# Advisory Committee of Health Care Providers and Carriers meeting minutes

September 30, 2021
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

Bill Ely
Bob Crittenden
Dorothy Teeter
Jodi Joyce
Louise Kaplan
Mika Sinanan
Natalia Martinez-Kohler
Patricia Auerbach
Ross Laursen
Stacy Kessel
Todd Lovshin
Wes Waters

## Members absent

Mark Barnhart
Megan McIntyre
Mike Marsh
Paul Fishman
Vicki Lowe

## Agenda items

### Welcome, call to order, approval of meeting minutes

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 10:02 a.m. Minutes from July 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.

## Review of Board's decision: Benchmark methodology and value

Ms. Gellermann reminded Committee members of key decisions at the prior Board meeting and were informed of Board decisions related to trigger and review language and the selection of the cost benchmark.

The Committee was provided the Board-adopted language for review of the benchmark as follows: "the Board will annually review performance against the benchmark and may consider any impact of the cost benchmark on the overall health system, including access to care, quality of care, and impact on the specific populations, providers, or market sectors." One Committee member shared concerns that the purpose of the Board's consideration was not clear and requested clarification and additional language.

The Committee was also provided the Board-adopted language to trigger consider of changes to the benchmark as follows: "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." One Committee member asked for clarification of whether "highly significant changes" were limited to those related to the effect of the benchmark. Another committee member asked whether extraordinary circumstances that a positive effect on the health care market would trigger a consideration of change, and perhaps reduction of the benchmark.

Ms. Gellermann responded that the language was intended to broadly encompass highly significant changes of any kind, and that the Board's intent was to set the circumstance as broadly as possible. Clearer language was requested for both statements.

The Committee then reviewed information presented to the Board projecting savings under three selected benchmark scenarios. The projection was created by actuaries at Bailit Health, based on national data. Estimated savings over the 5-year period of the benchmark ranged between $10.8 billion in avoided cost, to $11.8 billion. Ms. Gellermann shared that the Board reviewed the information but did not seem strongly focused on the differences in cost avoidance between the three in the initiation 5-year period of the benchmark.

The Committee discussed the link between cost avoidance and affordability for consumers. Ms. Gellermann stated that the two were not directly linked, although it was likely that employer savings would be redirected to employee benefits and salary. One member pointed out that commercial plans are subject to rate review, and that as a result savings would likely be realized in monthly premium costs, and that overall lower trends would influence premiums lower. One member shared a concern that the two would be linked, pointing out that the last year of Covid had seen large reductions in utilization that did not translate to reduction in premium. A member raised the concerns related to the Covid pandemic, anticipating increased utilization and labor costs, and the pending finalization of contracts in 2022, raising the question of whether it was appropriate to begin measuring the benchmark in these extraordinary times.

Ms. Gellermann responded that the Board was aware of the issues, and that they posed important topics for future consideration. She informed the Committee that the Board selected the benchmark, but that it was not by consensus.

## Impacts to pursue and to avoid-developing baseline recommendations

Ms. Gellermann led the Committee in a discussion of things to be careful about as we consider the impact of the benchmark on our health care delivery systems and on the issues of access, quality, and cost. Considerations

identified as important considerations are likely to become the subject of future analyses, reports, or other efforts. One member provided the broad perspective of the importance of using the anticipated cost driver analysis to identify where the impacts are and where action can be taken, and that a failure to think creatively and change practices at a systemic level would result in continued increased cost.

Members identified the following issues:

- Disproportionate impact on historically disadvantaged people. Concerns include decreased access for patients and reduced supportive spending that will result in less care and increased disadvantage (equity issues). One member stressed the importance of impacting population health by incentivizing increased investments in supportive spending like peer counselors and community health workers, perhaps increasing near-term cost but perhaps resulting in long term savings.

- Tracking whether we are cutting costs, or cutting services, potentially will be cut from the most fragile systems including rural providers and primary care.

- The danger of thoughtless cuts in cost "across the board", to the detriment of services and consumers. The example provided was long-term care.

- Reductions in primary care reimbursement and utilization, which would have a substantial impact on health and health care cost.

- Adverse impact on smaller regional practices with lower market share and less leverage. One committee member shared that many of those practices have been strongly impacted by Covid.

- Impact of Covid that create impacts on spend that will influence benchmark results, including the impact of rising labor costs, changes in utilization, and analysis of data that is not representative of normal patterns.

- Impact of losing jobs at lower ends of the pay scale such as homebased workforce (equity for the workforce).

- Slimming in benefit design that does not benefit consumers.

- Rising cost must be connected to a problem, rather than just assuming that all increased cost is negative.

- The challenge of measuring across the whole health care ecosystem and learning from the data at a population and total investment level. One member suggested the creation of a "learning community" to support this.

## Public Comment

There was no public comment.

## Introduction to reporting against the cost growth benchmark

Ms. Gellermann shared a presentation previously reviewed by the Board related to how benchmark data will be reported. States typically report at four levels: state, market, payer, and large provider entity. Reporting on provider entities is limited to those that are large enough to influence the total cost of care. The Committee reviewed reporting at each level issued by other states.

One Committee member expressed a concern that the size of a provider should not be assessed by the number of patients in the group, but rather by the number covered by total cost of care contracts. One member stated that the reporting lens shown did not inform on whether the right services were given to the right person at the right time by the right professions, which is key to understanding opportunities for improvement.

## Methods selected to ensure the accuracy and reliability of benchmark performance measurement

Ms. Gellermann shared with the group the Board's activities related to development and design of the benchmark data call. The Board's intent is to use best practices to ensure accurate, valid, and consistent data to support confidence in the results. Larger decisions will be made by the Board with recommendations from the Advisory Committee on Data Issues, and some decisions will be made by staff. September design decisions will be related to confidence intervals and truncation of high-cost outliers.

Ms. Gellermann presented information about other states' use of confidence intervals, including Oregon, Connecticut, and Rhode Island. The Advisory Committee on Data Issues supported use of confidence intervals and recommended clear documentation on how the intervals were constructed. She reported that the Board approved use of confidence intervals. Staff would prepare a proposal for the Advisory Committee on Data Issues. One member asked whether Oregon's use of intervals was based on the use of population sampling. Sarah Bartelmann of the Oregon cost benchmark team was monitoring the meeting, and upon request responded that Oregon was not using population sampling and offered a full write-up of the Oregon methodology.

Ms. Gellermann shared information about mitigating the impact of high-cost outliers on per capita spending. The common solution is truncation, which involved capping individual spending at a high level. Ms. Gellermann shared some documented experience in other states related to the use of truncation and lessons learned. The Advisory Committee on Data Issues supported the use of truncation and had different opinions on how to set the levels. The Advisory Committee on Data Issues will be asked to make a recommendation regarding specific truncation levels at a future meeting.

## Adjourn

Meeting adjourned at 12:04 p.m.

# Next meeting

To be determined.