Washington State Health Care Authority

Health Care Cost Transparency Board meeting summary

April 19, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the board are available on the Health Care Cost Transparency Board webpage.

Members present

Sue Birch, Chair
Eileen Cody
Lois Cook
Bianca Frogner
Leah Hole-Marshall
Molly Nollette
Margaret Stanley
Kim Wallace
Edwin Wong

Members absent

Jodi Joyce
Mark Siegel
Carol Wilmes

Call to order

Sue Birch, Board Chair, called the meeting to order at 2:01 p.m.

Agenda items

Welcome, roll call, and agenda review

Chair Birch called the meeting to order and reviewed the agenda. Chair Birch introduced the new board member, Eileen Cody.

Approval of February meeting summary

The board approved the Meeting Summary from the February 2023 meeting.

Topics for Today

The main topics were: Data Committee new member application; Primary Care Committee: claims-based measurements; an overview of data projects; Washington hospital costs, price, and profit analysis: second level analysis methodology; a historical review of the data collected and methodology for the benchmark; and updates to the 2023 benchmark call.

Public Comment

Tamara Cesena, Regional Vice President, and Chief Financial Officer of Skagit Regional Health (SKR) noted SKR's understanding that they will be subject to the health care cost benchmark, but it's unclear if that's accurate. If individual providers haven't been defined, it seems unreasonable to hold them accountable without notice. How does the board account for factors that impact the ability to meet the benchmark? Additionally, how are mandated expenditures accounted for? A 3.2 percent benchmark is unreasonable given the current environment. SKR asked the board for other ways to assist providers with managing costs by helping to control the drivers over which health systems have little influence. Tamara encouraged a clear process for setting the benchmark and adjustments that account for increases in services, utilization, population acuity, and inflation. Unless there are unexplained and unjustifiable variances after considering all factors, hospitals shouldn't be named, shamed, or worse.

Katerina LaMarche, Washington State Hospital Association (WSHA) remarked on the uncertainty as to how the hospital cost analysis will be used in conjunction with the benchmark work. The proposed methodology only adjusts for wage index and adjusted discharges and compares the remaining measures of case mix index and teaching status independently. From there, the proposed analysis suggests using peer group comparisons on several different variables, but these factors should be used in combination. WSHA's recommended analysis centers around standard adjustments including wage index, case mix index, and teaching status. WSHA requests both clarification of how this hospital cost analysis will be used, and a consideration of WSHA's analytical approach described in their previously submitted letter to be used along with what the consultants will provide.

Jeb Shepard, on behalf of physicians and physician assistants (PAs), director of policy at the Washington State Medical Association (WSMA) noted that providers and carriers were provided a schedule of the board's activities planned for 2023. It appears that the group has deviated from the schedule. Jeb requested an updated schedule of meeting items to understand the trajectory of this work. Jeb requested clarity around which entities are subject to the benchmark, which will be publicly reported on, and when. Reducing administrative waste should be the highest priority of the board, given that patients, physicians, insurance carriers, and state budgets would benefit from lower costs. Administrative costs aren't included in the APCD and Jeb urged the board to examine administrative cost drivers as permitted by the authorizing legislation. OnPoint could help us understand the limitations in the absence of Employee Retirement Income Security Act (ERISA) plan data. Many state residents are covered by commercial ERISA plans and this seems like a large blind spot.

Data Committee New Member Application

Chair Birch

Chair Birch introduced Christa Able, from Virginia Mason Franciscan Health, who was recommended to fill the vacancy left by Scott Juergens on the Advisory Committee on Data Issues. Board member Eileen Cody made a motion to approve Christa Able's appointment and the motion passed.

Primary Care Committee: Claims-Based Measurements

Jean Marie Dreyer, Senior Health Policy Analyst, Health Care Authority

Jean Marie Dreyer updated the board on the Advisory Committee on Primary Care's progress with methodologies to measure primary care spending. The board approved the committee's proposed definition of primary care at the February 2023 meeting. The committee is in the process of finalizing a measurement methodology to assess claims-based spending. Thus far, providers and facilities have been approved, and the committee is wrapping up its choices for primary care service code selection. The committee is in the process of defining services for claims-

based measurements and has decided to focus primarily on those services that are core to primary care, rather than attempting to include every possible code.

There are several additional steps once the primary service codes have been selected by the committee. In May, the committee will hear presentations from Oregon and Bailit Health on non-claims-based spending. In June, the committee will present its claims-based measurement recommendations to both the Advisory Committee of Health Care Providers and Carriers and the Advisory Committee on Data Issues for feedback. Also in June, the board will hear a presentation of the committee's final claims-based recommendations, including any input from the other two subcommittees, for the board to approve. Finally, the board's annual August report to the legislature will include an update on the Advisory Committee on Primary Care's progress-to-date.

Board member Bianca Frogner asked about a letter to the board from WSMA requesting a modification to the board approved primary care definition. Jean Marie Dreyer clarified that the committee would vote on the proposed amendment mentioned in WSMA's letter at the April 27 meeting.

