

# Health Care Cost Transparency Board

**August 17, 2021**

## Health Care Cost Transparency Board Board Book

August 17, 2021  
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

### Meeting Materials

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# Agenda

# TAB 1

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## Health Care Cost Transparency Board

August 17, 2021  
2:00 p.m. – 4:00 p.m.  
Zoom Meeting

### AGENDA

#### Board Members:

<input type="checkbox"/>	Susan E. Birch, Chair	<input type="checkbox"/>	Sonja Kellen	<input type="checkbox"/>	Kim Wallace
<input type="checkbox"/>	Lois C. Cook	<input type="checkbox"/>	Pam MacEwan	<input type="checkbox"/>	Carol Wilmes
<input type="checkbox"/>	John Doyle	<input type="checkbox"/>	Molly Nollette	<input type="checkbox"/>	Edwin Wong
<input type="checkbox"/>	Bianca Frogner	<input type="checkbox"/>	Mark Siegel	<input type="checkbox"/>	Laura Kate Zaichkin
<input type="checkbox"/>	Jodi Joyce	<input type="checkbox"/>	Margaret Stanley		

Time	Agenda Items	Tab	Lead
2:00-2:08 (8 min)	Welcome, roll call, and agenda review	1	Susan E. Birch, Chair, Director Health Care Authority
2:08-2:10 (2 min)	Approval of July meeting minutes	2	AnnaLisa Gellermann, Board Manager Health Care Authority
2:10-2:15 (5 min)	Recap of last meeting and topics for today's discussion	3	AnnaLisa Gellermann, Board Manager Health Care Authority
2:15-2:25 (10 min)	Wrap up discussion on total health care expenditures and sources of coverage: Advisory Committee of Health Care Providers and Carriers' feedback and staff research  Discussion and Decision: Defining THCE and sources of coverage	4	Jodi Joyce, Board Member Unity Care NW  AnnaLisa Gellermann, Board Manager Health Care Authority
2:25-2:55 (30 min)	Wrap up discussion on cost benchmark recommendation: Advisory Committee of Health Care Providers and Carriers' feedback and staff proposed language for trigger  Discussion and Decision: Cost benchmark, review, and Trigger	5	Jodi Joyce, Board Member Unity Care NW  AnnaLisa Gellermann, Board Manager Health Care Authority
2:55-3:05 (10min)	Public comment	6	Susan E. Birch, Chair, Director Health Care Authority
3:05-3:25 (20 min)	Reporting performance against the cost growth benchmark		Michael Bailit and January Angeles Bailit Health

3:25-3:55 (30 min)	<p>Data call: Methods to ensure the accuracy and reliability of benchmark performance measurement including the Advisory Committee on Data Issues' Feedback</p> <p>Design Decisions:</p> <ul style="list-style-type: none"> <li>✓ Use of Confidence Intervals</li> <li>✓ Truncation of High-Cost Outliers</li> <li>✓ Accounting for utilization, service intensity and regional pricing</li> <li>✓ How to risk adjust data</li> <li>✓ Minimum population sizes</li> </ul>		Michael Bailit and January Angeles Bailit Health
3:55-4:00 (5 min)	Next steps and adjournment		Susan E. Birch, Chair, Director 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 Health Care Cost Transparency Board meeting will be conducted virtually.*

# July Meeting Minutes

## TAB 2

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## Health Care Cost Transparency Board meeting minutes

July 19, 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  
Sonja Kellen  
Jodi Joyce  
Molly Nollette  
Pam MacEwan  
Mark Siegel  
Margaret Stanley  
Kim Wallace  
Carol Wilmes  
Edwin Wong  
Laura Kate Zaichkin

### Members absent

Sonja Kellen

### Call to order

Sue Birch, Board Chair, called the meeting to order at 2:02 p.m.

### Agenda items

#### Welcoming remarks

Ms. Birch shared that she had listened into meetings of the Advisory Committees and was very pleased with the membership and the vigorous conversations. She reminded the Board that Jodi Joyce could be called upon to supplement and clarify comments from the Advisory Committee of Health Care Providers and Carriers.

#### Adoption of Minutes

Two amendments were made to the draft June minutes: Board member Molly Nollette was listed as present for the meeting, and the last sentence in page 3, paragraph 1 was revised to read “The Board asked questions about the impact of the legislative and budget schedule on setting the benchmark, but the majority of the Board were in favor



of at least 3 years, with many supporting a longer period of 4 or 5 years in consideration of the impact of the benchmark setting on the carrier filing process.”

The amended minutes were adopted unanimously, and consensus was put on the record.

### Advisory Committee on Data Issues: Proposal and approval of additional member

J.D. Fischer, facilitator of the Advisory Committee on Data Issues, presented a recommendation from staff to add Jared Collings, Assistant Director - Actuarial, Regence Blue Shield, as an additional member of the Committee. The Board voted unanimously to approve Mr. Colling’s appointment.

### Presentation: Topics for today’s discussion

Bailit Health presented the list of topics for the meeting, which are summarized in more detail below.

### Presentation: Recap of discussion and preliminary recommendations from the last meeting

Bailit Health provided a summary of discussions and recommendations from the June Board meeting.

- The Board recommended setting the benchmark value using a 70/30 hybrid of historical median wage and potential gross state product (PGSP). This weighting yields a benchmark value of 3.2% (20-year historical median wage at 3.0%, PGSP forecast 2021-2025 at 3.8%).
- The Board recommended setting benchmark values for a period of 5 years.
- The Board indicated a desire to adjust the benchmark over the 5-year period but did not settle on how to do so.
- The Board wanted a trigger to allow the benchmark methodology to be revisited. It expressed interest in linking the trigger to change in inflation but did not adopt a recommendation.

### Presentation: Review of the Advisory Committee of Health Care Providers and Carriers’ feedback on Cost Benchmark Methodology

At the June 29 Advisory Committee meeting, AnnaLisa Gellermann presented materials on the cost benchmark methodology and the Board’s discussion. She recapped the Board’s previous discussion on the benchmark methodology (recapped above). Bailit Health then presented feedback from the Advisory Committee of Health Care Providers and Carriers.

The Committee members supported the selection of median wage and PGSP as elements of the benchmark but withheld comment on the recommended ratio until they can review the actual values. Some committee members preferred a greater emphasis on PGSP. One Committee member asked if any benchmark helped improve equitable access to health care.

The Committee also supported the Board’s recommendation of a 4–5-year benchmark, with a value that is stable over that period. They further recommended incorporating a trigger to re-evaluate and potentially adjust the benchmark, which should be formalized. Suggested triggers include severe impact on one part of the health care ecosystem, if the benchmark fails to bend the cost curve, or if there are unintended consequences such as adverse impacts on treatment, services or health equity.

In considering this feedback, the Board questioned why a benchmark that stays the same over the initial period would be better than one that predictably adjusts, as both would provide certainty. A Board member acknowledged the importance of measuring adverse impacts, but questioned the need or feasibility to use such



events as a trigger for re-evaluating the benchmark. It was suggested that the Board revisit the issue of monitoring for adverse impacts when it discusses the data use strategy.

### Presentation: Options for a phasedown of benchmark values

As requested by the Board in the June meeting, Bailit Health presented three options for phasing down a benchmark.

- Option 1 phases down over two years to the benchmark value, from 3.6% (2022) to 3.4% (2023) to 3.2% (2024-2026).
- Option 2 phases down the values such that the average benchmark value over 5 years is 3.2%, from 3.4% (2022-2023), to 3.2% (2024), to 3.0% (2025-2026).
- Option 3 phases down over a 5-year period, from 3.2% (2022-2023) to 3.0% (2024-2025), to 2.8% (2026).

For context, the Board was presented information showing that Washington's average health care cost increases were higher than other states, at 6.7% between 1994 and 2014. The Board requested additional comparative information from states of equal population size to Washington and for Colorado and Montana, all of which will be presented at a future meeting.

The Board's discussion focused on affirming their rationale for the chosen methodology (70/30 median wage/PGSP), and a strong intention to select a benchmark that would drive health care spending down and provide relief to consumers and employers. Board members did not feel Option 1 would achieve that goal. The Board weighed Options 2 and 3, and ultimately selected Option 3, which would phase down the benchmark 5-year period, from 3.2% (2022-2023) to 3.0% (2024-2025), to 2.8% (2026).

### Presentation and Discussion: Trigger for revising the benchmark methodology. Design recommendation: Re-evaluating the benchmark methodology?

In response to the Board's desire for a trigger that would allow the benchmark methodology to be revisited, Bailit Health presented other states' criteria for revisiting and possibly changing the benchmark methodology and/or values. Specifically, Connecticut may revisit should there be a sharp rise in inflation between 2021 and 2025; Delaware annually reviews and may change if the PGSP forecast changes "in a material way"; Massachusetts can modify the benchmark subject to legislative review; Rhode Island can revisit if there are "highly significant" changes in the economy. The Board also reviewed options for a trigger related to inflation, by monitoring changes in Personal Consumption Expenditures (PCE).

