Advisory Committee of Health Care Providers and Carriers

April 6, 2022

Washington State Health Care Authority

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Advisory Committee of Health Care Providers and Carriers Meeting Materials Book

April 6, 2022
2:00 p.m. – 4:00 p.m.

(Zoom attendance only)

Agenda and Presentations

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Agenda

TAB 1

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Advisory Committee of the Health Care Providers and Carriers

April 6, 2022
2:00 p.m. – 4:00 p.m.
Zoom Meeting

AGENDA

Committee Members:					
☐	Mark Barnhart	☐	Stacy Kessel	☐	Megan McIntyre
☐	Bob Crittenden	☐	Ross Laursen	☐	Mika Sinanan
☐	Bill Ely	☐	Todd Lovshin	☐	Dorothy Teeter
☐	Paul Fishman	☐	Vicki Lowe	☐	Wes Waters
☐	Jodi Joyce	☐	Mike Marsh		
☐	Louise Kaplan	☐	Natalia Martinez-Kohler		

Committee Facilitator:
AnnaLisa Gellermann

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome and roll call		AnnaLisa Gellermann, Board Manager Health Care Authority
2:05 – 2:08 (3 min)	Approval of February meeting minutes	2	AnnaLisa Gellermann
2:08 – 2:10 (2 min)	Topics we will discuss today	3	AnnaLisa Gellermann
2:10 – 2:20 (10 min)	Strategies for reducing cost growth	4	AnnaLisa Gellermann
2:20 – 2:45 (25 min)	Considering data on state health costs	5	AnnaLisa Gellermann
2:45 – 3:05 (20 min)	Impact of Covid and Inflation on Benchmark	6	AnnaLisa Gellermann
3:05 – 3:15 (10 min)	Public Comment	7	
3:15 – 3:30 (15 min)	Primary Care Expenditures	8	AnnaLisa Gellermann
3:30 – 4:00 (30 min)	Benchmark Reporting Discussion	9	AnnaLisa Gellermann
4:00	Adjourn		AnnaLisa Gellermann

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.

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February meeting minutes

TAB 2

Washington State Health Care Authority

Advisory Committee of Health Care Providers and Carriers meeting minutes

February 1, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
9:00 a.m. – 11:00 a.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

Bill Ely
Bob Crittenden
Dorothy Teeter
Louise Kaplan
Mika Sinanan
Mike Marsh
Natalia Martinez-Kohler
Ross Laursen
Stacy Kessel
Todd Lovshin

Members absent

Jodi Joyce
Mark Barnhart
Megan McIntyre
Paul Fishman
Vicki Lowe
Wes Waters

Agenda items

Welcome, call to order, approval of meeting minutes

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 9:02 a.m. Minutes from September were approved.

Topics we will discuss today

Ms. Gellermann shared that the group would hear a recap of the board's September meeting and adoption of benchmark methodology and value, discuss the impacts of the benchmark to pursue and avoid, get an introduction to reporting against the cost growth benchmark, and statistical methods to ensure the accuracy and reliability of

benchmark performance measurement. Finally, the group would review principles to guide the process of sharing benchmark data.

Review meeting plan for Year 2

AnnaLisa Gellermann, Committee facilitator
PowerPoint presentation

Ms. Gellermann presented to the Committee a calendar of future meetings, including reviewing cost driver analysis strategy and recommended areas of prioritization, review of existing data on cost growth drivers, developing an accountability recommendation to the Board and identifying cost growth mitigation strategies of interest.

