Washington State Health Care Authority

Advisory Committee on Data Issues

March 1, 2022

Advisory Committee on Data Issues

March 1, 2022

Washington State Health Care Authority

Washington State Health Care Authority

Agenda

TAB 1

Washington State Health Care Authority

March 1, 2022
10:00 a.m. – 12:00 p.m.
Zoom Meeting

Advisory Committee on Data Issues
AGENDA

Committee Members:					
☐	Megan Atkinson	☐	Jason Brown	☐	David Mancuso
☐	Amanda Avalos	☐	Jerome Dugan	☐	Ana Morales
☐	Allison Bailey	☐	Leah Hole-Marshall	☐	Hunter Plumer
☐	Jonathan Bennett	☐	Scott Juergens	☐	Mark Pregler
☐	Purav Bhatt	☐	Lichiou Lee	☐	Julie Sylvester
☐	Bruce Brazier	☐	Josh Liao	☐	

Committee Facilitator:
AnnaLisa Gellermann

Time	Agenda Items	Tab	Lead
10:00 – 10:05 (5 min)	Welcome, call to order, and roll call		AnnaLisa Gellermann Health Care Authority
10:05 – 10:10 (5 min)	Approval of January meeting minutes	2	AnnaLisa Gellermann Health Care Authority
10:10 – 10:15 (5 min)	Topics for today	3	AnnaLisa Gellermann Health Care Authority
10:15 – 10:20 (5 min)	Recap of January discussion	4	AnnaLisa Gellermann Health Care Authority
10:20 – 11:00 (40 min)	Office of the Insurance Commissioner Cost Analysis	5	Amy Kinner, OnPoint Jane Beyer, Office of the Insurance Commissioner Simon Casson, Office of the Insurance Commissioner
11:00 – 11:10 (10 min)	Public comment		AnnaLisa Gellermann Health Care Authority
11:10 – 11:40 (30 min)	Data on Spending and Spending Growth in Washington	6	January Angeles, Bailit Health
11:40 – 11:50 (10 min)	Benchmark Performance Assessment	7	January Angeles, Bailit Health Ross McCool, Health Care Authority
11:55 – 12:00 (5 min)	Wrap-up and adjournment		AnnaLisa Gellermann 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 Advisory Committee of Providers and Carriers will be conducted virtually.

Washington State Health Care Authority

January meeting minutes

TAB 2

Advisory Committee on Data Issues meeting minutes

January 31, 2022
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

Board Members:
Allison Bailey
Amanda Avalos
Ana Morales
Bruce Brazier
David Mancuso
Hunter Plumer (joined at 10:41)
Jerome Dugan
Jonathan Bennett
Josh Liao
Julie Sylvester
Leah Hole-Marshall (joined at 10:48)
Lichiou Lee
Mark Pregler
Megan Atkinson
Purav Bhatt
Scott Juergens

Members absent:
Jason Brown

Agenda items

Welcome, Roll Call, Agenda Review
AnnaLisa Gellermann, committee facilitator, called the meeting to order at 10:02 a.m.

Approval of Minutes
AnnaLisa Gellermann provided a recap of the October Committee meeting, and the Committee approved the October meeting minutes.

Topics for Today

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

- Review meeting plan for Year 2.
- Discuss analysis of cost and cost growth drivers
- Review pre-benchmark data collection plan and timeline
- Review payer survey of provider entity contracts
- Wrap up discussion on benchmark performance assessment

Meeting Plan for Year 2

Michael Bailit, Bailit Health
PowerPoint presentation

Mr. Bailit presented to the Committee an overview of intended activities for the following year.

Analyses of cost and cost growth drivers

Michael Bailit, Bailit Health
PowerPoint presentation

Michael Bailit of Bailit Health reminded the Committee of the difference between the cost benchmark analysis (aggregate data allowing for benchmark performance at several levels) and the cost driver analysis (granular claims and encounter data to analyze cost and cost growth). The purpose of the cost driver analysis is to determine where spending is problematic, determine what is causing the problem, and identify accountable entities. The presentation identified two phases of cost driver analyses. Phase one consists of standard analytic reports produced on an annual basis at the state and market levels. Phase two will contain supplemental in-depth analyses developed based on results from standard reports and Board discussion.
HCA staff proposed the following areas for initial reports: spend and trend, stratified by geographic rating area; impact of price and utilization on spending; spend and trend by health condition; spend and trend by demographic. Work would need to be done in all areas to further refine appropriate variables. HCA staff also propose monitoring of potential unintended adverse consequences in the areas of quality, access, and provider composition. These analyses would be reported at the state and market levels. Bailit presented analyses in these areas from other states.
Committee members asked about the overlap between the cost benchmark data and the cost driver analysis. Mr. Bailit responded that the two analyses would not show identical trend rates, as the cost benchmark analysis includes significant data elements not included in the APCD. But the two analyses should work together to provide greater insight. The Committee asked whether price and utilization would be combined, and Mr. Bailit responded that initially it would be likely but that opportunities for stratification would be available and could be pursued. One Committee member mentioned that WHA reports include intensity, and other states are looking to adopt the same process. One Committee member noted that the CMS chronic condition warehouse data should be considered as an option. A question was raised about whether pediatric conditions could or should be considered independently from adult conditions, and Mr. Bailit responded that these analyses were certainly possible. One Committee member asked if geographic areas had been specified and supported use of the 9 insurance rating areas as coinciding with price. Mr. Bailit responded that the statute required rating regions, but that there would be flexibility. Some Committee members agreed that the initial approach seemed reasonable.

Public Comment
There was no public comment.

Review pre-benchmark data collection plan and timeline
Ross McCool, Health Care Authority

Mr. McCool presented to the Committee an overview of the timeline for the benchmark data collection. Payer seminars and office hours will be held in May and June, and a request for preliminary data submission will be open on June 30. More information will be provided over the next months.

Review payer survey of provider entity contracts
Ross McCool, Health Care Authority

Mr. McCool described the upcoming payer survey that would be sent to payers. The purpose of the survey is to ensure that the Board has correctly identified the larger provider entities that will be the subject of benchmark reporting. Payers will be asked to identify those provider entities with whom they have total cost of care contracts. The survey is expected to go out in the end of February.

Wrap up discussion on benchmark performance assessment
January Angeles, Bailit Health

Ms. Angeles resented information to the board on benchmark performance assessment, including truncation and risk adjustment. For measurement at the insurer and provider entity level, the Board had previously decided to truncate spending on high-cost outliers at a to-be-determined threshold. Specifically, Ms. Angeles sought feedback on what the truncation thresholds should be and whether they should vary by market. HCA proposed an approach consistent with Rhode Island, with the following threshold: Commercial, $150k, Medicaid, $250k, and Medicare, $100k. Two members shared that the limits appear high, especially when risk-sharing contracts are involved, with concern that too many claims would be excluded. One member shared that he had observed large variability in claims thresholds. In response to a question, Ms. Angeles clarified that truncation amounts would be valued at the member level, cumulatively (rather than at the treatment level), and that it would be applied to the analysis of provider groups and insurers by market. Truncation would not be applied at the state and market level analyses. The committee indicated that Washington specific data on the impact of truncation levels would be supportive in decision-making. The group also recommended an approach that would permit reviewers to understand what had been excluded (either through the ability to "toggle" the truncation on and off, or through an ad-hoc report
Due to time, an anticipated discussion of risk adjustment did not occur.

Wrap Up and Adjournment
Meeting adjourned at 12:00 p.m.

Next meeting
Tuesday, March 1, 2022
Meeting to be held on Zoom
10:00 a.m. – 12:00 p.m.

Washington State Health Care Authority

Topics for today

TAB 3

Topics for today

- Recap of January meeting discussion
- Presentation of OIC Price/Utilization analysis
- Data on spending and spending growth in Washington state

Washington State Health Care Authority

Recap of January Discussion

TAB 4

Recap of January Meeting Discussion

Washington State Health Care Authority

Recap

- Introduction of cost analyses and cost growth drivers
- Phase 1 (standard analytic reports), and Phase 2 (in-depth analysis based on results of Phase 1).
- Initial reports will include price/utilization, health condition, and demographics.
- Truncation will be applied to reporting at the provider and carrier levels.
- The committee recommended an approach that would permit visibility of truncation totals.