In discussion, Board members were most drawn to the Oregon model, that calls for review of 20-year historic values of the state's per capita gross state product trend, median wage trend and health system performance against the benchmark during year 4 of Oregon's benchmark program. In discussing the Oregon model, the Board observed that it is important to balance a stable and predictable benchmark with the ability to intervene and adapt to extraordinary and unpredictable developments in the state and health care economy. The Board concluded that it would not recommend a trigger for review of the benchmark for the initial 5-year period but would be open to considering the option under extraordinary circumstances. The Board directed staff to develop language for their consideration.

### Public Comment

Ms. Birch called for comments from the public. There was no public comment.



**Presentation: Total Health Care Expenditures Methodology: Review of Advisory Committee feedback.**  
**Design Decision: Defining TCHE and TME**

Bailit Health reviewed Committee feedback on the Board's recommendations for defining total health care expenditures (THCE) and total medical expense (TME). Feedback included a desire to include expenditures related to social determinants of health as TME, as well as provider expenses related to charity care and bad debt. The Board concluded that neither met the definition of TME, the former because it did not represent medical expenditure, and the latter because it did not involve payment.

In addition, one Committee member suggested inclusion of payments for non-covered services and by uninsured individuals. Bailit Health explained that other states did not include such payments because there was no available data source to capture the spending. There was also a suggestion to have a process to reflect on what is not being captured and periodically re-evaluate whether new data are available. The Board voiced interest in such periodic reexamination.

**Presentation: Total Health Care Expenditures Sources of Coverage: Review of Staff Research.**  
**Design Decision: Sources of Coverage to include**

The meeting ran out of time; this agenda item will be considered at a future meeting.

**Adjournment**

**Next meeting**

Monday, August 17, 2021  
Meeting to be held on Zoom  
2:00 p.m. – 4:00 p.m.

Meeting adjourned at 4:00 p.m.



# Health Care Cost Transparency Board

August 17, 2021

At the bottom of the slide, there are decorative wavy lines in blue and green, mirroring the design at the top.

# Recap of last meeting and topics for today's discussion

## TAB 3

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Washington State  
Health Care Authority

Recap of last meeting and  
topics for today's discussion



## Recap of last meeting

- The benchmark would be set using a **70/30 hybrid** of **historical median wage** and **potential gross state product**.
  - This would convey that health care should not grow more than growth in consumer finances and the economy.
- The benchmark would phase down as follows:
  - 2022-2023: **3.2%**
  - 2024-2025: **3.0%**
  - 2026: **2.8%**
- Requested staff to develop language for “extraordinary circumstances” review.

## Topics we will discuss today:

- Total health care expenditure: Committee feedback and staff research.
- Cost benchmark recommendation: Committee feedback and staff proposed language for trigger.
- Reporting performance against the cost growth benchmark.
- Methods to ensure the accuracy and reliability of benchmark performance measurement.

Wrap up discussion on total  
health care expenditures and  
sources of coverage

TAB 4

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Washington State  
Health Care Authority

Wrap up discussion on total health  
care expenditures and sources of  
coverage

# Primary sources of health care coverage

- Medicare
  - Fee-for-service
  - Medicare Advantage
- Medicaid
  - Fee-for-service
  - Managed care
- Medicare & Medicaid “Duals”
- Commercial
  - Fully-insured
  - Self-insured

All cost growth benchmark states include these sources of coverage.

HB 2457 requires all public and private sources of coverage to be included, which we assume to be those listed.

# Other sources of health care coverage

- State labor and industries state fund benefits
- State correctional health system
- Indian Health Services (IHS)
- Public health individual clinical spending

Staff has reviewed these additional identified sources.

## Advisory Committee of Health Care Providers feedback on sources of coverage to include benchmark measurement

- Committee members agreed with the Board's recommendation to include Medicaid, Medicare, and commercial spending for all Washington residents, regardless of where they receive their care.
- There was also agreement with the recommendation to try and capture the following sources spending:
  - State labor and industries state fund benefits.
  - State correctional health system.
  - Public health spending on personal services.
  - Worker's compensation medical spending.
- Some Committee members expressed doubt in HCA's ability to obtain Indian Health Service spending data.

# Staff research on data availability for certain sources of coverage

- State labor and industries state fund
  - \$800M annual spend.
  - Can provide data at service category level.
- State correctional health system
  - Approximately \$80M annual spend on all service categories, excluding staffing/records.
  - Costs are tracked and can be shared by service categories (e.g., inpatient, pharmaceutical, laboratory).

# Staff research on data availability for certain sources of coverage cont.

- IHS - Tribal Data
  - Requires release agreement with each tribe.
  - Data sovereignty concerns.
  - Multiple payers and double counting concerns.
- Public health spending on personal services
  - Engaged in clarifying elements of spend and obtaining estimate.



## Design decision: Defining THCE

- What are the source of coverage that will be included in the data call for the cost benchmark?
- Staff recommendation:
  - Medicare (including fee-for-service and Medicare Advantage).
  - Medicaid (Fee-for-service and managed care).
  - Medicare & Medicaid “duals.”
  - Commercial (fully insured and self insured).
  - State labor and industries state fund.
  - State Correctional health system.

# Wrap up discussion on cost benchmark recommendation

## TAB 5

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# Wrap up discussion on Cost Benchmark Recommendation

# Cost benchmark recommendations

- The benchmark would be set using a **70/30 hybrid** of **historical median wage** and **potential gross state product**.
  - This would convey that health care should not grow more than growth in consumer finances and the economy.
- The benchmark would phase down as follows:
  - 2022-2023: **3.2%**
  - 2024-2025: **3.0%**
  - 2026: **2.8%**
- Requested staff to develop language for “extraordinary circumstances” review.

## Trigger Language proposal

- The Board will annually review performance against the benchmark and may consider any impacts on the overall health system, including cost of care, access to care, quality of care, and impact on specific populations, providers or market sectors.
- In the event of extraordinary circumstances including highly significant changes in the economy or significant negative consequences within the health care system, the Board may consider changes to the benchmark, or to the benchmark methodology.

## Advisory Committee of Health Care Providers and Carriers feedback on benchmark values

- Accepted 3.2%
- Agreed with data-based methodology and emphasis on consumer affordability.
- Concern about changing ratios to impact benchmark number.
- Majority indicated benchmark should not go below 3.2%.
- Recommended a stable benchmark (unvarying).
- Agreed with “extraordinary circumstances” trigger.
- Recognized importance of annual review for impact.



## Design decision: Benchmark methodology and values

- Based on the Committee's feedback, does the Board wish to make adjustments to its decision on the benchmark methodology and values?
- Staff proposed language:

# Reporting performance against the cost growth benchmark

## TAB 6

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Washington State  
Health Care Authority

Reporting performance against the  
cost growth benchmark



# Reminder: Cost growth benchmark analysis vs data use strategy



How will we determine the level of cost growth from one year to the next?

## Benchmark Analysis

- **What is this?** A calculation of health care cost growth over a given time period using payer-collected aggregate data.
- **Data Type:** Aggregate data that allow assessment of benchmark achievement at multiple levels, e.g., state, region, insurer, large provider entity.
- **Data Source:** Insurers and public payers.

