

Advisory Committee on Data Issues

August 10, 2021

Advisory Committee on Data Issues Meeting Materials Book

August 10, 2021
10:00 a.m. – 12:00 p.m.

(Zoom Attendance Only)

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Topics for Today’s Discussion.....	3
Overview of Preliminary Benchmark Decisions and Measurement.....	4
Reporting Performance Against the Cost Growth Benchmark.....	5
Methods to Ensure the Accuracy and Reliability of Benchmark Performance Measure	6

Agenda

TAB 1

Advisory Committee on Data Issues

August 10, 2021
10:00 a.m. – 12:00 p.m.
Zoom Meeting

AGENDA

Committee Members:

<input type="checkbox"/>	Megan Atkinson	<input type="checkbox"/>	Jarred Collings	<input type="checkbox"/>	Dave Mancuso
<input type="checkbox"/>	Amanda Avalos	<input type="checkbox"/>	Jerome Dugan	<input type="checkbox"/>	Ana Morales
<input type="checkbox"/>	Allison Bailey	<input type="checkbox"/>	Leah Hole-Marshall	<input type="checkbox"/>	Thea Mounts
<input type="checkbox"/>	Jonathan Bennett	<input type="checkbox"/>	Karen Johnson	<input type="checkbox"/>	Hunter Plumer
<input type="checkbox"/>	Purav Bhatt	<input type="checkbox"/>	Scott Juergens	<input type="checkbox"/>	Mark Pregler
<input type="checkbox"/>	Bruce Brazier	<input type="checkbox"/>	Lichiou Lee	<input type="checkbox"/>	Julie Sylvester
<input type="checkbox"/>	Jason Brown	<input type="checkbox"/>	Josh Liao		

Committee Facilitator:

J.D. Fischer

Time	Agenda Items	Tab	Lead
10:00-10:05 (5 min)	Welcome, call to order, and agenda review	1	J.D. Fischer Health Care Authority
10:05-10:07 (2 min)	Introduce new committee member		J.D. Fischer Health Care Authority
10:07-10:10 (3 min)	Approval of meeting minutes	2	J.D. Fischer Health Care Authority
10:10-10:15 (5 min)	Topics we will discuss today	3	January Angeles and Michael Bailit Bailit Health
10:15-10:20 (5 min)	Overview of preliminary benchmark decisions and measurement	4	January Angeles and Michael Bailit Bailit Health
10:20-10:30 (10 min)	Reporting performance against the cost growth benchmark	5	January Angeles and Michael Bailit Bailit Health
10:30-11:45 (75 min)	Methods to ensure the accuracy and reliability of benchmark performance measurement	6	January Angeles and Michael Bailit Bailit Health
11:45-11:55 (10 min)	Public comment		J.D. Fischer Health Care Authority
11:55-12:00 (5 min)	Wrap-up and adjournment		J.D. Fischer Health Care Authority

In accordance with Governor Inslee's Proclamation 20-28 et seq amending requirements of the Open Public Meeting Act (Chapter 42.30 RCW) during the COVID-19 public health emergency, and out of an abundance of caution for the health and welfare of the Board and the public, this meeting of the Advisory Committee of Providers and Carriers will be conducted virtually.

July Meeting Minutes

TAB 2

Advisory Committee on Data Issues meeting minutes

July 8, 2021
Health Care Authority
Meeting held electronically (Zoom) and telephonically
10:00 a.m. – 12:00 p.m.

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

Members present

Megan Atkinson
Amanda Avalos
Allison Bailey
Jonathan Bennett
Purav Bhatt
Bruce Brazier
Jason Brown
Jerome Dugan
Leah Hole-Marshall
Karen Johnson
Scott Juergens
Lichiou Lee
Josh Liao
Ana Morales
Thea Mounts
Hunter Plumer
Mark Pregler
Julie Sylvester

Agenda items

Welcome and Call to Order

J.D. Fischer, committee facilitator, called the meeting to order at 10:03 p.m.

Welcoming remarks

Sue Birch, Health Cost Transparency Board, Chair

Ms. Birch welcomed the group. Ms. Birch reminded the Committee that they had been selected to represent the diverse participants in the health care market and asked them to have thorough discussions and provide frank insight and feedback.

Committee member and staff introductions

Advisory Committee on Data Issue meeting minutes
07/08/2021



Open public meetings training

Katy Hatfield, AAG

PowerPoint presentation

Ms. Hatfield provided the Committee with an overview of the Open Public Meetings Act (OPMA), relevant guidelines for adherence based on the Washington State Supreme Court's interpretations of the OPMA, and its applicability to Committee meetings and communications. The presentation covered topics including:

- The purpose of the OPMA.
- Which meetings are subject to OPMA,
- What constitutes a "governing body" and a "meeting."
- Regular, special, and emergency meetings and executive sessions.
- Penalties for violations and risk management tips.
- COVID-19 impacts on OPMA.

Washington's Health Care Cost Growth Benchmark Legislation

Mich'l Needham, Chief Policy Officer, Health Care Authority

PowerPoint presentation

Ms. Needham provided the Committee with an overview of House Bill 2475 which established the Health Care Cost Transparency Board and tasked it with:

- Establishing a health care cost growth benchmark or target percentage for growth.
- Analyzing total health care expenditures.
- Identifying trends in health care cost growth.
- Identifying entities that exceed the health care cost growth benchmark.
- Appointing two advisory committees.
- Reporting to the Governor and the Legislature on progress towards developing the benchmark and annual total health care expenditures relative to the benchmark.

