Washington State Health Care Authority

Health Care Cost Transparency Board

September 14, 2021

Washington State Health Care Authority

Health Care Cost Transparency Board
Board Book

September 14, 2021
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting Materials

Committee Feedback

Background Material

Washington State Health Care Authority

Agenda

TAB 1

Washington State Health Care Authority

Health Care Cost Transparency Board
AGENDA

September 14, 2021
2:00 p.m. – 4:00 p.m.
Zoom Meeting

Board Members:					
☐	Susan E. Birch, Chair	☐	Sonja Kellen	☐	Kim Wallace
☐	Lois C. Cook	☐	Pam MacEwan	☐	Carol Wilmes
☐	John Doyle	☐	Molly Nollette	☐	Edwin Wong
☐	Bianca Frogner	☐	Mark Siegel	☐	Laura Kate Zaichkin
☐	Jodi Joyce	☐	Margaret Stanley		

Time	Agenda Items	Tab	Lead
2:00-2:10 (10 min)	Welcome, roll call, and agenda review	1	Susan E. Birch, Chair, Director Health Care Authority
2:10-2:15 (5 min)	Approval of August meeting minutes	2	AnnaLisa Gellermann, Board Manager Health Care Authority
2:15-2:20 (5 min)	Recap of last meeting and topics for today's discussion	3	AnnaLisa Gellermann, Board Manager Health Care Authority
2:15-2:45 (30 min)	Finalizing the benchmark methodology and value	4	Michael Bailit and January Angeles Bailit Health
2:45-2:55 (10 min)	Reporting performance against the cost growth benchmark	5	Michael Bailit and January Angeles Bailit Health
2:55-3:45 (50 min)	Data call: Methods to ensure the accuracy and reliability of benchmark performance measurement including the Advisory Committee on Data Issues' Feedback Design Decisions: ✓ Use of Confidence Intervals ✓ Truncation of High-Cost Outliers	6	Michael Bailit and January Angeles Bailit Health
3:45-3:55 (10 min)	Public comment		Susan E. Birch, Chair, Director Health Care Authority

3:55-4:00 (5 min)	Next steps and adjournment		Susan E. Birch, Chair, Director 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 Health Care Cost Transparency Board meeting will be conducted virtually.

Washington State Health Care Authority

August meeting minutes

TAB 2

Health Care Cost Transparency Board meeting minutes

August 17, 2021
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 is available on the Health Care Cost Transparency Board webpage.

Members present

Sue Birch, chair
Lois Cook
John Doyle
Bianca Frogner
Jodi Joyce
Sonja Kellen
Pam MacEwan
Molly Nollette
Mark Siegel
Margaret Stanley
Kim Wallace
Carol Wilmes
Laura Kate Zaichkin

Members absent

Edwin Wong

Call to order

Sue Birch, Board Chair, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

Ms. Birch welcomed the group and shared that she had recently convened with nine other states on the challenges of health care, and that Washington remains a leader in innovation for the nation. Today, she invited the group to evaluate the topic of the cost benchmark impact on the Washington health care market, and to speak from their individual perspectives.

Adoption of minutes

Two corrections were proposed: Sonja Kellen to be correctly reflected as absent, and date of next meeting corrected. Minutes were adopted with proposed corrections.

Presentation: Recap of last meeting and topics for today's discussion

AnnaLisa Gellermann, HCA staff, provided a summary of the preliminary recommendations of the Board on the cost benchmark methodology as preparation for hearing Committee feedback.

The Board's preliminary recommendations were as follows:

- Setting the benchmark value using a 70/30 hybrid of historical median wage and potential gross state product (PGSP). This weighting yields a benchmark value of 3.2%.
- Setting benchmark values for a period of 5 years, as follows: 2022-2023 at 3.2%, 2024-2025 at 3%, and 2026 at 2.8%.

The agenda included hearing committee feedback on proposed sources of coverage to be included in Total Health Care Expenditure (THCE) and on the Board's cost benchmark recommendation, and evaluation of draft trigger language requested from HCA staff. Bailit Health would also introduce the topic of the data call, focusing on reporting performance against the cost growth benchmark and discussing methods to ensure accuracy and reliability of the measurement.

Presentation: Wrap up discussion on total health care expenditures and sources of coverage: Advisory Committee of Health Care Providers and Carriers' feedback and staff research.
Discussion and Decision: Defining THCE and sources of coverage

AnnaLisa Gellermann, HCA staff, recapped the primary sources of health care coverage the Board previously recommended for inclusion in THCE. Jodi Joyce then provided the Board with feedback from the Advisory Committee of Health Care Providers and Carriers on this topic. Committee members agreed with the Board's recommendation to include spending in these markets for all Washington residents, regardless of where they receive care. Members also agreed with the recommendation to capture additional sources if feasible.

Ms. Gellermann provided staff research into the spending totals and feasibility of additional sources of coverage requested by the Board, including the WA Labor and Industries state fund, WA Department of Corrections, Tribal-Indian Health Services (HIS) spending, and public health spending on individuals.

The Board had a lengthy discussion and asked clarifying questions about how information is captured for both claims-based and non-claims-based payments, and coding in public health spending. The Board affirmed its commitment to broadly including in the future as many sources as possible, including IHS and Tribal data, WA Labor and Industries self-insured data, and public health spending.

The Board approved the definition of THCE as including the following sources:

- Medicare (including fee-for-service and Medicare Advantage)
- Medicaid (including fee-for-service and managed care)
- Medicare and Medicaid "duals."
- Commercial (both fully insured and self-insured).
- Labor and Industries state fund.
- Correctional health system.

Presentation: Wrap up discussion on cost benchmark recommendations: Advisory Committee of Health Care Providers and Carriers' feedback and staff proposed language for trigger
Discussion and Decision: Cost benchmark, review, and Trigger

Ms. Gellermann recapped the Board's previous recommendation for the cost benchmark methodology, and staff proposed "trigger language" prompting changes to the benchmark. Ms. Gellermann and Jodi Joyce provided feedback from the Committee, and Ms. Birch led a Board discussion to determine if the Board wished to adjust its decision on benchmark methodology and values.

The Board determined to revisit the benchmark value and implementation, and various Board members made suggestions related to the benchmark value and stability over the initial 5-year period. The Board requested to review the benchmark value and stability at the next meeting.

