

Health Care Cost Transparency Board

November 17, 2021

Health Care Cost Transparency Board Board Book

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

(Zoom Attendance Only)

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Agenda

TAB 1

Health Care Cost Transparency Board AGENDA

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

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"/>	Jodi Joyce	<input type="checkbox"/>	Margaret Stanley		

Time	Agenda Items	Tab	Lead
2:00 - 2:10 (10 min)	Welcome, roll call, and agenda review	1	Susan E. Birch, Chair, Director Health Care Authority
2:10 - 2:15 (5 min)	Approval of September meeting minutes	2	AnnaLisa Gellermann, Board Manager Health Care Authority
2:15 - 2:20 (5 min)	Recap of last meeting discussions	3	Michael Bailit and January Angeles Bailit Health
2:20 - 3:05 (45 min)	Using risk adjustment when determining benchmark performance <i>Design Decision: Accounting for utilization, service intensity, and regional pricing.</i> <i>Design Decision: How to risk adjust data?</i>	4	Michael Bailit and January Angeles Bailit Health
3:05 - 3:15 (10 min)	Public comment		Susan E. Birch, Chair, Director Health Care Authority
3:15 - 3:55 (40 min)	Key questions to address for provider level reporting <i>Design Decision: How should members be attributed to clinicians?</i> <i>Design Decision: How should clinicians be organized into large provider entities?</i>	5	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.

September meeting minutes

TAB 2

Health Care Cost Transparency Board meeting minutes

September 14, 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
Bianca Frogner
Carol Wilmes
Edwin Wong
Jodi Joyce
John Doyle
Kim Wallace
Laura Kate Zaichkin
Lois Cook
Margaret Stanley
Molly Nollette
Pam MacEwan
Sonja Kellen

Members absent

Mark Siegel

Call to order

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

Agenda items

Welcoming remarks

Ms. Birch welcomed the members and reminded them of a track record of making difficult decisions. She informed the members of the pending decision related to the cost benchmark and urged them to share perspectives.

Adoption of minutes

The minutes were adopted.

Presentation: Recap of last meeting and topics for today's discussion

AnnaLisa Gellermann, HCA staff, provided a very brief overview of the agenda, indicating that the first presentation would be a more detailed recap of the cost benchmark discussion.

DRAFT
Health Care Cost Transparency Board meeting minutes
09/14/2021



Presentation: Finalizing the benchmark methodology and value

Michael Bailit of Bailit Health presented a summary of the Board's initial recommendation: 3.2% for 2022-23, 3.0% for 2024-25, and 2.8% for 2026. This was based on a 70/30 blend of historical median wage and potential gross state product. Mr. Bailit also recapped the feedback from the Advisory Committee of Health Care Providers and Carriers, which supported a 3.2% value but expressed desire for an unvarying benchmark that did not go below 3%.

Mr. Bailit recapped the Board's August discussion, in which the Board wanted to consider other potential benchmark values that would be responsive to the Advisory Committee's feedback without compromising the overall goal of leveraging the benchmark to make health care more affordable for consumers. Board members also wanted to understand the impact of moving away from the original proposal.

The Board reviewed the trigger language adopted at the August meeting that provided for annual review of performance of the benchmark, and the opportunity to revisit the benchmark value under extraordinary circumstances.

The Board also reviewed 3 scenarios, modeled to show potential inflation cost avoided over a 5-year period arising from 3 different options for benchmark values in the initial benchmark period of 2022-2026. The cost avoidance estimates were based upon projections derived from national data, Option 1, the original recommendation, was estimated to avoid 10.8 billion dollars overall. Option 2, 3.2% for 2022-2024 and 3.0 for 2025-2026, was estimated to avoid 10.4 billion dollars overall. Option 3, 3.0% for 2022-2024, and 2.8% for 2025-2026 was estimated to avoid 11.8 billion dollars overall.