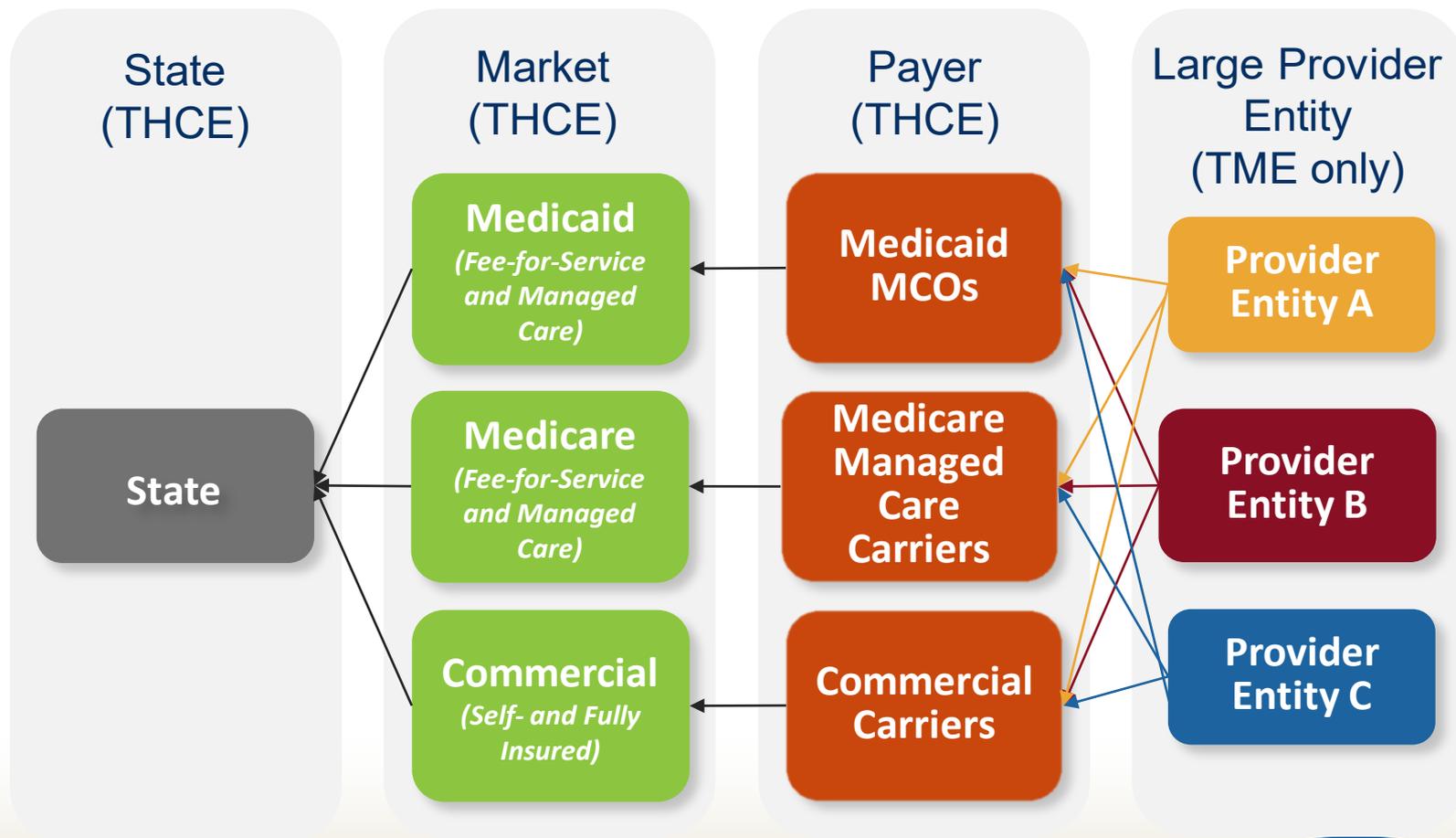


How will we determine what is driving overall cost and cost growth? Where are there opportunities to contain spending?

## Data Use Strategy

- **What is this?** A plan to analyze cost drivers and identify promising opportunities for reducing cost growth and informing policy decisions.
- **Data Type:** Granular data (claims and/or encounters).
- **Data Source:** APCD.

# States typically report benchmark performance benchmark at four levels

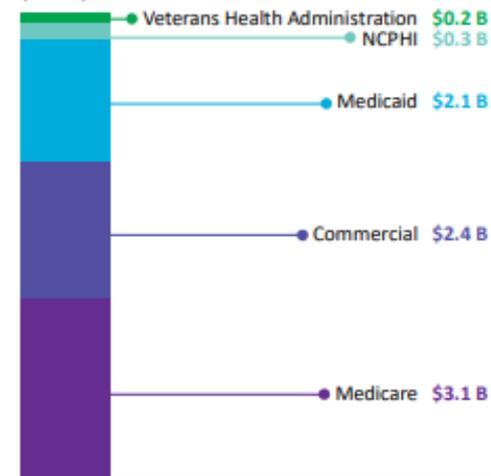


# Reporting at the state level: DE example

## TOTAL HEALTH CARE EXPENDITURES

- Total health care expenditures (THCE) went from \$7.6 billion in CY 2018 to \$8.2 billion in CY 2019 an 8.5% increase
- CY 2019 spending by component (similar to CY 2018 spending mix):
  - Medicare (FFS and managed care): 37.3% of spending
  - Commercial (fully and self-insured): 29.8% of spending
  - Medicaid (FFS and managed care): 26.2% of spending
  - Net Cost of Private Health Insurance (NCPHI): 4.2% of spending
  - Veterans Health Administration: 2.5% of spending

Figure 1. CY 2019 State Total Health Care Expenditures (THCE)



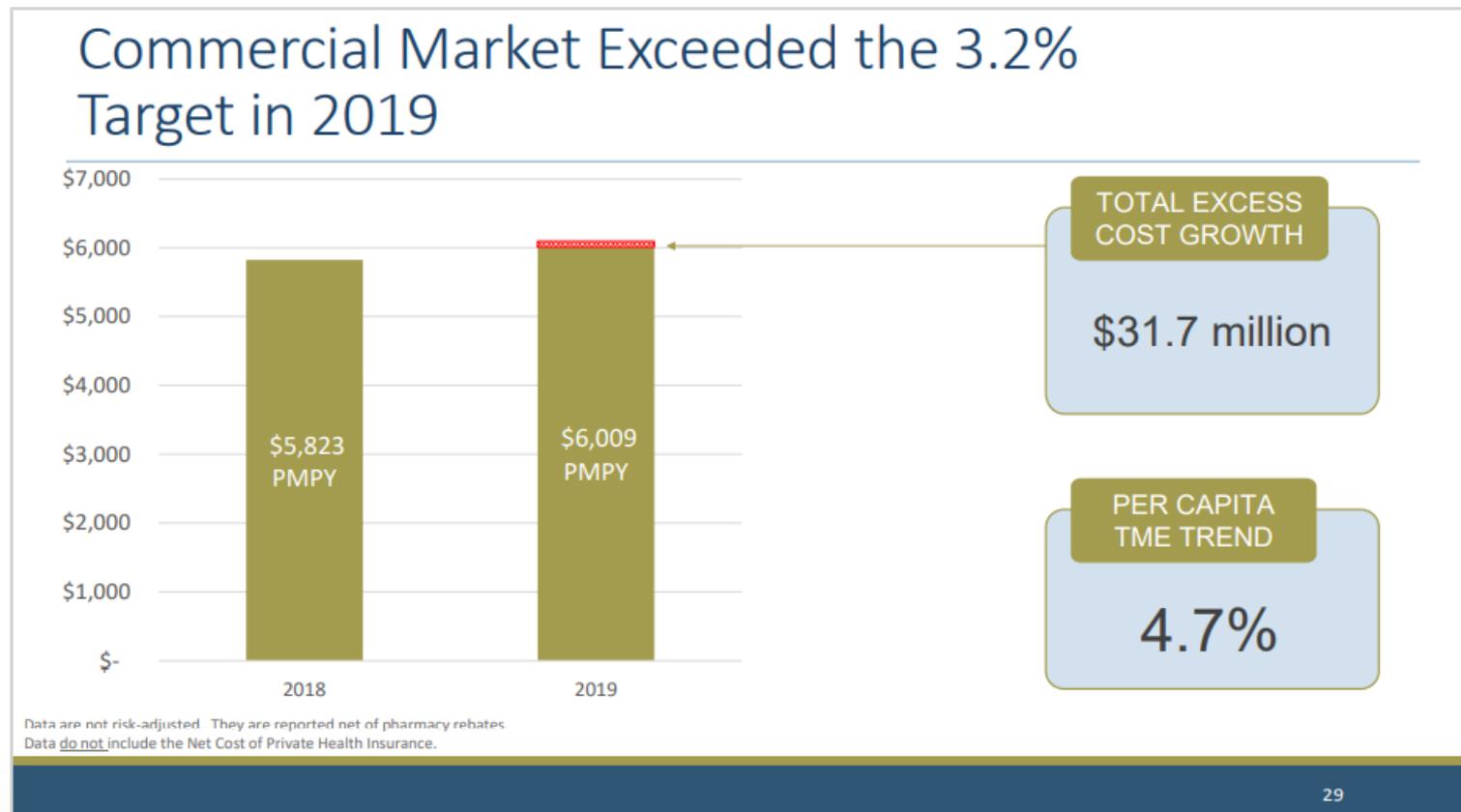
OVERVIEW OF BENCHMARK TREND REPORT: CY 2019 RESULTS

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\* Medicare FFS, Medicaid FFS, and Veterans Health Administration does not have NCPHI, so expressed as a percentage of THCE, NCPHI is relatively low.

SOURCE: Overview of Benchmark Trend Report Calendar Year 2019 Results and Proposed Quality Measures, April 1, 2021, available at: <https://dhss.delaware.gov/dhcc/files/benchmarkpresentation033021.pdf>.