Analyses of cost and cost growth drivers (Discussion: Phase 1 and Phase 2 proposed analyses)

AnnaLisa Gellermann, Committee facilitator
PowerPoint presentation

Ms. Gellermann presented to the Committee information presented to the Board, detailing the Peterson Milbank framework for cost growth driver analysis: where is spending problematic, what is causing the problem, and who is accountable. Cost driver analyses will have two phases. Phase 1 is the production of standard analytic reports produced on an annual basis at the state and market levels. Phase 2 is supplemental in-depth analyses, and ad-hoc drill down analyses to identify opportunities for actions to reduce cost growth.
Some committee members discussed the Phase 1/Phase 2 methodology discussed in the article cited in the slide describing a data use strategy for state action to address health care cost growth, and the article was provided to committee members in response to their request. Concerns were raised about the impact of changes in the healthcare ecosystem due to the Covid-19 pandemic, and how that would impact cost analyses and the ability to achieve any goals set by the Board. One committee member suggested that the impact of regulatory and policy changes including new benefit mandates should be considered in the analysis. One Committee member asked for clarification about who is performing the analysis and who is the customer for the data. Ms. Gellermann clarified that the Cost Board is an independent entity supported the Health Care Authority to do the data work. The Cost Board is the customer of the data, and the ultimate audience for the data and recommendation are purchasers, providers, the public and the legislature.
Ms. Gellermann presented the staff recommendations to the Board for the Phase 1 analyses, to be included in ongoing reporting, with examples of similar reporting in other states. The recommendations are reports at the state and market level for the following five areas: spend and trend by geography, trends in price and utilization, spend and trend by condition (to be determined), spend and trend by demographics, and monitoring of potential unintended adverse consequences.
One committee member pointed out that risk stratification would be important in a price utilization analysis, to determine if changes in health of patients would have a strong impact on cost, and that comparing similar populations would be important. One committee member asked if unintended adverse consequences was related to data analyses, and Ms. Gellermann responded that it had not been determined what could and should be measured. One committee member commented that the approach was thoughtful but reiterated that the 3.2% benchmark was an unachievable target and adding stress to a vulnerable system.
The committee was asked for suggestions related to Phase 1 analyses. In the ensuing discussion, members suggested the following:

- Adding to the Phase 1 routine reporting: Pharmaceuticals, Inpatient vs. Outpatient costs, and signature procedures (e.g. colonoscopies, hip replacements).
- Analysis of the provider mix, and specifically availability of providers as having a significant impact on cost.
- Tracking access, to ensure that reduced cost does not negatively impact the ability to get care.
- Tracking BMI data as driving utilization and chronic health care issues.
- Consider batching health conditions into actionable groups like rheumatologic conditions, or diabetes.
- Consider how to determine by geography vulnerable populations, by zip code and/or by legislative district.

The Committee was presented a list of legislative suggestions for Phase 2 analyses. Ms. Gellermann indicated a deeper discussion of Phase 2 topics would occur in April.
Ms. Gellermann shared the proposed process for conducting and vetting cost growth driver analyses.

Public Comment

Eric Lewis, Chief Financial Officer of Washington State Hospital Association
Mr. Lewis shared his concern that the 2022 benchmark of 3.2% was questionable and perhaps not reasonable, given the impacts on hospitals related to the pandemic, the Governors' non-emergent shut-down, work force shortages, and inflation of wage and supply cost.

Review pre-benchmark data collection process and timeline

Ross McCool, Health Care Authority

Mr. McCool presented to the Committee a timeline of the benchmark data all. Payer seminars and office hours will be held in May through June of 2022, and preliminary data submission will begin on June 30. Board and Committee review of preliminary results is anticipated in October.

Review payor survey of provider entity contracts

Ross McCool, Health Care Authority

Mr. McCool informed the committee of payer survey that will be issued in March confirming total cost of care contracts. The purpose of the survey is to confirm the list of providers entities that will be the subject of benchmark reporting data.

Accountability

AnnaLisa Gellermann, Committee facilitator
PowerPoint presentation

Ms. Gellermann presented materials describing the legislative requirements for reporting, including that payers and providers exceeding the benchmark "shall" be identified. She reviewed the accountability activities including the preparation of analyses, review and consultation with identified entities, and public reporting and recommendations. She shared an overview of the process in Massachusetts and invited committee members to review their hearings online.
The committee reviewed draft principles for the process, including a transparent and predictable process that will identify the entities reported on. Discussion of the topic was deferred due to time. The committee will discuss

accountability at the next meeting and provide a recommendation to the Board on both principles and specific elements of the process.

Adjourn

Meeting adjourned at 11:00 a.m.

