Washington State Health Care Authority

Health Care Cost Transparency Board

January 19, 2022

Washington State Health Care Authority

Health Care Cost Transparency Board
Board Book

January 19, 2022
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting Materials

Resources

Washington State Health Care Authority

Agenda

TAB 1

Washington State Health Care Authority

Health Care Cost Transparency Board
AGENDA

January 19, 2022
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 December meeting minutes	2	AnnaLisa Gellermann, Board Manager Health Care Authority
2:15 – 2:20 (5 min)	Topics for today	3	Michael Bailit and January Angeles Bailit Health
2:20 – 2:55 (35 min)	Reflections on Year 1 activities and process	4	Michael Bailit and January Angeles Bailit Health
2:55-3:05 (10 min)	Public comment		Susan E. Birch, Chair, Director Health Care Authority
3:05-3:20 (15 min)	Review of meeting plan for Year 2	5	Michael Bailit and January Angeles Bailit Health
3:20-3:55 (35 min)	Discussion of analyses of cost and cost growth drivers	6	Michael Bailit and 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

December meeting minutes

TAB 2

Health Care Cost Transparency Board meeting minutes

December 15, 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
Mark Siegel
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

Molly Nollette

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.

Approval of minutes

The minutes were approved.

Presentation: Recap of last meeting discussions

January Angeles of Bailit Health reviewed the discussion and decisions of the November Board meeting. The Board determined to address the legislative mandate to account for utilization, service intensity and regional pricing differences in cost growth driver analyses. The Board directed staff to perform age/sex risk adjustment using

standard weights developed by HCA based on current resources, and also recommended that staff pursue the ability to perform clinical risk adjustment normalization using data from the All-Payer Claims Database (APCD).

Presentation: Attribution in Health Care Authority programs

January Angeles of Bailit Health provided the Board with a second presentation on attribution methods, reminding them that in order to achieve the mandate to report cost trends at the provider level, payers would need instructions on how to do two levels of attribution: member to clinician and clinician to large provider entity. Staff presented two options, requiring insurers to apply a standard attribution methodology (primary care based), and allowing insurers to use their own attribution methodology, either with or without a recommended hierarchy. All states use the second approach.

The Board learned about the attribution methodology of the Washington Health Alliance (WHA), that uses primary care physician (PCP) based attribution, as a potential common methodology that could be utilized by payers for this data call. It was pointed out that the WHA method contained a proprietary process developed by a contractor. Staff recommended allowing insurers to use their own PCP based attribution methodology, within the following hierarchy: member selection, contract arrangement, and utilization.

During the Board's discussion, some members asked questions about the benefits of standardization, contrasting use of the WHA method with asking payers to use their own methods. It was also noted that from the provider perspective, differences between payer methodologies present a challenge in evaluating accuracy of outcomes.

Design decision: Member attribution methodology

The Board decided to approve the staff recommendation of allowing insurers to use their own PCP based attribution methodology, based on a hierarchy that prioritizes member selection, then contract arrangements, then utilization. The Board expressed a desire for a common methodology and requested staff to pursue this potential for future use.

Public comment

Ms. Birch called for comments from the public.

Nancy Guinto, Chief Executive Officer, WHA, commented that WHA membership includes every Medicaid managed care organization and commercial plan in the state, and provide data to it. She expressed her concern that variations in reporting could cause confusion, and that providers in particular would support consistency with the existing methods used by the WHA that have been subject to extensive stakeholder review and engagement.

Presentation: Provider entities accountable for total medical expenditures

January Angeles of Bailit Health presented the Board with information related to how to attribute clinicians to large provider entities. Provider entities for purposes of the benchmark are large entities that in theory could take on a total cost of care contract because they employ both PCPs and can exert some level of influence over where a patient receives care. Under this definition, accountable providers would be health systems with contracted PCPs, hospitals with outpatient clinics with PCPs, medical groups with PCPs, and independent physician associations. Board materials include a draft list of Washington accountable providers by name, which will be further refined by staff.

