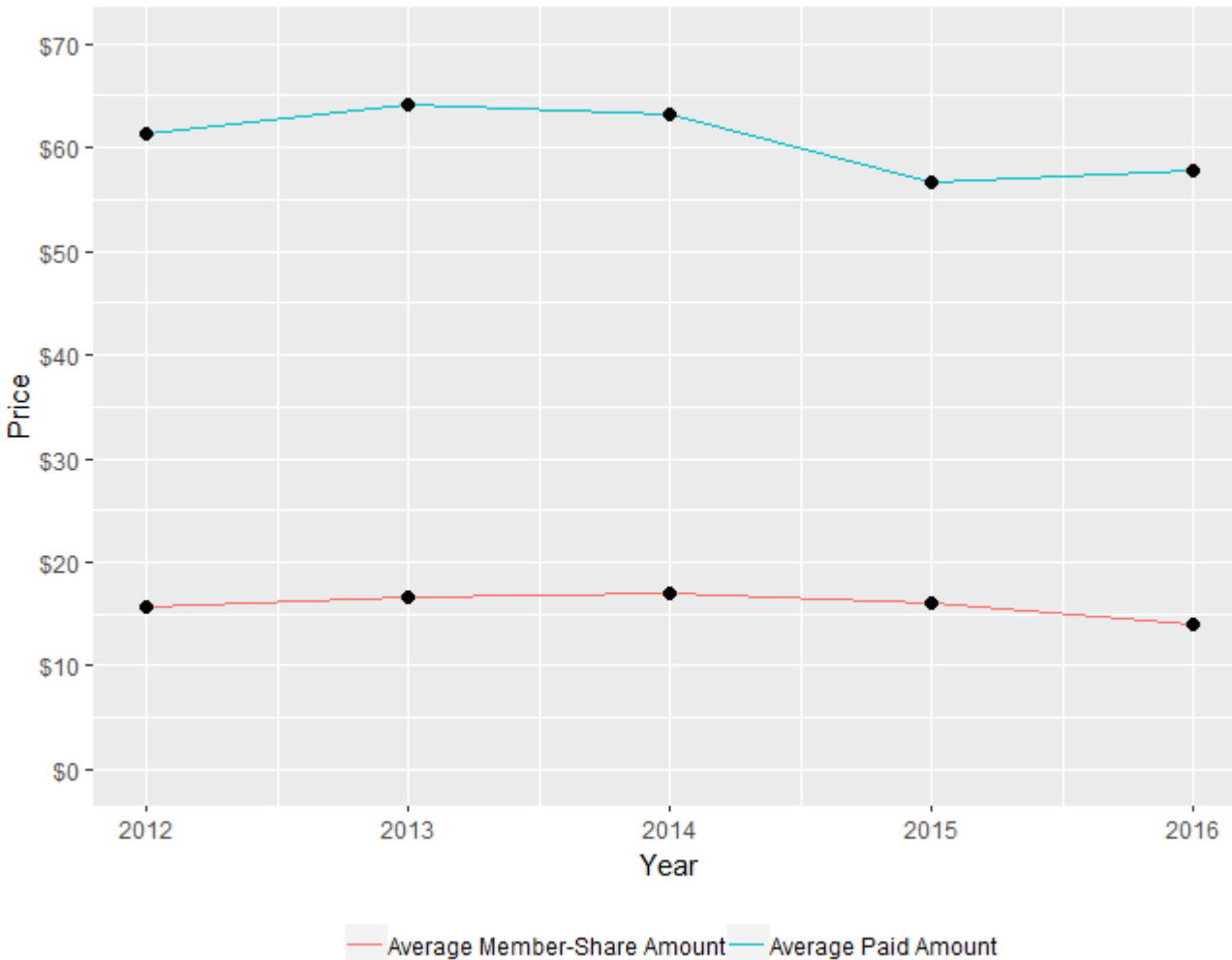
Office visits (2012 - 2016)

