Washington State Health Care Authority

Health Care Cost Transparency Board

December 15, 2021

Washington State Health Care Authority

Health Care Cost Transparency Board
Board Book

December 15, 2021
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting Materials

Topical Material

Washington State Health Care Authority

Agenda

TAB 1

Washington State Health Care Authority

Health Care Cost Transparency Board
AGENDA

December 15, 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		
☐	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 November meeting minutes	2	AnnaLisa Gellermann, Board Manager Health Care Authority
2:15 – 2:20 (5 min)	Recap of decisions from the last meeting	3	January Angeles Bailit Health
2:20 – 2:50 (30 min)	Attribution in Health Care Authority programs Design Decision: *Member attribution methodology*	4	January Angeles Bailit Health
2:50 – 3:00 (10 min)	Public comment		Susan E. Birch, Chair, Director Health Care Authority
3:00 – 3:30 (30 min)	Provider entities accountable for total medical expenditures Design Decision: *Clinical attribution*	5	January Angeles Bailit Health
3:30 – 4:55 (25 min)	Cost growth benchmark accountability	6	January Angeles Bailit Health
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

November meeting minutes

TAB 2

Washington State Health Care Authority

Health Care Cost Transparency Board meeting minutes

November 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
Bianca Frogner
Jodi Joyce
Sonja Kellen
Pam MacEwan
Molly Nollette
Mark Siegel
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

John Doyle

Call to order

Sue Birch, Board Chair, called the meeting to order at 2:05 p.m.

Agenda items

Welcoming remarks

Ms. Birch welcomed the members.

Adoption of minutes

The minutes were adopted.

Presentation: Recap of last meeting discussions

Michael Bailit of Bailit Health reviewed the discussion and decisions of the September Board meeting. The Board finalized the cost benchmark at 3.2% for 2022-23, 3.0% for 2024-25, and 2.8% for 2026. The Board also discussed strategies to ensure the accuracy and reliability of measurement and endorsed two strategies: the application of confidence intervals, and truncation above a to-be-defined threshold for very high-cost members.

Presentation: Using risk adjustment when determining benchmark performance

Michael Bailit of Bailit Health gave a presentation about the use of risk adjustment to account for changes in population health status that might impact spending growth. Also known as clinical risk adjustment, available models use claim and encounter data such as diagnoses, procedures, and prescription drugs. For purposes of benchmark reporting, risk adjustment is performed at the carrier and provider level, and not the state or market level.

HB 2457 requires Washington's benchmark to consider health status, utilization, intensity of services, and difference in input prices. Mr. Bailit shared that adjusting the benchmark for utilization, intensity of services, and differences in input pricing would not be feasible or desirable, and that no other state adjusts the benchmark for these factors. The Advisory Committee on Data Issues recommended that these factors be addressed in the cost driver analysis rather than benchmark risk adjustment. Ms. Birch asked about the impact of the pandemic on utilization and the benchmark, and Mr. Bailit shared that these years would be recognized as an anomaly in reporting and that states are not changing methodology. One Board member shared her opinion that if all the listed risk adjustments were made to the benchmark there would be nothing of value left.

Mr. Bailit then discussed risk adjustment for health status, reporting that risk scores have been growing every year in a way that does not appear correlated with changes in population health status. He shared the experience of both Massachusetts and Rhode Island that have observed steadily rising risk scores unexplained by demographic trends or changes in disease prevalence. The effect can be to disguise increases in the spending increases in population risk.

Mr. Bailit presented the Board with four options to risk adjust health data: age/sex adjustment performed by the payers, age/sex adjustment performed by the state, clinical risk adjustment normalization performed by payers, and clinical risk adjustment normalization performed by the state. One Board member expressed concern over oversight and consistency if payers submit their own risk adjusted data. Mr. Bailit responded that results were not as "clean" as the state performing one method for all payers and requiring payers to use the same software/method year after year provided a more consistent comparison.