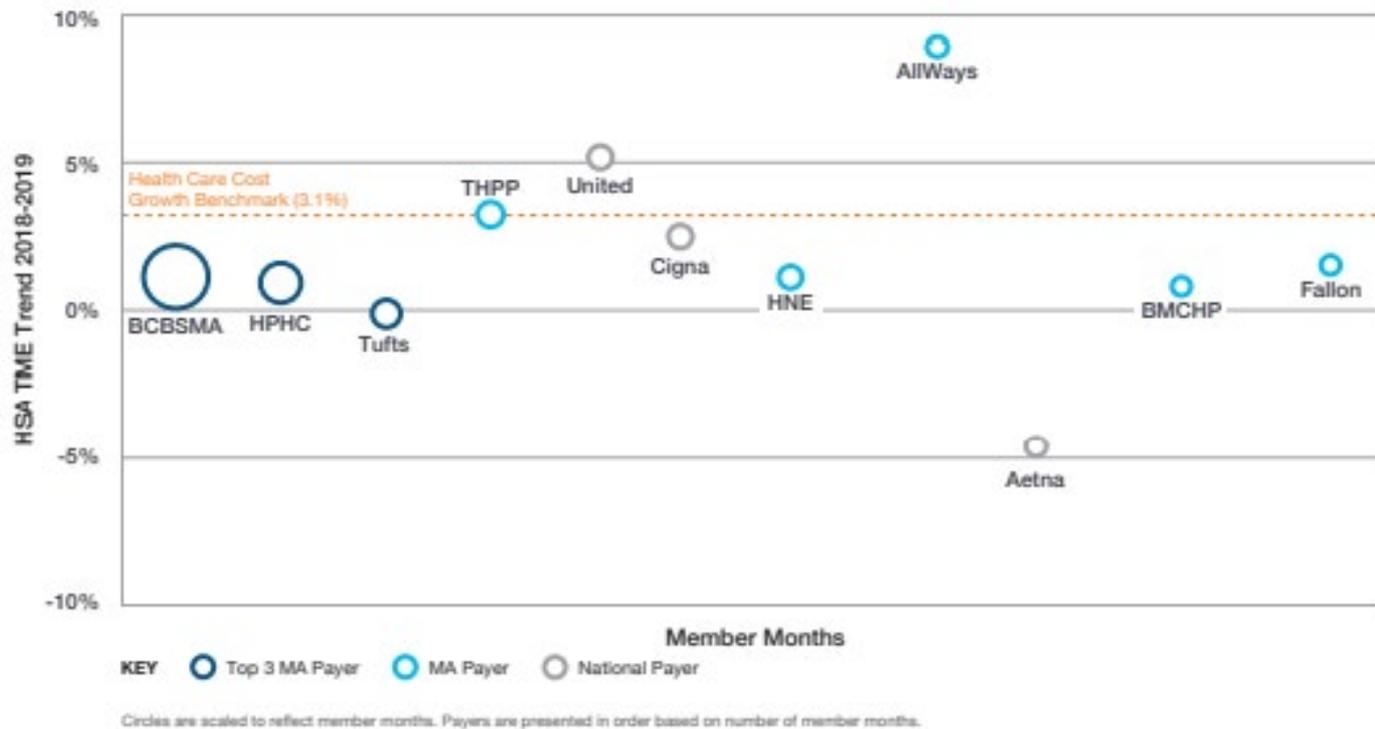
# Reporting at the market level: RI example (commercial)



SOURCE: April 29, 2021 presentation to the Rhode Island Cost Trends Steering Committee.

# Reporting at the payer level: MA example (commercial)

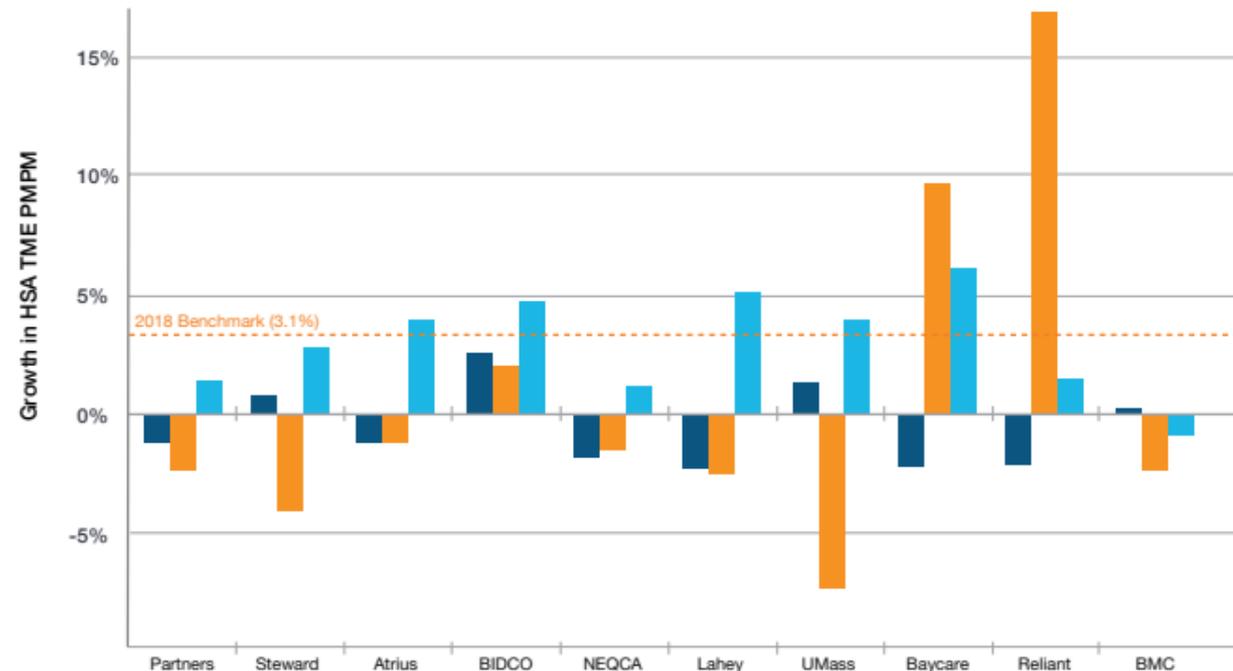
Change in Preliminary Commercial HSA TME by Payer, 2018-2019



SOURCE: Massachusetts Center for Health Information and Analysis, "Annual Report on the Performance of the Massachusetts Health Care System," March 2021.

## Change in Final Managing Physician Group Commercial HSA TME, 2017-2018

Reporting  
at the  
provider  
level:  
MA  
example



BCBSMA, HPHC, and Tufts Share of Group's Managed Member Months	94.7%	81.0%	89.8%	72.9%	96.9%	89.7%	79.9%	47.3%	61.6%	66.3%
Total Managed Member Months in 2018	3.1M	2.3M	2.2M	1.6M	1.3M	1.2M	1.0M	0.8M	0.7M	0.5M

**Key** ■ BCBSMA ■ HPHC ■ Tufts

The largest physician groups experienced varied HSA TME growth by network in 2018.

SOURCE: Massachusetts Center for Health Information and Analysis, "Annual Report on the Performance of the Massachusetts Health Care System," March 2021.

# A note on reporting at the provider level

- Benchmark performance reporting at the provider level is limited to those providers that:
  - Are sufficiently large such that performance against the benchmark can be accurately and reliably measured.
  - Have responsibility for meeting all a patient's needs (i.e., primary care providers and systems that can typically engage in total cost of care contracts).
- How to specifically define and identify provider entities whose performance will be measured against the benchmark is an issue that the Board will need to address later.

# Methods to ensure the accuracy and reliability of benchmark performance

## TAB 7

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

# The problem of small numbers

- Random fluctuations in medical expenditures and service use can impact per capita cost growth of entities with small populations.
- Payers and provider entities must have sufficient member/patient volume:
  - For detected changes in annual per capita total medical expenditures to be accurate and reliable.
  - To minimize the effect of a few unusually complex and expensive patients on an entity's benchmark performance.
- In determining benchmark performance, it is important to ensure that entities are more likely to be impacted by such random variation are not unfairly assessed.

# Strategies for ensuring that benchmark performance data are reliable

- There are some strategies we can implement to reduce the chance that random variation plays a significant part in a carrier or provider entity's performance and increase our confidence in HCA's performance assessment:
  - Perform statistical testing on benchmark performance data.
  - Mitigate the impact of high-cost outliers.
  - Apply risk adjustment.
  - Only report on entities with sufficient population sizes for which performance can be measured reliably.

# Considerations for mitigating the impact of small population sizes

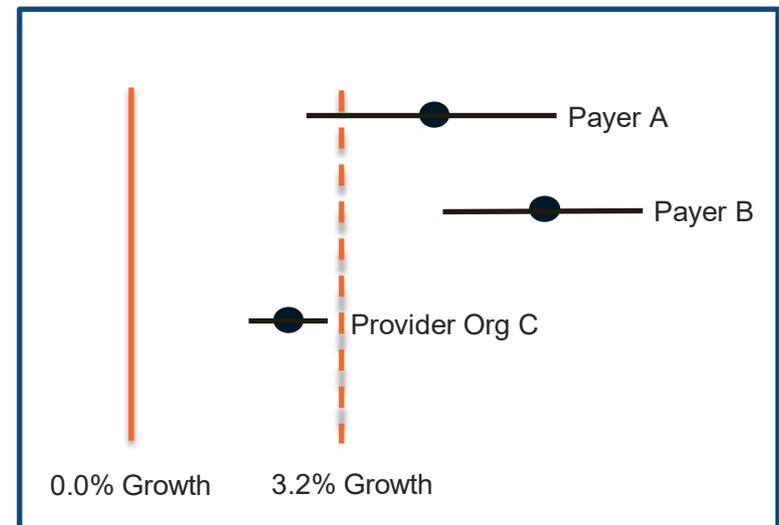
- Implementing strategies to minimize the impact of small population sizes on insurer and provider performance involves balancing multiple factors:
  - Having a high degree of confidence of the accuracy and reliability of performance data.
  - Data completeness.
  - Payers' data reporting burden.
  - Project staff workload to collect, validate, and analyze data.