☐ Office visits per member per year by Payer over time



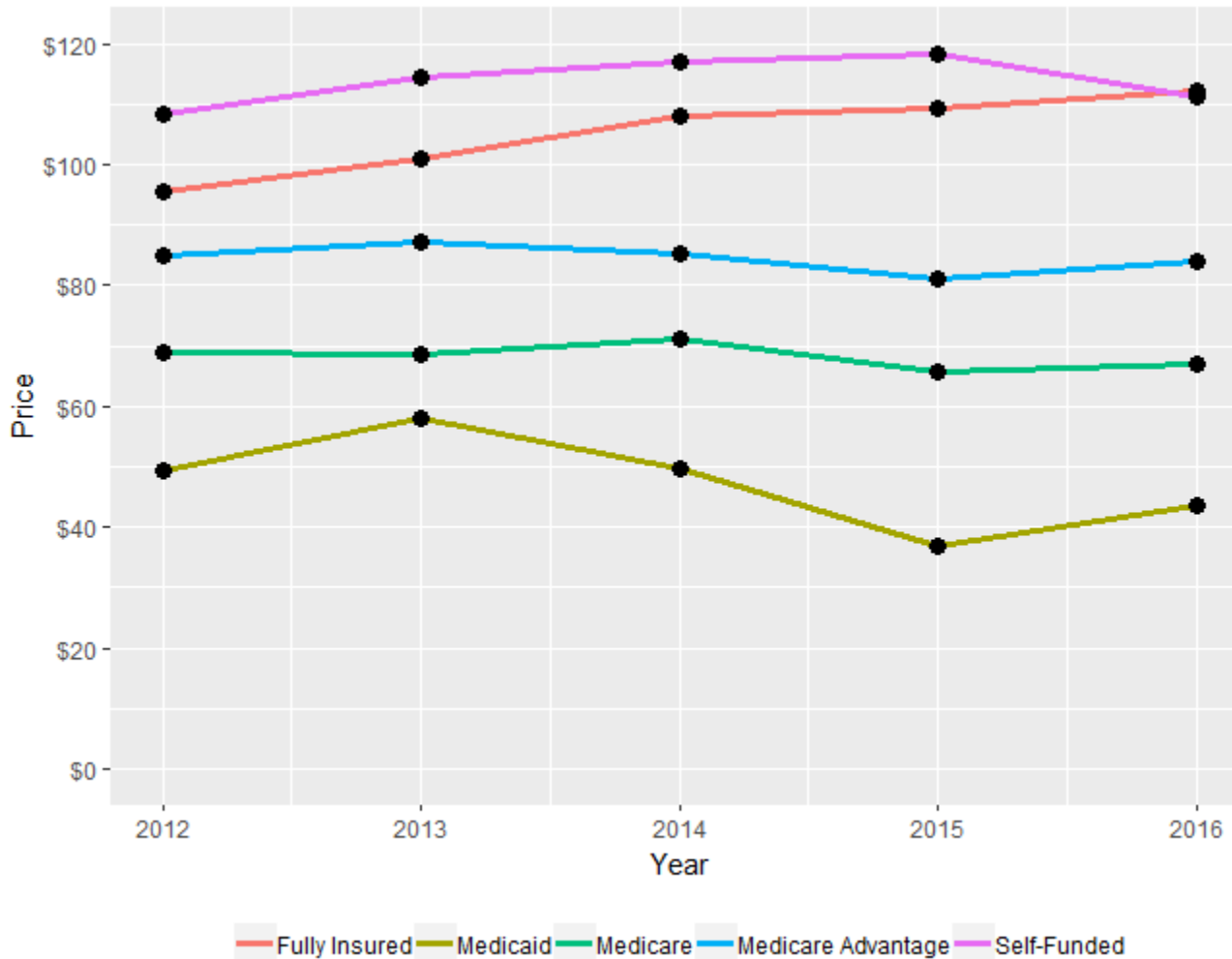
- Total office visits for Fully Insured and Self – Funded plans remained consistent over time (approximately 3 visits per member each year).
- Total office visits for Medicaid plans was consistent from 2012 to 2014 (4 visits per member each year). Between 2015 and 2016, total office visits per member increased to 5 visits per year.
- For Medicare Advantage plans, total office visits dipped slightly in 2014 and have subsequently risen.
- Total office visits per Medicare beneficiary increased from 2012 onward from 8 visits to 9 visits per beneficiary.

Average price (2012 - 2016)



