Washington State Health Care Authority

Advisory Committee on Data Issues meeting minutes

August 10, 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

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

Members absent

Jason Brown
Josh Liao
Megan Atkinson

Agenda items

Welcome, Roll Call, Agenda Review

J.D. Fischer, committee facilitator, called the meeting to order at 10:02 a.m.

New Member Introduction

Jared Collings, Regence Blue Shield

The Cost Board appointed Mr. Collings to the Advisory Committee on Data Issues in July. Mr. Collings introduced himself to the Committee, sharing his background and expertise in measuring, tracking, and assessing health care cost and utilization patterns.

Approval of Minutes

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

Topics for Discussion

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

- Overview of preliminary benchmark decisions and measurement.
- Reporting performance against the cost growth benchmark.
- Methods to ensure the accuracy and reliability of benchmark performance measurement.

Overview of Preliminary Benchmark Decisions and Measurement

January Angeles and Michael Bailit, Bailit Health
PowerPoint presentation

Ms. Angeles and Mr. Bailit presented an overview of the Board's preliminary benchmark decisions to the Committee. The Board made the preliminary decision to set the benchmark value using a 70/30 hybrid of historical median wage and potential gross state product. The benchmark would phase down over time:

- 2022-2023: 3.2%
- 2024-2025: 3.0%
- 2026: 2.8%

Ms. Angeles and Mr. Bailit reviewed what constitutes total health care expenditures (THCE) measured against the cost growth benchmark. THCE comprises total medical expense (TME) and the net cost of private health insurance (NCPHI). To collect data for benchmark performance analysis, commercial, Medicare Advantage, and Medicaid managed care plans must submit aggregate claims and non-claims data for provider entities, stratified by market segment. HCA staff will collect supplementary data from other sources, including Centers for Medicare & Medicaid Services (CMS) for Medicare fee-for-service (FFS) claims and Part D spending, Medicaid FFS spending, other sources of public health coverage (e.g., Veteran's Health Administration, Department of Corrections, workers' comp., etc.), and regulatory reports for NCPHI.

Reporting Performance Against the Cost Growth Benchmark

January Angeles and Michael Bailit, Bailit Health
PowerPoint presentation

Ms. Angeles and Mr. Bailit presented material to the Committee relating to reporting performance against the cost growth benchmark, beginning with comparing the benchmark analysis (i.e., how the Board will determine the cost growth from one year to the next) with the data use strategy (i.e., how the Board will determine what is driving overall cost and cost growth). Other states have typically reported benchmark performance at four levels:

statewide (THCE), market segments (THCE), payers (THCE), and large provider entities (TME only). Ms. Angeles provided examples for each report level from other states and noted that the Board will need to address the method of specifically defining and identifying provider entities whose performance will be measured against the cost growth benchmark. Mr. Bailit reiterated the important connection between the data use strategy and the benchmark analysis, where the latter heavily supports the former.

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 to the Committee topics related to ensuring accuracy and reliability in the benchmark performance measurement, including:

- Statistical testing on benchmark performance data.
- Mitigating the impact of high-cost outliers.
- Applying risk adjustment.
- Ensuring sufficient population sizes.

Statistical testing on benchmark performance data:
Ms. Angeles and Mr. Bailit presented the option of developing confidence intervals around benchmark performance which would allow the Board to state a 95% confidence that the interval between the lower bound and upper bound contains the true rate of cost growth for a given entity. In determining performance with the use of confidence intervals, the performance *cannot be determined* when the upper or lower bound intersects with the benchmark but *can be determined* when either the lower bound is fully over the benchmark or the upper bound is fully below the benchmark. One committee member asked how confidence intervals would apply to the statewide analysis, and Ms. Angeles and Mr. Bailit confirmed that a confidence interval would not be necessary for statewide analysis due to the size of the data set. Ms. Angeles and Mr. Bailit asked if the Committee wished to recommend applying statistical testing and using confidence intervals to determine entities' benchmark performance.

Committee members supported this recommendation. One Committee member supported the use of confidence intervals provided there is clear documentation within the reports pertaining to the methodology used to construct the confidence intervals.