One Board member expressed concern that some entities intentionally do not employ PCPs, and instead focus on specialty care that might drive cost. Under this definition, those entities would not be captured or held accountable. Other board members echoed concern that expensive services might not be adequately captured and heard that this would be possible through the cost driver analysis. The Board asked for any information about difficulties experienced in other states (all of whom are using similar methods). They were informed that states without provider directories were struggling with provider attribution, and states were also working to understand the appropriate size of reporting entity to provide the most useful information. One Board member pointed out that an example of size might be Optum, which could also be reported at the clinic level (since both clinics are large). One board member pointed out that a very large specialty organization could meet the definition of influence over care, even without employing PCPs.

Previously, staff had presented two options for attributing clinicians to large provider entities: use of a statewide provider directory (Massachusetts and Oregon), and attribution based on contracting arrangements (Connecticut and Rhode Island). The Board also revisited staff research investigating the feasibility of existing state directories and data sources, including WHA, Health Benefit Exchange, OneHealthPort, and the Office of the Insurance Commissioner. Staff concluded that the WHA's directory would be the most useful, but that work needed to be done on the potential of contracting. Staff recommended pursuing use of the WHA directory and asking issuers to do attribution based on contracting arrangements as a fallback option should a WHA contract not prove feasible.

Design decision: Clinical attribution

The Board accepted staff recommendation to pursue use of WHA's directory, and then to ask issuers to do attribution based on contracting arrangement as a fallback option.

Staff were directed to explore whether there were other large entities in the state who do not employ PCPs that would be appropriate for inclusion.

Presentation: Cost growth benchmark accountability

January Angeles of Bailit Health presented the Board with information intended to jumpstart the conversation around benchmark accountability. She asked several questions of the Board, including what process should be in place for reporting cost growth benchmark performance, how performance should be reported, how much and what types of communication should accompany the report, and what other activities they would like to engage in. The Board reviewed Massachusetts' accountability process.

One Board member stated that communication was vitally important, both with parties subject to reporting and to payers, including information about impacts on cost. This was supported by many Board members, emphasizing strong communication, collaboration and partnership including feedback to the Board. One Board member also wanted to learn from other states and keep consistent with them for comparative purposes.

Adjournment

Meeting adjourned at 3:56 p.m.

Next meeting

Wednesday, January 19, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Health Care Cost Transparency Board

January 19, 2022

Washington State Health Care Authority

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Topics for today

TAB 3

Topics for today

- Reflections on Year 1 activities and process.
- Review of meeting plan for Year 2.
- Discussion of analyses of cost and cost growth drivers.

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Reflections on Year 1 activities and process

TAB 4

Reflections on Year 1 activities and process

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Reminder: The logic model for the cost growth benchmark

Measure
Measure performance relative to the cost growth benchmark

Analyze
Analyze spending to understand cost trends and cost growth drivers

Report
Publish performance against the benchmark and analysis of cost growth drivers

Identify
Identify opportunities and strategies to slow cost growth

Implement
Implement strategies to slow cost growth

Topics discussed and decisions made in Year 1

- What is a cost growth benchmark and how have other states implemented it.
- Methodology for setting the benchmark value and mechanisms for revisiting the value, if necessary.
- Assessing performance against the benchmark, and strategies for improving reliability and validity of measurement.
- Identification of payers and large provider entities that will be subject to the benchmark, and attribution of spending to such entities.

Board reflections on Year 1

- Do Board members have any reflections on Year 1 activities they would like to share?
- Are there suggestions you would like to make on how to improve our processes?

Public comment

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Review of meeting plan for Year 2

TAB 5

Review of meeting plan for Year 2

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Meeting plan for 2022

Meeting date	Meeting topic
January	Cost driver analysis strategy - Recommended areas for prioritization - Plan, process, and timeline for supporting the work
February	Cost growth mitigation strategy - Criteria and process for strategy review and adoption - Review of strategies adopted thus far by other states
March	Review of existing data on Washington cost growth drivers
April	Cost growth mitigation strategy - Review of current HCA initiatives - Review of other potential strategy options

Meeting plan for 2022

Meeting date	Meeting topic
May	Cost growth mitigation strategy - Areas of interest to the Board - Potential methods for pursuing the strategies
June	- Continued discussion of cost growth mitigation strategies of interest - Preview of pre-benchmark data call process, which payers and providers will report / be reported on
July	To be determined
August	- Review of initial cost driver analysis - Cost growth mitigation strategy update
October – December	To be determined

Board feedback on 2022 meeting plan

- Does the Board agree with the proposed meeting plan?
- Are there other discussion topics of particular importance to the Board that are not reflected in the meeting plan?