Next meeting

Wednesday, April 6, 2022
*Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.
**Zoom meeting is dependent on public health emergency.*

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Topics for today

TAB 3

Topics for today

- Strategies for reducing cost growth
- Considering data on state health care costs
- Impact of Covid on benchmark
- Session 2022: Primary Care
- Reporting discussion

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Strategies for reducing cost growth

TAB 4

Strategies for Reducing Cost Growth

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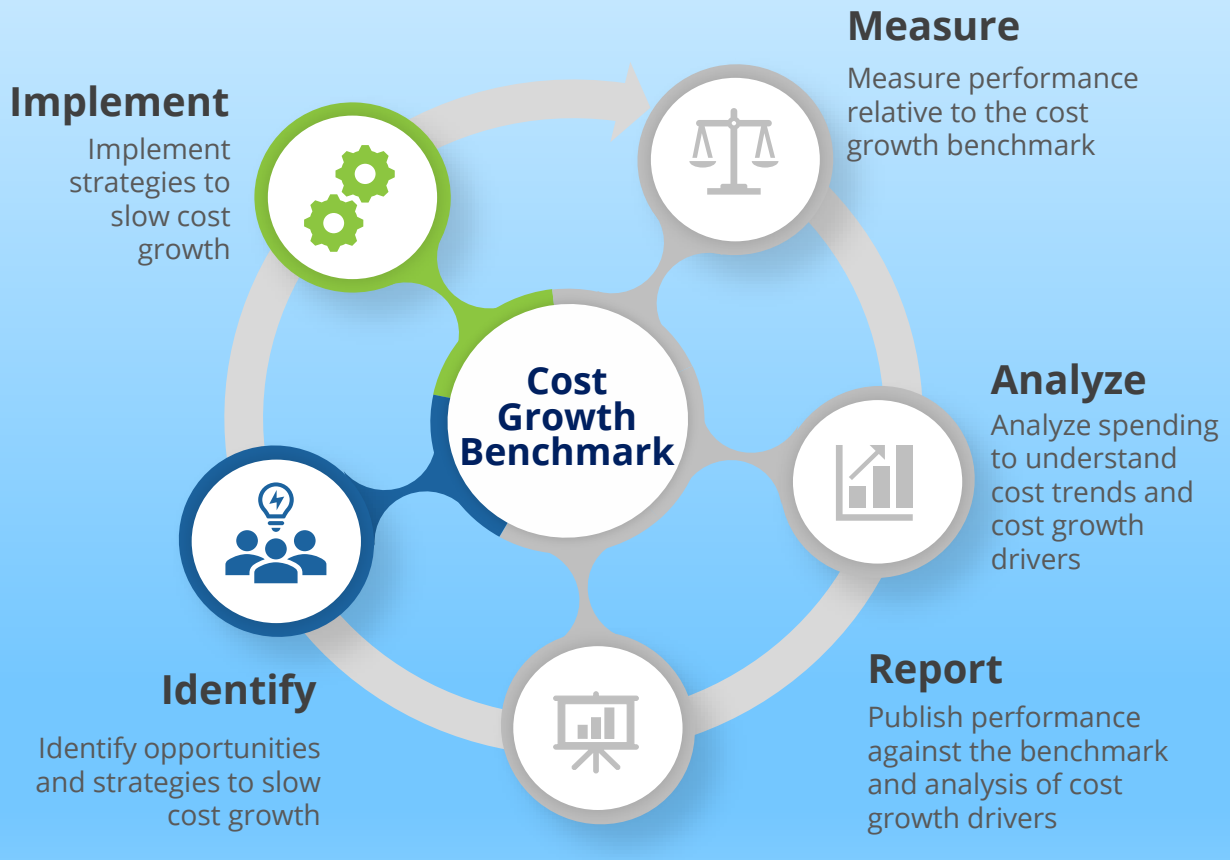
Reminder: the cost growth benchmark logic model

- A cost growth benchmark serves as an anchor, establishing an expectation that can serve as the basis for transparency.
- To be effective, it must be complemented by supporting strategies designed to mitigate cost growth.