The Board engaged in a lengthy discussion of the options presented. Several members acknowledged the efforts of providers to reduce cost, and the struggles they face to cut cost while maintaining quality and access. Some members focused on the desire for a number that varied less over time and acknowledged concerns about setting the benchmark below 2.8% as being too aggressive. Most of the Board focused on impact of increasing prices on consumers as the primary issue and supported an assertive benchmark. The Board agreed to reject Option 3 with the largest projected savings but were unable to reach consensus in choosing between Options 1 and 2. Ms. Birch called for a motion to approve Option 1, and in the subsequent vote the majority voted affirmatively to approve Option 1 as the benchmark value.

Presentation: Reporting performance against the cost growth benchmark

Michael Bailit of Bailit Health introduced the Board to the topic of the two data analyses that the Board will conduct: a cost benchmark data call that will reveal performance against the benchmark, and a cost driver analysis that is an analysis of existing claims-related data to determine the most significant drivers of increasing health care cost.

The Board reviewed material related to how other states report benchmark performance, including reporting at four levels: state, market, payer, and provider.

Presentation: Data call: Methods to ensure the accuracy and reliability of benchmark performance measurement including the Advisory Committee on Data Issues' feedback

Michael Bailit of Bailit Health presented the Board with information related to the anticipated cost benchmark data call, and various methods to ensure reliability of the measurement. These included discussion of the

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Care Cost Transparency Board meeting minutes

09/14/2021



problems of small numbers and random variation. Mr. Bailit instructed the Board on some common methods to reduce the impact of these problems, including statistical testing the use of confidence intervals in determining performance, and the use of truncation to address high-cost outliers.

The Board was asked to decide whether to use statistical testing and confidence intervals. They were provided feedback from the Advisory Committee on Data Issues supporting both techniques (so long as the interval construction was clearly documented). In discussion, Ms. Birch asked about experience in other states, and indicated that Washington should learn from that experience. One Board member commented that statistical testing and confidence intervals were a typical approach. One Board member mentioned the unique status of entities that might be both payers and providers as an issue for clarification. The Board unanimously approved the use of both statistical testing and confidence intervals.

The Board was asked to approve the use of truncation. They were provided feedback from The Advisory Committee on Data Issues generally supporting its use, with additional comments related to how to set truncation points. The Board approved use of truncation but did not address truncation points.

Public Comment

Ms. Birch called for comments from the public.

Jeb Shepherd, Director of Policy, Washington State Medical Association (WSMA) commented that as noted in prior comment and a letter submitted to the Board, WSMA did not support the benchmark selected by the Board as overly aggressive and not supported by the Board's rationale. He clarified that WSMA supported a 5-year stable benchmark.

Alicia Eyler, Policy Director, Health Access of the Washington State Hospital Association (WSHA) commented that her organization appreciated the thoughtful approach and attention to their prior comments, evident in the Board's discussion of the benchmark. WSHA does not support a 2.8% benchmark in 2026, as too aggressive and a lower value percentage than any other state, and is concerned the number was arrived at for policy reasons rather than based on methodology and rationale.

Adjournment

Meeting adjourned at 4:00 p.m.

Next meeting

Tuesday, October 14, 2021
Meeting to be held on Zoom
10:00 a.m. – 12:00 p.m.



Health Care Cost Transparency Board

November 17, 2021

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Topics we will discuss today:

1. Recap of last month's meeting.
2. The use of risk-adjustment when determining benchmark performance.
3. Key questions to address for provider-level reporting.
 - Patient attribution to clinicians.
 - Organizing clinicians into large provider entities

Recap of last meeting discussions

TAB 3



Washington State
Health Care Authority

Recap of the last meeting's
discussions



Recap of the last meeting's discussions

- The Board finalized the cost growth benchmark as follows:
 - 2022: 3.2%
 - 2023: 3.2%
 - 2024: 3.0%
 - 2025: 3.0%
 - 2026: 2.8%

Recap of the last meeting's discussions

- We reviewed benchmark performance reporting, and started discussing strategies to ensure the accuracy and reliability of benchmark performance measurement.
- Board members unanimously agreed on the implementation of two strategies:
 - Using confidence intervals to determine benchmark performance.
 - Truncating spending above certain thresholds for high-cost outliers.