Mr. Bailit also shared feedback from the Advisory Committee on Data issues that the option of age/sex adjustment performed by the state received the most support, but that several Committee members preferred that the state performs clinical adjustment normalization on all payer data. Staff shared that this option was not feasible within current resources.

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

The Board decided not to adjust the benchmark for utilization, intensity of services and difference in input pricing, and expressed an expectation that these factors would be present in the cost driver analysis.

Design Decision: How to risk adjust data

The Board decided to select age/sex adjustment performed by the state. The Board directed that staff explore future adoption of clinical risk adjustment normalization performed by the state, as resources become available.

Public Comment

Ms. Birch called for comments from the public.

Vishal Chaudry, Chief Data Officer, HCA, updated the Board on national developments related to state All Payer Claims Databases (APCD). Specifically, the Federal No Surprises Act creates an advisory committee on the pathway to submit self-insured data to state APCDs. Mr. Chaudry expressed his opinion that the Board creates a shared incentive for all payers to participate in the database.

Presentation: Key questions to address for provider level reporting

January Angeles of Bailit Health presented the Board with information related to provider level reporting, including how members should be attributed to clinicians, and how clinicians should be organized into provider entities for reporting. She reminded the Board that all cost benchmark states report on large provider entities. Spending that cannot be attributed to a particular entity will still be captured in the data call and in the statewide and market measures. Members may be attributed through a common methodology, or through each purchaser's own attribution methodology. Ms. Angeles shared that all other states use primary care providers (PCP), attribution, leaving the methodology up to the insurer. Massachusetts and Oregon add specificity of reporting in a hierarchy by member selection, contract arrangement, and utilization.

The Board asked several questions about attributing through PCP, recognizing that many members have no PCP, have no utilization, or do not engage PCPs in seeking care.

Ms. Angeles also summarized the feedback from the Advisory Committee on Data issues that a standard methodology would be difficult for carriers, but that there was value in material consistency in the attribution of methodologies. One Committee member suggested that the state more specifically define and provide a primary care taxonomy or procedure codes. The option that received the most support was to adopt the methodology used in Massachusetts and Oregon of using individual payer methodology with a reporting hierarchy.

Ms. Birch asked what other attribution resources were available in the state, or what else might be considered. The Board discussed attribution related to the Department of Labor and Industries spend, and issues of PCP attribution related to access and accountability. One Board member asked for clarification on the methodologies used by the Washington Health Alliance and One Health Port.

Ms. Angeles shared the two basic methods for organizing clinicians into large provider entities: using a state-wide provider directory (as in Massachusetts) or using a pre-defined list of providers and requesting payers report on them through information in provider contracts. Ms. Angeles shared that Oregon intends to use their data call to assist in building a provider directory and has asked payers to report provider organization by their tax identification numbers (TIN). States without a provider directory, including Rhode Island and Connecticut, perform attribution based on providing payers with a list of identified providers and asking payers to report on them based on existing contracts.

The Advisory Committee on Data Issues felt it was important to identify large provider entities based on a framework of cost accountability.

Design Decision: How to attribute patients to clinicians

The Board deferred the decision and requested staff to provide additional information on available attribution methods.

Design Decision: How to organize clinicians into large provider entities

The Board did not consider this issue and deferred the topic to the next meeting.

Adjournment

Meeting adjourned at 4:00 p.m.

Next meeting

Wednesday, December 15, 2021
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Health Care Cost Transparency Board

December 15, 2021

Washington State Health Care Authority

Topics for today

- Recap of recommendations and discussions from the last meeting.
- Attribution in Washington Health Care Authority programs.
- Finalizing Board recommendations on attribution.
- Cost growth benchmark accountability.

Washington State Health Care Authority

Recap of last meeting discussions

TAB 3

Recap of decisions from the last meeting

Board decisions around risk-adjustment

- The Board decided to address the legislative mandate to account for utilization, service intensity and regional pricing differences in cost growth driver analyses.
- Based on current timing and capacity, the Board determined that HCA should perform age/sex risk adjustment using standard weights developed by the HCA.
- The Board also recommended that for the future, HCA consider performing clinical risk adjustment normalization using data from the All-Payer Claims Database, as resources allow.