Mitigating the impact of high-cost outliers:
Ms. Angeles and Mr. Bailit presented mitigation strategies for addressing the impact of high-cost outliers, i.e., members/patients with extremely high levels of annual health care spending. While such patients represent real spending, they often present randomly within a population and there are limits to how much of their spending can be influenced due to the medical complexity of their condition(s) and high resource intensity care needs. A common practice to address such outliers is to *truncate* expenditures to prevent high-cost outliers from significantly affecting providers' per capita expenditures. Truncation involved capping individual patient spending at a high level (e.g., between $100k and $150k for commercial populations). Mr. Bailit noted that truncating high-cost outlies will shrink the confidence interval and make it easier for the Board to draw a conclusion about whether an entity performed above or below the benchmark. Mr. Bailit provided an example from Rhode Island of how the inclusion of high-cost outlier spending affected a provider entity's cost growth by several percentage points, and how the state consequently changed its methodology to use truncation to mitigate the impact of high-cost outliers. One Committee member noted how quickly annual costs can rise for certain patients with oncologic conditions and who are on biologics and suggested different truncation points. Another Committee member noted that differential treatment of high-cost outliers based on disease would make data collection complex. Most

Committee members agreed to recommend to the Board that they utilize the truncation of high-cost outliers' spending when measuring insurer and provider entity benchmark performance. One Committee member did not support the recommendation and indicated that there was a need to evaluate the use of truncation along with other mitigation strategies. Another Committee member suggested while the Board should utilize truncation, outlier costs should be retained for the data use strategy for additional analysis.

Applying risk adjustment:
Ms. Angeles and Mr. Bailit described how states typically risk adjust data to account for population changes over time and reviewed various risk adjustment models, such as clinical risk adjustment and adjusting for utilization. They explained that risk adjustment is only performed at the carrier and provider levels. Further, HB 2475 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."* Ms. Angeles and Mr. Bailit described the difficulties of risk-adjusting based on utilization, service intensity and regional pricing differences, and recommended addressing these in the data use strategy instead of the reporting of benchmark performance. Committee members agreed to make this recommendation to the Board. Mr. Bailit described other states' experience with risk adjustment and associated challenges associated with the impact of provider claim coding practices on risk scores. One state has decided to only risk-adjust by age and sex due to rising risk scores, which is significantly driven by improvements in documentation of patient condition on claims rather than changes in the population's underlying risk. This had the effect of essentially raising the cost growth benchmark value. Committee members generally agreed that risk-adjusting by age and sex to assess benchmark performance seems reasonable. However multiple Committee members were concerned about the missed opportunity to understand variation across entities within a given reporting period, and to compare total cost vs. trend. One Committee member indicated that risk-adjusting by age and sex would only work assuming there isn't significant movement in patients/members across provider entities/insurers. Multiple Committee members expressed a desire to get additional input from actuaries and carrier and provider organizations before making a recommendation to the Board.

Ensuring sufficient population sizes:
Mr. Bailit described the need to gather benchmark data and report benchmark performance only for entities with "sufficient" population sizes. Three questions drive the determination of the minimum population sizes:

- 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?

Mr. Bailit provided a summary of how other states have determined thresholds for payer reporting and public reporting of provider performance. Mr. Bailit's recommendation based on other states' experience was to require all Medicaid managed care organizations and carriers with commercial or Medicare Advantage market share at five percent or higher to submit data reports and deferring the provider entity thresholds until Oregon and Connecticut have completed their pre-benchmark analyses that will inform the population size at which point confidence intervals become so large as to make a benchmark performance determination difficult. One Committee member requested additional information about Washington State markets to make a more informed recommendation, but did not oppose the strategy itself, and other members agreed. One Committee member noted how the individual market makes up a small portion of the commercial market (approximately four percent) but includes 13 carriers. Mr. Bailit agreed to bring additional market level information to the Committee at a future meeting.

Public Comment

There was no public comment.

Wrap Up and Adjournment

Meeting adjourned at 11:58 a.m.

Next meeting

Wednesday, September 8, 2021
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.