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Two approaches to addressing cost drivers and cost growth drivers

1. Devise specific strategies to address cost drivers and cost growth drivers identified through analysis.
2. Advance broad-based strategies that may impact overall cost growth without targeting one contributor in particular.

State strategies to address cost growth

- Strategies used by cost growth benchmark states to address cost growth generally fall under the following categories:
  - Market consolidation oversight (OR, WA)
    - WA OIC reviews consolidation in commercial market
    - AGO oversees anti-trust
  - Price growth caps (DE, RI)
  - Prescription drug pricing legislation (CT, MA, RI)
    - WA has a drug price transparency program
    - Proposed legislation pending on affordability
  - Advanced value-based payment models (OR, RI, WA)

Approved: criteria for selecting strategies to support cost growth benchmark attainment

- Implementation of the strategy is likely to have a substantive impact on cost growth benchmark attainment.
  - Evidence supports the strategy, or if not, there is a compelling logic model for the strategy.
- The strategy is actionable for the state, payers or provider organizations.
  - Approval from federal partners is not required to implement the strategy, or there is a high likelihood of obtaining required approval.
- Relevant stakeholder have the capacity to design and execute the strategy thoughtfully and successfully.

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Considering data on state health care costs

TAB 5

Considering data on state health care costs

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

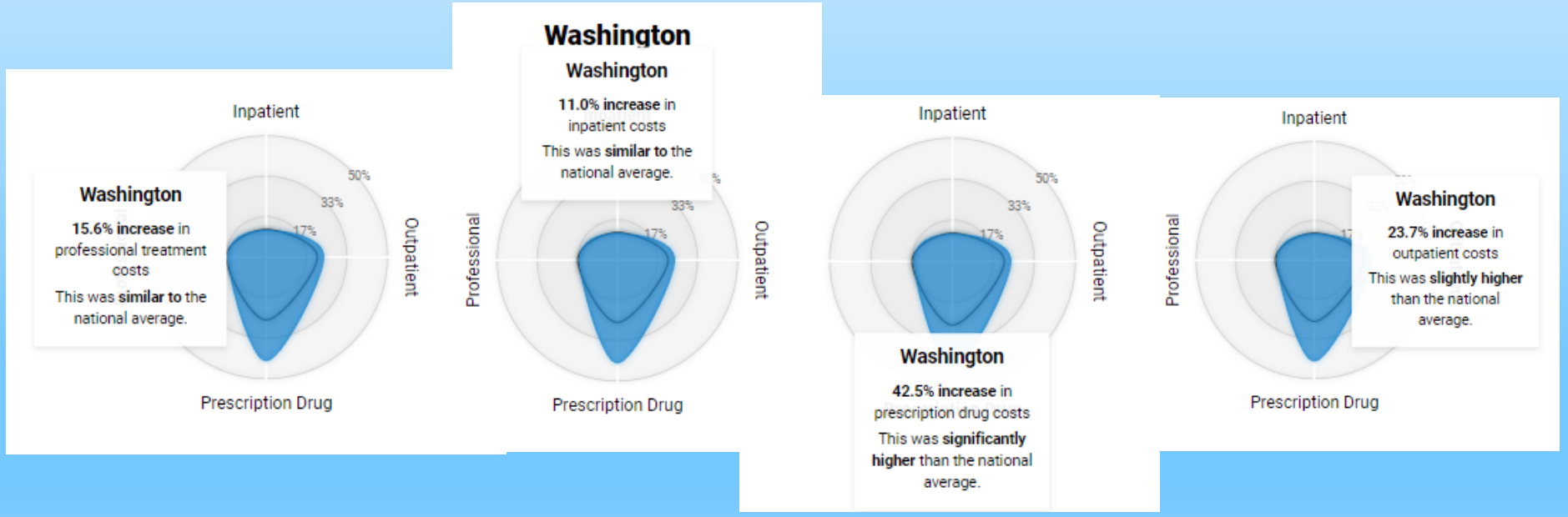
1. What does the data say about where the costs are highest and rising fastest?