# 1. Performing statistical testing on benchmark performance

- Washington could develop confidence intervals around benchmark performance.
- The confidence interval shows the possible range of values in which we are fairly sure our true value lies.
- In practice, it allows us to make the following statement:
  - We are 95% confident that the interval between A [lower bound] and B [upper bound] contains the true rate of cost growth for entity C.

## Determining performance with confidence intervals

- Performance **cannot be determined** when upper or lower bound intersects the benchmark (payer A).
- Benchmark has **not been achieved** when lower bound is fully over the benchmark (payer B).
- Benchmark **has been achieved** when the upper bound is fully below the benchmark (provider org C).



Note: Figure is not to scale

## Other states' use of statistical testing

- OR and CT will be the first states to use confidence intervals in determining benchmark performance.
  - OR developed the methodology, which CT then adopted.
  - Both states are now collecting or analyzing their pre-benchmark data.
- RI recently adopted the use of confidence intervals, which is being incorporated into the 2020 data request (RI's second performance year).
- MA's methodology is defined in statute and cannot be changed without legislation.
- DE only reported at the state and market level, for which statistical testing is not critical.

# Advisory Committee on Data Issues' feedback on use of confidence intervals

- The Advisory Committee on Data Issues supported the use of confidence intervals to assess benchmark performance.
- One Committee member indicated that it would be important to provide clear documentation within the reports on how the confidence intervals were constructed.



## Design recommendation: Use of confidence intervals

Does the Board wish to adopt the recommendation to apply statistical testing and the use of confidence intervals to determine insurer and provider entities' benchmark performance?

## 2. Mitigating the impact of high-cost outliers on per capita spending

- High-cost outliers are members/patients with extremely high levels of health care spending.
  - The members/patients represent real spending, but often present randomly in a population and there are limits to how much of their spending can be influenced due to their complex medical condition and high resource intensity care needs.
  - It is not fair to judge insurer and provider performance against the benchmark when it is significantly influenced by spending on high-cost outliers.

# How to address high-cost outliers

- It is common practice in total cost of care contracts to *truncate* expenditures to prevent a small number of extremely costly members from significantly affecting providers' per capita expenditures.
- Truncation involves capping individual patient annual spending at a high level, often between \$100k and \$150k for commercial population contracts.
  - Spending above the cap is excluded from benchmark performance assessment at the insurer and provider entity levels.

# RI's experience with high-cost outliers

- In RI, analyses showed that high-cost outliers significantly affected performance of provider entities.
  - For one RI ACO, including high-cost outlier spending raised the trend rate by several percentage points.
- Furthermore, total cost of care (TCOC) risk contracts typically remove high-cost outlier spending.
  - The differential treatment of high-cost outliers in the cost growth benchmark program and in TCOC contracts led to confusion and tension around reporting of performance.
- As a result, RI will truncate high-cost outliers starting with 2020 performance data.

## Advisory Committee on Data Issues' feedback on truncation

- Most Committee members supported the use of truncation for high-cost outlier spending.
  - One member did not support it, indicating the need to further understand the interaction with other strategies.
- Some Committee members expressed differing opinions on how to set truncation points.
  - One member suggested setting truncation points by disease type/prevalence.
  - Another member responded by stating that doing so would make data collection more complex.
  - Another suggested setting different truncation points for pharmacy and non-pharmacy spending.



## Design decision: Truncation of high-cost outliers

Does the Board wish to adopt the recommendation to truncate high-cost outliers' spending when measuring insurer and provider entity benchmark performance?

## 3. Applying risk adjustment

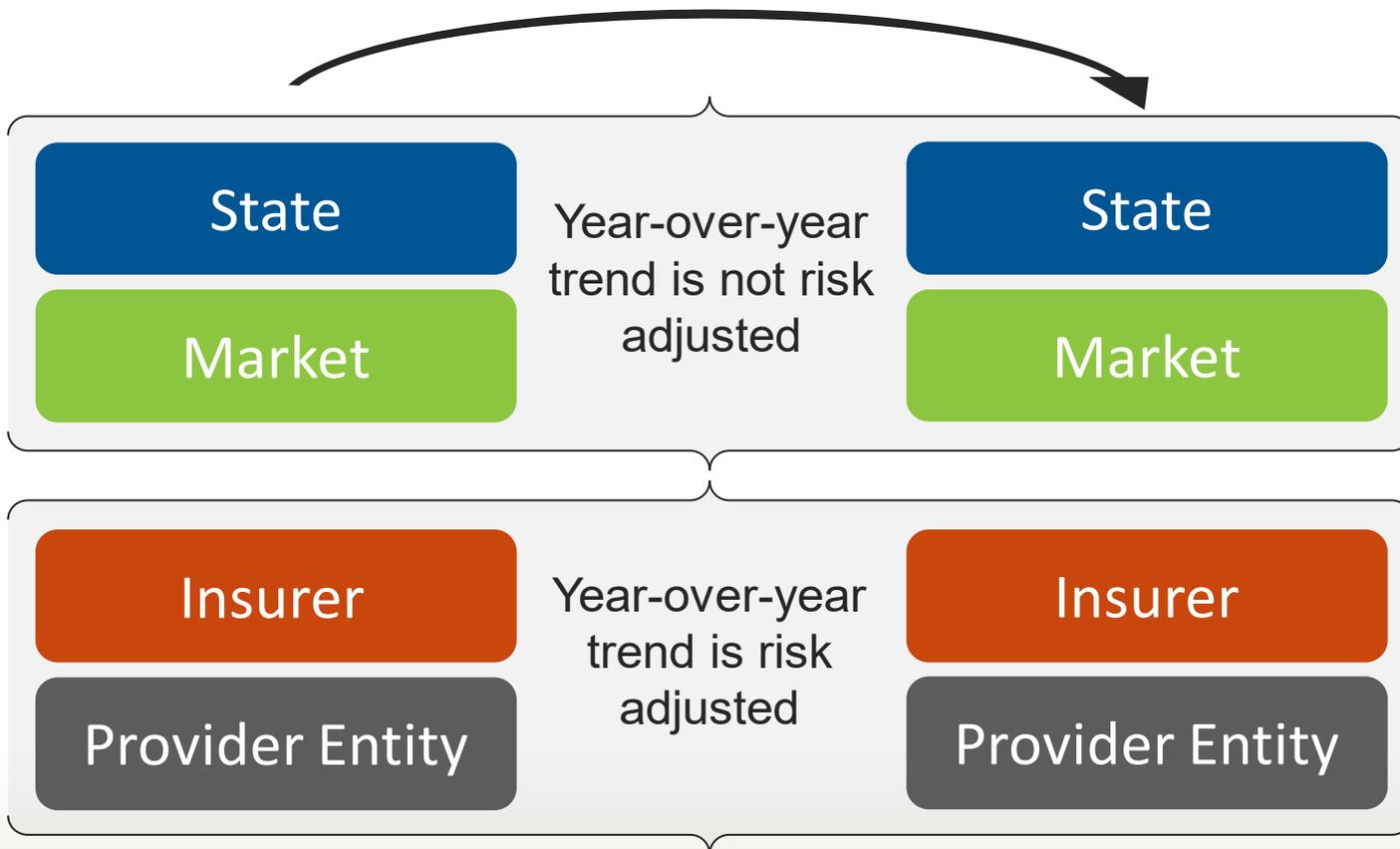
- Cost growth benchmark states typically risk adjust data to account for population changes over time.
  - The composition of a payer's or provider's population may change over the course of a year.
  - Such changes will impact spending growth, e.g., a population that is sicker than a year prior is expected to have higher spending than it would have otherwise.

# Risk adjustment models

- *Clinical risk adjustment* is used to assess conditions diagnosed and treated during the performance year to predict spending in the same year.
- Available models use claim encounter data, such as diagnoses, procedures, and prescription drugs.
  - They do not include medical record information (e.g., clinical indicators of severity, measures of prior use, lifestyle or supplemental demographic information).
- The best risk adjustment models can explain about half of the variation on health care spending, and a little more if spending for the highest cost outliers is truncated.\*

\*Accuracy of Claims-Based Risk Scoring Models, Society of Actuaries, October 2016.

# Risk adjustment is only performed at the carrier and provider levels



# HB 2457 requirements around risk adjustment

- HB 2457 requires the Board to:
  - “annually calculate total health care expenditures and health care cost growth... for each health care provider or provider system and each payer, taking into account the health status of the patients of the health care provider or the enrollees of the payer, utilization by the patients of the health care provider or the enrollees of the payer, intensity of services provided to the patients of the health care provider or the enrollees of the payer, and regional differences in input prices.”*
- We will walk through how we propose to address these requirements in the implementation.