The Board reviewed staff proposed language for the annual review of the benchmark and the "trigger" for possible changes to the benchmark. After discussion and amendment, the Board approved the following language:

> The Board will annually review performance against the benchmark and may consider any impacts on the overall health system, including cost of care, access to care, quality of care, and impact on specific populations, providers, or market sectors.
>
> In the event of extraordinary circumstances including highly significant changes in the economy or the health care system, the Board may consider changes to the benchmark or to the benchmark methodology.

Public Comment

Ms. Birch called for comments from the public.

Jeb Shepherd, Director of Policy, Washington State Medical Association (WSMA) reiterated key points from the organization's letter submitted to the Board. Mr. Shepherd reported that WSMA supports the adoption of a stable and achievable benchmark but does not support a benchmark that goes below 3.2%, or changes over the initial 5-year period. Mr. Shepherd cited concerns that a lower benchmark would negatively impact providers and undermine confidence in the ability to achieve the goal. He also cited the complication of contracting cycles on a moving target.

Alicia Eyler of the Washington State Hospital Association (WSHA) shared the organization's support of discovering ways to decrease cost trends without causing negative impacts to high quality care. Ms. Eyler described 3.2% as a "high mark" and concurred with the comments of Mr. Shepherd that a lower target might be perceived as unachievable, which would negatively impact community confidence and support. WSHA plans to submit a letter to the Board with more detailed comments.

Presentation: Reporting performance against the cost growth benchmark

The meeting ran out of time; this agenda item will be considered at a future meeting.

Presentation: Data call: Methods to ensure the accuracy and reliability of benchmark performance measurement including the Advisory Committee on Data Issues' Feedback

The meeting ran out of time; this agenda item will be considered at a future meeting.

Adjournment

Next meeting

Tuesday, September 14, 2021
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Meeting adjourned at 4:00 p.m.

Washington State Health Care Authority

Health Care Cost Transparency Board

September 14, 2021

Washington State Health Care Authority

Finalizing the benchmark methodology and values

TAB 3

Washington State Health Care Authority

Finalizing the benchmark methodology and value

Recap of our last meeting

- As a reminder, the Board originally recommended the following benchmark values:
  - 2022-2023: 3.2%
  - 2024-2025: 3.0%
  - 2026: 2.8%
- This was based on 70/30 blend of historical median wage and potential gross state product, meant to convey that health care should not grow faster than growth in consumer finances and the economy.
- We relayed that the Advisory Committee of Providers and Carriers supported the 3.2% value but expressed desire for a stable (unvarying) benchmark value, and concern about the value going below 3.0%.

Recap of our last meeting

- After hearing the Advisory Committee's feedback, the Board carefully weighed:
  - the Advisory Committee's desire for an achievable and stable benchmark; and
  - the need to drive down cost growth.
- The Board considered other potential benchmark values that would be responsive to the Advisory Committee's feedback without compromising the overall goal of leveraging the benchmark to make health care more affordable for consumers.
- Board members also wanted to understand the impact of moving away from the original proposal.

Washington State Health Care Authority

Finalizing the benchmark methodology and value

- To inform today's discussion, we modeled the potential savings from implementing a health care cost growth benchmark under three scenarios:

Years	Benchmark Values		
	Option 1	Option 2	Option 3
2022	3.2%	3.2%	3.0%
2023	3.2%	3.2%	3.0%
2024	3.0%	3.2%	3.0%
2025	3.0%	3.0%	2.8%
2026	2.8%	3.0%	2.8%

Reminder: Trigger language would allow for re-visiting the benchmark value

The Board will annually review performance against the benchmark and may consider any impact of the cost benchmark on the overall health system, including access to care, quality of care, and impact on the specific populations, providers, or market sectors.

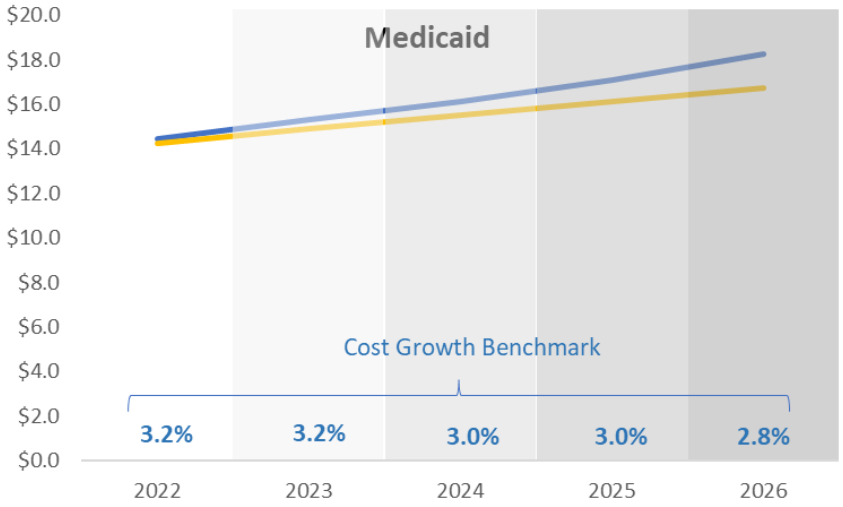
In the event of extraordinary circumstances including highly significant changes in the economy or the health care system, the Board may consider changes to the benchmark or to the benchmark methodology.

Washington State Health Care Authority

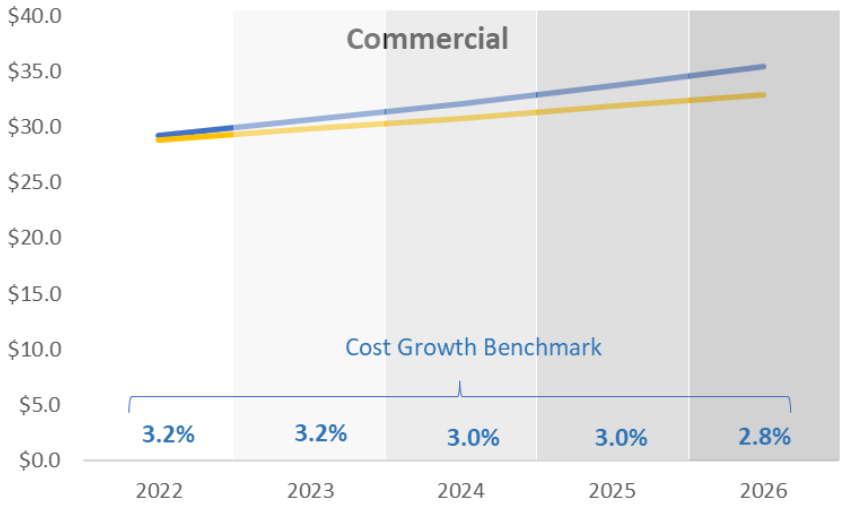
Projected savings under Option 1

CMS' projected health care cost growth compared to health care cost growth with benchmark Option 1, 2022-2026

Medicaid could save $3.8b



Private insurance could save $7.0b



Spending using CMS's projections of spending growth
Spending using benchmark spending growth

NOTE: Projections were derived by taking state-specific estimates of spending in 2014 using CMS's National Health Expenditures data, and projecting them forward using growth in national spending and enrollment (historical through 2018 and projected through 2026). Estimates do not account for COVID-19 impacts. Medicaid estimates only reflect Medicaid and do not include CHIP.