2. Do you identify any concerns we should be consider when interpreting the data?

3. What further analyses should HCA consider to better understand what is driving spending and spending growth?

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.

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OIC Cost Trend Analysis

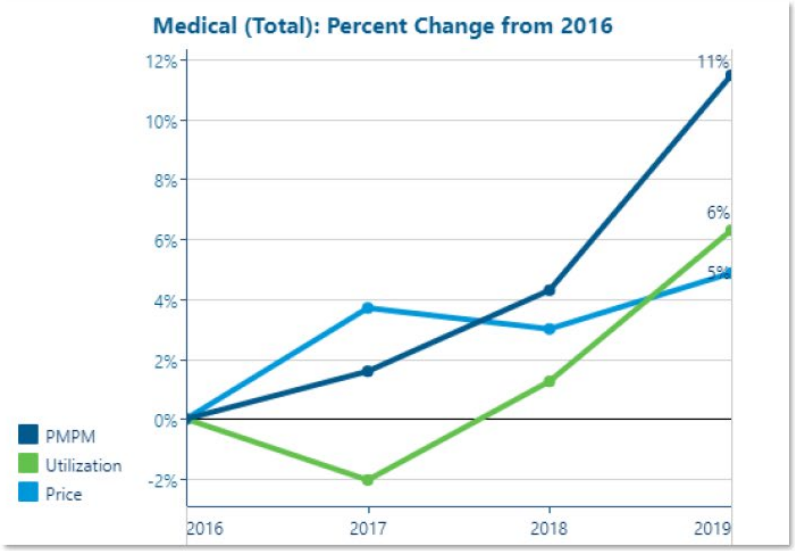
- Calculate rate of cost growth for commercial spending
- Identify driver of cost: acute inpatient, outpatient ED, outpatient non-ED, professional, pharmacy, ambulance
- Allocate cost change to price vs. utilization
- Additional drill-downs: type of inpatient service, mental health services, air ambulance services, Exchange and PEBB

OIC Methodology

- Conducted by OnPoint
- Source is APCD data 2016-2019
- Population = commercial carriers, ages 0-64, WA state residents only
- Claims= first service date between Jan 1 and Dec 31 of the study year
- Eligibility= members with both pharm and med
- Fee for service= limited to members in groups with the majority of their care paid in a fee-for-service (non-capitated)

Example of Key Takeaway

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%).

WHA Total Cost of Care Tool

- Drawn from WHA data base including self-funded claims information.
- Reported on a per member per month (PMPM) basis
- Sets the state average as a benchmark to allow comparison of costs across geographic areas.
- Can be viewed
  - geographically on a state map to compare average county and ACH PMPMs and risk scores;
  - by setting, inpatient, outpatient, professional services, prescription drugs, and ancillary;
  - by services, including surgical, maternity, preventive, emergency, urgent care, and home health care;
  - a side-by-side comparison of Medicaid and commercial results; and
  - a year-over-year comparison.

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.

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Board identified areas for deeper dives

- Board members were most interested in diving deeper into the following issues:
  - **Market oversight**, including oversight of market consolidation and setting affordability standards.
  - **Hospital pricing strategy**, including global budgets and understanding the impact of labor costs.
  - **Value-based payments**, in particular challenges to getting traction.

Committee discussion: areas for deeper dives

- What feedback does the Committee wish to provide related to the areas selected for deeper dives?
- What are the challenges you anticipate in identifying or developing cost mitigation strategies in these areas?
- Are there other areas that the Board should consider in addition to these three?

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Impact of Covid-19 and rising inflation on the Cost Growth Benchmark Program

TAB 6

The impact of COVID-19 and rising inflation on the Cost Growth Benchmark Program

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COVID-19 resulted in unusual spending trends in 2020 and 2021

- What we know about COVID-19 impact on health care utilization:
  - Utilization dropped dramatically during March and April of 2020 nationally. While it rebounded thereafter, it never reached the 2019 baseline level.
  - Utilization was higher in 2021, but despite the impacts of delayed care, may not have reached the annual level of 2019.
- What this means for benchmark performance assessment:
  - Trend for 2019-2020 will be very low (e.g., Minnesota has has reported -2%).
  - Trend for 2020-2021 will be much higher.

