Office Visits Over Time
2012 - 2016

Green Mountain Care Board Meeting
September 12, 2018
Ekua Kotoka
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

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

- 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)

- 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 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.
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.
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.