Washington State Health Care Authority

Office of the Insurance Commissioner Cost Analysis

TAB 5

ONPOINT Health Data

Washington All-Payer Claims Database (WA-APCD) Cost Trend Analysis

January 5, 2021

Goals of Project

- Calculate rate of cost growth in Washington for commercial insurance spending
- Identify drivers of cost
  - Acute inpatient, outpatient ED, outpatient non-ED, professional, pharmacy, ambulance
- How much of the change in cost is due to price versus utilization?
- Additional drill-downs/dashboards:
  - Type of inpatient service
  - Mental health services
  - Air ambulance services
  - Exchange and PEBB

Methodology – Population Criteria

- Population
  - Commercial carriers only
  - Aged 0-64
  - WA state residents only
  - 2016-2019
- Claims – Limited to first service date between Jan 1 and Dec 31 of the study year
- Eligibility – Limited to members with both pharmacy and medical eligibility during the study year
- Fee for service – Limited to members in groups with the majority of their care paid in a fee-for-service (non-capitated)

Methodology – Key Metrics

- Per Member Per Month (PMPM) rates
  - Sum of all dollars paid by the plan and member/total member months of coverage for the population
- Utilization per 1,000 Average Members
  - Total services*12,000/total member months of coverage for the population
  - Services = claims for most services; discharges for inpatient; prescription fills for pharmacy
- Average price – Total amount paid by the plan and member for services in category/count of services
- Percent Change – All percent changes represent the aggregate percent change from baseline year 2016

Methodology – Service Categories

Term	Definition
Total (All Claims)	The sum of all pharmacy and medical claims for a patient during the year
Medical (Total)	The sum of all medical claims for a patient during the year
Pharmacy (Total)	The sum of all pharmacy claims for a patient during the year (excluding pharmacy services reported in the medical claims)

Methodology – Service Categories

Term	Definition
Acute Inpatient	Includes all of the claims for services incurred during an acute inpatient stay (both professional and facility claims). Acute stays are identified using place of setting.
Outpatient ED	Includes all claims for services rendered in the emergency department (ED). These include professional and facility claims billed for ED services.
Outpatient non-ED	Includes all of the facility claims for services incurred where the type of setting was outpatient, excluding any claims rendered in the ED setting. Outpatient non-ED could include hospitals, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), free-standing ambulatory surgery centers, etc.
Outpatient (Total)	The sum of outpatient ED and outpatient non-ED claims
Professional	The sum of all claims where the claim type was professional and the type of setting was provider. Professional claims for services rendered in the ED setting or acute inpatient setting are not included in this category to avoid double-counting.

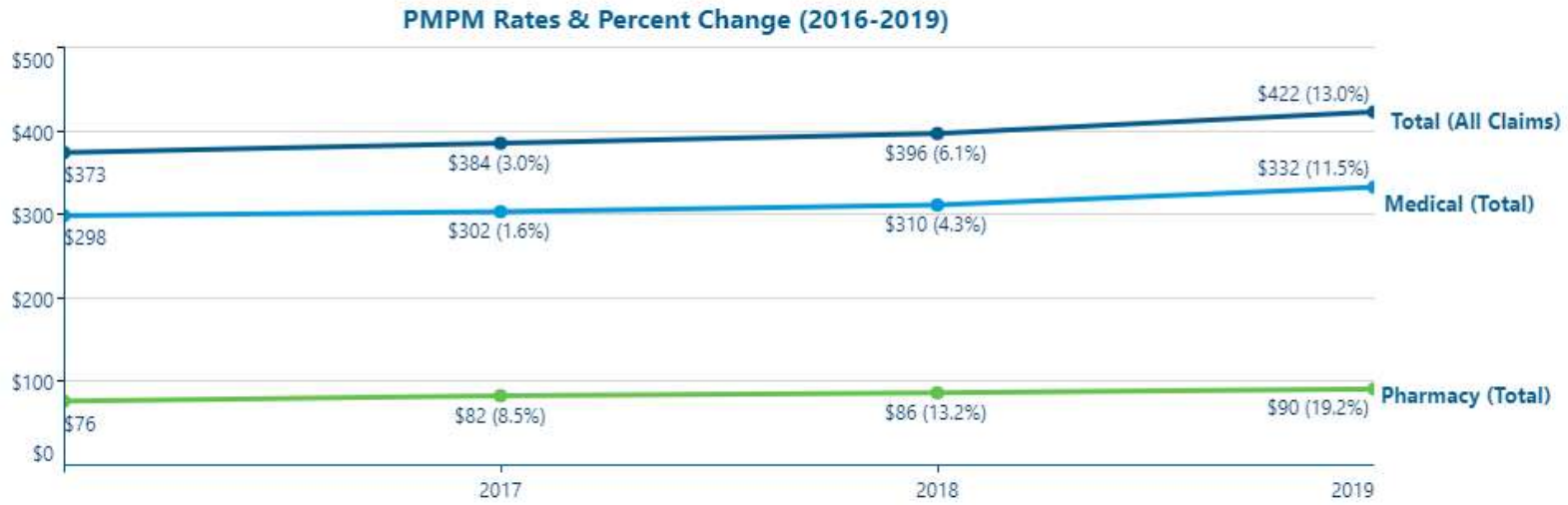
Methodology – Service Categories

Term	Definition
Ambulance	The sum of all ambulance claims
Air Ambulance	The sum of claims where procedure codes A0430 or A0431 were billed. All lines of the claim have been included as one air ambulance service.
Other Ambulance	Any ambulance claims not identified as air ambulance services.
Mental Health Services	Limited to claims with primary diagnoses of mental health. Because substance use disorder claims are not consistently submitted to the WA-APCD due to 42 CFR Part 2 regulations, this study does not include substance use disorder claims.