Public Comment

There was no public comment.

Introduction to Health Care Cost Growth Benchmarks

AnnaLisa Gellermann, Board Manager, Health Care Authority

PowerPoint presentation

Ms. Gellerman presented an overview of health care cost growth benchmarks to the Committee. The overview included the following topics:

- The definition and value of a cost growth benchmark.
- Examples from other states that have pursued cost growth benchmarks and their selected benchmark values.
- The logic model for a cost growth benchmark.
- Calculating total health care expenditures.
- Cost driver analysis.



Future Topics and Design Decisions Requiring Committee Input

J.D. Fischer, Facilitator, and Ross McCool, Health Care Authority
PowerPoint presentation

Mr. Fischer and Mr. McCool provided an overview to the Committee of future topics and design decisions for which the Board will require Committee input. Topics included:

- Benchmark performance evaluation design decisions, including:
 - Minimum payer/provider size for requiring data submission and publicly reporting performance.
 - Application of risk adjustment.
 - Strategies for dealing with high-cost outliers.
 - Using standard deviation/variance/confidence interval/statistical testing to evaluate whether the benchmark was achieved.
 - Methodology for attributing providers to large provider organizations.
- Data use strategy design decisions, including:
 - Goals of the data use strategy.
 - Identifying types of analyses and data sources.
 - Interpretation of analyses.
- The definition of rationale and framework for a data use strategy.
- Request data examples.
- Recommended analytic reports.

Next meeting

Tuesday, August 10, 2021
Meeting to be held on Zoom
10:00 a.m. – 12:00 p.m.

Meeting adjourned at 11:41 a.m.

Topics for today's discussion

TAB 3

Topics we will discuss today:

1. Overview of preliminary benchmark decisions and measurement.
2. Reporting performance against the cost growth benchmark.
3. Methods to ensure the accuracy and reliability of benchmark performance measurement.
 - Statistical testing on benchmark performance data.
 - Mitigating the impact of high-cost outliers.
 - Applying risk adjustment.
 - Ensuring sufficient population sizes.

Overview of preliminary benchmark decisions and measurement

TAB 4



Washington State
Health Care Authority

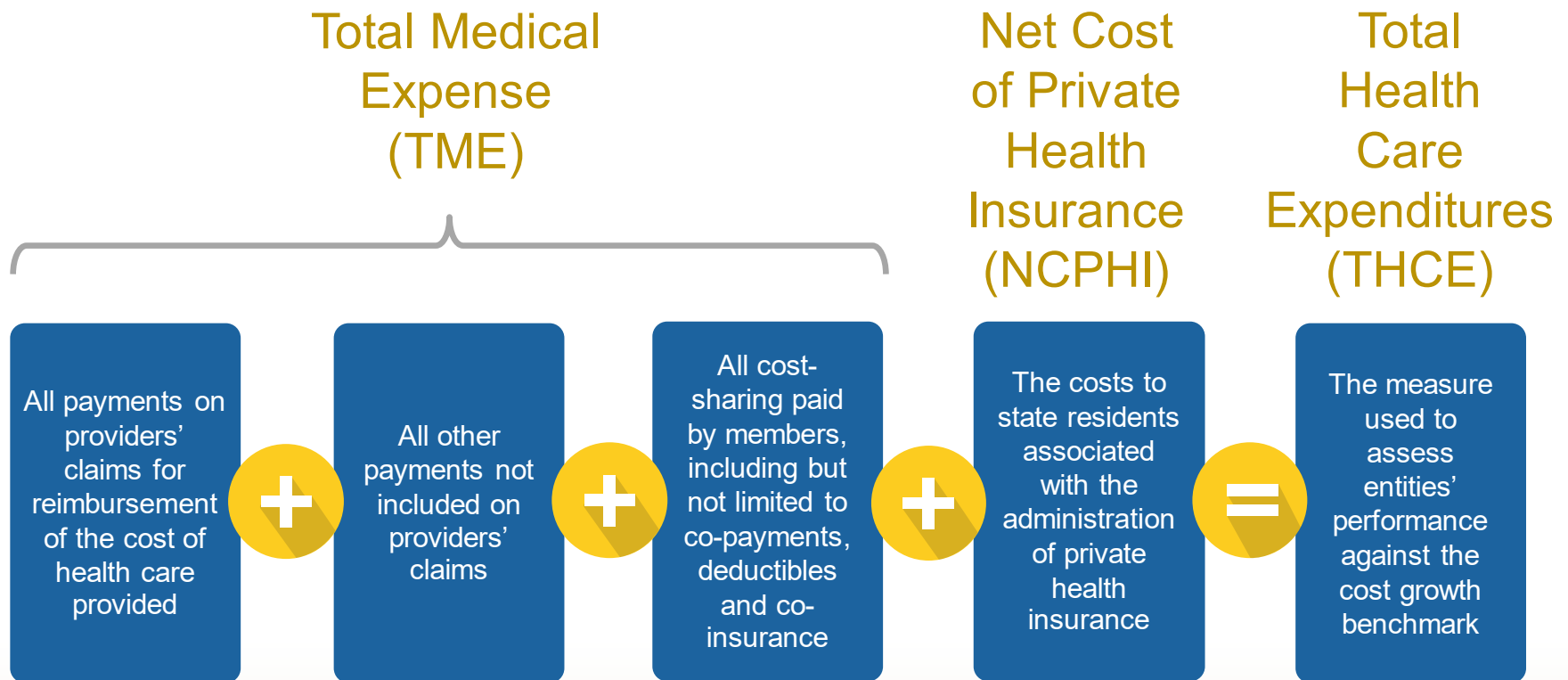
Overview of preliminary benchmark decisions and measurement