# Adjusting for utilization, service intensity, and regional pricing differences

- Reporting of benchmark performance to account for “*utilization... intensity of services... and regional differences in input prices*” would not be feasible.
  - Not all risk-adjustment models account for these elements, and none account for input prices. Most rely heavily on diagnosis data.
- Understanding how these factors affect cost and cost growth is something that is probably best done through the *data use strategy*.

## Advisory Committee on Data Issues' feedback on how to account for utilization, service intensity, and regional pricing

- The Advisory Committee on Data Issues recommended using the data use strategy, and not benchmark risk adjustment, to understand the impact of utilization, service intensity and regional pricing on cost and cost growth.



## Design decision: Accounting for utilization, service intensity, and regional pricing

Does the Board wish to adopt the recommendation to understand the impact of utilization, service intensity, and regional pricing differences via the data use strategy instead of adjusting for it when reporting performance relative to the benchmark?

# Coding completeness and rising risk scores

- HB 2457's requirement to take into account "*health status*" suggests the use of clinical risk adjustment, which can be problematic due to rising risk scores.
- Risk scores of a full population are typically stable over time because changes in the demographic and health characteristics that might affect an entire population's risk score occur slowly.
- However, risk scores can change over time without changes in the population's underlying risk due to improved documentation of patient condition on claims.

# MA's experience with rising risk scores

- MA has observed steadily rising risk scores year after year, amounting to an 11.7% increase between 2013 and 2018.
  - Only a small portion of the increase could be explained by demographic trends or changes in disease prevalence.
  - The MA Health Policy Commission now recommends evaluating payer and provider performance based on growth in unadjusted spending.

## RI's experience with rising risk scores

- In RI, excluding the duals plans, payer risk scores grew 4.6% from 2018 to 2019.
  - Rising risk scores had the effect of essentially raising the cost growth target value by 3.2% doubling to 6.4% the trend that would meet the cost growth target with an average rising risk score.
  - Consequently, RI decided to only risk-adjust data by age and sex starting with the 2020 performance year.

# Recommendations for addressing changing population risk

- Adjust performance data using age/sex factors only.
  - Using clinical risk scores overcompensates for possible yearly changes in population health status and creates distortion due to claim coding practices.
  - Age/sex adjustment will capture the impact of an incrementally aging population, which may be the most significant change affecting population health status over the course of a year.

# Advisory Committee on Data Issues' feedback on risk-adjustment

- The Advisory Committee on Data Issues generally supported risk-adjusting by age and sex instead of using clinical risk scores.
  - However, some members wanted additional input from actuaries and carrier and provider organizations before making a recommendation to the Board.
- Committee members concerns around using age and sex risk-adjustment included the following:
  - There would not be an ability to understand variation across entities and perform comparisons of total cost vs. trend.
  - Age and sex risk-adjustment would not yield accurate results if there is a significant shift in a payer or provider entity's population over a year.



## Design decision: How to risk adjust data

Does the Board wish to apply only age/sex factors in the risk-adjustment of benchmark performance data?

## 4. Reporting for “sufficient” population sizes

- In determining “sufficient” population sizes, there are three separate, but related questions to address:
  - How many enrolled lives must a **payer** have to report THCE?
  - How many attributed lives must a **provider entity** have with a payer for its TME to be reported?
  - How many lives must a **payer/provider entity** have in a line of business for its performance to be publicly reported?

# Population size thresholds established by other states

State	Payers Required to Report	Thresholds for Public Reporting Provider Performance
DE and RI	The largest insurers in the state	By line of business, provider entities with: <ul style="list-style-type: none"> <li>• At least 10,000 attributed commercial or Medicaid lives</li> <li>• At least 5,000 attributed Medicare lives</li> </ul>
CT	The largest commercial and Medicare insurers representing ~85% of covered lives in the state	TBD
MA	Payers with at least 3,600 attributed lives	No published standard for public reporting
OR	At least 1,000 covered lives across all lines of business	Across all markets, provider entities with at least 10,000 attributed lives

# Determining what is a “sufficient” population size

- Determining “sufficient” population sizes becomes less pressing with the adoption of confidence intervals.
- In addition, OR and CT are collecting “pre-benchmark” data, which should shed light on the population sizes at which confidence intervals become so large as to make it difficult to determine benchmark performance.
- For now, we recommend:
  - Requiring reporting from all Medicaid MCOs and carriers with commercial or Medicare Advantage market share at 5% or higher.
  - Deferring on provider entity thresholds until OR and CT have completed their pre-benchmark analyses.

## Advisory Committee on Data Issues' feedback on minimum population size

- The Advisory Committee on Data Issues requested additional information about the Washington State market before making a recommendation to the Board.
- One Committee member noted that the individual market is a small portion of the overall commercial market but includes 13 carriers.



## Design decision: Minimum population sizes

Does the Board agree with the following recommendations:

- Requiring reporting from all Medicaid managed care organizations and carriers with commercial or Medicare Advantage market share at 5% or higher?
- Deferring on provider entity thresholds until OR and CT have completed their pre-benchmark analyses?

# Committee feedback

## TAB 8

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## Washington Academy of Family Physicians Proposal for Health Care Cost Transparency Board (HCCT) 7-25-21

### Benchmark Methodology

- The Washington Academy of Family Physicians (WAFP) supports a hybrid metric to project appropriate growth in healthcare spending in the state of Washington, consisting of:
  - **Median Wage:** 70% contribution to forecasted growth
  - **Potential Gross State Product (PGSP):** 30% contribution to forecasted growth
- The WAFP appreciates that a forecasting metric that emphasizes median wage may lead to tighter provider spending controls; however, the WAFP supports a forecasting methodology that best reflects the financial resources of most Washingtonians.
- Forecasted growth should be a fixed number, recalculated every 3 years.

### New Investment in Primary Care and Social Services

- Primary care and social services are critically important elements to improving health in Washington state, and new investment must be incorporated into spending benchmarks. The Bree Collaborative, the HCA, the state legislature and the Washington Health Alliance have all focused on increasing the resources in primary care to improve outcomes. The Washington State Transformation Project, the State Legislature and many community organizations have identified investments in social determinants as necessary to improve the health of the people in the state. The WAFP proposes that the HCCT Board reduces barriers to primary care and social services investment without raising consumer premiums or cost sharing by incentivizing spending attributable to **new** spending in primary care and/or social services that leads to spending beyond the established benchmark.
- **Primary Care**
  - On average, the US invests 5-7 percent of total health care spending on primary care; a 2019 OFM study found Washington spends 4.4 to 5.6 percent.<sup>i</sup>
  - We propose that HCCT incentivize, monitored through rate review, **new** investment in primary care up to a 0.50 percent annual growth in healthcare spending above the benchmark until primary care spending is at 10% of total spending.
  - This new investment in supports new primary care per member per month payments for:
    - Wellness Care
    - Chronic Disease Management/Care Coordination
    - Integrated Behavioral Health
- **Social Services**
  - Propose that HCCT encourages **new** investment in social services spending up to a 0.50 percent growth in healthcare spending above the benchmark per year.
  - New social services investment from public and private payers should emphasize addressing **mental health and housing instability**, and chosen interventions must be decided upon and supervised by the communities most impacted.
  - This work can be facilitated and investments prioritized by scaling and focusing the **Accountable Communities of Health (ACH) model**: Nine independent regional organizations initiated as part of WA Medicaid Transformation Project, whose aim is to promote health equity and coordinate investment and interventions surrounding social determinants of health.<sup>ii</sup> Washington's payer community can invest and collaborate as equal partners with Medicaid in supporting ACH's in implementing community-led social services interventions.

### Sample Forecasting Benchmark Calculation

- **Initial Benchmark:** (Growth in Median Wage)\*0.70 + (Growth in PGSP)\*0.30= 3.5%
- **Enhanced Benchmark:** 3.5% + 0.5% new primary care investment + 0.50% new social services spending = 4.5% annual growth in health and healthcare related spending

<sup>i</sup> Primary Care Expenditures: Summary of current primary care expenditures and investment in Washington Report to the Legislature, Washington Office of Financial Management, December 2019

<sup>ii</sup> Accountable Communities of Health (ACHs). *Washington Health Care Authority*. <https://www.hca.wa.gov/about-hca/medicaid-transformation-project-mtp/accountable-communities-health-achs> (Link last visited July 23, 2021).

August 13, 2021

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Dear Members of the Health Care Cost Transparency Board,

On behalf of the Washington State Medical Association and our physician and physician assistant members, thank you for the opportunity to submit comments on the work-to-date of the Washington State Health Care Cost Transparency Board (Board).

The WSMA seeks to be an engaged and constructive partner in this important work. We believe that for this endeavor to be successful, benchmarks should be meaningful, supported by evidence, and achievable to maintain credibility and garner confidence and support from stakeholders including members of our Washington state community, health plans and the legislature, but also physician practices and health systems. It is in that spirit we offer the comments below which we hope you will take into consideration going forward.