ONPOINT Health Data

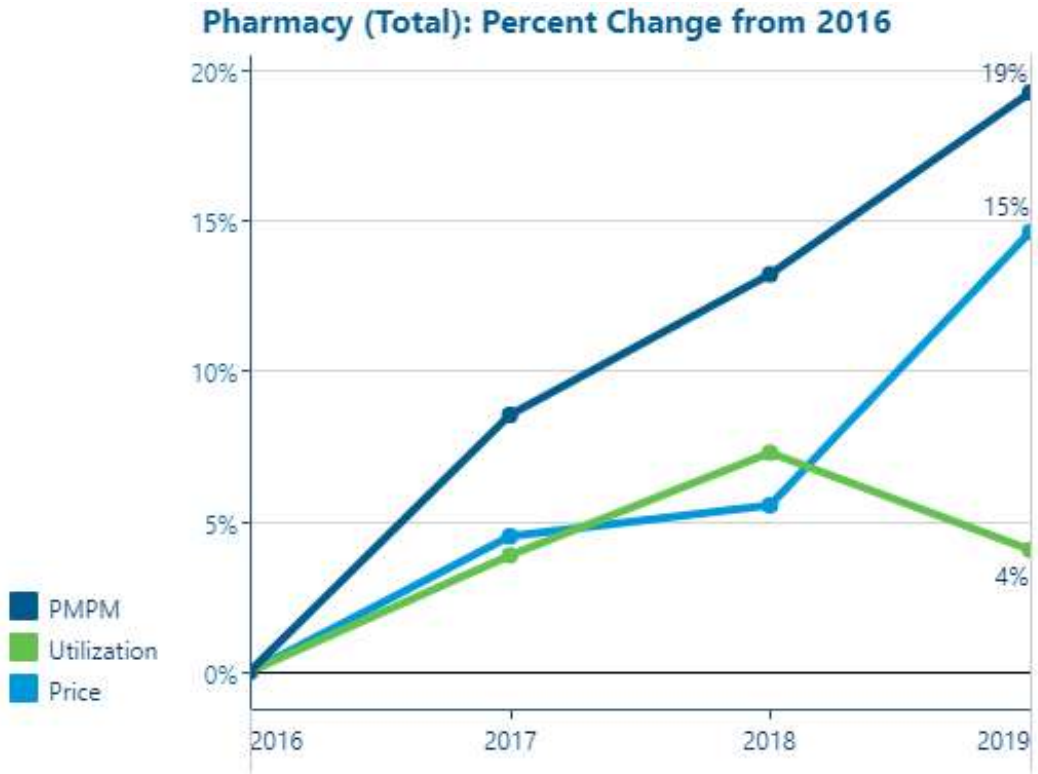
Summary of Key Findings

PMPM Spending in Washington Increased 13% between 2016 and 2019

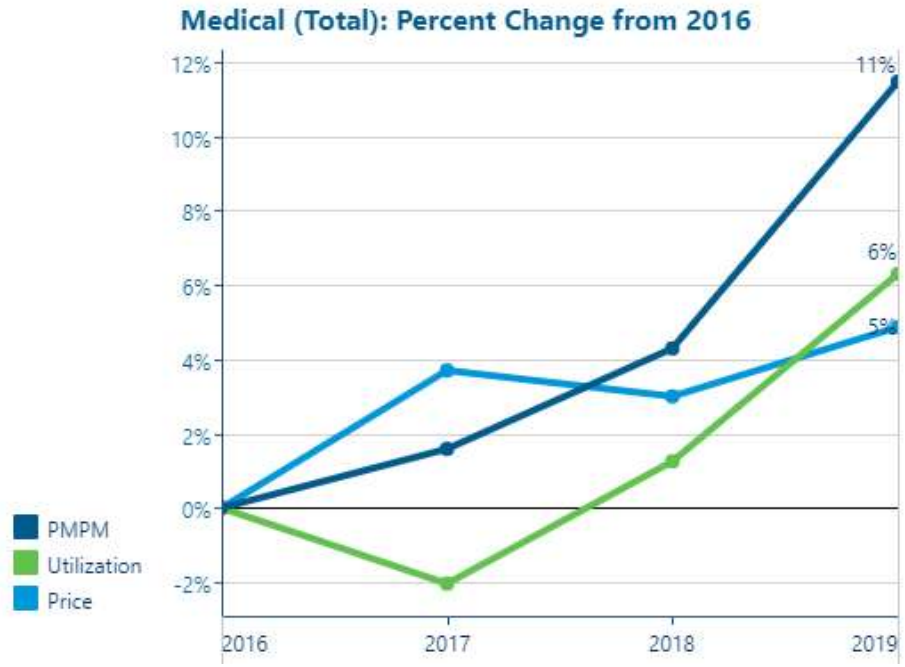


Total Commercial spending was $422 per member per month (PMPM) in 2019. Of this, medical spending comprised $332, while pharmacy accounted for $90 PMPM. Pharmacy spending increased at a greater rate from the 2016 baseline (19.2%), than medical spending 11.5%.

The Rise in Pharmacy Spending (19%) was Driven by a 15% Increase in Average Price per Fill

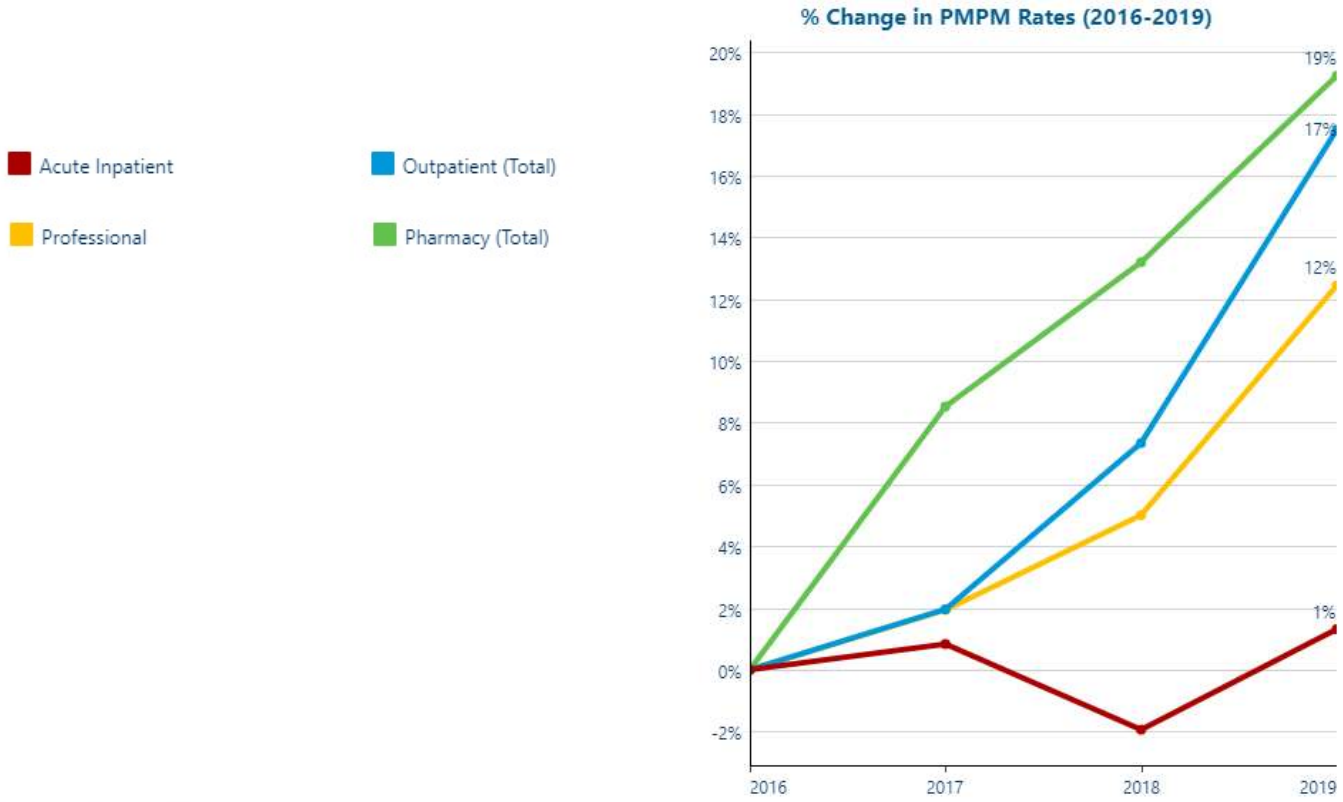


Medical Spending (Total) PMPM Increased by 11% between 2016 and 2019

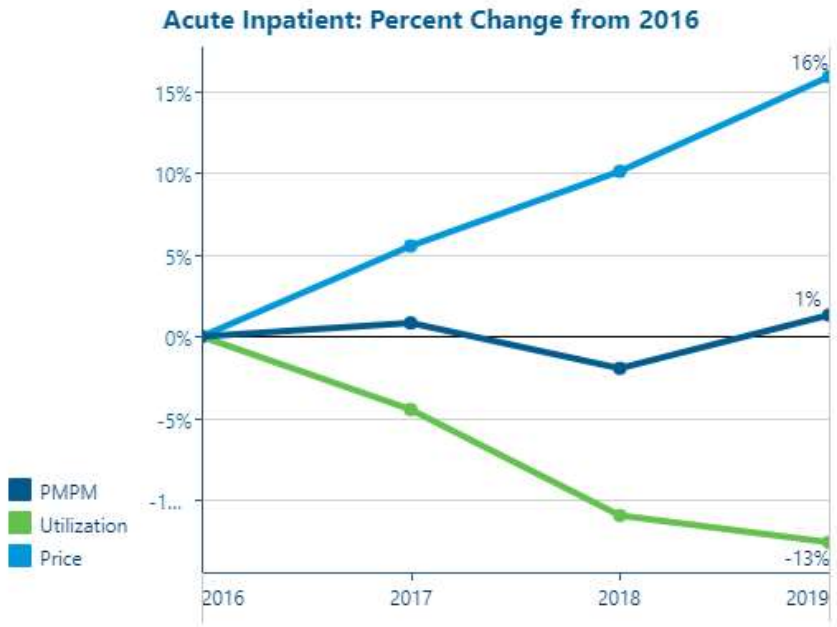


The increase in total medical spending was driven by both price (+5%) and utilization (+6%).