The Board's preliminary benchmark decisions

- The Board made a preliminary decision to set the benchmark value using a 70/30 hybrid of historical median wage and potential gross state product.
 - The Board wanted to use these indicators to send the message that health care should not grow more than consumer finances and the economy overall.
- The benchmark would phase down over time as follows:
 - 2022-2023: **3.2%**
 - 2024-2025: **3.0%**
 - 2026: **2.8%**

What is being measured against the cost growth benchmark



Data collection to determine benchmark performance

- Most data come from payer-submitted reports.
 - Commercial, Medicare Advantage and Medicaid managed care plans submit aggregate claims and non-claims spending for provider entities stratified by market.
- Staff will also collect data from other sources.
 - Centers for Medicare & Medicaid Services for Medicare fee-for-service (FFS) claims and Part D spending.
 - HCA for FFS Medicaid spending.
 - Other sources of public coverage (e.g., Veteran's Health Administration, Department of Corrections, workers' comp).
 - Regulatory reports for net cost of private health insurance (NCPHI).

Reporting performance against the cost growth benchmark

TAB 5



Washington State
Health Care Authority

Reporting performance against the
cost growth benchmark



Cost growth benchmark analysis vs data use strategy



How will we determine the level of cost growth from one year to the next?

Benchmark Analysis

- **What is this?** A calculation of health care cost growth over a given time period using payer-collected aggregate data.
- **Data Type:** Aggregate data that allow assessment of benchmark achievement at multiple levels, e.g., state, region, insurer, large provider entity.
- **Data Source:** Insurers and public payers.