Data Projects Overview

Ross McCool, Data Analyst, Health Care Authority

Ross McCool presented an overview of the board's current data projects. The data projects chart is meant to serve as a reference/answer to frequently asked questions for the board. The cost growth benchmark is the metric/goal ceiling for health care growth and reflects the affordability of healthcare for consumers and purchasers. Performance against the benchmark is aggregate with adjustments made for age and sex. The cost driver analysis is a drill down analysis into the APCD to see what claims produce the highest costs. The analysis started with a high-level examination and will proceed with multiple, more detailed analyses. It only uses claims-based data.

Bianca Frogner asked for clarification regarding performance, specifically around the severity of illness risk adjustment and why this was marked as not applicable. Ross McCool clarified that the intent is to provide transparency. Cost growth benchmark states have also moved away from clinical risk adjustment due to unsubstantiated increasing risk scores that didn't correspond with changes in underlying population health. Vishal Chaudhry added that adjusting risk at the provider level is apples and oranges. There have been proxy measures used, e.g., inpatient Medicare case mix index (MCI), though all chosen measures have sufficient deficiencies because they only capture part of the population. The benchmark analysis is done at a business entity level. Risk adjustment will apply for the cost driver analysis which looks at disease level.

Board member Leah Hole-Marshall requested removal of the sentence about what's not included and suggested instead stating what is being adjusted. Ross McCool noted that when risk adjustment is applied depends on the type of cost driver analysis. Leah Hole-Marshall requested specifying when it might be applicable, and when it might not.

Board member Edwin Wong requested asked as to the completeness of the Washington state population. There wasn't Medicare fee for service (FFS) data. What other gaps are there in the APCD? Vishal Chaudhry clarified that Medicare data is delayed and most self-funded data isn't included. The analysis still represents close to 70 percent of the state's population. Edwin Wong asked if the cost driver analysis would be lagged or would skip Medicare data. Vishal Chaudhry replied that the intent is to make Medicare data available but that it will be lagged compared to other sources. This board has limited ability to impact Medicare purchasing paradigms. It's not clear to what degree inclusion of Medicare data is helpful. Chair Birch requested staff consider incorporating footnotes and other feedback into the chart.

Washington Hospital Costs, Price, and Profit Analysis: Second-Level Analysis Methodology

John Bartholomew and Tom Nash, Bartholomew-Nash & Associates

John Bartholomew and Tom Nash (Bartholomew Nash& Associates) reviewed their first level analysis. The phase two analysis of Washington hospital costs, price, and profit analysis would build upon the initial report with additional metrics. The first analysis looked at hospitals with more than 25 beds. Of the 45 total hospitals analyzed, 15 were found to be high-price and 12 of those were high-cost. Two of the 12 high-cost hospitals were high-profit. Of those that were not high-priced, there were four hospitals that were high-profit but normal cost, six hospitals that were not high-price but were high-cost, and at least one hospital that wasn't high-priced but was high-profit.

A deeper dive is needed to further understand price, cost, and profit variations from the national median over time. Measures such as case mix, service intensity, teaching intensity, payer mix, and other financial measures are needed to enable better comparisons between hospitals. The goal of the analysis is to adjust service intensity, acuity, location, and other differences so that cost variation is isolated to either business decisions or price discrimination.
The second level analysis will include two types of methodology enhancements and additional financial review, consisting of the following: calculated adjustments to the first level analysis of costs; creation of additional groupings beyond bed size, to allow for comparisons to the national database; and a Washington hospital margin analysis.

Bartholomew-Nash & Associates formed a workgroup to review the assumptions to address methodology enhancements for the second level hospital financial analysis with a collection of Washington state subject member experts. Workgroup members included representatives from WSHA, HealthTrends, UW Medicine, HCA leadership, Tom Nash, and John Bartholomew. The workgroup held a series of meetings and conversations in early 2023. At the conclusion of the workgroup meetings, Bartholomew-Nash & Associates summarized their recommendations based on the group's discussions.

Adjustments to the cost data will include an adjustment to hospital-only operating expense by removing Council for Community and Economic Research (C2ER) as a cost-of-living adjustment. The analysis will utilize the labor wage index information from Centers for Medicare and Medicaid (CMS) wage index files and from the Medicare Cost Report at the hospital level. The labor wage index will be applied to the salary amount of costs of each hospital, with remaining costs applying the C2ER statistic.

The second analysis will contain additional groupings to create more informed peer groupings for hospital comparisons, both within Washington and nationally, using data from the Medicare Cost Report. In addition to bed size, the secondary analysis will utilize one or a combination of the following measures to further refine the ability to compare "like" hospitals: teaching intensity measure; service intensity measure; and MCI. The second level analysis will also review the payer mix measure. The second level analysis will be completed and presented to the board in July 2023.

Board member Margaret Stanley asked how useful it is to compare Washington to other states that don't have Washington's lower admission rates. John Bartholomew responded that the analysis looks at utilization and profit which are comparable between Washington and other states. Each state needs to hold their individual hospitals accountable. The information used for the second level analysis will inform the work around the cost growth benchmark, particularly around the cost driver analysis. The data for this second analysis are the inputs into the APCD data.