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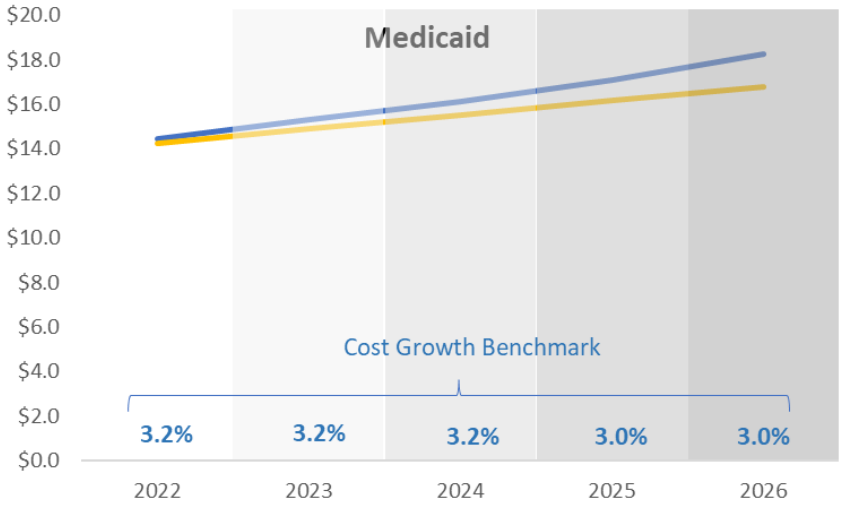
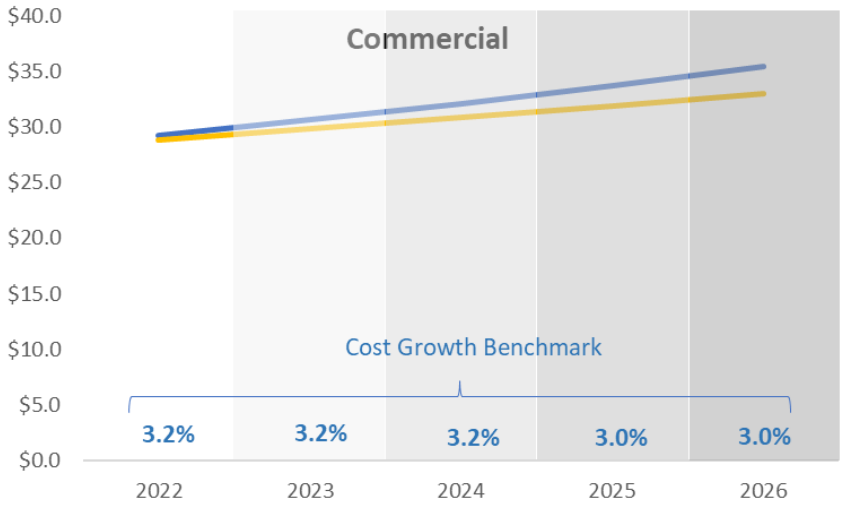
Projected savings under Option 2

CMS' projected health care cost growth compared to health care cost growth with benchmark Option 1, 2022-2026

Medicaid could save $3.6b



Private insurance could save $6.8b



Spending using CMS's projections of spending growth
Spending using benchmark spending growth

NOTE: Projections were derived by taking state-specific estimates of spending in 2014 using CMS's National Health Expenditures data, and projecting them forward using growth in national spending and enrollment (historical through 2018 and projected through 2026). Estimates do not account for COVID-19 impacts. Medicaid estimates only reflect Medicaid and do not include CHIP.

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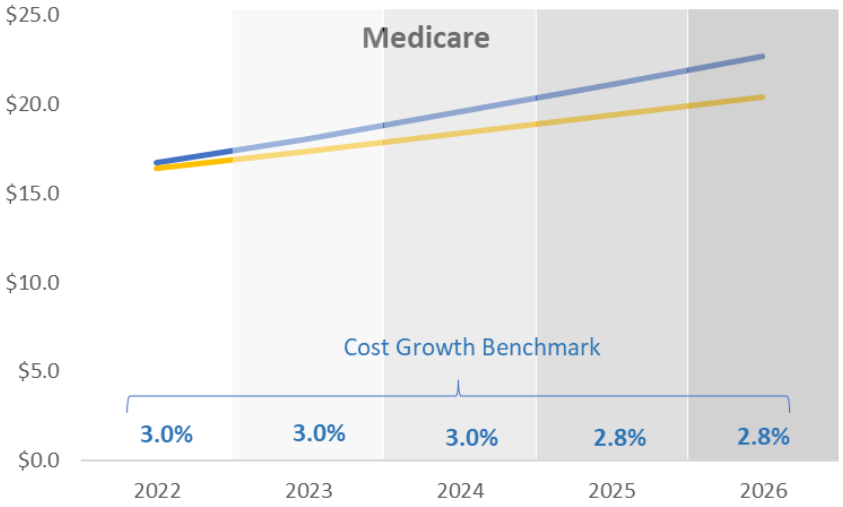
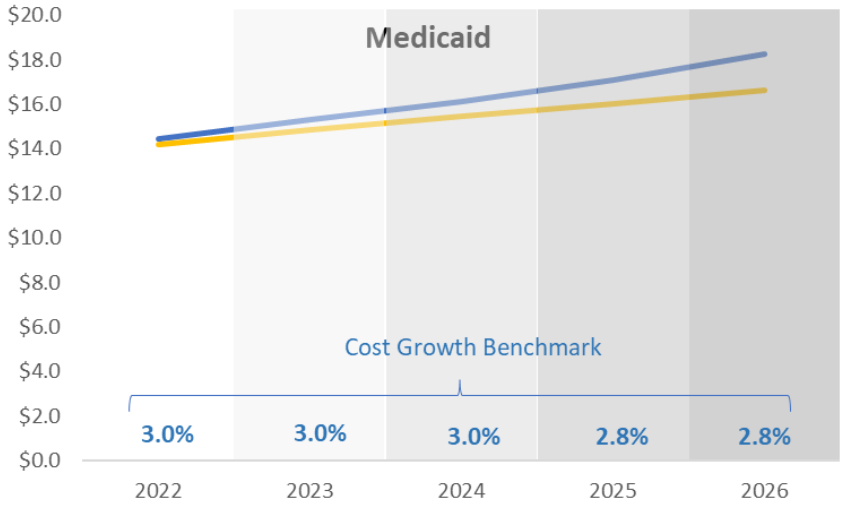
Projected savings under Option 3