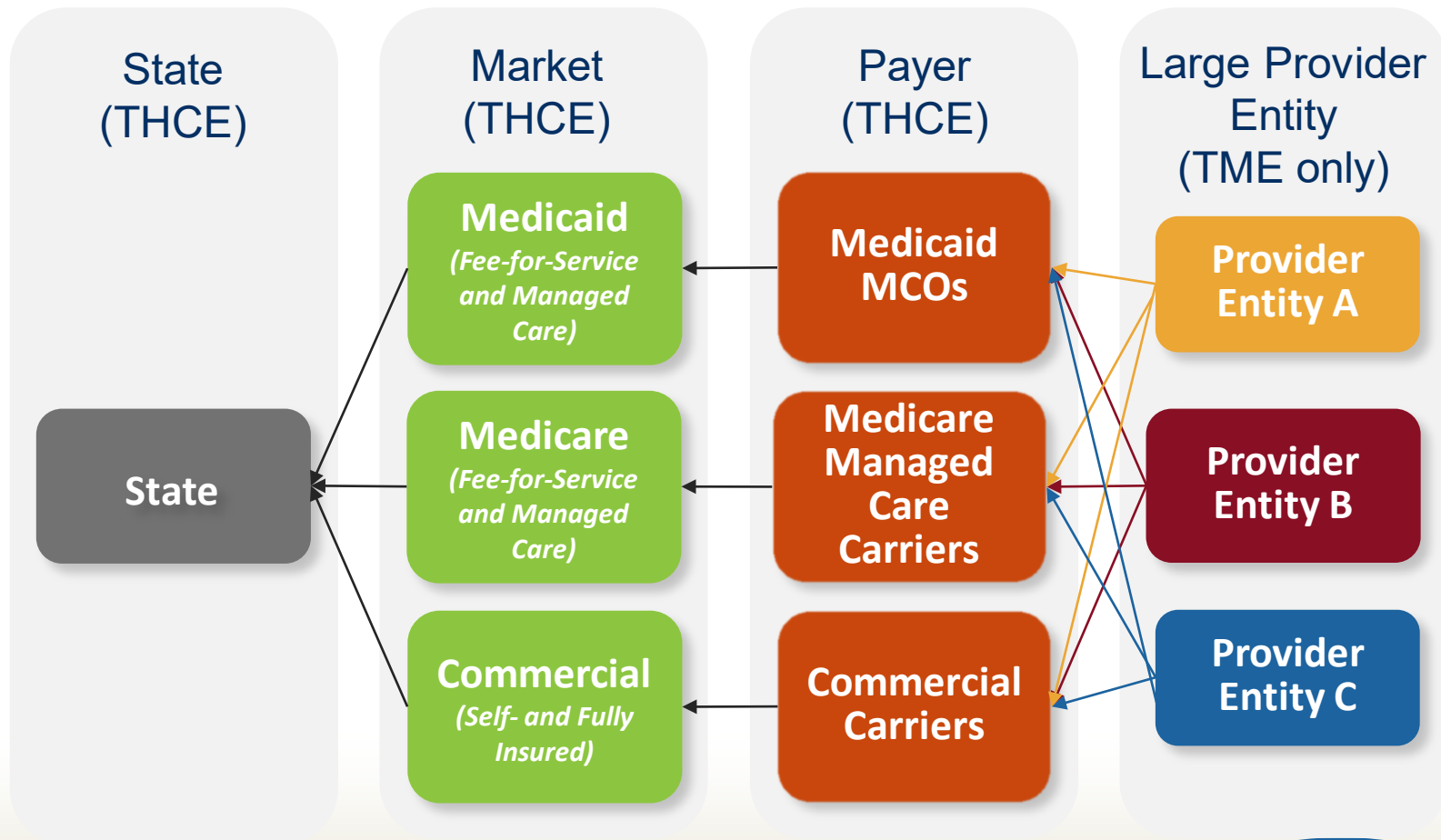


How will we determine what is driving overall cost and cost growth? Where are there opportunities to contain spending?

Data Use Strategy

- **What is this?** A plan to analyze cost drivers and identify promising opportunities for reducing cost growth and informing policy decisions.
- **Data Type:** Granular data (claims and/or encounters).
- **Data Source:** APCD.

States typically report benchmark performance benchmark at four levels

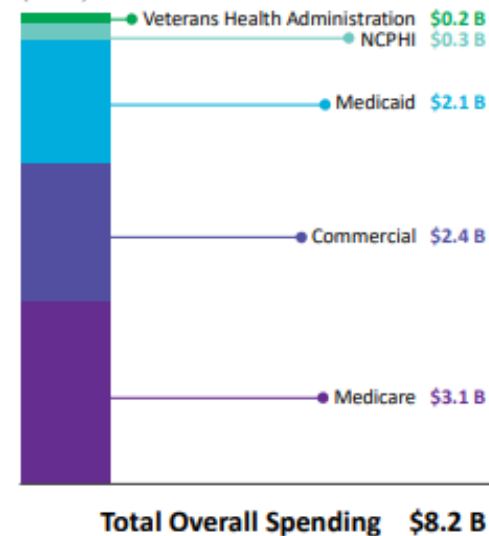


Reporting at the state level: DE example

TOTAL HEALTH CARE EXPENDITURES

- Total health care expenditures (THCE) went from \$7.6 billion in CY 2018 to \$8.2 billion in CY 2019 an 8.5% increase
- CY 2019 spending by component (similar to CY 2018 spending mix):
 - Medicare (FFS and managed care): 37.3% of spending
 - Commercial (fully and self-insured): 29.8% of spending
 - Medicaid (FFS and managed care): 26.2% of spending
 - Net Cost of Private Health Insurance (NCPHI): 4.2% of spending
 - Veterans Health Administration: 2.5% of spending

Figure 1. CY 2019 State Total Health Care Expenditures (THCE)



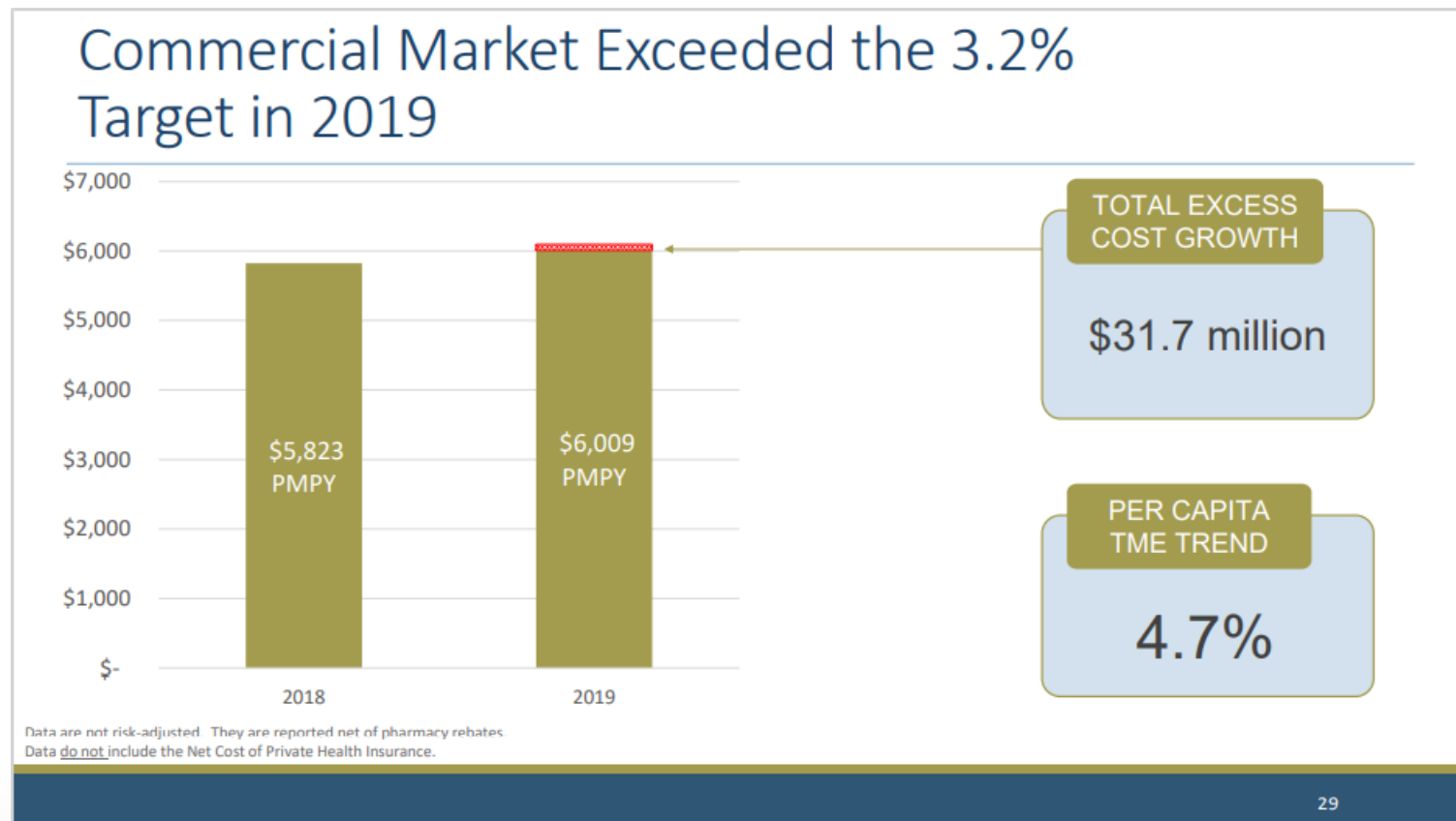
OVERVIEW OF BENCHMARK TREND REPORT: CY 2019 RESULTS