Using risk adjustment when determining benchmark performance

TAB 4



Washington State
Health Care Authority

Using risk adjustment when
determining benchmark
performance



Application of risk adjustment to cost growth benchmarking programs

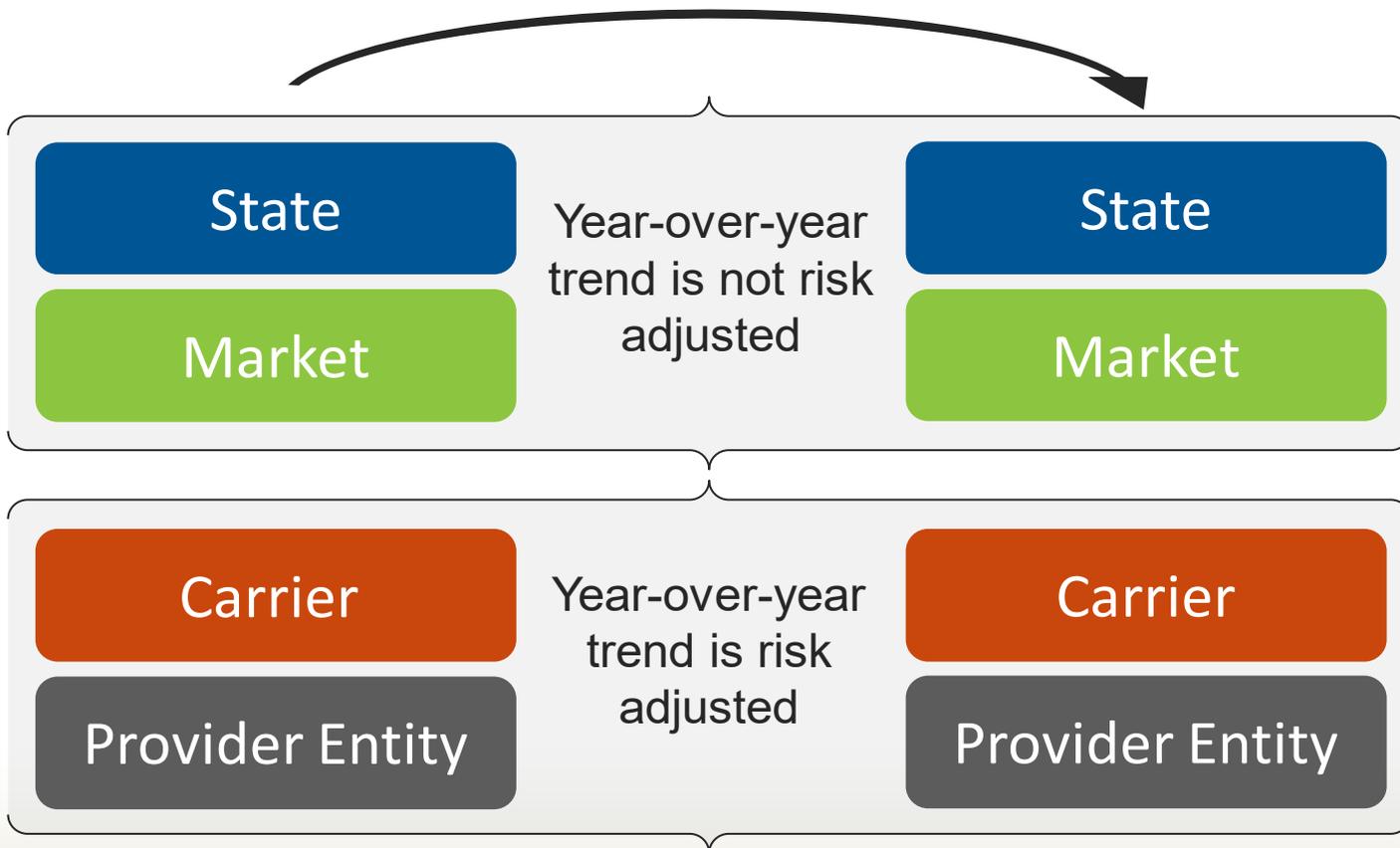
- Cost growth benchmark states typically risk-adjust spending data to account for changes in population health status.
 - The composition of a payer's or provider's population may change over the course of a year.
 - Such changes will impact spending growth, e.g., a population that is sicker than a year 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 and encounter data, such as diagnoses, procedures, and prescription drugs.
 - They do not include medical record information, e.g., clinical indicators of severity, prior service use under different coverage, health behaviors, social risk factors 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 now walk through how we propose to address these legislative requirements.