Increased Outpatient and Professional PMPM Rates Drove the Rise in Medical Spending

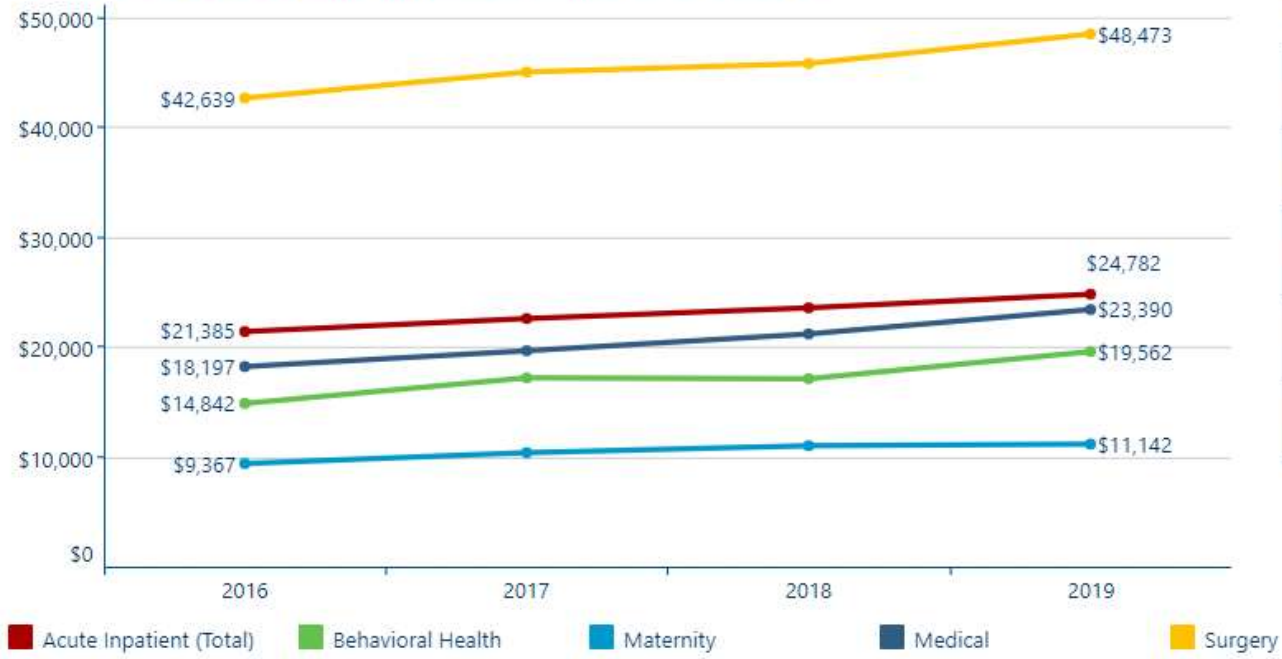


Acute Inpatient PMPMs Stayed Steady Due to Reduced Utilization Despite Significant Average Price Increases



Average Prices for Acute Inpatient Discharges Increased for All Categories

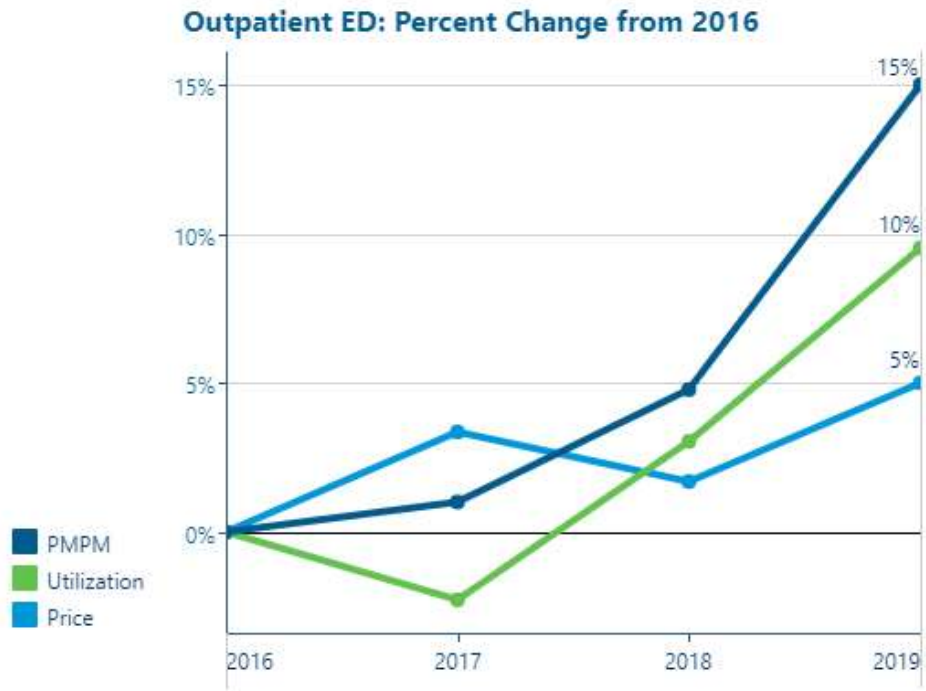
Average Price of an Acute Inpatient Discharge (2016-2019)



Increase in Average Price per Discharge (2016-2019)

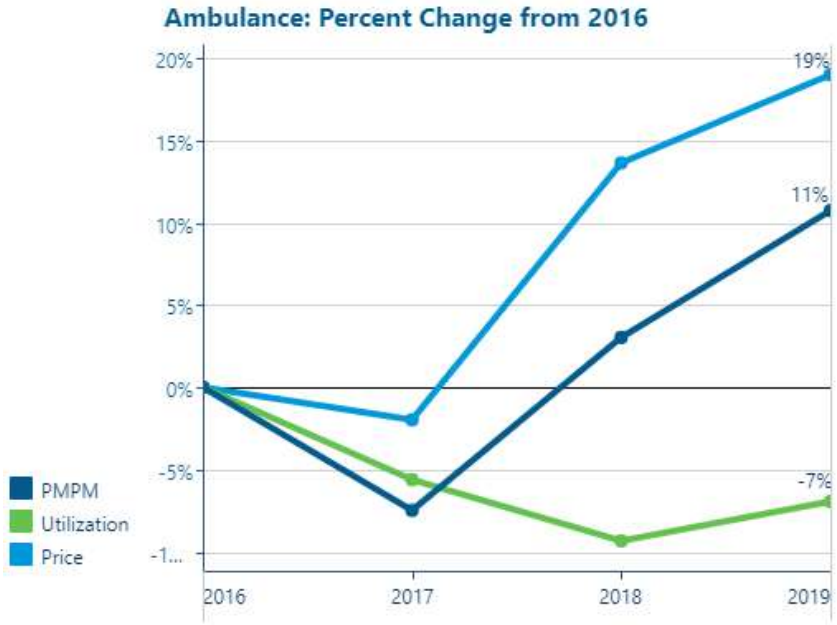
Acute Inpatient (Total)	**$3,397**
Behavioral Health	**$4,719**
Maternity	**$1,775**
Medical	**$5,194**
Surgery	**$5,834**