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* Medicare FFS, Medicaid FFS, and Veterans Health Administration does not have NCPHI, so expressed as a percentage of THCE, NCPHI is relatively low.

SOURCE: Overview of Benchmark Trend Report Calendar Year 2019 Results and Proposed Quality Measures, April 1, 2021, available at: <https://dhss.delaware.gov/dhcc/files/benchmarkpresentation033021.pdf>.

Reporting at the market level: RI example (commercial)



SOURCE: April 29, 2021 presentation to the Rhode Island Cost Trends Steering Committee.

Reporting at the payer level: MA example (commercial)

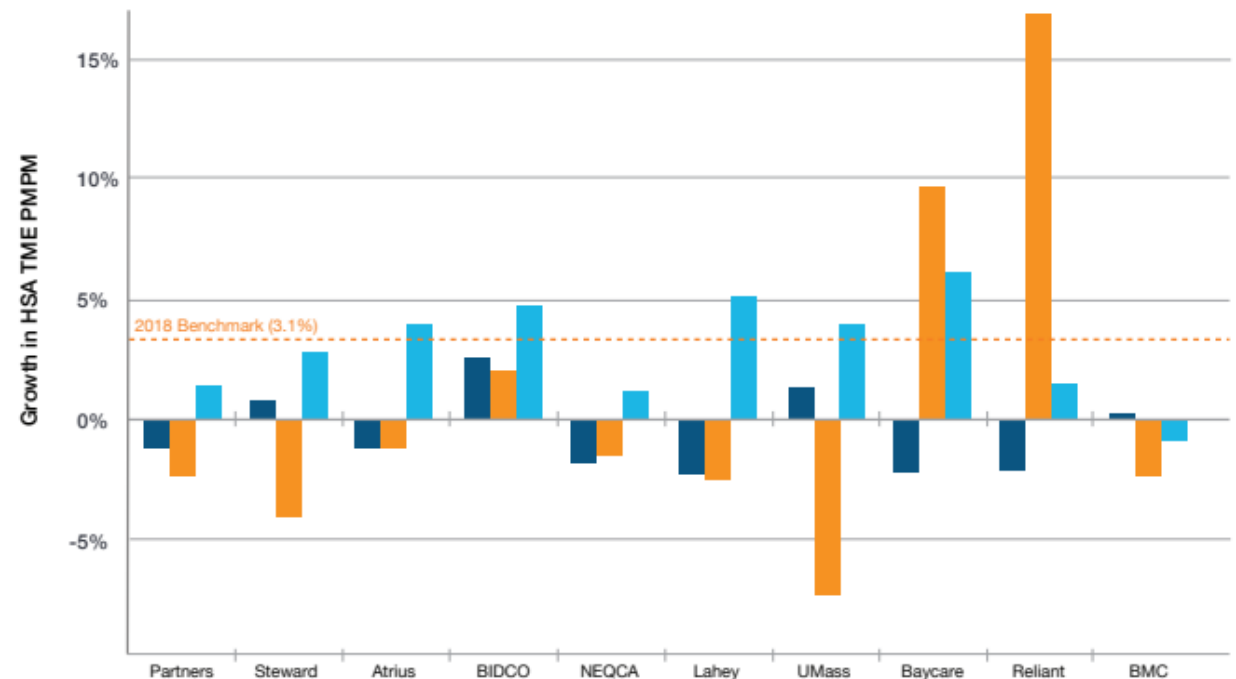
Change in Preliminary Commercial HSA TME by Payer, 2018-2019



SOURCE: Massachusetts Center for Health Information and Analysis, "Annual Report on the Performance of the Massachusetts Health Care System," March 2021.