Washington State Health Care Authority

Attribution in Health Care Authority programs

TAB 4

Attribution in Health Care Authority programs

Washington State Health Care Authority

Reminder of decision points on attribution

- To facilitate the reporting of spending data, payers need instructions on how to do two levels of attribution:

Board discussion around member attribution (continued)

- Staff presented two options for attributing *members to clinicians*:
  1. Require insurers to apply a *standard attribution methodology* that is primary care-based.
  2. Allow insurers to use their *own attribution methodology* (either based on their value-based payment contracts or on internal quality initiatives).
- All states use the second approach but ask insurers to use a primary care-based attribution model.
  - Oregon and Massachusetts, allow insurers to use their own primary care-based attribution methodology, and suggest following a hierarchy that prioritizes primary care provider selection, followed by contracting arrangements, and then primary care utilization.

Board discussion around member attribution (continued)

- Some Board members expressed concerns about using a primary care-based attribution methodology, noting that:
  - It could penalize primary care providers (PCPs) who may not play a role in the individual's care.
  - There is no accountability for non-PCPs that may be contributing to high and rising costs.

Considerations for defining the attribution methodology

- It is standard for attribution in total cost of care (TCOC) contracts to be primarily, if not exclusively, PCP-based.

The Washington Health Alliance attribution methodology

- The WHA applies a PCP-based attribution "based on the concept that the PCP is the clinician who is primarily responsible for a patient's preventive care management."
- Each patient is assigned to a single PCP based on the following hierarchy:
  1. Greatest number of Evaluation and Management (E&M) visits.
  2. Highest sum of relative value units associated with the services based on the E&M visits in #1 above.
  3. Most recent service date.

Staff Assessment of Feasibility of Using the Washington Health Alliance Methodology

- The attribution methodology has been vetted with clinical leaders and payers across the state.
  - To the extent that the Board wishes to require payers to use a standard methodology, this methodology has the greatest likelihood of gaining acceptance.
- However, some payers would likely have difficulty implementing the second level of the attribution methodology which relies on proprietary software.

Staff recommendations on member attribution

- Staff recommend allowing insurers to use their own primary care-based attribution methodology that, if possible, prioritizes:
  1. Member selection
  2. Contract arrangement
  3. Utilization
- This is in line with recommendations made by the Advisory Committee on Data Issues.
- It is also based on staff assessment that this would strike the best balance between having some level of standardization and operational feasibility for insurers.

Design decision: Member attribution methodology

Does the Board wish to require that payers attribute members to clinicians based on:

- Payers' own methodologies?
- Payers' own methodologies, that, if possible, prioritizes member selection, contract arrangements, and then utilization?
- A common methodology, specifically the Alliance methodology?

Public comment

Washington State Health Care Authority

Washington State Health Care Authority

Provider entities accountable for total medical expenditures

TAB 5

Provider entities accountable for total medical expenditures

Provider entities accountable for total medical expenditures

- While patients are attributed to a specific provider, the accountability for total medical expenditures (TME) falls to the large provider entity, not to the individual clinician.
- TME-accountable provider entities typically include those that could (in theory) take on total cost of care contracts because they:
  - Include PCPs who direct a patient's care.
  - Can exert influence over where a patient receives care.
- Provider entities do not have to be in actual TCOC contracts to be TME-accountable.

Health Systems

With contracted and/or employed PCPs

May include combination of hospitals, medical groups, and ancillary providers

Hospitals

Not part of health systems

- with PCPs
- w/o PCPs

Medical Groups

Not part of health systems

- with PCPs
- w/o PCPs

Independent Physician Associations (IPAs)

Network of independent physician practices, including PCPs

- Free-Standing Ancillary Providers
- Solo / Small Providers (not PCP)
- Post-Acute Providers
- Pharmacy

Accountable for TME

Not accountable for TME

Washington State Health Care Authority

Board discussion around clinician attribution

- Staff presented two options for attributing *clinicians to large provider entities*:
  1. Attribution based on a statewide provider directory (Massachusetts and Oregon approach).
  2. Attribution based on contracting arrangements (Connecticut and Rhode Island approach).
- Board members discussed available options for developing a provider directory including:
  - The Health Insurance Exchange's provider directory.
  - A database maintained by the Office of the Insurance Commissioner that includes all contracted providers and their NPI numbers.
  - Directories maintained by OneHealthPort and the WHA.