Adjusting for health status

- Change in population health status is typically captured through clinical risk adjustment software which uses diagnosis data on claims, coupled with basic demographic data (age, sex).
- In other states, it is customary to include an adjustment for change in health status. There are some technical challenges to doing this, however, which we will discuss shortly.

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” is not feasible or desirable.
 - To use utilization and price data to adjust for risk would be self-referencing. Price data are never used in models.
- The Data Committee recommended addressing this directive through the cost growth driver analysis, and not via benchmark risk adjustment.
 - As a reminder, the cost growth driver analysis refers to a complementary set of analyses of APCD and/or other data to understand the drivers of spending and spending growth.



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

Before we return to discussing accounting for changes in health status, does the Board wish to address utilization, service intensity, and regional pricing differences in the cost growth driver analyses instead of the benchmark performance analyses?

The issue of coding completeness and rising risk scores

- Clinical risk adjustment, while seemingly reasonable for fair assessment of carrier and provider entity performance, can be problematic due to systemically rising risk scores.
- Risk scores of a full population are typically stable over time because changes in the demographic and health characteristics that affect an entire population's health status occur slowly.
- However, risk scores can change over time without changes in the population's underlying health due to improved documentation of patient condition on claims.

Massachusetts' experience with rising risk scores

- Massachusetts has observed steadily rising risk scores year after year, amounting to an 11.7% increase between 2013 and 2018.
 - Following a comprehensive analysis, 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.

Rhode Island's experience with rising risk scores

- In Rhode Island, 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, Rhode Island decided to change to risk-adjusting data by age and sex starting with the 2020 performance year.

Risk-adjustment options to address coding intensity and rising risk scores

- Staff evaluated options for addressing the impact of increased coding intensity and presented four options for consideration by the Advisory Committee on Data Issues:
 1. age/sex adjustment performed by the payers;
 2. age/sex adjustment performed by the state;
 3. clinical risk adjustment normalization performed by payers, and
 4. clinical risk adjustment normalization performed by the state.
- Option 4 would require state use of its APCD.

Option 1: Age/sex adjustment performed by each payer at provider entity level

Payers submit provider entity risk scores that reflect only age and sex weights by market developed using the payer's risk-adjustment software and applied to the payer's data.

Strengths

- Eliminates code creep impact
- Weights will vary from payer to payer
- Easy for the state to administer

Weaknesses

- Does not fully account for changes in population health status
- Problematic when a payer or large provider entity experiences a significant shift in membership or patient population

Option 2: Age/sex adjustment performed by the state using payer data

Payers submit unadjusted spending data stratified by line of business and by age/sex bands. The state would use these data to develop an age/sex risk adjustment factor for each payer and large provider entity by line of business.

Strengths

- Eliminates code creep impact
- Weights are standardized
- Assures consistency of method
- Relatively easy for the state to administer

Weaknesses

- Does not fully account for changes in population health status
- Problematic when a payer or large provider entity experiences a significant shift in membership or patient population

Option 3: Clinical risk adjustment normalization performed by payers

Payers would determine the average risk scores across all large provider entities and divide each large provider entity's risk score by the average risk score to calculate a final risk score.

Strengths

- Limits “code creep” impact
- Model would account for any changes in population health status and shifts in provider entity patient panel
- Easy for the state to administer

Weaknesses

- Can't be applied at the insurer level
- Depends upon proper execution by payers
- Difficult to validate

Option 4: Clinical risk adjustment normalization performed by the state

The state would determine the average risk score for the entire population and divide each payer and large provider entity's risk score by the average risk score to calculate the final risk score.