Hospitals and health care systems are contending with rising costs

- Health care providers are being affected by supply chain issues, labor shortages and elevated labor costs.
  - The *New York Times* reported that the Consumer Price Index climbed 7.5% in January 2022.
  - According to the Bureau of Labor Statistics, employment in health care is down 378,000 or 2.3% from its level in February 2020.
  - An analysis of hospital financial data showed that labor expenses climbed despite lower staffing levels.
- Such trends are raising concerns about near-term prospects for meeting the benchmark

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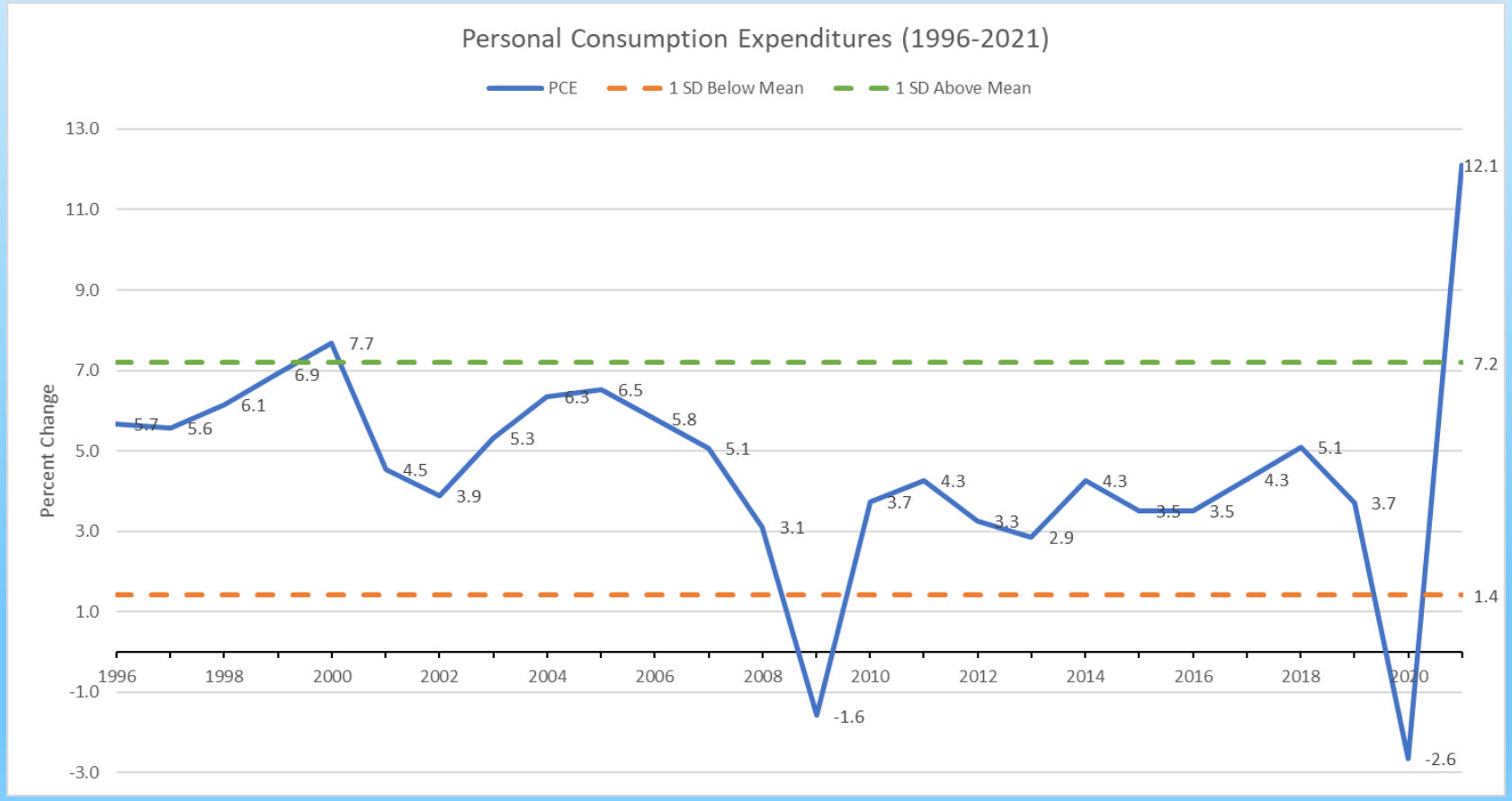
Sources: Jeanna Smialek and Madeleine Ngo, "Rapid Inflation Stokes Unease From Wall Street to Washington," *The New York Times*, February 10, 2022; Bureau of Labor Statistics, "The Employment Situation – January 2022," February 4, 2022; and KaufmanHall, "National Hospital Flash Report," December 2021.

