Washington State Health Care Authority

Health Care Cost Transparency Board's
Advisory Committee on Data Issues meeting minutes

April 4, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2 p.m. – 4 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials are available Advisory Committee on Data Issues webpage.

Members present

Amanda Avalos
Allison Bailey
Jonathan Bennett
Bruce Brazier
Lichiou Lee
Ana Morales
Hunter Plumer
Mark Pregler
Russ Shust
Mandy Stahre

Members absent

Megan Atkinson
Jason Brown
Chandra Hicks
Leah Hole-Marshall
David Mancuso
Julie Sylvester

Agenda items

Welcoming, Roll Call, Agenda Review

Vishal Chaudhry, committee facilitator, called the meeting to order at 2:03 p.m.

Approval of Minutes

The committee approved the November 2022 and February 2023 meeting minutes.

Topics for Today

Topics include Washington hospital costs, price, and profit analysis; updates from the Advisory Committee on Primary Care; a historical review of benchmark data collected and methodology; updates to the 2023 benchmark data call; and the cost growth drivers study and specifications for Phase 1 analysis.

Public comment

Katerina LaMarche, Washington State Hospital Association (WSHA), commented that the analyses should be more uniform to ensure consistency between findings. Creating more continuous standardized adjustments by Case Mix Index (CMI), Medicare wage index, and teaching status would improve comparisons between states and hospitals. The hospital cost analysis accounts for year-to-year changes in inpatient and outpatient rates but does not include a discussion of changes in case mix between the years for different treatment for hospitals depending on whether they are low or high-cost compared to peers. There should be a more technical discussion on the appropriate use of analytical exercises to gain a better understanding of how they will be used.

Washington Hospital Costs, Price, and Profit Analysis: Second Level Analysis Methodology

John Bartholomew and Tom Nash, Bartholomew-Nash & Associates

John Bartholomew reviewed the two project goals: How the Washington hospital industry looks compared to the nation on costs and margins/profits, and how to identify Washington hospital outliers on cost and margins/profits. The first level analysis provided a high-level review of self-reported Medicare Cost Report data using price per patient, cost per patient, and profit per patient. Hospitals with more than 25 beds were grouped into high price or not high price and the analysis compared cost and profit. For fair and accurate comparisons between hospitals, other measures need to be reviewed, such as case mix, service intensity measures, level of teaching intensity, payer mix, and other financial measures. The goal is to adjust for service intensity, acuity, location, and other differences so that the cost variation can be isolated to business decisions or price discrimination.

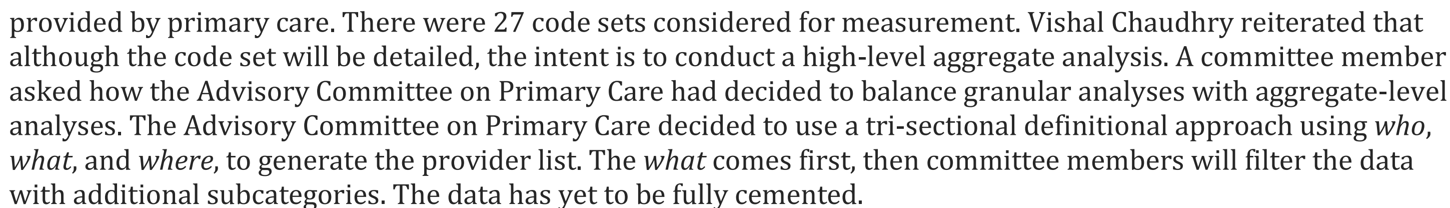
The committee heard an overview of the process for the second level hospital financial analysis and the recommendations for methodology enhancement. There are two methodological enhancements and an additional financial review: calculated adjustments to the first level analysis on costs, creating additional groupings beyond bed size, and the using a Washington hospital margin analysis. The margin analysis will review profit and margin compared to the nation. The Hospital-only Operating Expense will be adjusted by applying the Centers for Medicare & Medicaid Services (CMS) wage index files to the salary amounts, while the remaining costs from the Medicare Cost Report will be adjusted for inflation using the C2ER statistic. Salary percentage will be calculated from the Medicare Cost Report. The cost of doing business factors are likely more important than inflation factors. In addition to bed size, one or a combination of teaching intensity, service intensity, and Medicare CMI measures can be utilized. Payer mix will also be reviewed.