CMS' projected health care cost growth compared to health care cost growth with benchmark Option 1, 2022-2026

Medicaid could save $4.1b



Private insurance could save $7.7b



Spending using CMS's projections of spending growth
Spending using benchmark spending growth

NOTE: Projections were derived by taking state-specific estimates of spending in 2014 using CMS's National Health Expenditures data, and projecting them forward using growth in national spending and enrollment (historical through 2018 and projected through 2026). Estimates do not account for COVID-19 impacts. Medicaid estimates only reflect Medicaid and do not include CHIP.

Design decision: Finalizing the benchmark methodology and value

- What should the benchmark values be for 2022 through 2026?

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Reporting performance against the cost growth benchmark

TAB 4

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Reporting performance against the cost growth benchmark

Reminder: 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.

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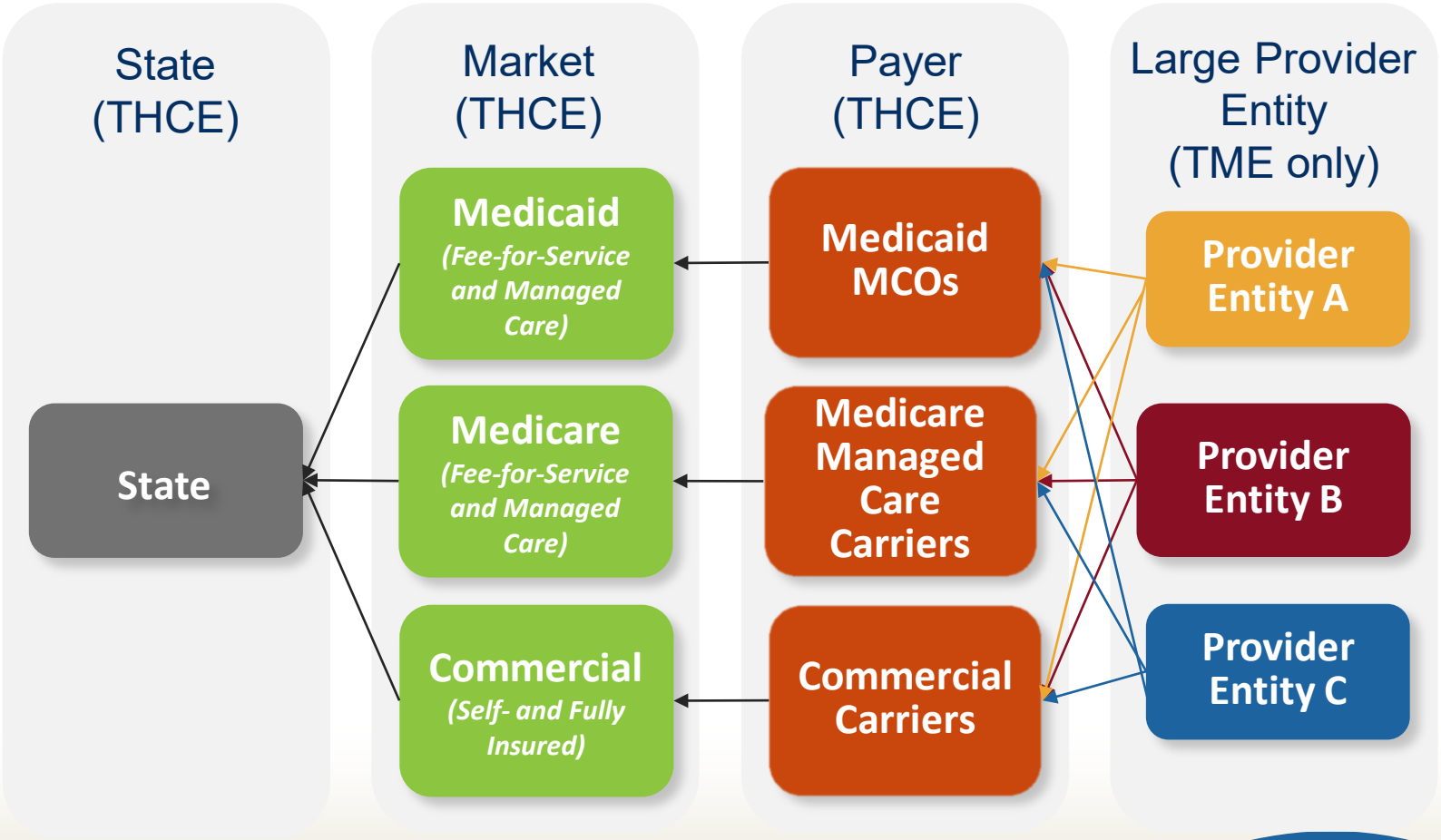
States typically report benchmark performance benchmark at four levels

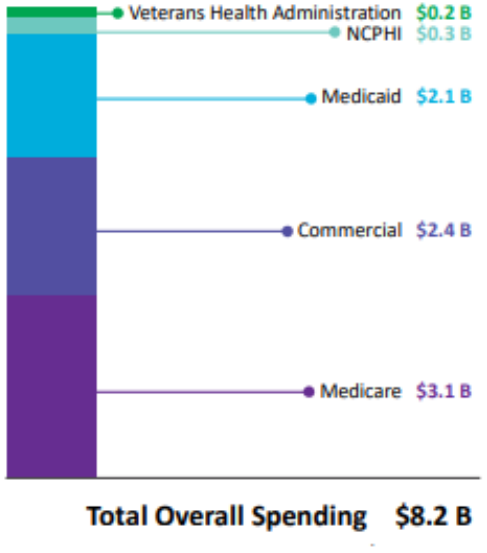


Reporting at the state level: DE example

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 14

* 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.