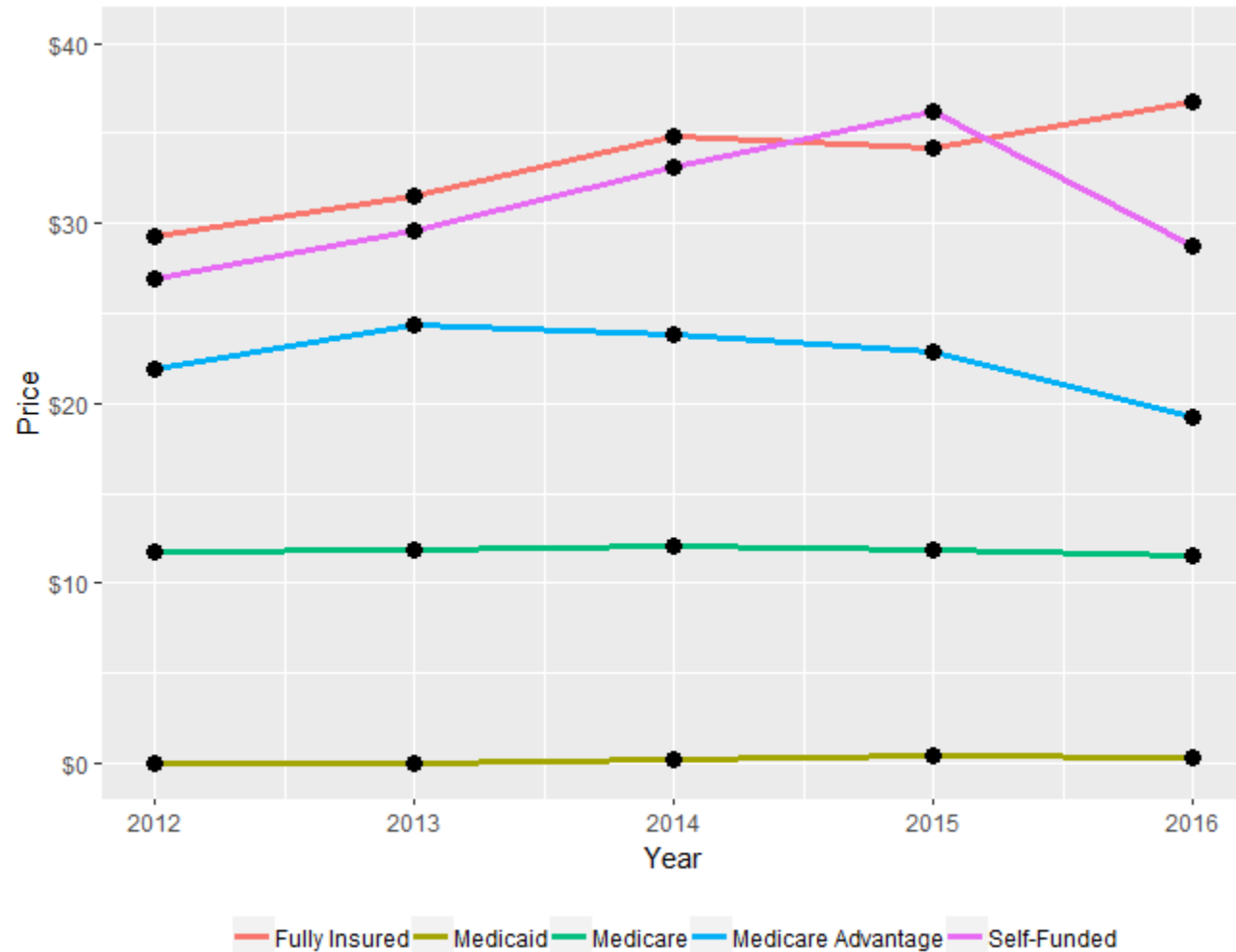
- Average member-shared amount increased approximately \$16 to \$17 from 2012 – 2014.
- In 2016, the average member-shared amount decreased (approximately \$14 per member over time).
- Similarly, average paid amount increased in 2013, approximately \$61 (2012) to \$64.
- Between 2014 and 2016, average paid amount decreased from \$64 to \$58.

Average Allowed Amounts by Payer (2012 - 2016)



- Average allowed amount for Fully Insured plans increased over time (\$96 - \$112).
- Average allowed amount for Self - Funded plans increased from 2012 to 2015 (\$108 - \$118), then decreased in 2016 (\$111).
- Average allowed amounts were the same for Self - Funded and Fully Insured plans in 2016 as compared with early years when Self - Funded averages were higher.