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Discussion of analyses of cost and cost growth drivers

TAB 6

Discussion of analyses of cost and cost growth drivers

Cost growth benchmark analysis

- **What:** A calculation of health care cost growth over a given time period using payer-collected aggregate data.
- **Data type:** Aggregate data that allows for assessment of benchmark achievement at multiple levels.
- **Data source:** Insurers and public payers.

vs.

Cost driver analysis

- **What:** A plan to analyze cost and cost growth drivers and identify promising opportunities for reducing cost growth and informing policy decisions.
- **Data type:** Granular data (e.g., claims and encounters).
- **Data source:** Primarily, the APCD.

Peterson-Milbank framework for cost growth driver analyses

Where is spending problematic?

- High spending
- Growing spending
- Variation in spending
- Spending compared to benchmarks

What is causing the problem?

- Price
- Volume
- Intensity
- Population characteristics

Who is accountable?

- State
- Market
- Payer
- Provider organization

https://www.milbank.org/publications/a-data-use-strategy-for-state-action-to-address-health-care-cost-growth/

Two major types of cost driver analyses

Phase 1

What: Standard analytic reports produced on an annual basis at the state and market levels.

Purpose: Inform, track, and monitor the impact of the cost growth benchmark.

Phase 2

What: Supplemental in-depth analyses developed based on results from standard reports.

Purpose: Supplement Washington's ability to identify opportunities for actions to reduce cost growth.

https://www.milbank.org/publications/a-data-use-strategy-for-state-action-to-address-health-care-cost-growth/

Recommended Phase 1 analyses

- Start with standard analyses, produced annually, that:
  - Examine the effects of price, volume, service intensity, and population characteristics on changes to spending and spending growth.
  - Use at least two years of data.
  - Are produced on a total and per capita spending basis.
  - Are released concurrently with public reporting of performance relative to the cost growth benchmark.

https://www.milbank.org/publications/a-data-use-strategy-for-state-action-to-address-health-care-cost-growth/

HCA's proposed plan for Phase 1 analyses

- HCA has reviewed the recommended Peterson-Milbank standard analyses.
- The following slides walk through the analyses HCA proposes to implement in the next year for initial reporting.
- HCA also recommends including these analyses in *ongoing* annual reporting.

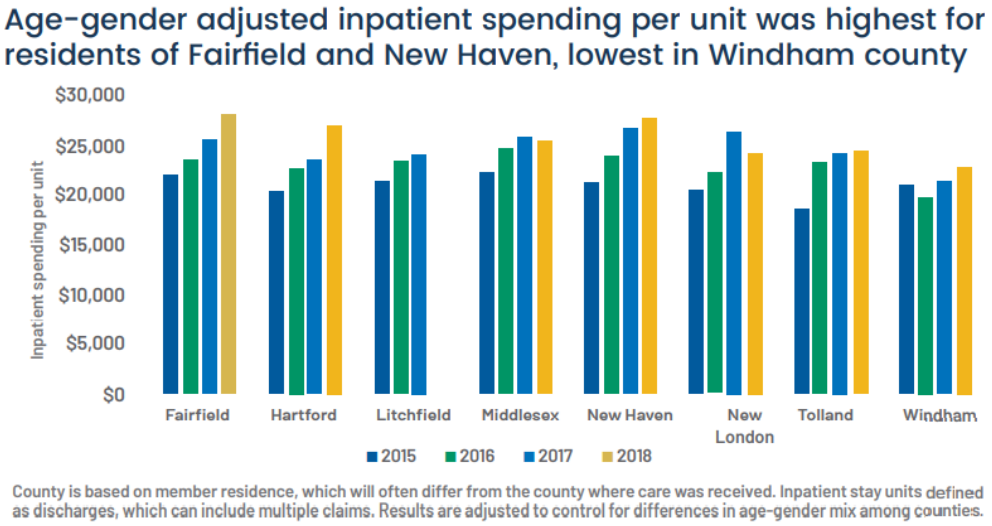
All-Payer Claims Database (APCD) as the primary source of data

Strengths	Limitations
• Includes claims and enrollment data from most payers for fully insured products. • Data include charged, allowed, and paid amounts. • Can be analyzed at a very granular level (by payer, region, provider type, provider, patient segment, service type, diagnosis, etc.). • Updated quarterly.	• Except for PEBB and SEBB, does not capture self-insured data. • Does not contain non-claims costs (e.g., shared savings, capitated payments made outside the claims system, etc.). • Limited clinical data. • Significant lag times related to loading claims into the APCD and ensuring sufficient claims runout.