Outpatient ED PMPM Rates Increased by 15%

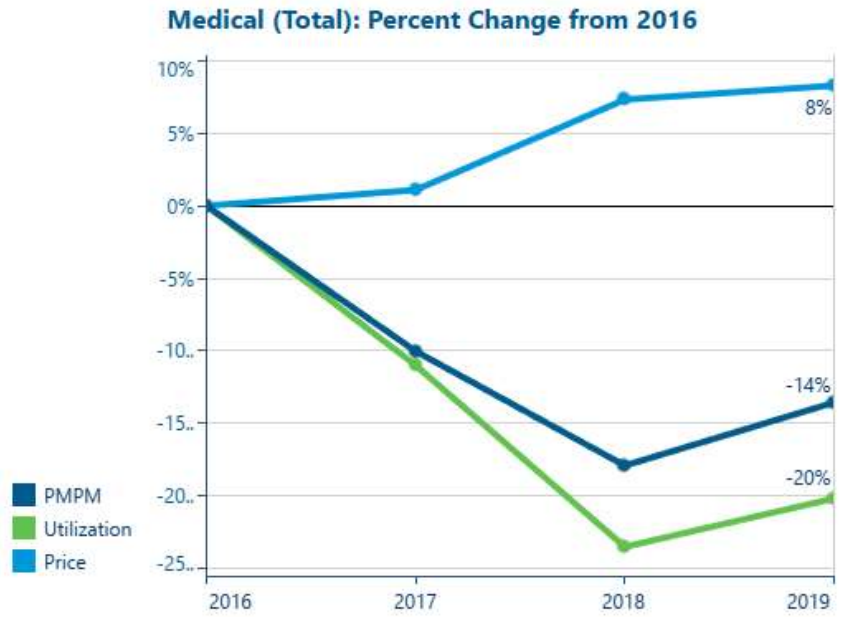


Professional PMPM Rates Increased by 12%

Ambulance PMPM Rates Increased by 11% due to Price Increases of 19%



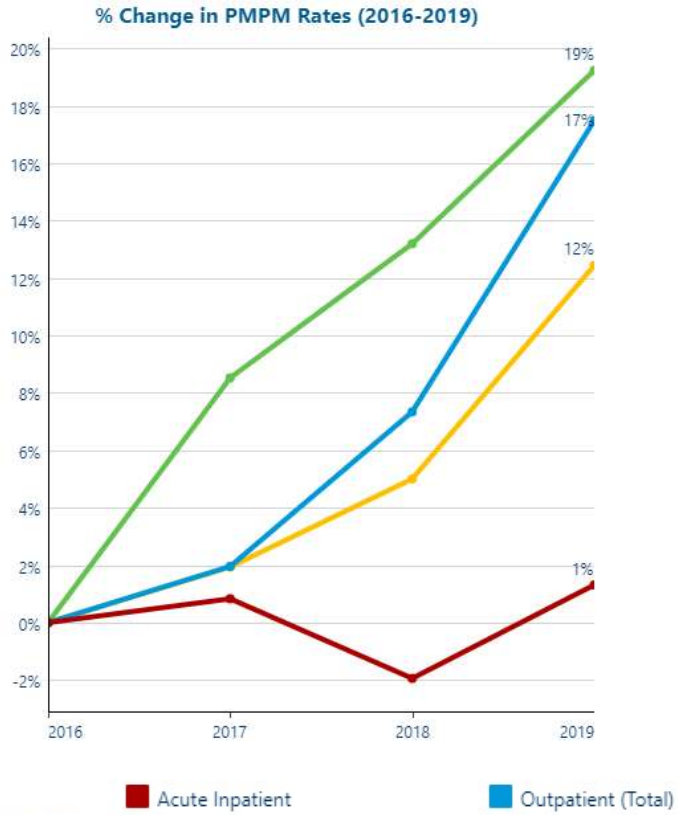
Exchange Plans: PMPM Rates for Medical Services Decreased by 14% due to Decreased Utilization



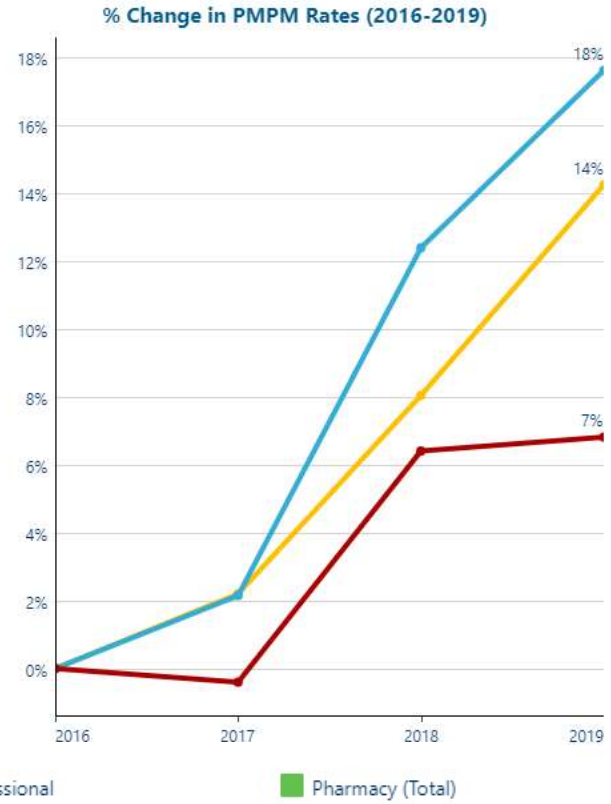
Acute Inpatient Outpatient (Total) Professional Pharmacy (Total)

PEBB: PMPM Trends Were Similar to Statewide

Statewide Commercial



PEBB



Public comment

Washington State Health Care Authority

Data on spending and spending growth in Washington

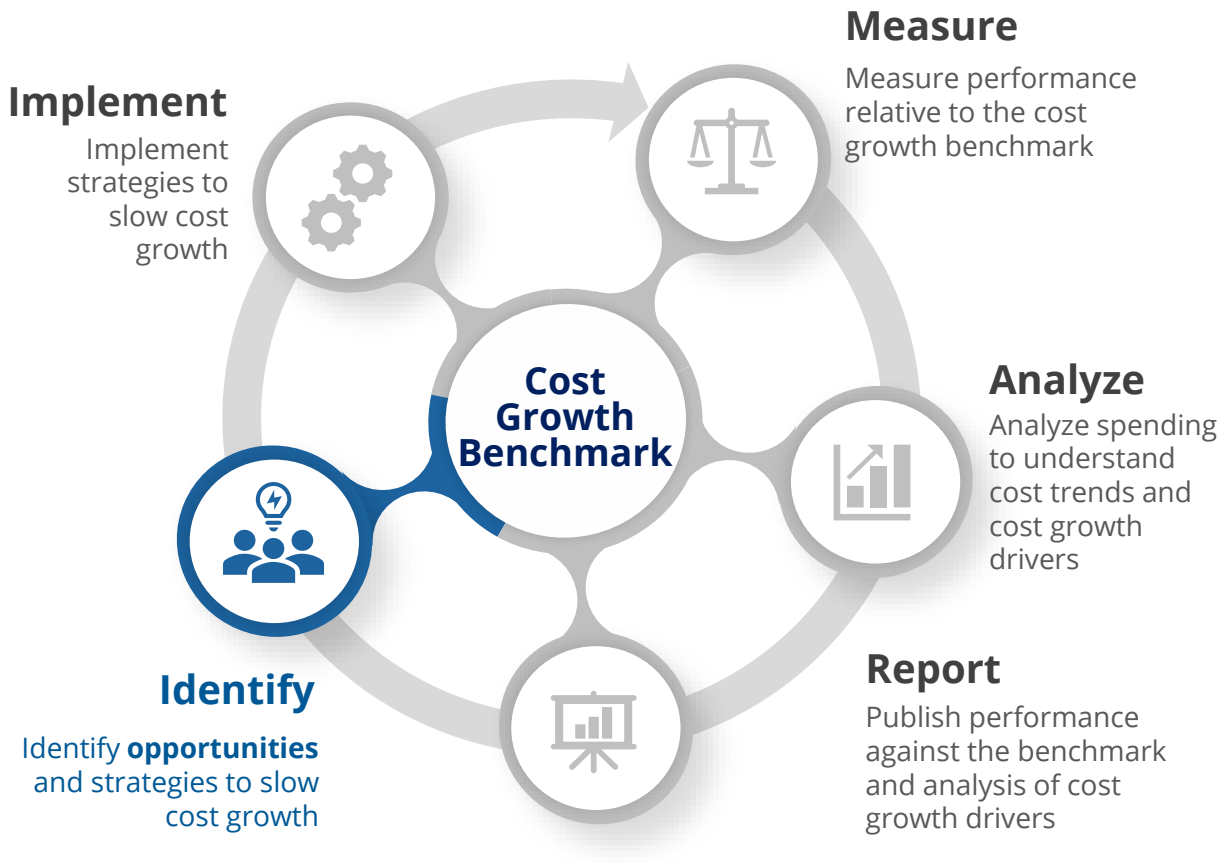
TAB 6

Data on Spending and Spending Growth in Washington

Washington State Health Care Authority

Goals for today's discussion

- To be effective, a cost growth benchmark must be complemented by supporting strategies designed to identify and mitigate cost growth.
- We will look at existing data about health care spending in Washington to identify potential opportunities to slow cost growth.



