

Advisory Committee on Data Issues

October 28, 2021

Advisory Committee on Data Issues Meeting Materials Book

October 28, 2021
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

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Agenda

TAB 1

Advisory Committee on Data Issues

October 28, 2021
2:00 p.m. – 4:00 p.m.
Zoom Meeting

AGENDA

Committee Members:

<input type="checkbox"/>	Megan Atkinson	<input type="checkbox"/>	Jarred Collings	<input type="checkbox"/>	Ana Morales
<input type="checkbox"/>	Amanda Avalos	<input type="checkbox"/>	Jerome Dugan	<input type="checkbox"/>	Thea Mounts
<input type="checkbox"/>	Allison Bailey	<input type="checkbox"/>	Leah Hole-Marshall	<input type="checkbox"/>	Hunter Plumer
<input type="checkbox"/>	Jonathan Bennett	<input type="checkbox"/>	Scott Juergens	<input type="checkbox"/>	Mark Pregler
<input type="checkbox"/>	Purav Bhatt	<input type="checkbox"/>	Lichiou Lee	<input type="checkbox"/>	Julie Sylvester
<input type="checkbox"/>	Bruce Brazier	<input type="checkbox"/>	Josh Liao	<input type="checkbox"/>	
<input type="checkbox"/>	Jason Brown	<input type="checkbox"/>	David Mancuso	<input type="checkbox"/>	

Committee Facilitator:

J.D. Fischer

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome, call to order, and agenda review	1	J.D. Fischer Health Care Authority
2:05-2:10 (5 min)	Approval of meeting minutes	2	J.D. Fischer Health Care Authority
2:10-2:15 (5 min)	Topics we will discuss today	3	January Angeles and Michael Bailit Bailit Health
2:15-2:20 (5 min)	Summary of last meeting's discussions	4	January Angeles and Michael Bailit Bailit Health
2:20-2:25 (5 min)	Board decisions and recommendations provided by the Committee	5	January Angeles and Michael Bailit Bailit Health
2:25-2:45 (20 min)	Defining the list of carriers to report total health care expenditures for the cost growth benchmark	6	January Angeles and Michael Bailit Bailit Health
2:45-3:05 (20 min)	Defining the list of providers for whom total medical expenditures data will be reported by carriers	7	January Angeles and Michael Bailit Bailit Health
3:05-3:45 (40 min)	Methods to strengthen benchmark performance measurement: Options for risk adjustment	8	January Angeles and Michael Bailit Bailit Health

3:45-3:55 (10 min)	Public comment		J.D. Fischer Health Care Authority
3:55-4:00 (5 min)	Wrap-up and adjournment		J.D. Fischer 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.

September meeting minutes

TAB 2

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.



Advisory Committee on Data Issues

October 28, 2021

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Topics we will discuss today

TAB 3

Topics we will discuss today:

1. Recap of the last Committee meeting.
2. Board response to Committee recommendations.
3. Identification of carriers to report benchmark spending.
4. Identification of large providers for whom payers will report benchmark spending.
5. Risk adjustment options analysis.

Summary of last meeting's discussions

TAB 4



Summary of last meeting's discussions

Summary of discussion on patient to clinician attribution methodology

- The Committee did not recommend mandating a specific methodology, but felt it was important to have material consistency in attribution methodologies, and have documentation of those methodologies from payers.
- The Committee recommended allowing payers to use their own attribution methodology based on the following a hierarchy:
 - Member selection
 - Contract arrangement
 - Utilization

Summary of discussion on patient to clinician attribution methodology

- There was a suggestion for the state to define and provide primary care taxonomy or procedure codes.
 - It was noted that if HCA defines primary care more specifically for the carriers, that it be done consistent with how other work within the state has defined primary care.

Summary of discussion on attributing clinicians to large provider entities

- Committee members felt it was important to identify large provider entities based on a framework of cost accountability. Two options discussed in detail included reporting on:
 - Accountable Care Organizations (ACOs) (e.g., RI approach).
 - Large provider entities that *could be accountable* and engage in a total cost of care contract, regardless of whether they actually had one (e.g., CT approach).
- Some noted that because payers define ACOs very differently, it would be problematic to aggregate provider entity data across payers if ACO contract arrangements were the basis for attribution.

Summary of discussion on attributing clinicians to large provider entities

- Some members commented that it would be helpful to have specific IDs (e.g., TINs or NPIs) that would be the basis for assigning clinicians to large provider entities.
- Staff committed to conducting further research on payers' contracting to understand options for defining large provider entities other than through an accountable care contract.