Strengths

- Limits code creep impact
- Model would account for changes in population health status and shifts in payer or provider entity membership or patient panel

Weaknesses

- Requires a tested and validated state APCD with clinical risk-adjustment software
- APCD lacks over 50% of the commercial market
- Significant work for the state using its All-Payer Claims Database

Data Committee feedback on risk-adjustment

- Several members supported Option 2 - having the state develop and apply age/sex weights.
 - Members who supported this option emphasized the importance of using a standardized method, and expressed concern about the inability to validate risk adjustment performed by payers.
 - One member indicated that the strongest factor influencing health spending growth is price followed by population growth and age, while disease prevalence and utilization have minimal impact.
 - One member representing a health system did not support this option, expressing concerns about potential negative impacts on access.

Data Committee feedback on risk-adjustment

- A few members supported Option 4, having the state perform clinical risk-adjustment normalization.
 - One member noted that building capacity for this option would be important as part of a larger set of objectives:
 - To build analytical capacity, better conduct cost trend analyses, and assist policymakers and the public discern differences across carriers and benefit plans.
 - Another member noted that this option would provide more information on all the moving parts that contribute to cost growth.



Design decision: How to risk adjust data

Which risk-adjustment option(s) does the Board wish to use in analyzing benchmark performance data?

Public comment

Key questions to address for provider level reporting

TAB 5



Key questions to address for provider-level reporting

Key questions to address for provider-level reporting

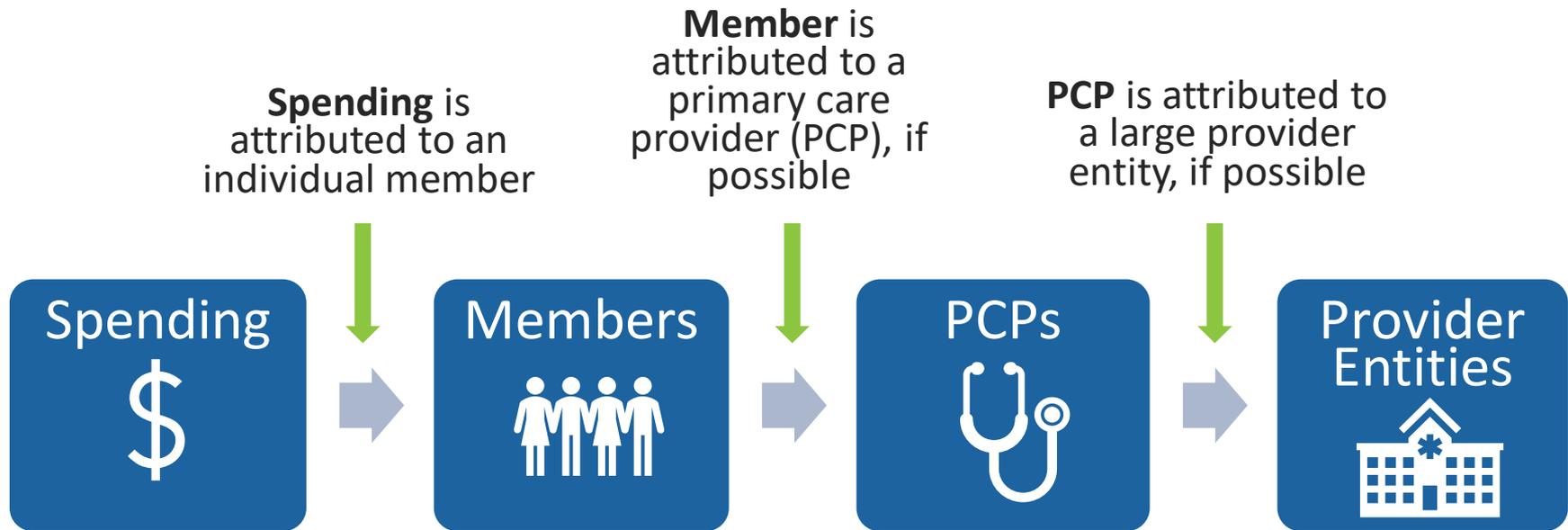


1. How should members be attributed to a clinician?



2. How should clinicians be organized into large provider entities (for the purpose of reporting)?

Resident and provider attribution for benchmark performance reporting



Insurers report spending by large provider entity. Insurers report spending in aggregate for members who cannot be attributed to a PCP and for PCPs who cannot be attributed to a large provider entity.