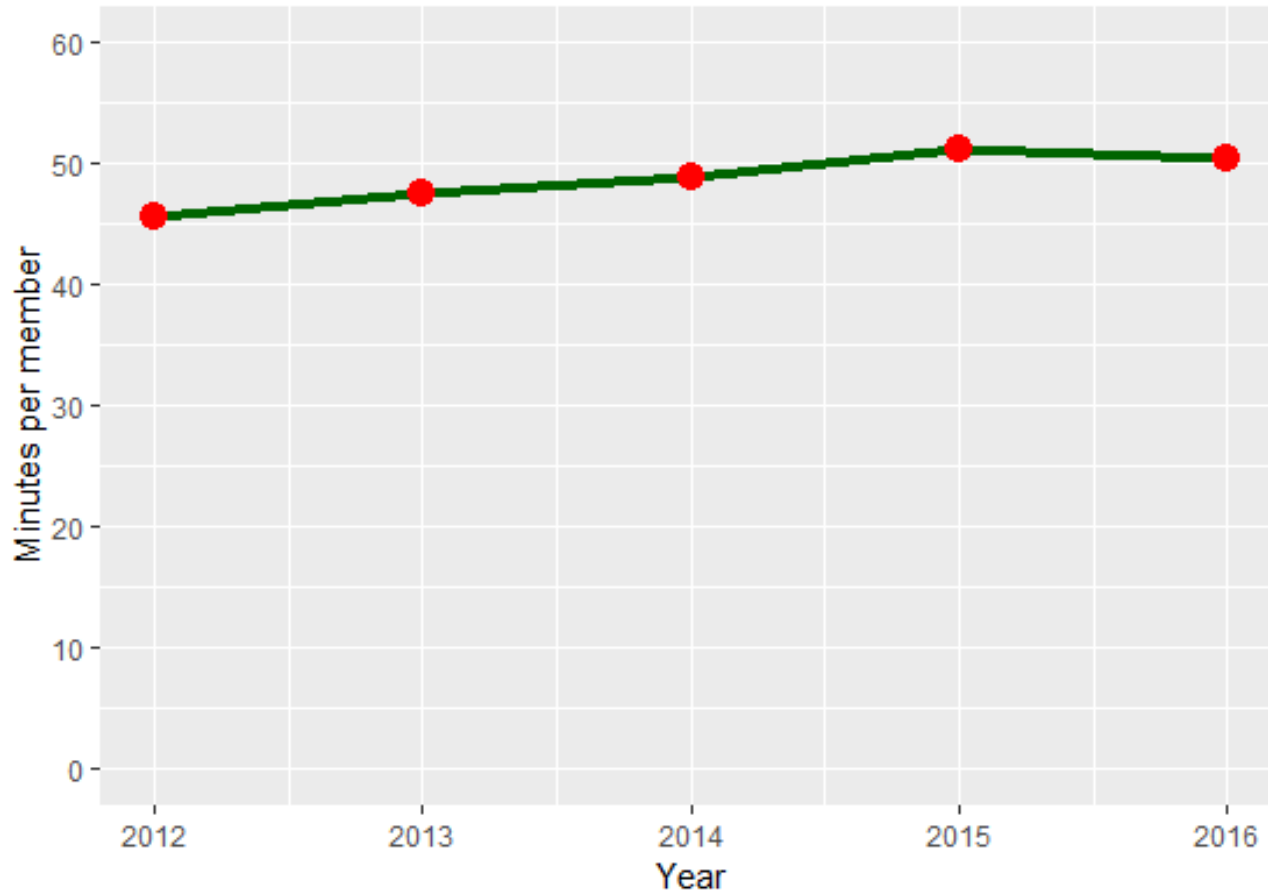
Average Member Responsibility (2012 - 2016)



- Cost sharing for Medicaid and Medicare plans have remained relatively stable.
- More variability has been observed for Medicare Advantage plans.
- Average member – shared amount increased at similar rate for Self – Funded and Fully Insured plans from 2012 to 2014.
- The average cost sharing for Self – Funded members declined substantially from 2015 to 2016, likely due in part to the effects of *Gobeille*.

Intensity (2012 - 2016)