The Washington Health Alliance provider directory

- The WHA maintains a roster of providers that are assigned to clinics, some of which are assigned to larger medical groups or health systems.
- The rosters are updated by providers themselves, some of whom provide more frequent updates than others.
- Staff are reviewing the WHA's guidelines for external use of Alliance intellectual property to determine the feasibility of using the WHA's provider directory.

Options for attributing clinicians to a large provider entity

1. Provide insurers with a provider directory that details organizational affiliations so they can perform the attribution.
2. Instruct insurers to attribute clinicians based on their contracting arrangements with large provider entities.
   - Insurer contracts should specify which clinicians are part of the contract with the large provider entity.

Pros and cons of approaches to clinician attribution

Option	Pros	Cons
Option 1: Insurers do attribution based on the Alliance provider directory	Clear delineation of entities to which clinicians "belong"	Feasibility depends on terms of licensing agreement for provider directory
Option 2: Insurers do attribution based on contracting arrangement	More closely aligned with payer and provider arrangements around accountability	Definition of which clinicians belong to which provider entity may vary from payer to payer or by product line

Design decision: Clinician attribution

- Staff recommend Option 1 if determined to be feasible, with Option 2 as the fallback should terms for using the Alliance's provider directory not allow for Option 1.
- Does the Board support moving forward with the above recommendation?

Washington State Health Care Authority

Cost growth benchmark accountability

TAB 6

Cost growth benchmark accountability

Washington State Health Care Authority

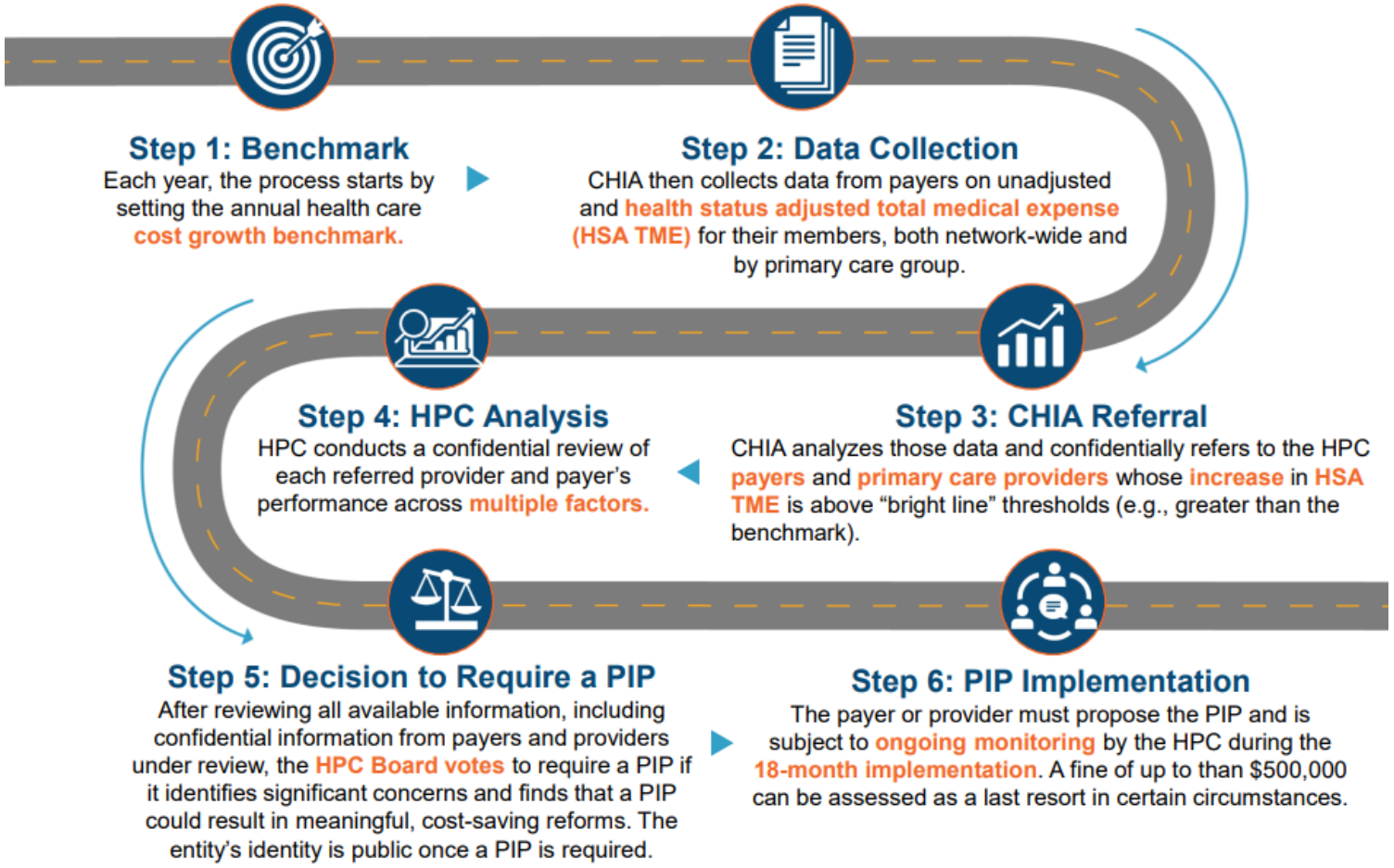
Legislative language on benchmark accountability