Washington State Health Care Authority

Three key questions to consider while reviewing data on state health care costs

1. What do the data say about where the costs are highest and rising fastest?
2. Do you identify any concerns we should be taking into account when interpreting the data?
3. What further analyses should HCA consider to better understand what is driving spending and spending growth?

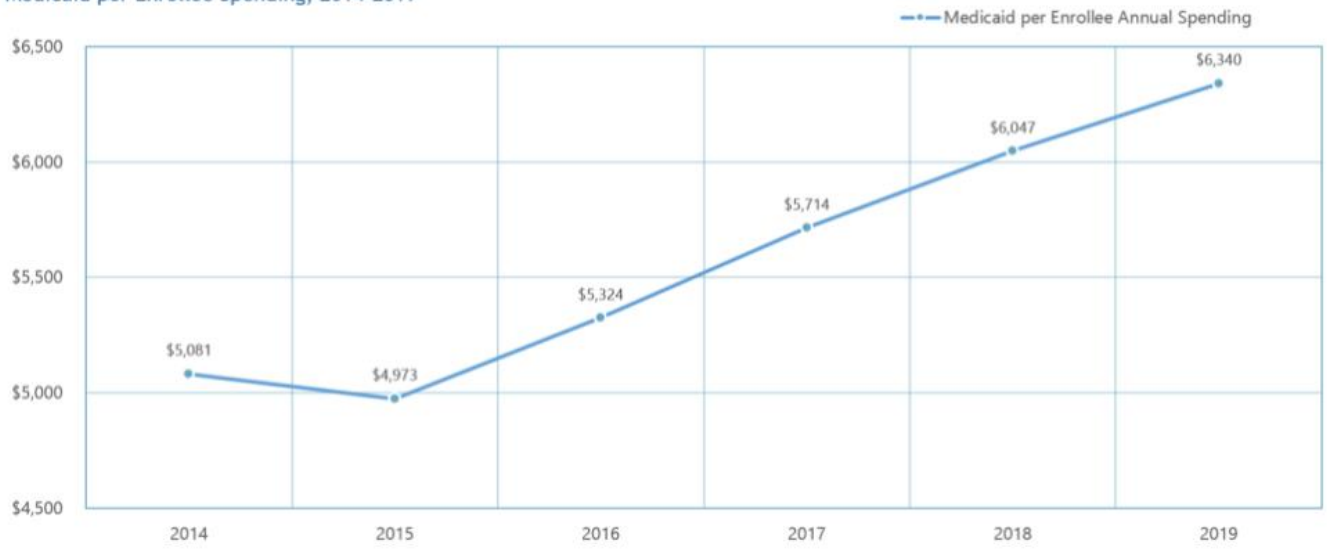
Overall Market Trends

Medicaid per enrollee spending increased 25% from 2014-2019

Medicaid per Enrollee Spending in Washington State, 2014-2019

	Medicaid Expenditures		Medicaid Average Member Enrollment		Medicaid per Enrollee Annual Spending	
2014	$7,770,845,879		1,529,351		$5,081	
2015	$8,601,485,828	11% Change	1,729,490	13% Change	$4,973	-2% Change
2016	$9,541,115,297	11% Change	1,792,218	4% Change	$5,324	7% Change
2017	$10,268,142,189	8% Change	1,797,122	0% Change	$5,714	7% Change
2018	$10,629,921,937	4% Change	1,757,854	-2% Change	$6,047	6% Change
2019	$10,933,109,371	3% Change	1,724,390	-2% Change	$6,340	5% Change

Medicaid per Enrollee Spending, 2014-2019



- Medicaid's per enrollee spending increased an average of 4.6% annually.

Source: Washington Health Alliance, Health Care Spending in Washington State, 2021.

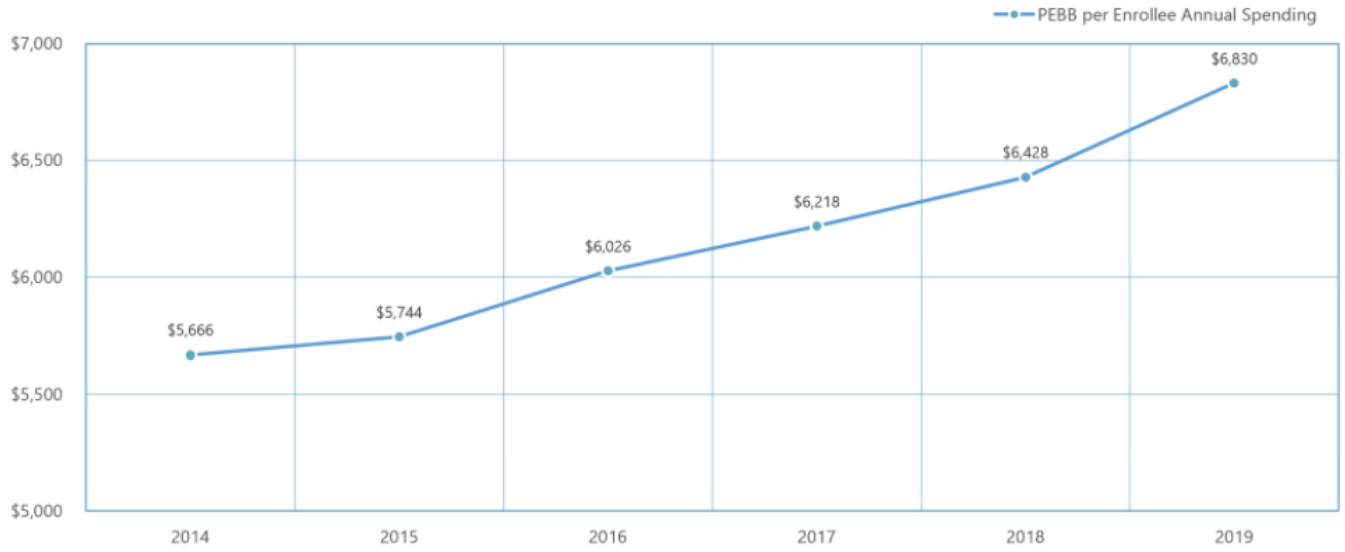
Washington State Health Care Authority

PEBB per enrollee spending increased 21% from 2014-2019

PEBB per Enrollee Spending in Washington State, 2014-2019

	PEBB Expenditures		PEBB Average Member Enrollment		PEBB per Enrollee Annual Spending	
2014	$1,544,516,576		272,595	0% Change	$5,666	
2015	$1,568,336,379	2% Change	273,060	1% Change	$5,744	1% Change
2016	$1,662,664,532	6% Change	275,896	2% Change	$6,026	5% Change
2017	$1,744,640,727	5% Change	280,568	2% Change	$6,218	3% Change
2018	$1,836,343,715	5% Change	285,676	0% Change	$6,428	3% Change
2019	$1,951,826,186	6% Change	285,763	0% Change	$6,830	6% Change