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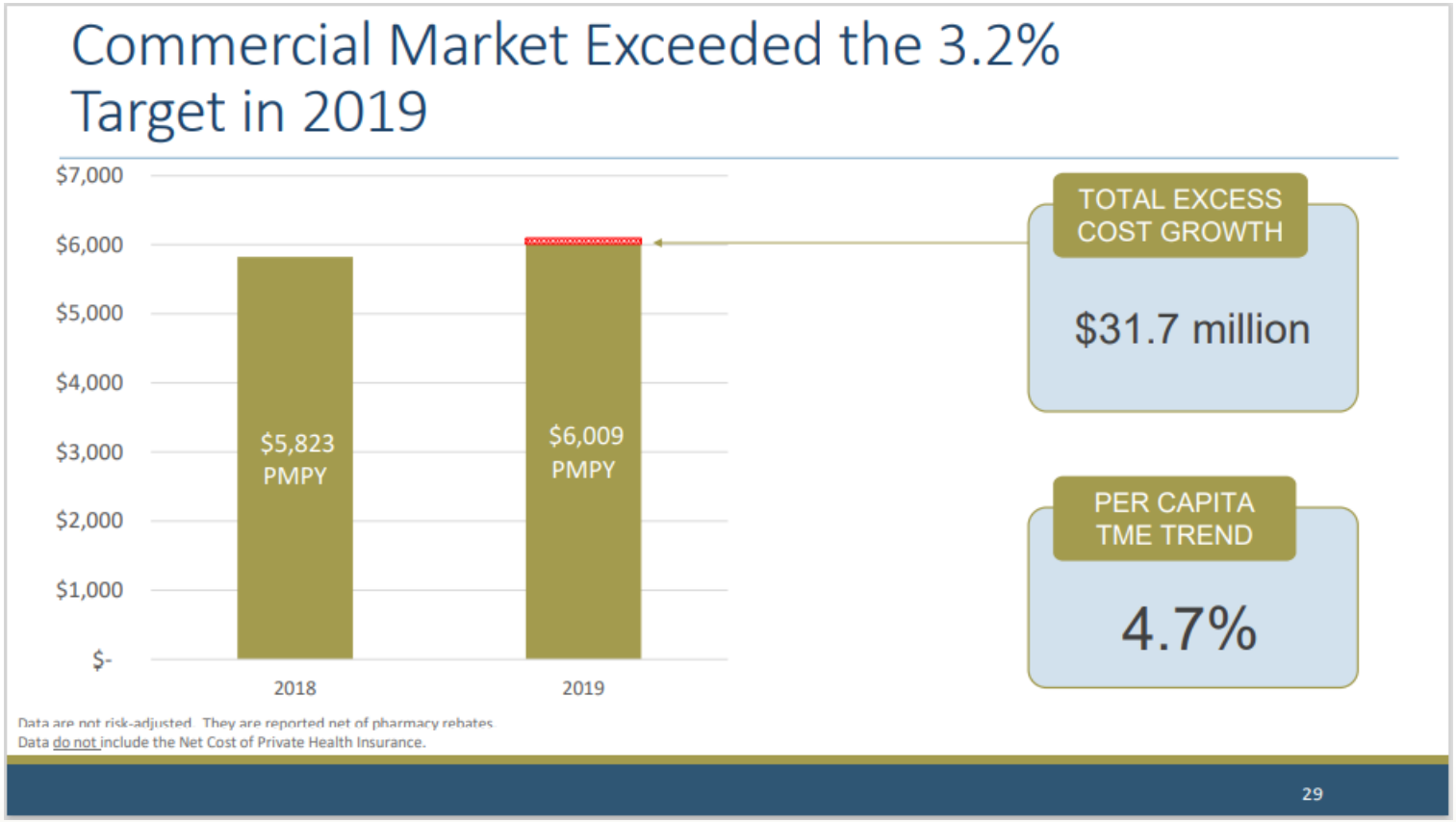
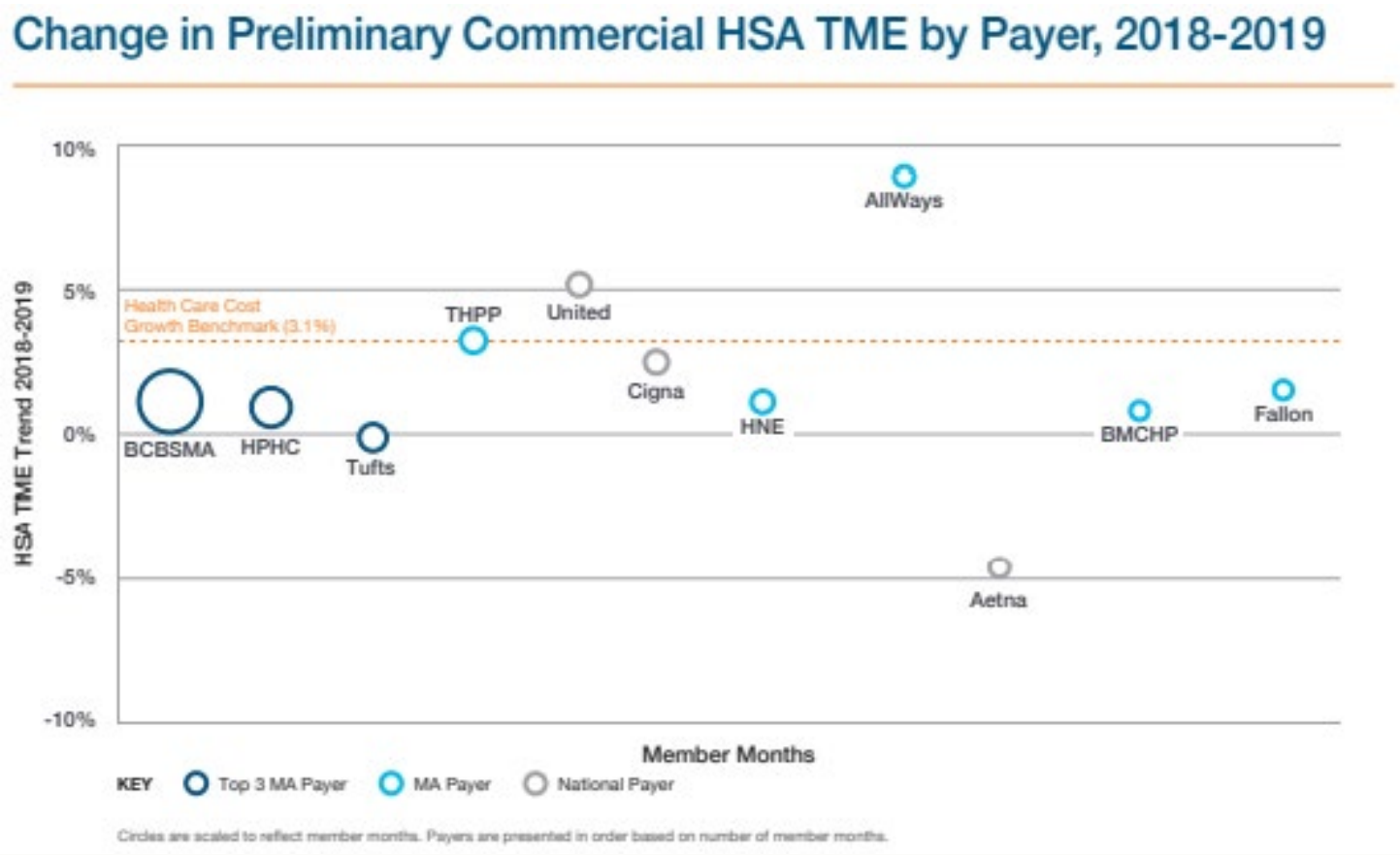
Reporting at the market level: RI example (commercial)