1. How should members be attributed to clinicians?

- Members need to be attributed to a clinician for the costs incurred by that member to be attributed to a clinician.
- Attribution is performed routinely by insurers for value-based contracts when clinicians and provider entities are held accountable for quality and/or the cost of care.
- Insurers also attribute members to clinicians and provider entities for their own internal analyses. Some states and quality improvement organizations do the same.

Attribution in the context of reporting on the cost growth benchmark

- Being attributed to a clinician for the purpose of analyses does not mean that:
 - The member was required to see that clinician.
 - The clinician delivered all of the care the patient received.
- Attribution is used, however, to indicate that a clinician had a caregiving relationship with a member and the clinician helped to direct the member's care in some manner.

Two approaches to attributing members to clinicians

Method	Pros	Cons
<p>Members are attributed using a common methodology, where insurers work together to agree upon the methodology and apply it to this process.</p>	<p>Supports potential comparisons of performance across insurers</p>	<p>Adds a layer of complexity to the process</p>
<p>Members are attributed using each insurer's own methodology employed with its value-based payment contracts or for other purposes</p>	<p>Makes reporting easier for insurers</p>	<p>Variation in methodology would produce inconsistent results and not be ideal for supporting provider comparisons across insurers</p>

Member attribution approach in other cost growth benchmark states

- Massachusetts, Delaware, Rhode Island, Connecticut, and Oregon are all using a **primary care attribution** model, and have all taken a similar approach, **leaving the exact methodology up to each insurer.**
- Massachusetts and Oregon have added some specificity, however, requiring that each carrier's primary care attribution method follow a hierarchy:
 - Member selection
 - Contract arrangement
 - Utilization

Data Committee feedback on patient to clinician attribution methodology

- The Data Committee did not recommend mandating a specific methodology, but felt it was important to have material consistency in attribution methodologies, and have documentation of those methodologies from payers.
- The Data Committee recommended allowing payers to use their own primary care attribution methodology based on the following a hierarchy:
 - Member selection
 - Contract arrangement
 - Utilization

Data Committee feedback on defining primary care

- One member suggested that the state define and provide a primary care taxonomy or procedure codes.
 - It was noted that if HCA defines primary care more specifically for the carriers, that it be done consistent with how other work within the state has defined primary care.



Design recommendation: Member attribution to clinicians

- Does the Board wish to require that payers report health care cost growth data using:
 - Their own attribution methodologies?
 - Their own attribution methodologies, but specifying a hierarchy?
 - A common, to-be-determined, member attribution methodology?

2. How should clinicians be organized into larger entities?

- To report data, payers need technical instructions on how to organize clinicians into provider entities.
- There are two general approaches to organizing clinicians into large entities for which benchmark performance can be reported:
 - Attribution based on statewide provider directory (Massachusetts and Oregon).
 - Attribution based on contracting arrangements (Rhode Island and Connecticut).