Change in Final Managing Physician Group Commercial HSA TME, 2017-2018

Reporting
at the
provider
level:
MA
example



BCBSMA, HPHC, and Tufts Share of Group's Managed Member Months	94.7%	81.0%	89.8%	72.9%	96.9%	89.7%	79.9%	47.3%	61.6%	66.3%
Total Managed Member Months in 2018	3.1M	2.3M	2.2M	1.6M	1.3M	1.2M	1.0M	0.8M	0.7M	0.5M

Key ■ BCBSMA ■ HPHC ■ Tufts

The largest physician groups experienced varied HSA TME growth by network in 2018.

A note on reporting at the provider level

- Benchmark performance reporting at the provider level is limited to those providers who:
 - Are sufficiently large such that performance against the benchmark can be accurately and reliably measured.
 - Have responsibility for meeting all a patient's needs (i.e., primary care providers and systems that can typically engage in total cost of care contracts).
- How to specifically define and identify provider entities whose performance will be measured against the benchmark is an issue that the Board will need to address later.

Methods to ensure the
accuracy and reliability of
benchmark performance
measurement

TAB 6



Methods to ensure the accuracy and reliability of benchmark performance measurement

The problem of small numbers

- Random fluctuations in medical expenditures and service use can impact per capita cost growth of entities with small populations.
- Payers and provider entities must have sufficient member/patient volume:
 - For detected changes in annual per capita total medical expenditures to be accurate and reliable.
 - To minimize the effect of a few unusually complex and expensive patients on an entity's benchmark performance.
- In determining benchmark performance, it is important to ensure that entities are more likely to be impacted by such random variation are not unfairly assessed.

Strategies for ensuring that benchmark performance data are reliable

- There are some strategies we can implement to reduce the chance that random variation plays a significant part in a carrier or provider entity's performance and increase our confidence in HCA's performance assessment:
 - Perform statistical testing on benchmark performance data.
 - Mitigate the impact of high-cost outliers.
 - Apply risk adjustment.
 - Only report on entities with sufficient population sizes for which performance can be measured reliably.

Considerations for mitigating the impact of small population sizes

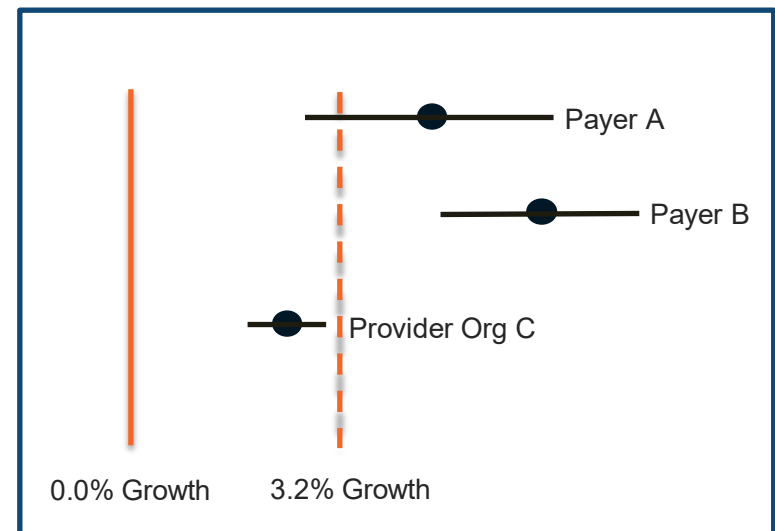
- Implementing strategies to minimize the impact of small population sizes on insurer and provider performance involves balancing multiple factors:
 - Having a high degree of confidence of the accuracy and reliability of performance data.
 - Data completeness.
 - Payers' data reporting burden.
 - Project staff workload to collect, validate, and analyze data.

1. Performing statistical testing on benchmark performance

- Washington could develop confidence intervals around benchmark performance.
- The confidence interval shows the possible range of values in which we are fairly sure our true value lies.
- In practice, it allows us to make the following statement:
 - We are 95% confident that the interval between A [lower bound] and B [upper bound] contains the true rate of cost growth for entity C.
- The confidence interval is influenced by the confidence level, the number of cases or observations, and the spread of costs associated with those cases.

Determining performance with confidence intervals

- Performance cannot be determined when upper or lower bound intersects the benchmark (payer A).
- Benchmark has not been achieved when lower bound is fully over the benchmark (payer B).
- Benchmark has been achieved when the upper bound is fully below the benchmark (provider org C).



Note: Figure is not to scale

Other states' use of statistical testing

- OR and CT are the first states to use confidence intervals in determining benchmark performance.
 - OR developed the methodology, which CT then adopted.
 - Both states are now collecting or analyzing their pre-benchmark data.
- RI recently adopted the use of confidence intervals, which is being incorporated into the 2020 data request (RI's second performance year).
- MA's methodology is defined in statute and cannot be changed without legislation.
- DE only reported at the state and market level, for which statistical testing is not critical.



Design recommendation: Use of confidence intervals

Does the Committee wish to recommend applying statistical testing and using confidence intervals to determine entities' benchmark performance?