A committee member commented that while reviewing factors independently might be helpful, it is also important to combine them together to see the bigger picture from a continuous standpoint. Tom Nash explained that wage index is easy to adjust, which is the adjustments based on hourly and salary information. However, with CMI, there is little correlation between case mix and net patient revenue per adjusted discharge. CMI will be used as one of the pure benchmarking factors when comparing hospitals with similar case mix. Outliers will be identified by grouping similar hospitals across the nation with minimal necessary adjustments to avoid masking information. Making multiple adjustments to a cost or a price measure could obscure the actual amount a consumer is paying. The first step of the second level analysis will be to apply the one cost adjustment and group hospitals to identify outliers. After these steps, other considerations and adjustments can be reviewed and applied.

Advisory Committee on Primary Care: Claims-Based Measurements

Jean Marie Dreyer, HCA

Jean Marie Dreyer provided an update on the primary care recommendations. The Advisory Committee on Primary Care created a high-level definition of primary care which the board approved. The committee is currently working on the second recommendation, an assessment of claims-based spending. The committee is using guiding principles for code selection, with a focus on ensuring the code set includes services that are predominantly



provided by primary care. There were 27 code sets considered for measurement. Vishal Chaudhry reiterated that although the code set will be detailed, the intent is to conduct a high-level aggregate analysis. A committee member asked how the Advisory Committee on Primary Care had decided to balance granular analyses with aggregate-level analyses. The Advisory Committee on Primary Care decided to use a tri-sectional definitional approach using *who*, *what*, and *where*, to generate the provider list. The *what* comes first, then committee members will filter the data with additional subcategories. The data has yet to be fully cemented.

Washington Cost Growth Benchmark Data Collection and Reporting

Michael Bailit, Bailit Health

Michael Bailit reminded the committee of the distinction between the benchmark analysis and the cost growth driver analysis. The benchmark analysis is used to determine the cost growth rate over a given period using payer-collected aggregate data. In contrast, the cost driver analysis provides a more detailed understanding of the trends observed in the aggregate data. The cost driver analysis utilizes granular data from the All-Payer Claims Database (APCD) and provides insight into what is driving overall cost growth.

The benchmark analysis, which measures performance against the benchmark, is reported at four levels: state, market, payer, and large provider entity. Benchmark components include Total Medical Expenses (TME), the Net Cost of Private Health Insurance (NCPHI), and Total Health Care Expenditures (THCE). The committee also reviewed the data sources used to calculate THCE as well as the data specifications for insurer submissions. A committee member asked if college students covered under their parents' plans would be included in the data population. A college student would typically be listed as a dependent and will appear as a state resident even if they are out-of-state. While these students will appear in the aggregate data for benchmark analysis, they will not show up in the APCD for the cost driver analysis since the datasets are different.