**Board decisions and
recommendations provided by
the Committee**

TAB 5



Board decisions on recommendations
provided by the Committee to date

Board decisions on strategies to strengthen benchmark performance assessments

- At the September Board meeting, staff presented the Committee's recommendations related to:
 - Confidence intervals to determine payer and provider performance against the cost growth benchmark; and
 - Truncation to mitigate the impact of high-cost outliers.
- The Board was unanimous in supporting the use of both methodologies.
 - Staff are beginning to explore the details for implementing the above methodologies.

Defining the list of carriers to
report total health care
expenditures for the cost
growth benchmark

TAB 6



Defining the list of carriers to report total health care expenditures data for the cost growth benchmark

Identifying carriers to report on total health care expenditures

- At the July Committee meeting, staff put forward a proposal to require reporting from Medicaid Managed Care Organizations, commercial carriers, and Medicare Advantage plans with market share at 5% or higher.
- Committee members requested additional information about the Washington State market before making a recommendation to the Board.
- Today we will revisit this issue and make a recommendation on the list of carriers.

Process for identifying carriers

- Staff looked at enrollment data from the Washington State Office of Insurance Commissioner's "2020 Market Information Report."¹
 - Enrollment data are not available for all plans.
 - Staff could not determine enrollment by market.
- Staff developed a list of carriers that would be required to report data to HCA, which was vetted with other state staff with knowledge of the market.
 - The list includes carriers with at least 10,000 enrolled lives and some carriers for which enrollment data were not available but were known as major market players.

¹ Available at: https://www.insurance.wa.gov/sites/default/files/documents/2020-market-information-report_0.pdf.

Considerations for identifying carriers

- At this time, we do not recommend including standalone third-party administrators (TPAs) not affiliated with a licensed insurer, and health care benefit managers (HCBMs) at this time.
 - Carriers will report aggregate spending data, including spending on services outsourced to a TPA or HCBM.
 - Data to indicate the market share for standalone TPAs is not available.
 - We plan to explore inclusion of standalone TPAs once the Office of the Insurance Commissioner has more data on them.

Considerations for identifying carriers

- Staff recommend including **12 carriers** with **major** market share, and not all carriers.
 - Together the 12 carriers account for **96%** of covered lives (after excluding limited benefit plans).
- As a reminder, data will also be collected from:
 - CMS for Medicare fee-for-service (FFS) spending.
 - HCA for Medicaid FFS spending.
 - Department of Labor & Industries for medical spending on state worker's compensation.
 - Department of Veteran Affairs for VA spending.
 - Department of Corrections for spending on correctional health.

Carriers recommended to report data for the cost growth benchmark

1. Kaiser Foundation Group
2. UnitedHealth Group*
3. Premera Blue Cross Group
4. Molina Healthcare Inc Group*
5. Cambia Health Solutions
6. Centene Corporation Group*
7. Community Health Network Group*
8. Anthem Inc. Group*
9. Humana Group
10. CVS Group
11. Health Alliance Northwest Health Plan
12. Cigna Health and Life Insurance Company

* Denotes carriers that hold Medicaid managed care contracts.



Committee discussion: List of carriers

- Does collecting spending data from the list of 12 carriers sufficiently capture information about Washington's health care market?
- Are there other carriers with major market share that are not reflected in this list?

List of Potential Carriers for Benchmark Performance Data Collection
DRAFT as of 10/26/21

Carrier	Covered Lives
Kaiser Foundation Grp	
Kaiser Found Hlth Plan of the NW	93,720
Kaiser Found Hlth Plan of WA Options	153,315
Kaiser Foundation Hlth Plan of WA	430,146
UnitedHealth Grp	
All Savers Ins Co	6,261
Pacificare Life & Hlth Ins Co	603
Sierra Hlth & Life Ins Co Inc	2,599
UnitedHealthcare Ins Co	Not available
UnitedHealthcare of OR Inc	117,916
UnitedHealthCare of WA Inc	273,312
Premera Blue Cross Grp	
Lifewise Assur Co	259,939
LifeWise Hlth Plan of WA	38,580
Premera Blue Cross	614,625
Molina Healthcare Inc Grp	
Molina Healthcare of WA Inc	977,248
Cambia Health Solutions Inc	
Asuris NW Hlth	38,840
BridgeSpan Hlth Co	2,169
Regence BCBS of OR	62,511
Regence Blue Shield	439,995
Regence Blue Shield of ID Inc	1,282
Centene Corp Grp	
Coordinated Care Corp	37,036
Coordinated Care of WA Inc	204,061
Health Net Hlth Plan of OR Inc	902
WellCare Hlth Ins Co of WA Inc	80
WellCare of WA Inc	1,442
Community Hlth Network Grp	
Community Health Plan of Washington	253,014
Anthem Inc Grp	
Amerigroup Washington Inc	208,826
Unicare Life & Hlth Ins Co	Not available
Humana Grp	
Arcadian Hlth Plan Inc	54,728
Humana Ins Co	103,917
CVS Grp	
Aetna Better Hlth of WA Inc.	22,235
Aetna Hlth & Lif Ins Co	Not available
Aetna Hlth Inc PA Corp	3,121