2. Mitigating the impact of high-cost outliers on per capita spending

- High-cost outliers are members/patients with extremely high levels of health care spending.
 - The members/patients represent real spending, but often present randomly in a population and there are limits to how much of their spending can be influenced due to their complex medical condition and high resource intensity care needs.
 - It is not fair to judge insurer and provider performance against the benchmark when it is significantly influenced by spending on high-cost outliers.

How to address high-cost outliers

- It is common practice in total cost of care contracts to *truncate* expenditures to prevent a small number of extremely costly members from significantly affecting providers' per capita expenditures.
- Truncation involves capping individual patient annual spending at a high level, often between \$100k and \$150k for commercial population contracts.
 - Spending above the cap is excluded from benchmark performance assessment at the insurer and provider entity levels.

RI's experience with high-cost outliers

- In RI, analyses showed that high-cost outliers significantly affected performance of provider entities.
 - For one RI ACO, including high-cost outlier spending raised the trend rate by several percentage points.
- Furthermore, total cost of care (TCOC) risk contracts typically remove high-cost outlier spending.
 - The differential treatment of high-cost outliers in the cost growth benchmark program and in TCOC contracts led to confusion and tension around reporting of performance.
- As a result, RI will truncate high-cost outliers starting with 2020 performance data



Design recommendation: Truncation of high-cost outliers

Does the Committee wish to recommend truncating high-cost outliers' spending when measuring insurer and provider entity benchmark performance?

3. Applying risk adjustment

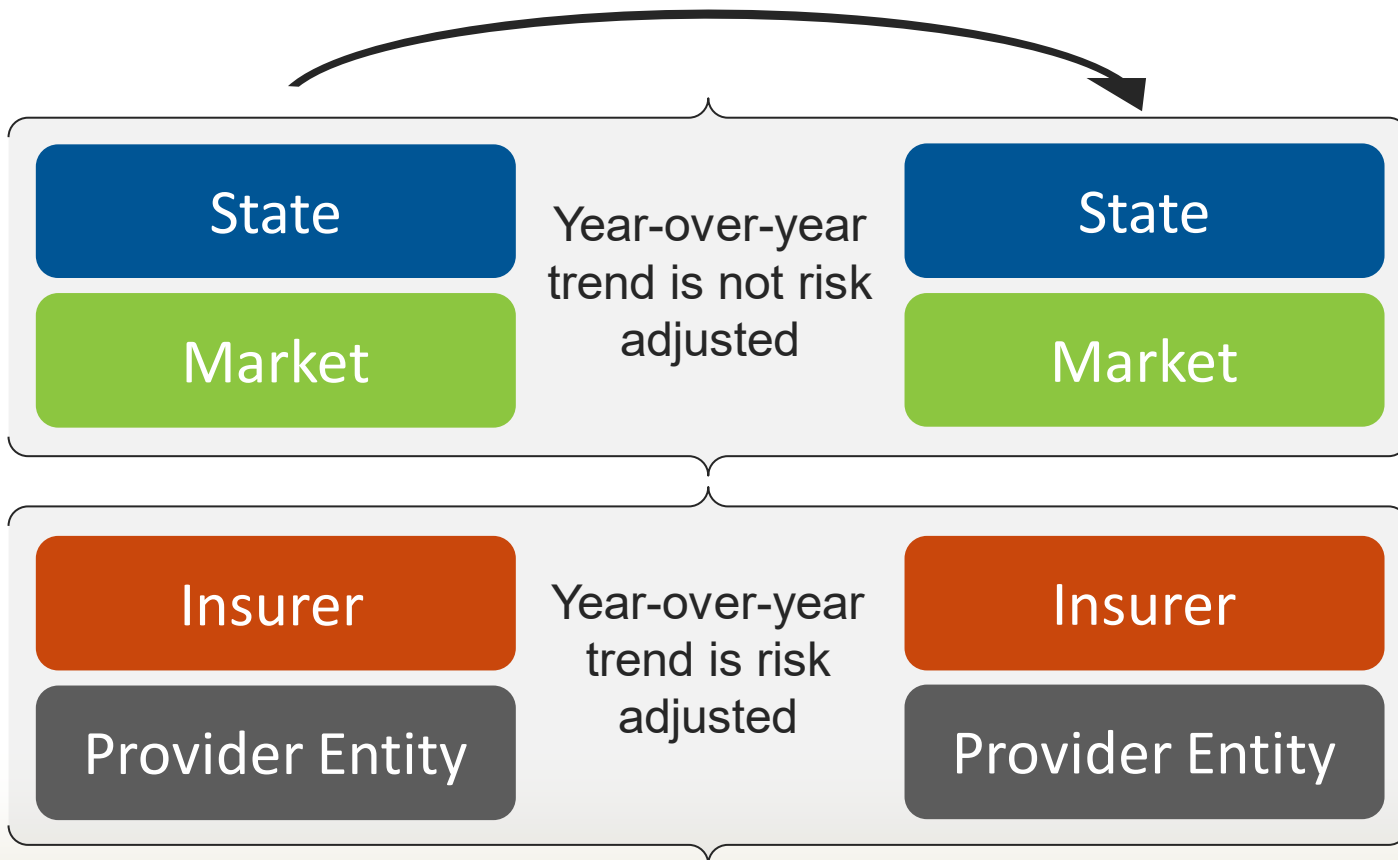
- Cost growth benchmark states typically risk adjust data to account for population changes over time.
 - The composition of a payer's or provider's population may change over the course of a year.
 - Such changes will impact spending growth, e.g., a population that is sicker than a year prior is expected to have higher spending than it would have otherwise.