Bianca Frogner noted hospitals' challenges discharging patients. How will this analysis help the board differentiate between system capacity and patient health? Tom Nash acknowledged that capacity has affected discharges and this could be added. Bianca Frogner requested adding length of stay and occupancy rates. John Bartholomew noted that occupancy rates are reported as a measure in the cost board report. The measure discharges per 1,000 won't be looked at in this analysis because it won't assist in the second level review.

Edwin Wong asked about the MCI and expressed concerns around groupings. The MCI is only constructed from inpatient among Medicare patients which highlights potential issues like misrepresenting patient populations. The analysis will be used for grouping but not adjusting data. Edwin Wong cautioned using the MCI even for groupings. Tom Nash noted that WSHA has observed a correlation between MCI and all-payer case mix, but that may not be the case for individual hospitals. For the analysis, the choice was made to use case mix as a grouping factor rather than an adjustor. John Bartholomew added that as the margin analysis is done, the profits can be compared with adjustments for payer mix, case mix, or other metrics.

Bianca Frogner asked for further clarification on the C2ER metric. Tom Nash explained that in the analysis, there is an attempt to recognize that the cost of doing business differs between states and that C2ER isn't used for inflation, but the Consumer Price Index (CPI) is. An adjustment for cost-of-living would only be used for out-of-state comparisons. For Washington hospitals, the analysis will look at unadjusted data.

Chair Birch asked the board whether the analysis work should continue into phase two. The board endorsed pursuit of a second analysis.

Benchmark: Historical Review of the Data Collected & Methodology

January Angeles, Bailit Health

January Angeles reviewed the purpose and methodology of the cost growth benchmark analysis. The data types and sources used by the cost growth benchmark analysis are different from those used in the cost growth analysis. The benchmark analysis uses aggregate data from insurers and public payers. The cost driver analysis is more granular and comes from claims/encounters from the APCD. The benchmark calculates health care cost growth over time, while the cost driver analysis looks at cost drivers to identify opportunities to reduce cost growth and inform policy decisions.

To assess performance against the benchmark, the performance analysis looks at total medical expenses (TME), which includes all payments on providers' claims, non-claims-based payments, and cost-sharing paid by members and adds the net cost of private health insurance (NCPHI) to add up to total health care expenditures (THCE). THCE are measured at the state level and compared against the benchmark. Performance against the benchmark is assessed at four levels, including state (TCHE), market, payer, and large provider entity (for TME only) levels.

Most data for performance comes from payer-submitted reports, including claims and non-claims-based spending, pharmacy rebate information, and fees from income of uninsured plans to calculate NCPHI. Other data sources include CMS for Medicare FFS claims and standalone Part D spending, State Medicaid agency data for non-managed care payments, other sources of public coverage and regulatory reports used to calculate NCPHI.

There are both member and data specifications for insurer benchmark submissions. The population represented by benchmark calculations includes all members who reside in Washington. Insurers aggregate report spending and membership data by large provider entity and insurance type. For members not attributable to a large provider entity, members are aggregated by insurance type. Other data specifications include a run-out period of

180 days (data is run six months after the conclusion of the performance period) and adjustments made to lines of business for which the insurer doesn't have all claims information (e.g., carved=out benefits).

There are different measurement situations which necessitate adjustments to performance data. When reporting spending and spending growth at the state and market levels, no adjustments are made. When reporting data at the insurer and large provider entity levels, HCA applies four different methodologies: 1) risk-adjusting aggregate spending data by age and sex 2) truncating spending for high-cost outliers 3) using confidence intervals around cost growth rates to determine benchmark performance 4) reporting performance only for insurers and large provider entities that meet a minimum threshold (still to be determined) for attributed lives.

Margaret Stanley asked about payer submission of data for self-insured and insured lives. Would third party administrators (TPAs) not report? January Angeles said HCA likely doesn't require data from TPAs but would need to confirm. Margaret Stanley asked what percentage of claims expense the upper limit of the commercial threshold would eliminate? January Angeles wasn't sure but thought maybe it was seven percent. Ross McCool mentioned that these limits were brought to the data committee.

Updates to 2023 Benchmark Data Call

Ross McCool, HCA

The data team completed updates to the 2023 benchmark data call. Changes to the 2023 data call include: 1) inclusion of calendar years 2020, 2021, and 2022 in the submission, and 2) the performance against the benchmark will be calculated using 2021 and 2022.

There will be updates to reference categories to clarify submission data. These updates include: 1) an additional insurance category for Federal Employee Health Benefits (FEHB) and 2) implementation of a new method to associate non-claims-based spending to providers without age/sex stratification.

These changes are incorporated into the technical manual for submitters. Training will be provided for submitters through a webinar beginning in July or early August. Submissions for 2023 benchmark data are due September 1.

Adjournment

Chair Birch adjourned the meeting at 4:00 p.m.

Next meeting

June 21, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.