Health Care Cost Transparency Board meeting minutes

November 17, 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

Sue Birch, chair
Lois Cook
Bianca Frogner
Jodi Joyce
Sonja Kellen
Pam MacEwan
Molly Nollette
Mark Siegel
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

John Doyle

Call to order

Sue Birch, Board Chair, called the meeting to order at 2:05 p.m.

Agenda items

Welcoming remarks

Ms. Birch welcomed the members.

Adoption of minutes

The minutes were adopted.

Presentation: Recap of last meeting discussions

Michael Bailit of Bailit Health reviewed the discussion and decisions of the September Board meeting. The Board finalized the cost benchmark at 3.2% for 2022-23, 3.0% for 2024-25, and 2.8% for 2026. The Board also discussed strategies to ensure the accuracy and reliability of measurement and endorsed two strategies: the application of confidence intervals, and truncation above a to-be-defined threshold for very high-cost members.

Presentation: Using risk adjustment when determining benchmark performance

Michael Bailit of Bailit Health gave a presentation about the use of risk adjustment to account for changes in population health status that might impact spending growth. Also known as clinical risk adjustment, available models use claim and encounter data such as diagnoses, procedures, and prescription drugs. For purposes of benchmark reporting, risk adjustment is performed at the carrier and provider level, and not the state or market level.

HB 2457 requires Washington's benchmark to consider health status, utilization, intensity of services, and difference in input prices. Mr. Bailit shared that adjusting the benchmark for utilization, intensity of services, and differences in input pricing would not be feasible or desirable, and that no other state adjusts the benchmark for these factors. The Advisory Committee on Data Issues recommended that these factors be addressed in the cost driver analysis rather than benchmark risk adjustment. Ms. Birch asked about the impact of the pandemic on utilization and the benchmark, and Mr. Bailit shared that these years would be recognized as an anomaly in reporting and that states are not changing methodology. One Board member shared her opinion that if all the listed risk adjustments were made to the benchmark there would be nothing of value left.

Mr. Bailit then discussed risk adjustment for health status, reporting that risk scores have been growing every year in a way that does not appear correlated with changes in population health status. He shared the experience of both Massachusetts and Rhode Island that have observed steadily rising risk scores unexplained by demographic trends or changes in disease prevalence. The effect can be to disguise increases in the spending increases in population risk.

Mr. Bailit presented the Board with four options to risk adjust health data: age/sex adjustment performed by the payers, age/sex adjustment performed by the state, clinical risk adjustment normalization performed by payers, and clinical risk adjustment normalization performed by the state. One Board member expressed concern over oversight and consistency if payers submit their own risk adjusted data. Mr. Bailit responded that results were not as "clean" as the state performing one method for all payers and requiring payers to use the same software/method year after year provided a more consistent comparison.

Mr. Bailit also shared feedback from the Advisory Committee on Data issues that the option of age/sex adjustment performed by the state received the most support, but that several Committee members preferred that the state performs clinical adjustment normalization on all payer data. Staff shared that this option was not feasible within current resources.

Design Decision: Accounting for utilization, service intensity and regional pricing

The Board decided not to adjust the benchmark for utilization, intensity of services and difference in input pricing, and expressed an expectation that these factors would be present in the cost driver analysis.

Design Decision: How to risk adjust data

The Board decided to select age/sex adjustment performed by the state. The Board directed that staff explore future adoption of clinical risk adjustment normalization performed by the state, as resources become available.

Public Comment

Ms. Birch called for comments from the public.

Vishal Chaudry, Chief Data Officer, HCA, updated the Board on national developments related to state All Payer Claims Databases (APCD). Specifically, the Federal No Surprises Act creates an advisory committee on the pathway to submit self-insured data to state APCDs. Mr. Chaudry expressed his opinion that the Board creates a shared incentive for all payers to participate in the database.

Presentation: Key questions to address for provider level reporting

January Angeles of Bailit Health presented the Board with information related to provider level reporting, including how members should be attributed to clinicians, and how clinicians should be organized into provider entities for reporting. She reminded the Board that all cost benchmark states report on large provider entities. Spending that cannot be attributed to a particular entity will still be captured in the data call and in the statewide and market measures. Members may be attributed through a common methodology, or through each purchaser's own attribution methodology. Ms. Angeles shared that all other states use primary care providers (PCP), attribution, leaving the methodology up to the insurer. Massachusetts and Oregon add specificity of reporting in a hierarchy by member selection, contract arrangement, and utilization.

The Board asked several questions about attributing through PCP, recognizing that many members have no PCP, have no utilization, or do not engage PCPs in seeking care.

Ms. Angeles also summarized the feedback from the Advisory Committee on Data issues that a standard methodology would be difficult for carriers, but that there was value in material consistency in the attribution of methodologies. One Committee member suggested that the state more specifically define and provide a primary care taxonomy or procedure codes. The option that received the most support was to adopt the methodology used in Massachusetts and Oregon of using individual payer methodology with a reporting hierarchy.

Ms. Birch asked what other attribution resources were available in the state, or what else might be considered. The Board discussed attribution related to the Department of Labor and Industries spend, and issues of PCP attribution related to access and accountability. One Board member asked for clarification on the methodologies used by the Washington Health Alliance and One Health Port.

Ms. Angeles shared the two basic methods for organizing clinicians into large provider entities: using a state-wide provider directory (as in Massachusetts) or using a pre-defined list of providers and requesting payers report on them through information in provider contracts. Ms. Angeles shared that Oregon intends to use their data call to assist in building a provider directory and has asked payers to report provider organization by their tax identification numbers (TIN). States without a provider directory, including Rhode Island and Connecticut, perform attribution based on providing payers with a list of identified providers and asking payers to report on them based on existing contracts.

The Advisory Committee on Data Issues felt it was important to identify large provider entities based on a framework of cost accountability.

Design Decision: How to attribute patients to clinicians

The Board deferred the decision and requested staff to provide additional information on available attribution methods.

Design Decision: How to organize clinicians into large provider entities

The Board did not consider this issue and deferred the topic to the next meeting.

Adjournment

Meeting adjourned at 4:00 p.m.

Next meeting

Wednesday, December 15, 2021
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.