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

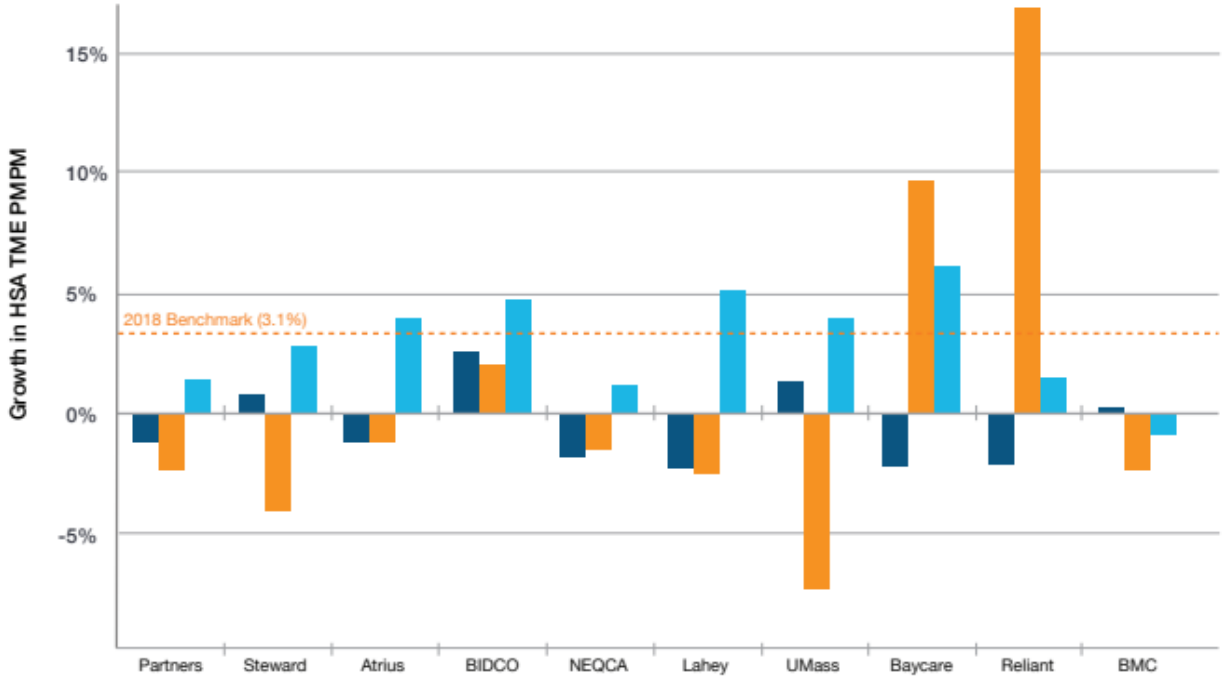
Reporting at the payer level: MA example (commercial)



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

Reporting at the provider level: MA example

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



	Partners	Steward	Atrius	BIDCO	NEQCA	Lahey	UMass	Baycare	Reliant	BMC
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.

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

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A note on reporting at the provider level

- Benchmark performance reporting at the provider level is limited to those providers that:
  - 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 discuss later.

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Data Call

TAB 5

Washington State Health Care Authority

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:
  1. Perform statistical testing on benchmark performance data.
  2. Mitigate the impact of high-cost outliers.
  3. Apply risk adjustment.
  4. 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.

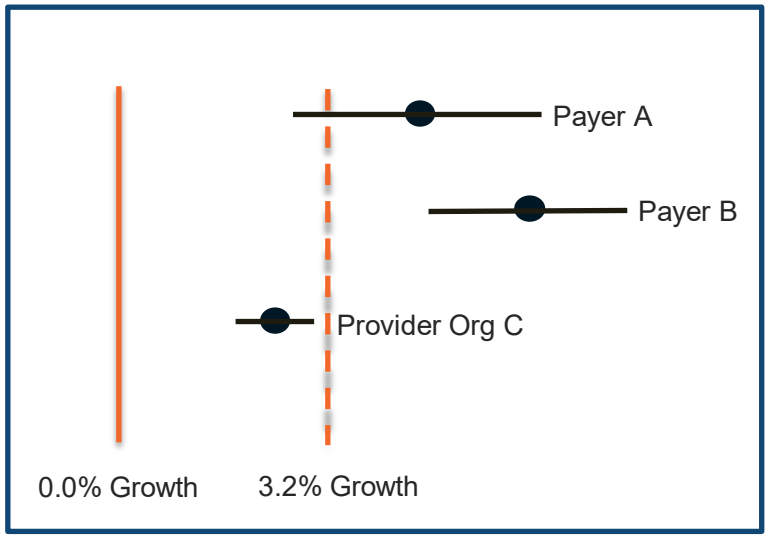
Washington State Health Care Authority

1. Performing statistical testing on benchmark performance

- Washington could develop confidence intervals around benchmark performance.
- The confidence interval would show 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 the assessed entity.