PEBB per Enrollee Spending, 2014-2019



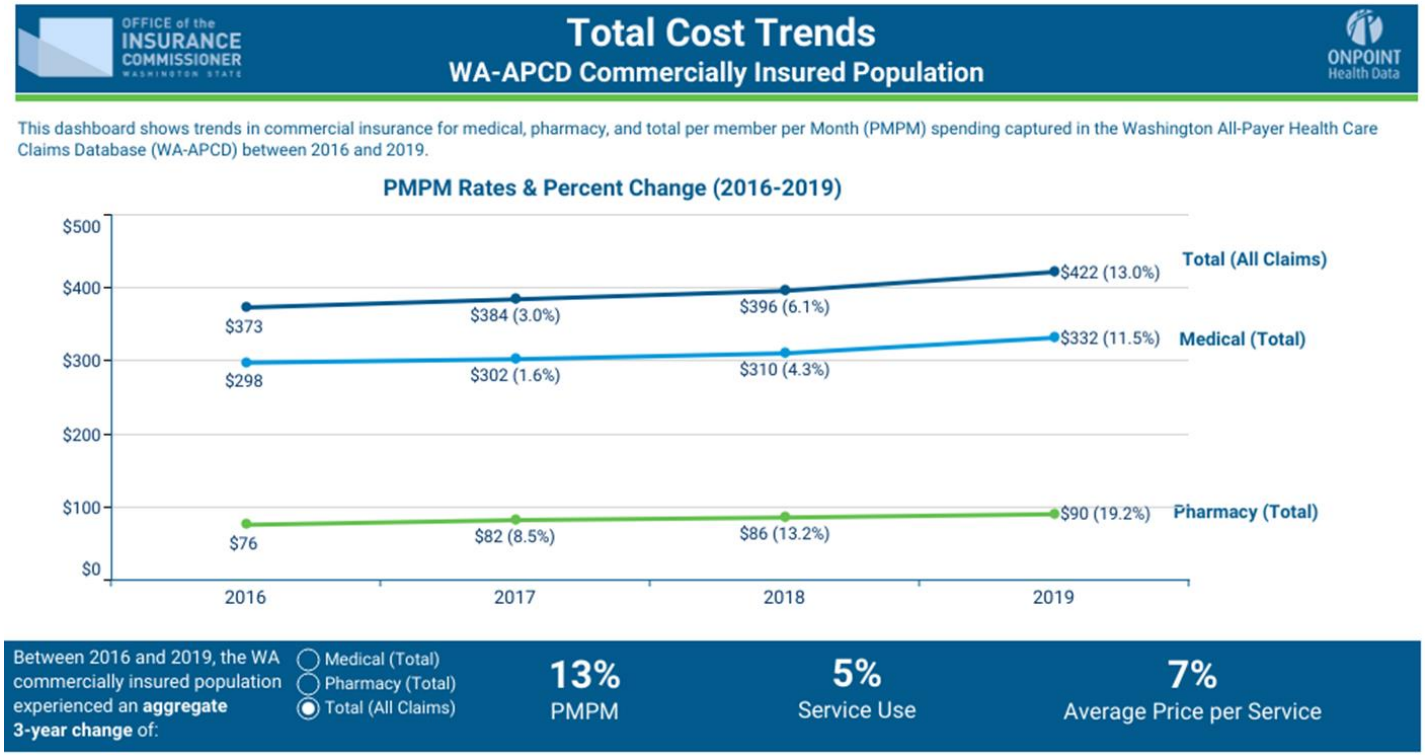
- PEBB's per enrollee spending increased an average of 3.6% annually.

Source: Washington Health Alliance, Health Care Spending in Washington State, 2021.

Washington State Health Care Authority

Non-PEBB commercially insured PMPM spending increased 13% from 2016-2019

- Commercial spending grew an average of 4.2% annually. Increases were driven by both price and utilization.



Source: Office of Health Insurance Commissioner, Interactive Dashboard on Total Cost Trends (2016-2019). Published Dec 15, 2021.

Washington's commercial health care spending compared to the US

Commercial spending is Washington is less than the national average, but has been **growing at a faster rate**.

Per Person Spending (2018)	
WA	**US Average**
$5,772	$5,892

Cumulative Growth (2014-2018)		
	Washington	**US Average**
Spending	21.1%	18.4%
Utilization	4.4%	3.1%
Price	16.3%	15.0%

Source: Health Care Cost Institute, 2018 Health Care Cost and Utilization Report, 2018.

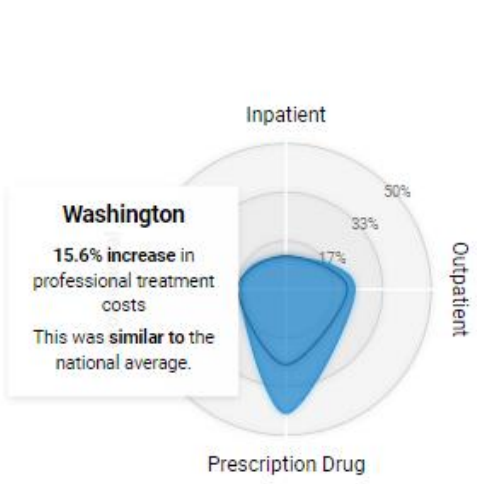
Washington State Health Care Authority

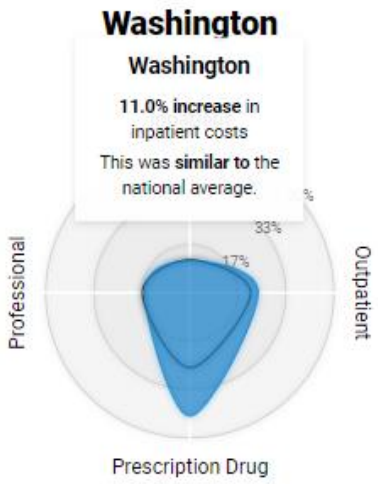
Service Category Level Trends in Spending

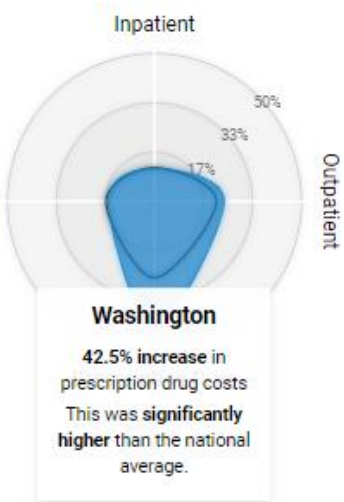
Washington State Health Care Authority

Washington vs national growth in service category spending for the commercial market

- Washington's increase in **prescription drug** spending was significantly higher than the national average.



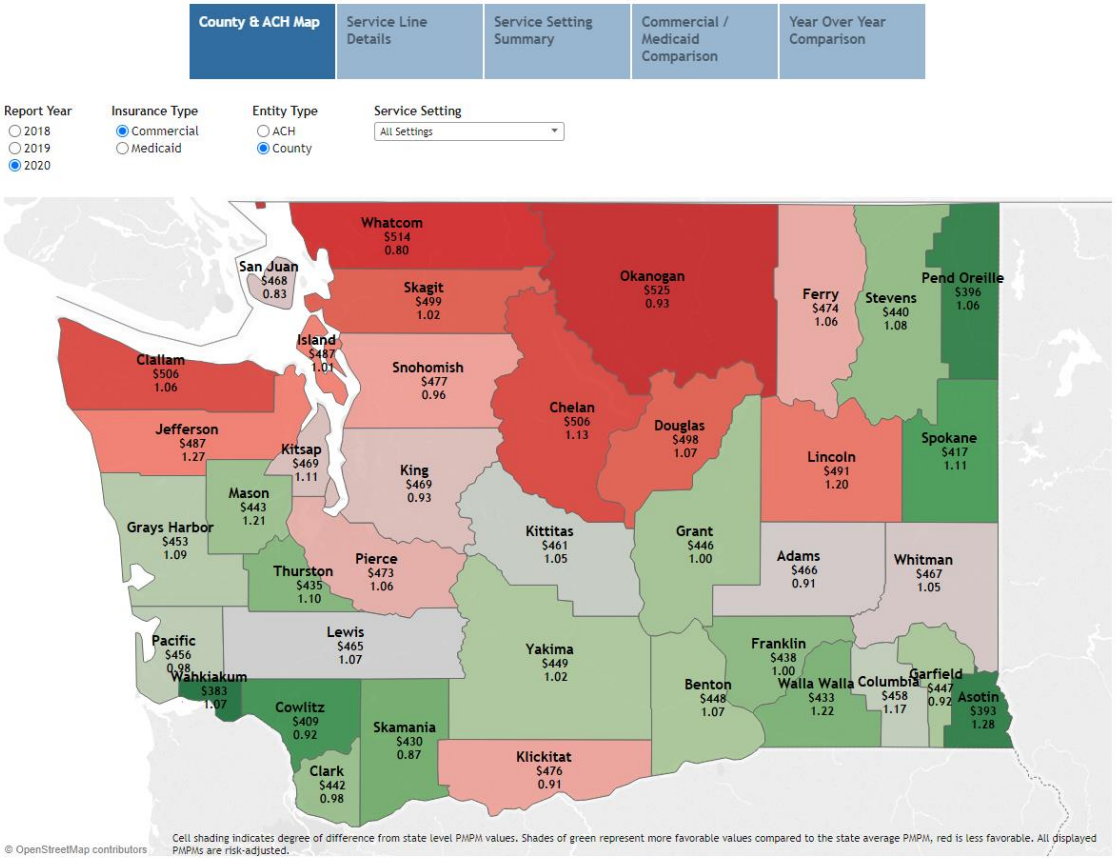




Source: Health Care Cost Institute, 2018 Health Care Cost and Utilization Report, 2018.