Risk adjustment models

- *Clinical risk adjustment* is used to assess conditions diagnosed and treated during the performance year to predict spending in the same year.
- Available models use claim encounter data, such as diagnoses, procedures, and prescription drugs.
 - They do not include medical record information, e.g., clinical indicators of severity, measures of prior use, lifestyle or supplemental demographic information.
- The best risk adjustment models can explain about half of the variation on health care spending, and a little more if spending for the highest cost outliers is truncated.*

*Accuracy of Claims-Based Risk Scoring Models, Society of Actuaries, October 2016.

Risk adjustment is only performed at the carrier and provider levels



HB 2457 requirements around risk adjustment

- HB 2457 requires the Board to:
 - “annually calculate total health care expenditures and health care cost growth... for each health care provider or provider system and each payer, taking into account the health status of the patients of the health care provider or the enrollees of the payer, utilization by the patients of the health care provider or the enrollees of the payer, intensity of services provided to the patients of the health care provider or the enrollees of the payer, and regional differences in input prices.”*
- We will walk through how we propose to address these requirements in the implementation.

Adjusting for utilization, service intensity and regional pricing differences

- Reporting of benchmark performance to account for “utilization... intensity of services... and regional differences in input prices” would not be feasible.
 - Not all risk-adjustment models account for these elements, and none account for input prices. Most rely heavily on diagnosis data.
- Understanding how these factors affect cost and cost growth is something that is probably best done through the *data use strategy*.



Design recommendation: Accounting for utilization, service intensity, and regional pricing

Does the Committee wish to recommend addressing utilization, service intensity, and regional pricing differences in the data use strategy instead of the reporting of benchmark performance?

Coding completeness and rising risk scores

- HB 2457's requirement to take into account "health status" suggests the use of clinical risk adjustment, which can be problematic due to rising risk scores.
- Risk scores of a full population are typically stable over time because changes in the demographic and health characteristics that might affect an entire population's risk score occur slowly.
- However, risk scores can change over time without changes in the population's underlying risk due to improved documentation of patient condition on claims.

MA's experience with rising risk scores

- MA has observed steadily rising risk scores year after year, amounting to an 11.7% increase between 2013 and 2018.
 - Only a small portion of the increase could be explained by demographic trends or changes in disease prevalence.
 - The MA Health Policy Commission now recommends evaluating payer and provider performance based on growth in unadjusted spending.

RI's experience with rising risk scores

- In RI, excluding the duals plans, payer risk scores grew 4.6% from 2018 to 2019.
 - Rising risk scores had the effect of essentially raising the cost growth target value by 3.2% - doubling to 6.4% the trend that would meet the cost growth target with an average rising risk score
 - Consequently, RI decided to only risk-adjust data by age and sex starting with the 2020 performance year.

Recommendations for addressing changing population risk

- Adjust performance data using age/sex factors only.
 - Using clinical risk scores overcompensates for possible yearly changes in population health status and creates distortion due to claim coding practices.
 - Age/sex adjustment will capture the impact of an incrementally aging population, which may be the most significant change affecting population health status over the course of a year.



Design recommendation: How to risk adjust data

Does the Committee wish to recommend applying only age/sex factors in the risk adjustment of benchmark performance data?

4. Reporting only on entities with “sufficient” population sizes

- In determining “sufficient” population sizes, there are three separate, but related questions to address:
 - How many enrolled lives must a payer have to report THCE?
 - How many attributed lives must a provider entity have with a payer for its TME to be reported?
 - How many lives must a payer/provider entity have in a line of business for its performance to be publicly reported?

Population size thresholds established by other states

State	Payers Required to Report	Thresholds for Public Reporting Provider Performance
DE and RI	The largest insurers in the state	By line of business, provider entities with: <ul style="list-style-type: none"> • At least 10,000 attributed commercial or Medicaid lives • At least 5,000 attributed Medicare lives
CT	The largest commercial and Medicare insurers representing ~85% of covered lives in the state	TBD
MA	Payers with at least 3,600 attributed lives	No published standard for public reporting
OR	At least 1,000 covered lives across all lines of business	Across all markets, provider entities with at least 10,000 attributed lives

Determining what is a “sufficient” population size

- Determining “sufficient” population sizes becomes less pressing with the adoption of confidence intervals.
- In addition, OR and CT are collecting “pre-benchmark” data, which should shed light on the population sizes at which confidence intervals become so large as to make it difficult to determine benchmark performance.
- For now, we recommend:
 - Requiring reporting from all Medicaid MCOs and carriers with commercial or Medicare Advantage market share at 5% or higher.
 - Deferring on provider entity thresholds until OR and CT have completed their pre-benchmark analyses.



Design recommendation: Minimum population sizes

Does the Committee agree with the following recommendations:

- Requiring reporting from all Medicaid MCOs and carriers with commercial or Medicare Advantage market share at 5% or higher?
- Deferring on provider entity thresholds until OR and CT have completed their pre-benchmark analyses?

Does the Committee wish to make a different set of recommendations to the Board?