Spend and trend by geography

What	•	Spend and trend, stratified by geographic rating area.
Data Source	•	APCD
Notes	•	HB2457 requires analyses by geographic rating area.

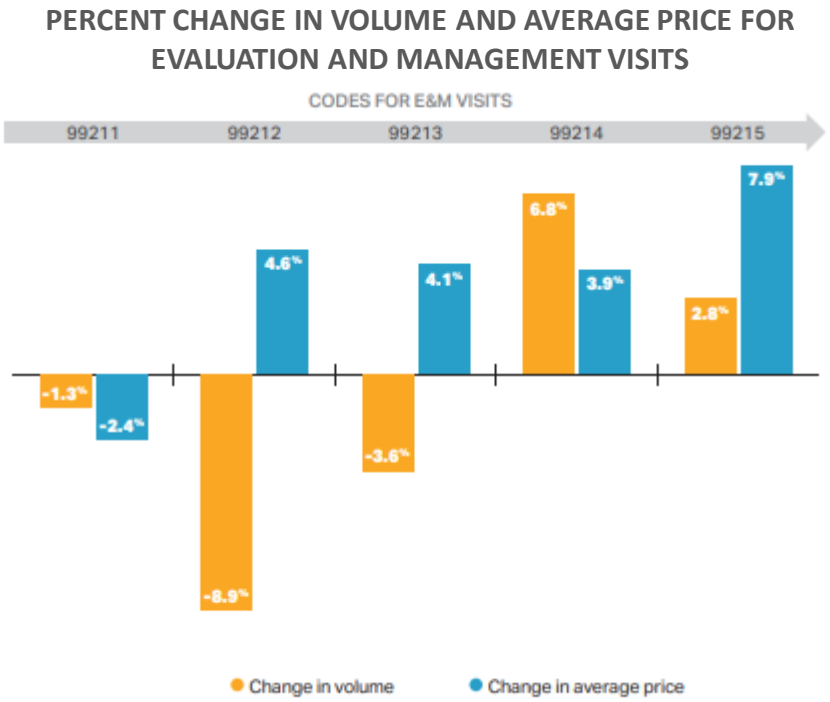
Example from Connecticut



Trends in price and utilization

What	•	Analysis of spending the impact of price and utilization on spending on services.
Data Source	•	APCD
Notes	•	Work will be needed to identify the services.

Example from Massachusetts



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Spend and trend by health condition

What	• Analyses to detect whether and how health conditions influence service utilization and spend.
Data Source	• APCD
Notes	• Work will be needed to determine the conditions to analyze.

Example from Connecticut

Condition	2018		
	Members with condition	%	PMPY for members with this condition
All members	**455,780**	**100.0**	**$6,151**
Hyperlipidemia	73,081	16.0	$11,842
Hypertension	70,419	15.5	$13,739
Rheumatoid Arthritis/Osteoarthritis	67,943	14.9	$13,866
Depression	50,979	11.2	$13,501
Diabetes	28,608	6.3	$14,197
Anemia	26,723	5.9	$25,355
Acquired Hypothyroidism	25,918	5.7	$12,911
Glaucoma	18,035	4.0	$9,004
Chronic Kidney Disease	17,732	3.9	$24,029
Asthma	17,500	3.8	$16,887
One or more of 27 chronic conditions	218,698	48.0	$10,536
Two or more of 27 chronic conditions	115,855	25.4	$14,379

Spend and trend by demographics

What	• Analysis of how trends differ among communities with different demographic characteristics.
Data Source	• APCD • Census Bureau survey data.
Notes	• Need to determine demographic variables.