Massachusetts matches NPIs to physician groups

	A	B	C
1	NPI Number	OrgID	TME Physician Group
2	1033171749	10910	Acton Medical Associates
3	1043292360	10910	Acton Medical Associates
4	1053302158	10910	Acton Medical Associates
5	1184690505	10910	Acton Medical Associates
6	1447365408	10910	Acton Medical Associates
7	1538170774	10910	Acton Medical Associates
8	1588861660	10910	Acton Medical Associates
9	1922205020	10910	Acton Medical Associates
10	1124019765	10995	Affiliated Pediatric Practices (APP)
11	1164412839	10995	Affiliated Pediatric Practices (APP)
12	1245221019	10995	Affiliated Pediatric Practices (APP)
13	1356332985	10995	Affiliated Pediatric Practices (APP)
14	1396736161	10995	Affiliated Pediatric Practices (APP)
15	1497748834	10995	Affiliated Pediatric Practices (APP)
16	1528059128	10995	Affiliated Pediatric Practices (APP)
17	1568664795	10995	Affiliated Pediatric Practices (APP)
18	1578554713	10995	Affiliated Pediatric Practices (APP)
19	1679835011	10995	Affiliated Pediatric Practices (APP)
20	1881685485	10995	Affiliated Pediatric Practices (APP)
21	1891909305	10995	Affiliated Pediatric Practices (APP)
22	1922061878	10995	Affiliated Pediatric Practices (APP)
23	1215305040	11764	Allied Pediatrics of Greater Brockton, Inc.
24	1780849943	11764	Allied Pediatrics of Greater Brockton, Inc.
25	1942301239	11764	Allied Pediatrics of Greater Brockton, Inc.
26	1003044272	9995	Atrius Health
27	1003939703	9995	Atrius Health
28	1013975457	9995	Atrius Health
29	1023074366	9995	Atrius Health
30	1023445228	9995	Atrius Health

- Massachusetts has a provider directory that maps individual physician NPI numbers to physician groups.
 - Some states develop a provider directory using Tax ID numbers.
 - Either approach to developing provider directories – using NPIs or TINs – has associated advantages and disadvantages to either.
- Insurers then report spending for the identified physician groups.

Oregon asks payers to report by TINs

- Oregon did not provide a pre-defined list of provider organizations.
- The state instead asked payers to report provider organizations by their tax ID numbers (TINs) and will build the provider directory based on the submissions.
- The state is now analyzing the submissions and determine for which provider entities it will report.

PRV01	PRV02
free text	text, 9 digits including leading zero
Provider Organization Name	Provider Organization TIN

Rhode Island identifies the largest accountable care organizations (ACOs)

ACO
Blackstone Valley Community Health Care
Coastal Medical
Integra Community Care Network
Integrated Healthcare Partners
Lifespan
Providence Community Health Centers
Prospect CharterCARE
Members Not Attributed to an ACO

- Total cost of care contracts require a listing of which individual primary care clinicians belong to an ACO.
- Rhode Island identified the commercial and Medicaid ACOs in the state.
- Insurers identify the individual clinicians “underneath” those ACOs, consistent with their own total cost of care contracts.

Connecticut developed a list based on carrier feedback on TCOC contracts

- Connecticut developed a list of provider entities based on feedback from carriers regarding their total cost of care contracts with “Advanced Networks” – providers with value-based payment contracts – and other known large provider entities in the state.
 - *For purposes of its baseline analysis only*, the state then narrowed the list to those large provider entities to 11 that had significant overlap in total cost of care contracts across the carriers.

Staff research on provider directories

- Washington does not currently have a statewide provider directory.
- Other organizations within the state may have a provider directory, but the ability to use them for the benchmark program is unclear. Staff are exploring the possibility of using these directories.
 - The Washington Health Alliance has one that is used for its Community Check-Up report.
 - OneHealthPort has custody over some quasi-directories.

Staff research on potential list of large provider entities

- Staff developed a list of approximately 50 large provider entities for which benchmark performance could potentially be reported.
 - 23 community health centers.
 - Four medical groups or independent physicians' associations.
 - 22 health systems.
- Further work and input from carriers is needed to refine the list to ensure we will be capturing data for all provider entities that are sufficiently large.

Data Committee feedback on attributing clinicians to large provider entities

- Data Committee members felt it was important to identify large provider entities based on a framework of cost accountability. Two options discussed in detail included reporting on:
 - ACOs (e.g., Rhode Island’s approach).
 - Large provider entities that could engage in a total cost of care contract, regardless of whether they actually have done so (e.g., Connecticut’s approach).