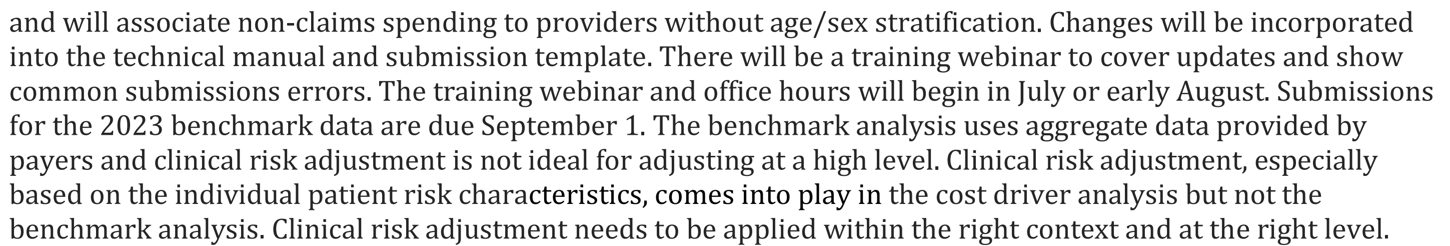
To increase confidence in the measurement and reporting of performance at the insurer and large provider entity levels, HCA will risk-adjust by age and sex, truncate spending for high-cost outliers, and use confidence intervals. HCA will not implement clinical risk-adjustment because the work in other states has shown that rising risk scores cannot be verified through independent measurement. There is increasing literature showing that rising risk scores usually reflect increasing intensity of diagnoses on claims rather than population changes. Currently, all states with cost growth benchmarks are not applying clinical risk adjustment due to its highly distortionary effects on performance assessment. An analysis in Rhode Island showed that truncating for high-cost outliers significantly affected the performance of provider entities. Confidence intervals minimize the impact of small numbers. HCA will also report performance for insurers and large provider entities that meet a minimum threshold for attributed lives. The board has recommended deferring the determination of the minimum membership sizes and will revisit the issue.

A committee member asked whether COVID-19 and fewer services being offered has created differences in acuity. There was a change in acuity from 2020 to 2021, but currently, there isn't a good method for measurement because the increasing intensity of diagnostic coding on claims creates distortion, and where the changes in intensity occur cannot be determined. A significant amount of data indicates that applying clinical risk adjustment is not a good approach. Other states use age/sex risk adjustment or no adjustment at all.

2023 Benchmark Data Call

Ross McCool, HCA

Ross McCool provided an update on the 2023 data call, which will include data from 2020, 2021, and 2022. Performance against the benchmark will be calculated using 2021 and 2022 data and the submission process will be the same as the 2022 data call. The 2023 data call will add a specification for Federal Employee Health Benefits



and will associate non-claims spending to providers without age/sex stratification. Changes will be incorporated into the technical manual and submission template. There will be a training webinar to cover updates and show common submissions errors. The training webinar and office hours will begin in July or early August. Submissions for the 2023 benchmark data are due September 1. The benchmark analysis uses aggregate data provided by payers and clinical risk adjustment is not ideal for adjusting at a high level. Clinical risk adjustment, especially based on the individual patient risk characteristics, comes into play in the cost driver analysis but not the benchmark analysis. Clinical risk adjustment needs to be applied within the right context and at the right level.

Study of Cost Drivers: Specifications for Phase 1 Analysis

Amy Kinner, OnPoint

Amy Kinner provided an overview of the cost driver analysis and the APCD. OnPoint reviewed spending and trends by market, geography, health conditions and demographics, and potential unintended consequences. OnPoint has analyzed five years of data (2017-2021). Payer types include commercial, Medicaid, Medicare Advantage, Medicare Fee-For-Service, the Public Employee Benefits Board, the Washington Health Benefit Exchange plans, and dual-eligibles (individuals eligible for Medicare and Medicaid). Categories of care are aligned closely with the benchmarking initiative. The study also includes cost comparisons for different chronic conditions. To capture potential unintended consequences, OnPoint analyzed access and quality measures. Some of the metrics used in the preliminary analysis include member months, eligibility, and expenditures. OnPoint used the primary care definition developed by the Office of Financial Management (OFM). OnPoint will incorporate the Advisory Committee on Primary Care's work moving forward. One committee member noted that significant overlap exists between the definition of primary care from OFM and the definition developed by the advisory committee. Even if the committee makes additional changes to the definition in the future, the cost isn't likely to change significantly.

Wrap Up Questions and Comments

A committee member asked how each of the different analyses and reports will be used and how they fit into the overall picture. Vishal Chaudhry acknowledged that it could be helpful to articulate how the different puzzle pieces fit together and requested that the question be noted for the next meeting. The committee member responded that having common themes and a standardized approach and methodology will benefit the board and its committees.

Adjournment

The meeting adjourned at 3:43 p.m.

Next meeting

June 6, 2023

The meeting will be held electronically through Zoom and in-person at the Health Care Authority

2 p.m. – 4 p.m.