Example from Connecticut

Decile	Percentage white	Median family income	PMPM (adj.)
All	**0 – 100**	**$97,310**	**$526.69**
1	0 – 31	$45,663	$545.33
2	31 – 50	$68,060	$561.26
3	50 – 61	$82,466	$562.29
4	61 – 71	$105,442	$494.28
5	71 – 77	$103,407	$497.68
6	77 – 82	$122,067	$499.30
7	83 – 87	$149,181	$506.68
8	87 – 91	$127,302	$481.19
9	91 – 94	$118,223	$484.70
10	94 – 100	$112,875	$526.69
Ratio of 1st to 10th decile		0.40	1.09

Monitoring of potential unintended adverse consequences

What	• Selected indicators to monitor for potential negative impacts of the cost growth benchmark.
Data Source	• To be determined.
Notes	• Need to determine what areas to prioritize.

- Potential analyses include:
  - Quality measures assessing utilization of preventive and chronic illness care.
  - Patient self-reported access to care, including but not limited to access to specialty care.
  - Changes in provider entity patient panel composition.
  - Stratified analyses to assess specific and disparate impact of the benchmark on economically and socially marginalized groups.

Connecticut's strategy for measuring unintended adverse consequences

- Connecticut has developed a measurement plan focused on three main domains of analyses:
  1. Underutilization
  2. Consumer out-of-pocket spending.
  3. Impact on marginalized populations.

- For each domain, Connecticut's plan identifies:
  - Potential measures that can be implemented immediately.
  - Potential measures that require further development.t
  - Level of analysis (e.g., market, provider organization, etc..)
  - Data source(s)
  - Accountability for data collection and analysis.

Proposed analyses to be included in the annual report

Analysis	State	Market	Payer/ Provider
Cost growth benchmark performance	X	X	X
Spend / trend by market	X	X	
Spend / trend by geography	X	X	
Trends in price and utilization	X	X	
Spend / trend by health condition	X	X	
Spend / trend by demographics	X	X	
Potential unintended adverse consequences	X	X	

Board discussion of Phase 1 analyses

- Does the Board support including the following analyses in its regular reporting?
  - Spend and trend by geography.
  - Trends in price and utilization.
  - Spend and trend by health condition.
  - Spend and trend by demographics.
  - Monitoring of potential unintended adverse consequences.
    - If so, what potential adverse consequences does the Board wish to monitor?

Board discussion of Phase 1 analyses

- Are there other analyses that the Board believes should be included in regular reporting?
  - If so, what types of analyses would you recommend?
- How should HCA prioritize the analyses that the Board recommends conducting on a regular basis?
  - What types of analyses should HCA seek to measure immediately?

Recommended Phase 2 analyses

- Once a regular cadence for the recommended standard reports has been established, develop supplemental reports to enhance ability to identify opportunities for action to reduce cost growth.

  Reports might include:

  - Trends in service intensity.
  - Supply as a cost driver.
  - Market consolidation as a cost driver.
  - Pharmacy cost drivers.
  - Changes in out-of-pocket spending.
  - Influence of site-of-care.
  - Professional spending analysis.