"The board shall provide analysis of the factors impacting these trends in health care cost growth and, after review and consultation with identified entities, shall identify those health care providers and payers that are exceeding the health care cost growth benchmark."

Questions for the Board to consider

- What process(es) should be in place for reporting cost growth benchmark performance?
- How should performance be reported?
  - Report only whether the entity met or exceeded the benchmark?
  - Report entity's cost growth?
- How much and what types of communication should accompany the cost trends report?
- What other activities, if any, should accompany the release of the cost trends report?

Massachusetts' accountability process



SOURCE: David Seltz, Presentation on the Benchmark Modification Process, March 25, 2021, available at: https://www.mass.gov/doc/presentation-benchmark-hearing-march-25-2021/download.

Washington State Health Care Authority

Washington State Health Care Authority

Topical material

TAB 7

List of Potential Carriers for Benchmark Performance Data Collection
DRAFT as of 10/26/21

Carrier	Covered Lives
Kaiser Foundation Grp	
Kaiser Found Hlth Plan of the NW	93,720
Kaiser Found Hlth Plan of WA Options	153,315
Kaiser Foundation Hlth Plan of WA	430,146
UnitedHealth Grp	
All Savers Ins Co	6,261
Pacificare Life & Hlth Ins Co	603
Sierra Hlth & Life Ins Co Inc	2,599
UnitedHealthcare Ins Co	Not available
UnitedHealthcare of OR Inc	117,916
UnitedHealthCare of WA Inc	273,312
Premera Blue Cross Grp	
Lifewise Assur Co	259,939
LifeWise Hlth Plan of WA	38,580
Premera Blue Cross	614,625
Molina Healthcare Inc Grp	
Molina Healthcare of WA Inc	977,248
Cambia Health Solutions Inc	
Asuris NW Hlth	38,840
BridgeSpan Hlth Co	2,169
Regence BCBS of OR	62,511
Regence Blue Shield	439,995
Regence Blue Shield of ID Inc	1,282
Centene Corp Grp	
Coordinated Care Corp	37,036
Coordinated Care of WA Inc	204,061
Health Net Hlth Plan of OR Inc	902
WellCare Hlth Ins Co of WA Inc	80
WellCare of WA Inc	1,442
Community Hlth Network Grp	
Community Health Plan of Washington	253,014
Anthem Inc Grp	
Amerigroup Washington Inc	208,826
Unicare Life & Hlth Ins Co	Not available
Humana Grp	
Arcadian Hlth Plan Inc	54,728
Humana Ins Co	103,917
CVS Grp	
Aetna Better Hlth of WA Inc.	22,235
Aetna Hlth & Lif Ins Co	Not available
Aetna Hlth Inc PA Corp	3,121