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, CT and RI will be the first states to use confidence intervals in determining benchmark performance.
  - OR developed the methodology, which CT and RI then adopted.
  - All three states are now collecting or analyzing data with plans to use this methodology.
- MA's methodology is defined in statute and cannot be changed without legislation.
- DE thus far has only reported at the state and market level, for which statistical testing is not critical.

Advisory Committee on Data Issues' feedback on use of confidence intervals

- The Advisory Committee on Data Issues supported the use of confidence intervals to assess benchmark performance.
- One Committee member indicated that it would be important to provide clear documentation within the reports on how the confidence intervals were constructed.

Design decision: Use of confidence intervals

Does the Board wish to apply statistical testing and the use of confidence intervals to determine insurer and provider 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, 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 is truncating high-cost outliers starting with 2020 performance data.

Advisory Committee on Data Issues' feedback on truncation

- Most Committee members supported the use of truncation for high-cost outlier spending.
  - One member did not support it, indicating the need to further understand the interaction with other strategies.
- Some Committee members expressed differing opinions on how to set truncation points.
  - One member suggested setting truncation points by disease type/prevalence.
  - Another member responded by stating that doing so would make data collection more complex.
  - Another suggested setting different truncation points for pharmacy and non-pharmacy spending.

Design decision: Truncation of high-cost outliers

Does the Board wish to truncate high-cost outliers' spending when measuring insurer and provider entity benchmark performance?

Risk adjustment and minimum population size

- The Advisory Committee on Data Issues weighed in on the topics of risk adjustment and minimum population size. Additional staff research is needed before the Committee will be ready to make a full recommendation to the Board.
- We will discuss risk adjustment and minimum population sizes at the next Board meeting.

Washington State Health Care Authority

Committee feedback

TAB 6

Washington State Hospital Association

August 19, 2021

Dear Members of the Health Care Cost Transparency Board:

On behalf of more than 100 member hospitals and health systems across Washington, the Washington State Hospital Association (WSHA) appreciates this opportunity to share the hospital perspective on the work of the Health Care Cost Transparency Board (HCCTB).

First, we want to emphasize and acknowledge the hard work and dedication of the HCCTB staff to open communication with stakeholders and a transparent process. WSHA sincerely appreciates the time and efforts made by HCCTB staff members to be accessible and share information with WSHA members and staff. We hope to continue this open and transparent relationship as this process continues, and WSHA hopes to remain a trusted and helpful partner.

Hospitals and health systems in Washington serve as care providers for Washington residents, as well as safety nets in our communities, providing services ranging from preventing illness and diseases, to lifesaving care, to assistance in achieving better overall population health. WSHA members support efforts to reduce the cost of health care, especially for the consumers we serve. The work of the HCCTB is an opportunity to identify significant drivers in health care spending and work together across the entire health care spectrum to uncover creative ways to slow the growth rate of health care costs in our state. This must be done without causing any unintended harms, especially guaranteeing protections to access to high quality care for everyone and maintaining the safety net in our communities.

With these critical components in mind, WSHA appreciates your consideration of the following comments as the work of the HCCTB continues. Specifically, we are asking you to reconsider the benchmark selection, especially the decision to decrease it lower than 3.2 percent; to rethink the process for decision-making and input of the advisory groups; and to consider how the goals of cost reduction can be achieved. Details for each of these points follows.

Thank you again for your consideration of these comments. WSHA looks forward to continuing an open dialogue and to serving as a collaborative partner as these efforts continue. Please do not hesitate to contact Alicia Eyler at AliciaE@WSHA.org if you would like to discuss this information further or have any questions.

Sincerely,

Chelene Whiteaker

Chelene Whiteaker
Senior Vice President, Government Affairs
Washington State Hospital Association

999 Third Avenue, Suite 1400 | Seattle, WA 98104-4041 | PHONE: (206) 281-7211 | FAX: (206) 283-6122 | www.wsha.org

WSHA Detailed Comments

Create a reasonably attainable and stable benchmark value, based on agreed upon formulas. At the HCCTB meeting in July, the board made a preliminary recommendation to establish a benchmark value of 3.2 percent and decrease to 2.8 percent over a five-year period. The 3.2 percent was developed from a formula of projected growth in state median wages and potential growth of state product. However, as emphasized during the July 29 Advisory Committee meeting of Health Care Providers and Carriers, there does not appear to be clear rationale to decrease the benchmark value from 3.2 percent in 2022-2023 to 2.8 percent in 2026.

The 3.2 percent benchmark is itself extremely aggressive. As the board heard, the average growth for WA from 1995 to 2014 was 6.7 percent. For 2019 to 2028, national projections show U.S. per capita health care expenditures are expected to average 5.4 percent. Staying below the national growth rate will be a harder lift in Washington than many other states since per capita costs are already comparatively low. Further, Washington State has worked hard to provide more robust coverage for Medicaid beneficiaries, which in turn increases overall costs. We do not want this work to undermine those gains to access. All this is on top of recurring major challenges, including cost increases from new health care technologies and shortages for nurses and other personnel.

Hospitals are committed to this process, and what we do not want to happen, is for the benchmark value to be gamed, dismissed as unattainable, or create loss of benefits or access to vital, high-quality services for our communities. At the very least, we think there is a need to allow time for health care entities to meet a new benchmark rate. We are concerned with the phase down, and support a stable, achievable benchmark value over five years.

Consider all cost drivers as part of the HCCTB recommendations. WSHA believes any recommendations made by the HCCTB should include a discussion about all the cost drivers in health care. The establishment of a cost containing "blunt instrument" which impacts certain sectors of health care in a disproportionate way has the strong likelihood to cause unintended consequences in our state's health system. So far, when participants have raised concerns around various cost drivers, such as unmet social needs, the concerns have not been addressed or punted to the future. It would be helpful to understand more about when these critical conversations will take place, and how the HCCTB is currently viewing certain health care cost drivers, such as new innovations, pharmaceuticals, and labor costs as discussed above, in their recommendations.

Consider recommendations from the advisory committees before decisions are made by the board. WSHA appreciates the recent adjustments to the process for reporting the advisory committee's feedback to the board. We believe, however, the current feedback process for the advisory committees is still confusing and could be streamlined. The health care experts on the advisory group provide an important perspective that should be considered by the board prior to making an initial recommendation. The current process appears to operate in reverse, with the board making an initial recommendation before hearing the input of the advisory committees.

