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.