### **Benchmark**

At the July Board meeting, the Board's two economists pointed out that there is no available data to support a "phased-down" approach. Despite these considerations, the Board recommended setting the following benchmark:

- 2022-2023: 3.2%
- 2024-2025: 3.0%
- 2026: 2.8%

The Advisory Committee of Health Care Providers and Carriers (Committee), comprised of experts in the healthcare system, reviewed this proposal and strongly recommended that the Board reconsider and adopt a stable benchmark supported by the data and evidence - for impacted entities to work toward over the next five years.

While we understand and share the desire of the Board to reduce healthcare costs, the WSMA is concerned by lack of evidence or sufficient rationale to support such an aggressive reduction.

The 3.2% cost growth benchmark is an already challenging target but is supported by data and a rationale that has been agreed upon by both the Board and Committee. It also adheres to the spirit of the enabling legislation. To achieve this goal, healthcare entities and practices will likely take several years to work through existing contracts and processes in a responsible fashion. We fear that setting unrealistically high expectations undermines future recommendations to the legislature and might lead healthcare providers to ignore the work of the Board, or worse, force them to initiate

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changes that have the effect of degrading access to high quality healthcare.

Many of the newest innovations in medical and surgical care (e.g. new Alzheimer's drugs, emerging gene therapy, surgical robotics, etc.) alone will make reducing costs by 3.2% challenging, but the recommended phased timeline would pose an enormous if not impossible challenge for our healthcare system.

This approach also does not take into consideration that contracting cycles between physician practices and insurance carriers are typically on multi-year cycles and that filings for 2022 and 2023 are taking place now. A stable, five-year benchmark would provide the flexibility needed to work toward the admirable target of 3.2% in a responsible way.

Physician practices have limited tools at their disposal to achieve the approach recommended by the Board. Many may be forced to take detrimental measures such as reducing the size of workforce and/or reducing or closing access to certain services entirely to achieve this cost growth target. Comments by the Board and by our Committee recognize that the benchmark is a target that will have to be approached gradually, over multiple years. A phased approach seems unnecessary and unnecessarily confusing.

#### **Benchmark trigger review**

The WSMA strongly supports the Board's recommendation to review the benchmark only under "extraordinary circumstances." Annual reviews that result in changing the benchmark would not provide the stability we are seeking as previously discussed.

#### **Address all cost drivers**

WSMA acknowledges that health care in our country is expensive, and that cost containment is an important component of efforts to expand access to health care and insurance coverage. We also feel it is imperative that any recommendations the Board makes to reduce cost not be disproportionately imposed on one component of the health care industry. Blunt and arbitrary tools will harm many medical groups and practices due to the risk to their overall financial viability. Efforts to contain costs should be primarily focused on ALL the major cost drivers in health care, rather than recommending restraints that will limit patients' access to care.

#### **Process concerns**

The WSMA requests that recommendations on elements of this work made by the Committee be discussed and formulated before the Board considers making a recommendation. The current feedback loop is confusing to participants. We are unsure why the Board would make recommendations before having considered the feedback of experts on the Committee.

Thank you again for the opportunity to provide feedback. With any questions or concerns, please do not hesitate to reach out to Jeb Shepard, WSMA Director of Policy, at [jeb@wsma.org](mailto:jeb@wsma.org).

Sincerely,

A handwritten signature in black ink that reads "Mika Sinanan MD". The signature is written in a cursive style with a large, stylized "M" at the beginning.

Mika Sinanan, MD, PhD  
President-Elect  
Washington State Medical Association

# Background material

## TAB 8

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# Advisory Committee of Health Care Providers and Carriers meeting minutes

July 29, 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

Bill Ely  
Bob Crittenden  
Byron Okutsu  
Dorothy Teeter  
Jodi Joyce  
Louise Kaplan  
Mark Barnhart  
Mike Marsh  
Mike Sinanan  
Natalia Martinez-Kohler  
Patricia Auerbach  
Paul Fishman  
Ross Laursen  
Stacy Kessel  
Todd Lovshin T  
Vicki Lowe  
Wes Waters

## Members absent

Mike Marsh  
Stacy Kessel

## Agenda items

### Welcome, Call to Order, Approval of meeting minutes

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 2:02 p.m. Minutes from June were approved.

### Topics for Today's Discussion

The Committee topics for the day included recap of the Board's June discussion, and July Board recommendations on the cost benchmark and the benchmark trigger.



## Recap of Board's June discussion and Preliminary Recommendations

As a reminder to committee members, Ms. Gellermann presented a summary of the Board's discussion and preliminary recommendations from the June Board meeting.

In June, the Board recommended setting the benchmark value using a 70/30 hybrid of historical median wage and Potential Gross State Product (PGSP). In addition, the Board proposed setting benchmark values for a period of 5 years, indicated a desire to adjust the benchmark value over the 5-year period, and requested a trigger that would allow the benchmark methodology to be revisited.

## Review of Board's July meeting; Review of Committee Feedback

For context, the Committee reviewed slides presented to the Board at their July meeting, with feedback from the Committee. The Board was informed that the Committee supports the selection of median wage and PGSP as elements of the benchmark but withheld comment on the ratio until they could review actual values.

The Board was further informed that the Committee supported a 4–5-year benchmark, a trigger for re-evaluation, and recommended a stable benchmark for the initial period (meaning a benchmark of the same value over the entire period).

## Benchmark Trigger: Board's July 19 Recommendation

Ms. Gellermann presented the Board's recommendation on the cost benchmark:

- 2022-2023: 3.2%
- 2024-2025: 3.0%
- 2026 2.8%

The Committee reviewed the three options presented to the Board for consideration, including a “phase-down” from 3.6% to 3.2% over 5 years, and another that phased down the benchmark from 3.45% to 3.0% over the 5-year period (representing an average value over the period of 3.2%).

The Committee also reviewed information about average increases in other states, noting that Washington has the highest 20-year average (at 6.7%) of the 6 states compared. Some Committee members questioned whether Washington's growth rate reflected richer benefits, or Medicaid expansion.

## Discussion of Recommended Benchmark Value and Committee Feedback

On the topic of the benchmark value, Committee members were unanimous in accepting 3.2% as the benchmark value and agreed that the data-based methodology (70/30 median wage/PGSP) places the appropriate emphasis on the Washington consumer experience. There was some expressed reluctance to vary from the methodology by changing the ratios of the indicators based only on a desire to push the benchmark number lower.

Committee members described the selected benchmark of 3.2% as a very significant improvement over current trend. Most members felt that the benchmark should not go below 3.2% during the first five years. One member described 3.2% as a “daunting” goal. Another member shared the view that contract negotiations require that both parties “get to yes”, and that setting the benchmark lower than 3.2% could create a significant hurdle and a risk that negotiation becomes untenable. Members, including the consumer representative, shared concern that an overly rapid decrease in the benchmark might lead to unintended consequences including decreased services, and an inequitable impact. Only one member, representing the Washington Association of Family Physicians, believed the benchmark should start at 3.2% and then go lower.



On the topic of benchmark variation over the initial period, the Committee recommended that the Board select a stable benchmark over the initial 5-year period. Members stated that simplicity was important to success. One member described that due to the nature of contracting, including multi-year agreements that include multiple targets (for population health, cost, and other values), a shifting value would add a layer of complexity and burden to the negotiation process.

Some members expressed concern that the benchmark could have negative consequences on “good” spending, for example on primary care. The suggestion was made that the benchmark might be targeted by sector, with a higher benchmark for primary care spending.

### Public Comment

There was no public comment.

### Benchmark Trigger: Board’s July 19 Recommendation

The Committee was presented with the Board’s July 19 recommendation regarding a trigger for review of the benchmark. The Board recommended no trigger for review in initial 5-year period, in part to provide certainty and signal serious intent. The Board was open to considering the option in extraordinary circumstances and requested staff to draft language for their consideration based on the Oregon model.

### Discussion of Recommended Trigger and Committee Feedback

Committee members were in general agreement that stability of the benchmark value is important and would encourage engagement and adoption. The Committee further agreed that a trigger for review of the benchmark would be necessary but should be reserved for extraordinary circumstances to support benchmark adoption and engagement.

The Committee suggested that appropriate triggers should include widespread failure to meet the benchmark, or negative trends in the health care system.

The Committee was unanimous in recognizing the importance of an annual review independent of a trigger, including an analysis of benchmark performance and impact on cost, access, services and contracting.

### Adjourn

Meeting adjourned at 4:00 p.m.

### Next meeting

Thursday September 30, 2021

Meeting to be held on Zoom

10:00 a.m. – 12:00 p.m.