Carrier	Covered Lives
Health Alliance NW Hlth Plan	**11,872**
Cigna Hlth & Life Ins Co	**Not available**
TOTAL	**4,414,295**

NOTES:

- Enrollment data obtained from the State of Washington Office of Insurance Commissioner's (OIC) 2020 Market Information Report, available at: https://www.insurance.wa.gov/sites/default/files/documents/2020-market-information-report_0.pdf
- List includes group and individual markets for Accident and Health LOB as Reported by OIC.
- Membership across all listed insurers with enrollment data comprise 66% of total membership if including limited benefit plans (e.g., prescription, dental, vision), and 96% of membership if excluding limited benefit plans.
- Medicaid managed care plans include:
    - Amerigroup – 211,402
    - Community Health Plan of Washington – 221,798
    - Coordinated Care of Washington – 187,972
    - Molina Healthcare of Washington – 915,234
    - UnitedHealthcare Community Plan – 224,943

  Medicaid managed care enrollment obtained from WA HCA Report titled, "Monthly Managed Care Enrollees by Program, Organization and RAC." Last checked: 8/13/2021, report run date: 7/12/2021 12:08:35 PM. Available at: https://www.hca.wa.gov/about-hca/apple-health-medicaid-and-managed-care-reports#managed-care-enrollment.

List of Potential Providers for Health Care Cost Growth Benchmark Measurement
DRAFT as of 10/26/21

Community Health Centers	Medical Groups and IPAs	Health Systems
1. Columbia Basin Health Association 2. Columbia Valley Community Health 3. Community Health Care 4. Community Health Association of Spokane 5. Community Health Center of Snohomish County 6. Community Health of Central Washington 7. Country Doctor Community Health Centers 8. Cowlitz Family Health Center 9. Family Health Centers 10. HealthPoint 11. International Community Health Services 12. Lewis County Community Health Services (Valley View Health Center) 13. Moses Lake Community Health Center 14. Neighborcare Health 15. NEW Health Programs Association 16. North Olympic Healthcare Network PC 17. Peninsula Community Health Services 18. Sea Mar Community Health Centers 19. Seattle-King County Public Health Dept (Health Care for the Homeless Network) 20. Tri-Cities Community Health 21. Unity Care Northwest 22. Yakima Neighborhood Health Services 23. Yakima Valley Farm Workers Clinic	1. Allegro Pediatrics 2. The Vancouver Clinic 3. Western Washington Medical Group 4. Whitman Medical Group	1. Astria Regional Medical Center 2. Confluence Health 3. EvergreenHealth 4. Harbor Regional Health 5. Inland Northwest Health Services 6. Kadlec 7. Kaiser 8. Kittitas Valley Healthcare 9. Legacy Health 10. LifePoint Health 11. Mason General Hospital and Family of Clinics 12. MultiCare Health 13. Olympic Medical Center 14. OptumCare 15. Overlake Medical Center & Clinics 16. Pacific Medical Centers 17. PeaceHealth 18. Providence Health 19. Skagit Regional Health 20. Swedish Health Services 21. UW Medicine 22. Virginia Mason Franciscan Health

NOTES:

- Focuses on large provider entities that provide primary care and could enter into total cost of care contracts.
- The list of Community Health Centers does not include four that have less than 5,000 covered lives: (1) Seattle Indian Health Board Inc; (2) Mattawa Community Medical Clinic; (3) The NATIVE Project; and (4) Colville Confederated Tribes.
- Some health systems include several medical centers that may be worth reporting on separately.