Carrier	Covered Lives
Health Alliance NW Hlth Plan	11,872
Cigna Hlth & Life Ins Co	Not available
TOTAL	4,414,295

NOTES:

- Enrollment data obtained from the State of Washington Office of Insurance Commissioner's (OIC) 2020 Market Information Report, available at: https://www.insurance.wa.gov/sites/default/files/documents/2020-market-information-report_0.pdf
- List includes group and individual markets for Accident and Health LOB as Reported by OIC.
- Membership across all listed insurers with enrollment data comprise 66% of total membership if including limited benefit plans (e.g., prescription, dental, vision), and 96% of membership if excluding limited benefit plans.
- Medicaid managed care plans include:
 - Amerigroup - 211,402
 - Community Health Plan of Washington - 221,798
 - Coordinated Care of Washington - 187,972
 - Molina Healthcare of Washington - 915,234
 - UnitedHealthcare Community Plan - 224,943

Medicaid managed care enrollment obtained from WA HCA Report titled, "Monthly Managed Care Enrollees by Program, Organization and RAC." Last checked: 8/13/2021, report run date: 7/12/2021 12:08:35 PM. Available at: <https://www.hca.wa.gov/about-hca/apple-health-medicare-and-managed-care-reports#managed-care-enrollment>.

Defining the list of providers for
whom total medical
expenditures data will be
reported by carriers

TAB 7



Defining the list of providers for whom
total medical expenditures data will be
reported by carriers

Identifying large provider entities

- It will be important to identify the large provider entities upfront, regardless of the methodology for attributing clinicians to large provider entities.
 - It would be a poor use of resources to collect and analyze spending data for provider entities that are so small that performance is not likely to be publicly reported.
 - Staff need to identify the large provider entities upfront to develop data reporting templates.
- As a reminder, having carriers report on a large provider entity does not mean that the entity's performance will be reported publicly.

Process for identifying providers

- To develop an initial list, staff reviewed:
 - The list of entities reported in the Washington Health Alliance’s Community Checkup report.
 - The Washington Association for Community Health’s list of Community Health Centers.
 - The Health Resources & Services Administration’s Health Center Program Uniform Data System Data.
 - The Washington State Department of Health’s 2019 Year End Hospital reports.
- The list was vetted with staff from other state agencies who were knowledgeable about the provider landscape.

Considerations for identifying large provider entities

- Staff focused on identifying entities that provide primary care and could be accountable for managing and meeting all of a patient's needs.
 - For the above reason, large specialty providers were not included if they did not also provide primary care.
- In addition, staff tried to limit the list to provider entities that are large enough for benchmark performance to be accurately and reliably measured.
 - There was no systematic way to identify how many patients are served by these large provider entities, however.

Large provider entities recommended to have spending reported on by carriers

- Staff have identified a list of 50 large provider entities:
 - 24 community health centers
 - 22 health systems
 - 4 medical groups and independent practice associations



Committee discussion: List of large provider entities

- Are there other major provider entities that are not reflected in the list?
- Are there provider entities in this list that should not be included?
- For some of the large health systems, should reporting occur at the health system level or at the clinic level?