Discuss end goals. WSHA and our members have been actively engaged with the work of the HCCTB, but the end goals for this process are still not abundantly clear. How are the savings going to be achieved? We hope in the near term to hear more about the strategic goals of the HCCTB, and where you ultimately see these efforts moving. WSHA and our hospitals are interested in discussing solutions and working constructively with the board and other stakeholders to achieve savings.

Washington State Health Care Authority

Background material

TAB 7

Advisory Committee on Data Issues meeting minutes

September 8, 2021
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 is available on the Health Care Cost Transparency Board webpage.

Members present

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

Agenda items

Welcome, Roll Call, Agenda Review

J.D. Fischer, committee facilitator, called the meeting to order at 2:01 p.m.

Approval of Minutes

Mr. Fischer provided a recap of the August Committee meeting, and the Committee approved the August meeting minutes.

Topics for Discussion

Topics relating to the cost growth benchmark measurement, reporting, and analysis presented to the Committee included the following:

- Recap of the Committee's feedback on methods to ensure the accuracy and reliability of benchmark performance measurement.
- Questions to address for provider-level reporting.
- Analyses to inform cost growth mitigation strategies.

Recap of feedback on methods to ensure the accuracy and reliability of benchmark performance measurement

January Angeles and Michael Bailit, Bailit Health
PowerPoint presentation

Ms. Angeles and Mr. Bailit presented a summary of Committee feedback on the use of confidence intervals, truncation, accounting for various factors called for in the benchmark legislation, risk-adjustment, and minimum population size.

One Committee member, who was unable to join the previous meeting, provided comments echoing concerns about using age and sex-based risk-adjustment, adding that alignment between the risk-adjustment and truncation approaches would be beneficial. Ms. Angeles confirmed that staff is conducting additional research on risk-adjustment and will plan to re-visit the topic with the Committee at the next meeting.

Another Committee member agreed with the summary provided and emphasized the importance of reviewing additional information to gain a better understanding of truncation, attribution, and risk-adjustment methodologies.

Key questions to address for provider-level reporting

January Angeles and Michael Bailit, Bailit Health
PowerPoint presentation

Ms. Angeles and Mr. Bailit presented material to the Committee detailing a series of important questions to address relating to the following topics:

- How members should be attributed to clinicians.
- How clinicians should be organized into larger entities.

How should members be attributed to clinicians?
Ms. Angeles and Mr. Bailit presented information to the Committee relating to member attribution methodologies for the purposes of assigning accountability. For benchmark reporting purposes, carriers will report spending by large provider entities, using an attribution methodology to connect spending for members to a primary care physician (PCP) and then connect that PCP to a large provider entity, if possible. For members who cannot be assigned to a PCP and for PCPs who cannot be tied to a large provider entity, carriers will report spending in aggregate. In general, there are two approaches for attributing members to clinicians: 1) a common methodology shared across carriers, which supports comparisons of performance across carriers but adds a layer of complexity to the process, and 2) allowing carriers to utilize their own methodology, which makes reporting easier for carriers but could lead to some inconsistencies in comparing providers across carriers. Ms. Angeles shared an example approach used in Massachusetts and Oregon where carriers are allowed to use their own attribution methodology so long as the methodology follows a hierarchy as follows:

1. Member selection
2. Contract arrangement
3. Utilization

Ms. Angeles posed the question to the Committee of how members should be attributed to clinicians. One Committee member asked about the appropriateness of attributing members to PCPs and connecting those PCPs to the cost growth, and Mr. Bailit reiterated that the purpose of attribution is for the reporting of health care spending, while those accountable for the cost growth benchmark are large provider entities.

Ms. Angeles asked if the Committee desired to recommend an attribution methodology or approach. One Committee member confirmed that from a carrier perspective, allowing plans to use the same attribution methodologies they use in their contracts would be beneficial for consistency and accuracy. Another Committee member asked if there has been an analysis of the variation in attribution methodologies within any of the states with a cost growth benchmark. Mr. Bailit shared that in a comparison of methodologies within one state, there were only minor differences, however the assessment was somewhat subjective, as it was made without running a more detailed simulation and data analysis. Mr. Bailit added that the general experience from other states is that requiring carriers to use a common attribution methodology that may deviate from the methodology they use in contracts is a significant challenge for insurers. He added that where insurers are permitted to use their own attribution methodology, there is a common expectation that carriers use the same methodology for their own reporting over time. Multiple Committee members voiced support for requiring consistent methodologies used over time, for transparency, and for adopting a hierarchy for carriers to follow within their attribution methodologies.

How should clinicians be organized into larger entities?
Ms. Angeles and Mr. Bailit presented information to the Committee related to the question of how to organize clinicians into larger provider entities. Ms. Angeles shared examples from other states with cost growth benchmarks on approaches to matching clinicians to organizations. Massachusetts matches National Provider Identifier (NPI) numbers to physician groups, Connecticut developed a list of provider organizations based on carrier feedback on total cost of care contracts, Rhode Island identifies the largest Accountable Care Organizations (ACOs) in the state, and Oregon asks payers to associate organizations with Tax Identification Numbers (TINs) that the state will analyze to determine the large provider entities that will be reported on. One Committee member suggested a focus on entities that have assumed accountability for patient populations, as in ACOs. The Committee discussed at length the ACO landscape in Washington, and Mr. Bailit clarified that an approach focused on Accountable Care Networks and ACOs would necessarily include both ACOs and those providers large enough to enter ACO arrangements but have not.

The Committee discussed the importance of capturing provider organizations through a chosen unit of analysis. Mr. Bailit shared the possibility of aggregating provider data across carriers, but not based on ACO, but rather through a defined size or type of provider entity.

With the meeting nearing its close, Ms. Angeles offered next steps to review the comments offered by the Committee and identify the information needed to more fully evaluate the options and answer questions raised. Mr. Bailit added that ultimately the Board must weigh in on the approach, but that it would be valuable to have further conversations with the Committee.

Analyses to inform cost growth mitigation strategies

January Angeles and Michael Bailit, Bailit Health
PowerPoint presentation

Ms. Angeles and Mr. Bailit prepared a presentation to the Committee relating to analyses to inform cost growth mitigation strategies. Due to time constraints, this topic was not addressed and will be covered in the next Committee meeting.

Public Comment

There was no public comment.

Wrap Up and Adjournment

Meeting adjourned at 3:58 p.m.

Next meeting

Thursday, October 28, 2021
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.