Proposed process for conducting and vetting cost growth driver analyses

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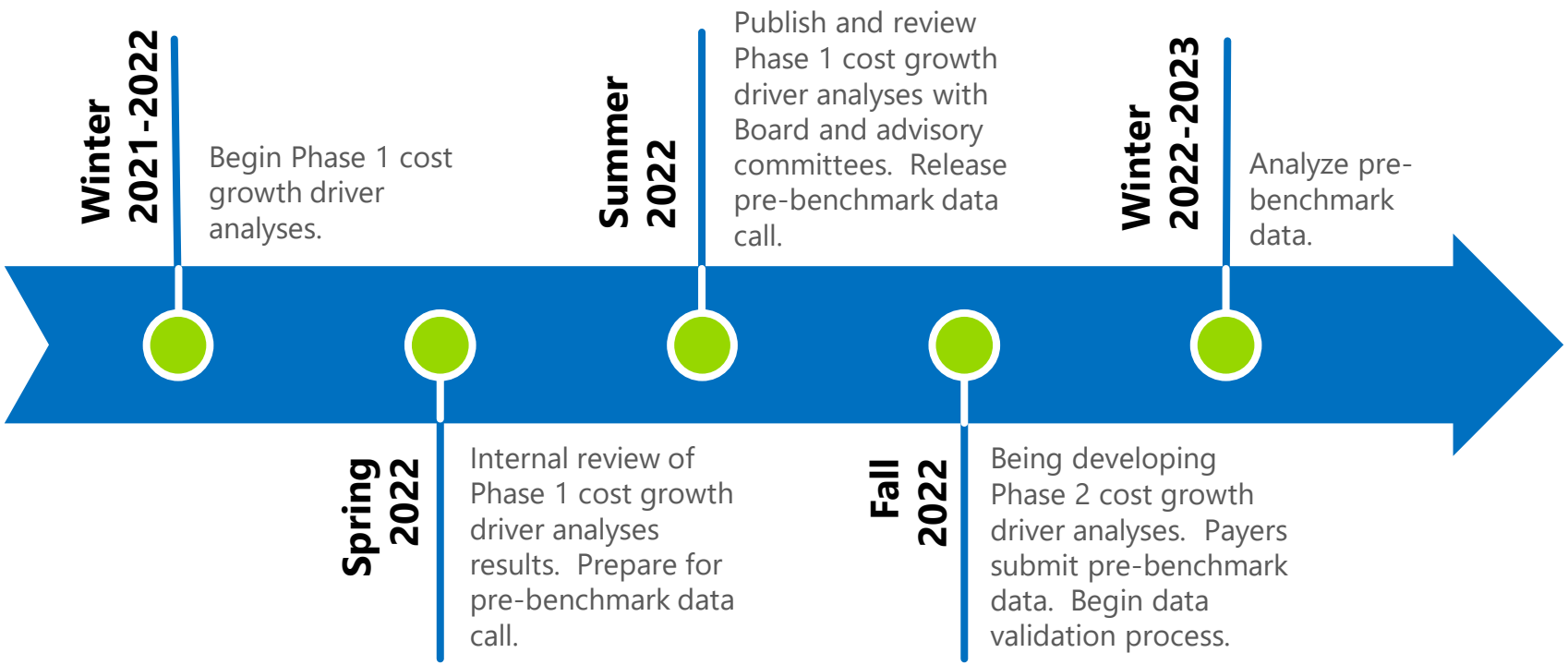
Proposed timeline for conducting cost growth driver and pre-benchmark analyses



Board discussion of process and timeline for analyses

- What feedback does the Board wish to provide on the proposed process and timeline?
- Are there other stakeholders – outside of the Board and two advisory committees – that should be consulted on the analyses?

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Resources

TAB 7

2022 HCCT Board Meetings and Committees

Washington State Health Care Authority

	Date	Time	Location
Board Meeting (January)	January 19	2-4	Zoom
Advisory Committee on Data Issues	January 31	10-12	Zoom
Board Meeting (February)	February 16	2-4	Zoom
Advisory Committee of Health Care Providers and Carriers	February 1	9-11	Zoom
Board Meeting (March)	March 16	2-4	Zoom
Advisory Committee on Data Issues	March 1	10-12	Zoom
Board Meeting (April)	April 20	2-4	Zoom
Advisory Committee of Health Care Providers and Carriers	April 6	2-4	Zoom
Board Meeting (May)	May 18	2-4	Zoom
Advisory Committee on Data Issues	May 5	10-12	Zoom
Board Meeting (June)	June 15	2-4	Zoom
Advisory Committee of Health Care Providers and Carriers	June 2	2-4	Zoom
Board Meeting (July)	July 20	2-4	Zoom
Advisory Committee on Data Issues	July 8	10-12	Zoom
Board Meeting (August)	August 17	2-4	Zoom
Advisory Committee of Health Care Providers and Carriers	August 3	2-4	Zoom
Board Meeting (September)	September 21	2-4	Zoom
Advisory Committee on Data Issues	September 8	10-12	Zoom
Board Meeting (October)	October 19	2-4	Zoom
Advisory Committee of Health Care Providers and Carriers	October 5	2-4	Zoom
Board Meeting (November)	November 16	2-4	Zoom
Advisory Committee on Data Issues	November 1	19-11	Zoom
Board Meeting (December)	December 14	2-4	Zoom
Advisory Committee on Data Issues	December 1	2-4	Zoom