

Health Care Cost Transparency Board meeting minutes

December 15, 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
John Doyle
Bianca Frogner
Jodi Joyce
Sonja Kellen
Pam MacEwan
Mark Siegel
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

Molly Nollette

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.

Approval of minutes

The minutes were approved.

Presentation: Recap of last meeting discussions

January Angeles of Bailit Health reviewed the discussion and decisions of the November Board meeting. The Board determined to address the legislative mandate to account for utilization, service intensity and regional pricing differences in cost growth driver analyses. The Board directed staff to perform age/sex risk adjustment using



standard weights developed by HCA based on current resources, and also recommended that staff pursue the ability to perform clinical risk adjustment normalization using data from the All-Payer Claims Database (APCD).

Presentation: Attribution in Health Care Authority programs

January Angeles of Bailit Health provided the Board with a second presentation on attribution methods, reminding them that in order to achieve the mandate to report cost trends at the provider level, payers would need instructions on how to do two levels of attribution: member to clinician and clinician to large provider entity. Staff presented two options, requiring insurers to apply a standard attribution methodology (primary care based), and allowing insurers to use their own attribution methodology, either with or without a recommended hierarchy. All states use the second approach.

The Board learned about the attribution methodology of the Washington Health Alliance (WHA), that uses primary care physician (PCP) based attribution, as a potential common methodology that could be utilized by payers for this data call. It was pointed out that the WHA method contained a proprietary process developed by a contractor. Staff recommended allowing insurers to use their own PCP based attribution methodology, within the following hierarchy: member selection, contract arrangement, and utilization.

During the Board's discussion, some members asked questions about the benefits of standardization, contrasting use of the WHA method with asking payers to use their own methods. It was also noted that from the provider perspective, differences between payer methodologies present a challenge in evaluating accuracy of outcomes.

Design decision: Member attribution methodology

The Board decided to approve the staff recommendation of allowing insurers to use their own PCP based attribution methodology, based on a hierarchy that prioritizes member selection, then contract arrangements, then utilization. The Board expressed a desire for a common methodology and requested staff to pursue this potential for future use.

Public comment

Ms. Birch called for comments from the public.

Nancy Guinto, Chief Executive Officer, WHA, commented that WHA membership includes every Medicaid managed care organization and commercial plan in the state, and provide data to it. She expressed her concern that variations in reporting could cause confusion, and that providers in particular would support consistency with the existing methods used by the WHA that have been subject to extensive stakeholder review and engagement.

Presentation: Provider entities accountable for total medical expenditures

January Angeles of Bailit Health presented the Board with information related to how to attribute clinicians to large provider entities. Provider entities for purposes of the benchmark are large entities that in theory could take on a total cost of care contract because they employ both PCPs and can exert some level of influence over where a patient receives care. Under this definition, accountable providers would be health systems with contracted PCPs, hospitals with outpatient clinics with PCPs, medical groups with PCPs, and independent physician associations. Board materials include a draft list of Washington accountable providers by name, which will be further refined by staff.

One Board member expressed concern that some entities intentionally do not employ PCPs, and instead focus on specialty care that might drive cost. Under this definition, those entities would not be captured or held accountable.



Other board members echoed concern that expensive services might not be adequately captured and heard that this would be possible through the cost driver analysis. The Board asked for any information about difficulties experienced in other states (all of whom are using similar methods). They were informed that states without provider directories were struggling with provider attribution, and states were also working to understand the appropriate size of reporting entity to provide the most useful information. One Board member pointed out that an example of size might be Optum, which could also be reported at the clinic level (since both clinics are large). One board member pointed out that a very large specialty organization could meet the definition of influence over care, even without employing PCPs.

Previously, staff had presented two options for attributing clinicians to large provider entities: use of a statewide provider directory (Massachusetts and Oregon), and attribution based on contracting arrangements (Connecticut and Rhode Island). The Board also revisited staff research investigating the feasibility of existing state directories and data sources, including WHA, Health Benefit Exchange, OneHealthPort, and the Office of the Insurance Commissioner. Staff concluded that the WHA's directory would be the most useful, but that work needed to be done on the potential of contracting. Staff recommended pursuing use of the WHA directory and asking issuers to do attribution based on contracting arrangements as a fallback option should a WHA contract not prove feasible.

Design decision: Clinical attribution

The Board accepted staff recommendation to pursue use of WHA's directory, and then to ask issuers to do attribution based on contracting arrangement as a fallback option.

Staff were directed to explore whether there were other large entities in the state who do not employ PCPs that would be appropriate for inclusion.

Presentation: Cost growth benchmark accountability

January Angeles of Bailit Health presented the Board with information intended to jumpstart the conversation around benchmark accountability. She asked several questions of the Board, including what process should be in place for reporting cost growth benchmark performance, how performance should be reported, how much and what types of communication should accompany the report, and what other activities they would like to engage in. The Board reviewed Massachusetts' accountability process.

One Board member stated that communication was vitally important, both with parties subject to reporting and to payers, including information about impacts on cost. This was supported by many Board members, emphasizing strong communication, collaboration and partnership including feedback to the Board. One Board member also wanted to learn from other states and keep consistent with them for comparative purposes.

Adjournment

Meeting adjourned at 3:56 p.m.

Next meeting

Wednesday, January 19, 2022

Meeting to be held on Zoom

2:00 p.m. – 4:00 p.m.