Washington State Health Care Authority

The Washington Health Alliance's Total Cost of Care Tool



Washington State Health Care Authority

Commercial spending by service category

- After growth in 2019, in 2020 spending on all service categories went down except for prescription drugs.
- Downward trend in 2020 occurred nationwide.

Service Setting	2020 PMPM Spend	Proportion of Total Spending	2018-2019 Trend	2019-2020 Trend
Facility Inpatient	$87.87	18.9%	0.1%	-9.6%
Facility Outpatient	$133.53	28.7%	8.8%	-6.8%
Professional	$137.47	29.6%	4.6%	-8.7%
Prescription Drug	$92.04	19.8%	2.9%	5.9%
Ancillary	$13.88	3.0%	5.6%	-3.4%
All Settings	**$464.80**	**100.0%**	**4.6%**	**-5.6%**

Source: Washington Health Alliance, Total Cost of Care Tool, 2022.

Washington State Health Care Authority

Medicaid spending by service category

- Prescription drug spending is the highest and fastest growing service category for Medicaid.

Service Setting	2020 PMPM Spend	Proportion of Spending	2018-2019 Trend	2019-2020 Trend
Facility Inpatient	$63.16	22.7%	20.8%	0.2%
Facility Outpatient	$54.40	19.6%	12.2%	-10.6%
Professional	$69.58	25.1%	25.3%	-2.0%
Prescription Drug	$79.20	28.5%	46.4%	23.6%
Ancillary	$11.41	4.1%	21.7%	-3.2%
All Settings	**$277.75**	**100.0%**	**25.1%**	**2.6%**

Source: Washington Health Alliance, Total Cost of Care Tool, 2022.

Commercial inpatient spending trends in Washington

- The Washington Health Alliance conducted a study of inpatient spending trends from 2015 to 2016.
- The analysis found that for all inpatient care, spending declined by 1.5% or $29.5 million.
  - A **decline in the volume** of inpatient treatments accounted for a $51.2 million reduction.
  - An **increase in the price** of inpatient care accounted for $21.7 million in increased spending.
    - This increase was due to both an increase in per unit price and service intensity.
  - Of 287 inpatient treatments analyzed, 21 accounted for half of inpatient spending in the state.

Source: Washington Health Alliance, Inpatient Spending Trends in Washington, 2021.

Washington State Health Care Authority

Data committee discussion on opportunities for cost growth mitigation

- What do the data say about where the costs are highest and rising fastest?
- Do you identify any concerns we should be taking into account when interpreting the data?
- Based on these data, what further analyses should HCA consider to better understand what is driving spending and spending growth?

Washington State Health Care Authority

Benchmark performance assessment

TAB 7

Benchmark performance assessment

Washington State Health Care Authority

Risk-adjustment

- For future measurement of carriers and large provider entity performance against the cost growth target, spending will be risk-adjusted using standard age/sex factors.
- To implement this, carriers will need to submit aggregate spending and member months data by age/sex cells.
- HCA proposes to use eight age bands for all markets.

Proposed Age Bands for All Markets	
0-1	55-64
2-18	65-74
19-39	75-84
40-54	85+

Committee discussion: Risk-adjustment

- Do the proposed age bands seem reasonable?

Proposed Age Bands for All Markets	
0-1	55-64
2-18	65-74
19-39	75-84
40-54	85+

- Members should only fall into one age/sex cell per year.
  - Is there a preference for which point in the year is used to set the age? (e.g., January 1, July 1, December 31?)

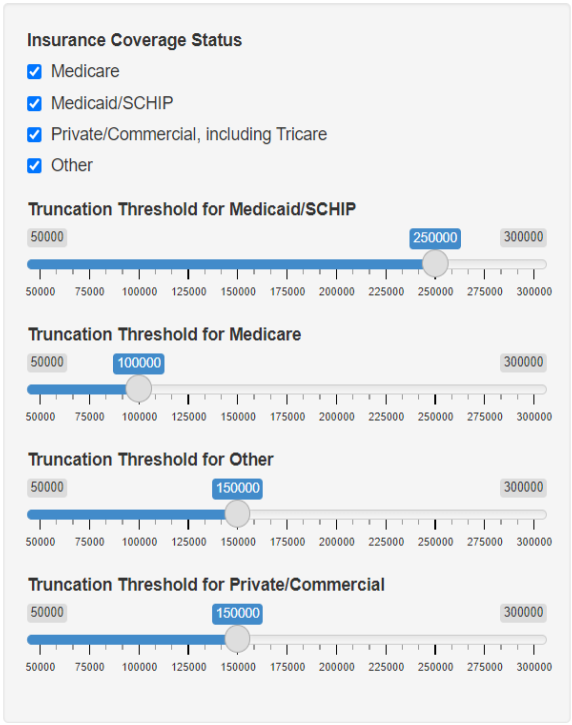
Truncation Analysis Update

- APCD analysis to be completed 3/31
- Truncation Dashboard: Hunter Plumer, Health Trends

Truncation Analysis Update

HCCTB Data Advisory | Truncation Decision Support Tool

By Hunter Plumer, MHA



Summary | Lorenz Curves

`The table and plots presented in this web application are based on calendar year 2019 health expenditure data from the Medical Expenditure Panel Survey (MEPS). These estimates account for MEPS' survey design and are weighted to be representative of the U.S. civilian noninstitutionalized population.`

Overall, there were 28,512 survey participants in MEPS' 2019 full-year consolidated data file. The survey participants were classified into the insurance categories displayed on the left sidebar. The insurance coverage status variable was constructed based on insurance status indicators at the end of year (12/31/2019) provided in the MEPS file. Medicare-Medicaid dual-eligibles are classified under 'Medicare'. Uninsured are included under 'Other'. Overall, of the 28,512 total survey participants, 6,074 are classified as Medicare, 5,636 as Medicaid/SCHIP, 12,752 as Private/Commercial/Tricare, and 4,050 as Other.

The default truncation thresholds, except for 'Other', are based on the Rhode Island values presented in the January 31, 2022 meeting. 'Other' default is set to $150K, but it can be changed in the web application on the left sidebar similar to the other truncation values. When the truncation values are changed, then the summary table below will automatically update. However, the density and Lorenz curve plots are based on nontruncated values; therefore, they are static and will not adjust if truncation values are updated.

This analysis is intended to be informative but not definitive. Given the limited survey sample size, the estimated percentage of health expenditures removed under truncation are likely underestimates, as the sample may not fully capture the very rare but high expenditure outliers at the population level.

Estimated Percentage of Total Health Expenditures Removed With Truncation

0% Minimum Lower Bound Set

	Insurance	Point_Estimate	CI_95_Lower	CI_95_Upper
1	Medicaid/SCHIP	0.5%	0.0%	1.2%
2	Medicare	4.6%	3.1%	6.1%
3	Other	1.7%	0.0%	3.9%
4	Private/Commercial, including Tricare	3.1%	1.5%	4.7%
5	Overall	3.3%	2.4%	4.3%

Source: Washington Health Alliance, Inpatient Spending Trends in Washington, 2021.

Washington State Health Care Authority