**List of Potential Providers for Health Care Cost Growth Benchmark Measurement
DRAFT as of 10/26/21**

Community Health Centers	Medical Groups and IPAs	Health Systems
1. Columbia Basin Health Association	1. Allegro Pediatrics	1. Astria Regional Medical Center
2. Columbia Valley Community Health	2. The Vancouver Clinic	2. Confluence Health
3. Community Health Care	3. Western Washington Medical Group	3. EvergreenHealth
4. Community Health Association of Spokane	4. Whitman Medical Group	4. Virginia Mason Franciscan Health
5. Community Health Center of Snohomish County		5. Harbor Regional Health
6. Community Health of Central Washington		6. Inland Northwest Health Services
7. Country Doctor Community Health Centers		7. Kadlec
8. Cowlitz Family Health Center		8. Kaiser
9. Family Health Centers		9. Kittitas Valley Healthcare
10. HealthPoint		10. Legacy Health
11. International Community Health Services		11. LifePoint Health
12. Lewis County Community Health Services (Valley View Health Center)		12. Mason General Hospital and Family of Clinics
13. Moses Lake Community Health Center		13. MultiCare Health
14. Neighborcare Health		14. Olympic Medical Center
15. NEW Health Programs Association		15. OptumCare
16. North Olympic Healthcare Network PC		16. Overlake Medical Center & Clinics
17. Peninsula Community Health Services		17. Pacific Medical Centers
18. Sea Mar Community Health Centers		18. PeaceHealth
19. Seattle-King County Public Health Dept		19. Providence Health
20. (Health Care for the Homeless Network)		20. Skagit Regional Health
21. Tri-Cities Community Health		21. Swedish Health Services
22. Unity Care Northwest		22. UW Medicine
23. Yakima Neighborhood Health Services		
24. Yakima Valley Farm Workers Clinic		

NOTES:

- Focuses on large provider entities that provide primary care and could enter into total cost of care contracts.
- The list of Community Health Centers does not include four that have less than 5,000 covered lives: (1) Seattle Indian Health Board Inc; (2) Mattawa Community Medical Clinic; (3) The NATIVE Project; and (4) Colville Confederated Tribes.
- Some health systems include several medical centers that may be worth reporting on separately.

Methods to strengthen benchmark performance measurement: Options for risk adjustment

TAB 8



Methods to strengthen benchmark performance measurement: options for risk adjustment

Recap: The issue coding completeness and rising risk scores

- Previously, we described the issue of coding completeness and rising risk scores, and its impact on benchmark performance measurement.
 - In RI, rising risk scores had the effect of essentially raising the cost growth target value by 3.2 percentage points.
- The Committee discussed and expressed support for adjusting data by using age/sex factors only.
 - Some wanted additional input from actuaries within their organizations before making a recommendation.
 - Members noted concerns that this would not yield accurate results if there is a significant shift in a payer or provider entity's population over a year.

Risk-adjustment options to address coding intensity

- Since our last discussion, staff have conducted additional research and vetted more options for consideration by the Committee:
 1. Age/sex adjustment performed by the payers.
 2. Age/sex adjustment performed by the state.
 3. Clinical risk adjustment normalization performed by payers.
 4. Clinical risk adjustment normalization performed by the state.

Option 1: Age/sex adjustment performed by each payer at provider entity level

Payers submit provider entity risk scores that reflect only age and sex weights by market developed using the payer's risk-adjustment software and applied to the payer's data.

Strengths

- Eliminates code creep impact
- Weights will vary from payer to payer
- Easy for the state to administer

Weaknesses

- Does not fully account for changes in population health status
- Problematic when a payer or large provider entity experiences a significant shift in membership or patient population

Option 2: Age/sex adjustment performed by the state using payer data

Payers submit unadjusted spending data stratified by line of business and by age/sex bands. The state would use these data to develop an age/sex risk adjustment factor for each payer and large provider entity by line of business.

Strengths

- Eliminates code creep impact
- Weights are standardized
- Assures consistency of method
- Relatively easy for the state to administer

Weaknesses

- Does not fully account for changes in population health status
- Problematic when a payer or large provider entity experiences a significant shift in membership or patient population

Option 3: Clinical risk adjustment normalization performed by payers

Payers would determine the average risk scores across all large provider entities and divide large provider entity's risk score by the average risk score to calculate a final risk score.

Strengths

- Limits code creep impact
- Model would account for changes in population health status and shifts in provider entity patient panel
- Easy for the state to administer

Weaknesses

- Can't be applied at the insurer level
- Depends upon proper execution by payers
- Difficult to validate

Option 4: Clinical risk adjustment normalization performed by the state

The state would determine the average risk score for the entire population and divide each payer and large provider entity's risk score by the average risk score to calculate the final risk score.

Strengths

- Limits code creep impact
- Model would account for changes in population health status and shifts in payer or provider entity membership or patient panel

Weaknesses

- Requires a tested and validated state APCD with clinical risk-adjustment software
- APCD lacks over 50% of the commercial market
- Significant work for the state



Committee discussion: Risk-adjustment options

- What input does the Committee want to give the Board on options for adjusting for changing population risk while mitigating the impact of systemic rising risk scores?