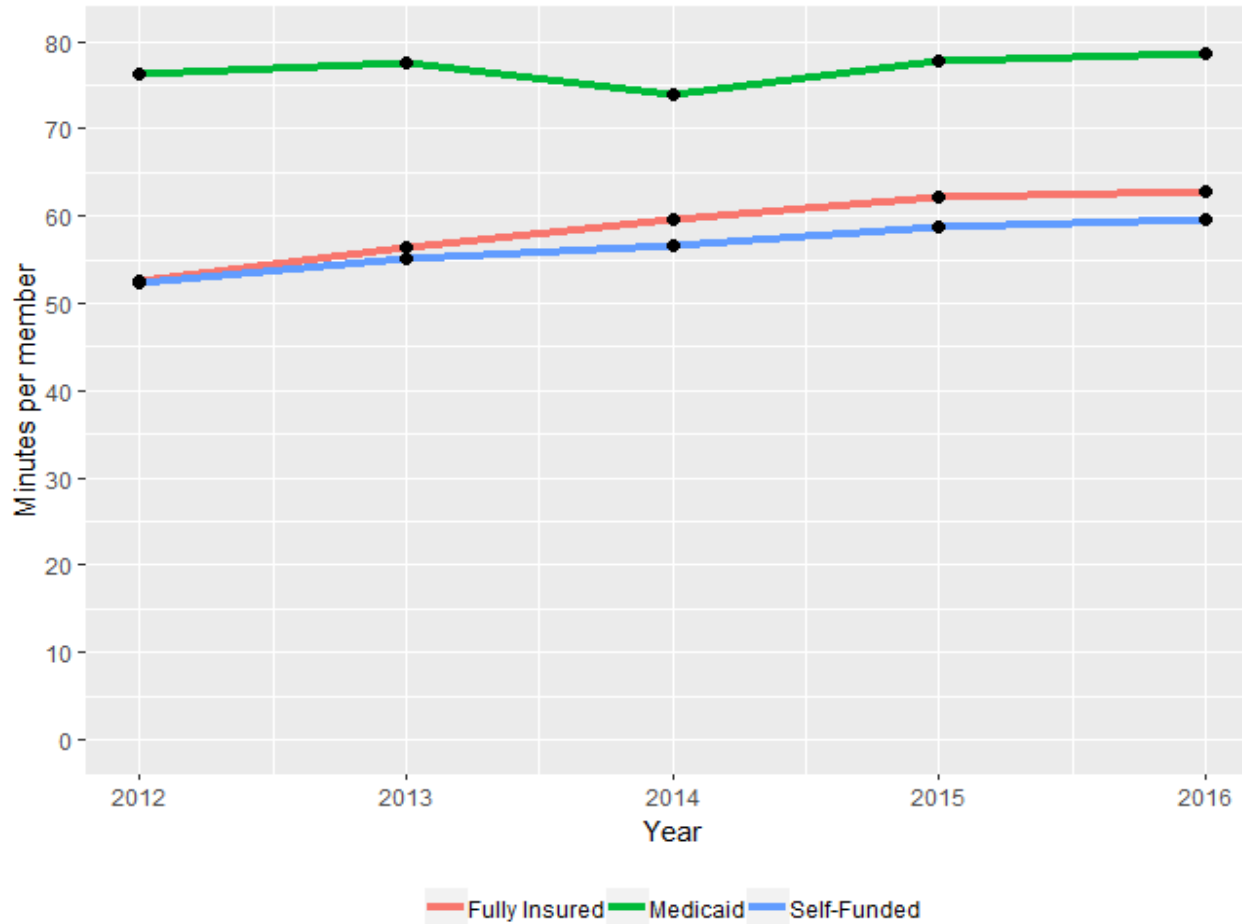
☐ Typical visit length



- Results *exclude* Medicare due to shift in 2014 to coding shift (one G code replaced the previous set of codes).
- From 2012 to 2015, visit length per member increased, then decreased.
- Steady increase in visit length per member were observed from 2012 to 2015.

Intensity (2012 - 2016)

□ Typical visit length by Payer over time



- Beneficiaries with Medicaid plans had the highest office visits length per member amongst other payers over time (excluding Medicare).
- Medicaid visit length increased by about 5 minutes between 2014 and 2016 (74- 79).
- Visit lengths increased for commercial plans, with fully insured plans showing a slightly longer average length in recent years.

Summary

Are outpatient visit utilization rates changing over time?

- Utilization has been increasing steadily since 2012, driven by Medicare.
- Rates observed for Medicaid and commercial plans have been relatively stable over the same time period.

Summary (continued)

Are the lengths of visits changing?

- Medicaid and commercial plans showed increases in typical visit length of about 5 minutes from 2014 to 2016.
- Medicare intensity cannot be measured the same way over this time period because it moved from using codes based on visit length to a single, all-inclusive code. This is an example of how payment reform can create measurement challenges.

Summary (continued)

How are prices changing over time (insurance paid and member responsibility)?

- Medicare showed relatively stable allowed amounts over time. Average Medicaid allowed amounts showed the most variability over the time period.
- Changes in average cost appeared similar for commercial plans. Self – Funded plans demonstrated higher average allowed costs prior to 2016.
- The *Gobeille* decision changed the population of Self – Funded plans reporting to VHCURES, which presents another challenge in measuring change.

Next steps

- ❑ Expand decomposition to include medical services by category (e.g. inpatient, outpatient, pharmacy).
- ❑ Include variables to account for changes in demographics (e.g. age and gender) and disease prevalence.