# Advisory Committee on Data Issues meeting minutes

August 10, 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

Allison Bailey  
Amanda Avalos  
Ana Morales  
Bruce Brazier  
Dave Mancuso  
Hunter Plumer  
Jared Collings  
Jerome Dugan  
Jonathan Bennett  
Julie Sylvester  
Karen Johnson  
Leah Hole-Marshall  
Lichiou Lee  
Mark Pregler  
Purav Bhatt  
Scott Juergens  
Thea Mounts

## Members absent

Jason Brown  
Josh Liao  
Megan Atkinson

## Agenda items

### Welcome, Roll Call, Agenda Review

J.D. Fischer, committee facilitator, called the meeting to order at 10:02 a.m.



## New Member Introduction

Jared Collings, Regence Blue Shield

The Cost Board appointed Mr. Collings to the Advisory Committee on Data Issues in July. Mr. Collings introduced himself to the Committee, sharing his background and expertise in measuring, tracking, and assessing health care cost and utilization patterns.

## Approval of Minutes

Mr. Fischer provided a recap of the July Committee meeting, and the Committee approved the July meeting minutes.

## Topics for Discussion

Topics relating to the cost growth benchmark measurement, reporting, and analysis presented to the Committee included the following:

- Overview of preliminary benchmark decisions and measurement.
- Reporting performance against the cost growth benchmark.
- Methods to ensure the accuracy and reliability of benchmark performance measurement.

## Overview of Preliminary Benchmark Decisions and Measurement

January Angeles and Michael Bailit, Bailit Health  
PowerPoint presentation

Ms. Angeles and Mr. Bailit presented an overview of the Board's preliminary benchmark decisions to the Committee. The Board made the preliminary decision to set the benchmark value using a 70/30 hybrid of historical median wage and potential gross state product. The benchmark would phase down over time:

- 2022-2023: 3.2%
- 2024-2025: 3.0%
- 2026: 2.8%

Ms. Angeles and Mr. Bailit reviewed what constitutes total health care expenditures (THCE) measured against the cost growth benchmark. THCE comprises total medical expense (TME) and the net cost of private health insurance (NCPHI). To collect data for benchmark performance analysis, commercial, Medicare Advantage, and Medicaid managed care plans must submit aggregate claims and non-claims data for provider entities, stratified by market segment. HCA staff will collect supplementary data from other sources, including Centers for Medicare & Medicaid Services (CMS) for Medicare fee-for-service (FFS) claims and Part D spending, Medicaid FFS spending, other sources of public health coverage (e.g., Veteran's Health Administration, Department of Corrections, workers' comp., etc.), and regulatory reports for NCPHI.

## Reporting Performance Against the Cost Growth Benchmark

January Angeles and Michael Bailit, Bailit Health  
PowerPoint presentation

Ms. Angeles and Mr. Bailit presented material to the Committee relating to reporting performance against the cost growth benchmark, beginning with comparing the benchmark analysis (i.e., how the Board will determine the cost growth from one year to the next) with the data use strategy (i.e., how the Board will determine what is driving overall cost and cost growth). Other states have typically reported benchmark performance at four levels:



statewide (THCE), market segments (THCE), payers (THCE), and large provider entities (TME only). Ms. Angeles provided examples for each report level from other states and noted that the Board will need to address the method of specifically defining and identifying provider entities whose performance will be measured against the cost growth benchmark. Mr. Bailit reiterated the important connection between the data use strategy and the benchmark analysis, where the latter heavily supports the former.

## 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 to the Committee topics related to ensuring accuracy and reliability in the benchmark performance measurement, including:

- Statistical testing on benchmark performance data.
- Mitigating the impact of high-cost outliers.
- Applying risk adjustment.
- Ensuring sufficient population sizes.

### **Statistical testing on benchmark performance data:**

Ms. Angeles and Mr. Bailit presented the option of developing confidence intervals around benchmark performance which would allow the Board to state a 95% confidence that the interval between the lower bound and upper bound contains the true rate of cost growth for a given entity. In determining performance with the use of confidence intervals, the performance *cannot be determined* when the upper or lower bound intersects with the benchmark but *can be determined* when either the lower bound is fully over the benchmark or the upper bound is fully below the benchmark. One committee member asked how confidence intervals would apply to the statewide analysis, and Ms. Angeles and Mr. Bailit confirmed that a confidence interval would not be necessary for statewide analysis due to the size of the data set. Ms. Angeles and Mr. Bailit asked if the Committee wished to recommend applying statistical testing and using confidence intervals to determine entities' benchmark performance.

Committee members supported this recommendation. One Committee member supported the use of confidence intervals provided there is clear documentation within the reports pertaining to the methodology used to construct the confidence intervals.

### **Mitigating the impact of high-cost outliers:**

Ms. Angeles and Mr. Bailit presented mitigation strategies for addressing the impact of high-cost outliers, i.e., members/patients with extremely high levels of annual health care spending. While such patients represent real spending, they often present randomly within a population and there are limits to how much of their spending can be influenced due to the medical complexity of their condition(s) and high resource intensity care needs. A common practice to address such outliers is to *truncate* expenditures to prevent high-cost outliers from significantly affecting providers' per capita expenditures. Truncation involved capping individual patient spending at a high level (e.g., between \$100k and \$150k for commercial populations). Mr. Bailit noted that truncating high-cost outliers will shrink the confidence interval and make it easier for the Board to draw a conclusion about whether an entity performed above or below the benchmark. Mr. Bailit provided an example from Rhode Island of how the inclusion of high-cost outlier spending affected a provider entity's cost growth by several percentage points, and how the state consequently changed its methodology to use truncation to mitigate the impact of high-cost outliers. One Committee member noted how quickly annual costs can rise for certain patients with oncologic conditions and who are on biologics and suggested different truncation points. Another Committee member noted that differential treatment of high-cost outliers based on disease would make data collection complex. Most

Advisory Committee on Data Issues meeting minutes  
08/10/2021



Committee members agreed to recommend to the Board that they utilize the truncation of high-cost outliers' spending when measuring insurer and provider entity benchmark performance. One Committee member did not support the recommendation and indicated that there was a need to evaluate the use of truncation along with other mitigation strategies. Another Committee member suggested while the Board should utilize truncation, outlier costs should be retained for the data use strategy for additional analysis.

**Applying risk adjustment:**

Ms. Angeles and Mr. Bailit described how states typically risk adjust data to account for population changes over time and reviewed various risk adjustment models, such as clinical risk adjustment and adjusting for utilization. They explained that risk adjustment is only performed at the carrier and provider levels. Further, HB 2475 requires the Board to *“annually calculate total health care expenditures and health care cost growth... for each health care provider or provider system and each payer, taking into account the health status of the patients of the health care provider or the enrollees of the payer, utilization by the patients of the health care provider or the enrollees of the payer, intensity of services provided to the patients of the health care provider or the enrollees of the payer, and regional differences in input prices.”* Ms. Angeles and Mr. Bailit described the difficulties of risk-adjusting based on utilization, service intensity and regional pricing differences, and recommended addressing these in the data use strategy instead of the reporting of benchmark performance. Committee members agreed to make this recommendation to the Board. Mr. Bailit described other states' experience with risk adjustment and associated challenges associated with the impact of provider claim coding practices on risk scores. One state has decided to only risk-adjust by age and sex due to rising risk scores, which is significantly driven by improvements in documentation of patient condition on claims rather than changes in the population's underlying risk. This had the effect of essentially raising the cost growth benchmark value. Committee members generally agreed that risk-adjusting by age and sex to assess benchmark performance seems reasonable. However multiple Committee members were concerned about the missed opportunity to understand variation across entities within a given reporting period, and to compare total cost vs. trend. One Committee member indicated that risk-adjusting by age and sex would only work assuming there isn't significant movement in patients/members across provider entities/insurers. Multiple Committee members expressed a desire to get additional input from actuaries and carrier and provider organizations before making a recommendation to the Board.

**Ensuring sufficient population sizes:**

Mr. Bailit described the need to gather benchmark data and report benchmark performance only for entities with “sufficient” population sizes. Three questions drive the determination of the minimum population sizes:

- How many enrolled lives must a payer have to report THCE?
- How many attributed lives must a provider entity have with a payer for its TME to be reported?
- How many lives must a payer/provider entity have in a line of business for its performance to be publicly reported?

Mr. Bailit provided a summary of how other states have determined thresholds for payer reporting and public reporting of provider performance. Mr. Bailit's recommendation based on other states' experience was to require all Medicaid managed care organizations and carriers with commercial or Medicare Advantage market share at five percent or higher to submit data reports and deferring the provider entity thresholds until Oregon and Connecticut have completed their pre-benchmark analyses that will inform the population size at which point confidence intervals become so large as to make a benchmark performance determination difficult. One Committee member requested additional information about Washington State markets to make a more informed recommendation, but did not oppose the strategy itself, and other members agreed. One Committee member noted how the individual market makes up a small portion of the commercial market (approximately four percent) but includes 13 carriers. Mr. Bailit agreed to bring additional market level information to the Committee at a future meeting.



### Public Comment

There was no public comment.

### Wrap Up and Adjournment

Meeting adjourned at 11:58 a.m.

### Next meeting

Wednesday, September 8, 2021

Meeting to be held on Zoom

2:00 p.m. – 4:00 p.m.