How different is current inflation from historical trends?



Source: U.S. Bureau of Economic Analysis, Personal Consumption Expenditures: Chain-type Price Index [PCEPI], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/PCEPI, March 7, 2022

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Economic changes impact health care spending on a lagged basis

- Inflation and real gross domestic product are strong predictors of health care spending growth.
- Changes in inflation filter through the health care system over a period of two years.
  - Contracting for health care services, in which parties typically negotiate prices over a period of about three years, have likely limited the scope of price increases in the near term.

Sources: Kaiser Family Foundation and Altarum Institute, "Assessing the Effects of the Economy on the Recent Slowdown in Health Spending." 2013; The Brookings Institution, "Health Spending Growth: The Effects of the Great Recession," 2015; and Thomas Getzen, "The Growth of Health Spending in the USA: 1776-2026," Temple University, 2017.

The Board included trigger language for revisiting the cost growth benchmark

"In the event of extraordinary circumstances including highly significant changes in the economy or the health care system, the Board may consider changes to the benchmark or to the benchmark methodology."

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Public Comment

TAB 7

Public comment

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Primary Care Expenditures and the HCCTB

TAB 8

Primary Care Expenditures and the HCCTB

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SB 5589

- Primary care expenditure target of 12% of total health care expenditures
- HCCTB shall report to the legislature, including:
  - How to define "primary care" for purposes measurement
  - Current level of primary care expenditures
  - Methods to incentivize achievement of the 12% target.
  - Reimbursement practices supporting legislative goals
- Reports continue annually
- Insurance Commissioner may include an assessment of carrier's primary care spending in rate and form reviews and require reporting.

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Reporting benchmark results

TAB 8

Reporting benchmark results

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Benchmark reporting-requirements

- This Board “shall” identify those health care providers and payers that are exceeding the health care cost growth benchmark.
- After review and consultation with identified entities.
- 2022: Board receives baseline data and publishes information at the state and market levels (legislative report).
- 2023: Board will report trend data at 4 levels: state, market, carrier and provider.

Benchmark reporting: draft principles

- The Board's benchmark reporting process will be transparent and predictable.
- The intent of benchmark reporting to curb increasing cost trends is enhanced by informed stakeholder participation.
- The public should be aware of and educated about benchmark results.

Benchmark reporting: draft principles

- What feedback, if any, does the Committee wish to provide the draft principles?
- Are there important principles that should be added?

Reporting activities (2022)

- Data Call- July 2022
- Preparation of analyses
- Identification of baseline trends at state and market level.
- Identification of baseline trends for providers and carriers (not public)
- Review and consultation with identified entities
- December 2022- legislative report

Reporting activities (2023)

- Data Call- July 2023
- Preparation of analyses
- Identification of trends at state, market, carrier and provider level.
- Identification of providers and carriers over benchmark.
- Review and consultation with identified entities.
- Legislative report and Public Hearing- Dec. 2023
  - Includes Cost Driver analyses

What should the Board consider for review and consultation?

- What would support the most collaborative process?
- Who should the Board expect at a meeting to discuss benchmark performance?
- What timeframe would be reasonable to prepare for the conversation?
- Should comparative information with other entities be provided?
- What else should the Board and staff consider to support effective review and consultation?