Data Committee feedback on attributing clinicians to large provider entities

- Some noted that ACO networks are defined very differently, which would make it problematic to aggregate provider entity data across payers if ACO contract arrangements were the basis for attribution.
 - Within a payers' contract, there is also often variation on how these networks are defined by insurance market and product.
- Some Data Committee members commented that it would be helpful to have specific IDs (e.g., TINs and/or NPIs) that would be the basis for assigning clinicians to large provider entities.



Design decision: How to organize clinicians into large provider entities

- How does the Board wish to proceed with respect to attributing clinicians to large provider entities? Does the Board wish to consider attribution based on:
 - Statewide provider directory?
 - Contracting arrangements – either through ACO contracts or through the identification of large provider entities that could engage in a total cost of care contract?

Committee feedback

TAB 6

November 5, 2021

Mika Sinanan, MD, PhD
President

Delivered electronically

Katina Rue, DO
President-Elect

Dear Members of the Healthcare Cost Transparency Board,

Nathan Schlicher, MD, JD, MBA
Past President

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

Nariman Heshmati, MD
Vice President

John Bramhall, MD, PhD
Secretary-Treasurer

The WSMA seeks to be an engaged and constructive partner in this important work. We believe that for this endeavor to be successful, decisions should be supported by evidence and achievable in order to maintain credibility and garner confidence and support from stakeholders. It is in that spirit we offer the comments below which we hope you will take into consideration going forward.

Jennifer Hanscom
Chief Executive Officer

Adjust benchmark for 2022-2024 or recommend to legislature it delay benchmark application until 2024

To ensure the benchmark is achievable, the WSMA requests the Board recommend to the legislature that it delay application of the benchmark until 2024. Alternatively, the Board could adjust the benchmark for 2022-2024 to accommodate both the market distortions created by COVID-19 and the nature of contracting cycles.

COVID-19 market distortions

The current targets that were adopted at the September 14 meeting are aggressive and would be a challenge under normal circumstances. The global pandemic has created significant distortions in Washington state's healthcare economy due to patients postponing elective surgery and delaying or forgoing routine and preventative care such as mammograms and colonoscopies. As such, the baseline from which the Board is working from is artificially low. With surgeries and other services poised to resume once the COVID-19 Delta surge subsides, healthcare cost expenditures are set to increase dramatically in 2022.

Other market distortions include continued increases in the number of high-acuity patients requiring longer hospital stays following the latest COVID-19 Delta surge, coupled with the impacts of nationwide labor shortages and worldwide supply chain issues.

There have been huge increases in the cost of labor due to the large number of traveling frontline health care professionals and cost increases in supporting

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workforce at hospitals that are at 100% utilization. According to the October 2021 Physician Flash Report¹ by KaufmanHall, employed physician expenses continue to climb above pre-pandemic levels due to higher revenue cycle costs and increases in drugs and supply expenses. Total Direct Expense per Physician FTE (including advanced practice practitioners) rose to \$914,045 in the third quarter, up 4.4% from Q2, 13.2% from Q3 2020, and 10.8% from Q3 2019.

The healthcare sector is not immune to current supply chain issues plaguing the broader economy, making certain goods scarce and increasingly more expensive. The current inflation rate of 5.4 % is at a 13 year high. It will be difficult if not impossible to offset significant increases in labor, supplies, and drugs caused by the pandemic while limiting growth to 3.2% in 2022.

We are in the middle of the kind of extraordinary circumstance the Board has already cited as being one reason for adjusting the benchmark and we urge reconsideration of the current target.

Contracting cycles

Practices, health systems, and insurance carriers are currently negotiating contracts for 2022 and 2023. There are also multi-year contracts that will already be in place next year by the time the Board's work is implemented, and there will be no opportunity to make adjustments in order to meet the benchmark.

Due to these realities, we believe the benchmark as currently constructed is not achievable and strongly urge the Board to consider recommending to the legislature that the application be delayed or that benchmark values be appropriately adjusted for 2022-2024.

Language for reviewing the benchmark

The phrase says "may consider" but to what end is unclear and the WSMA requests clarifying language.

Language to trigger consideration of changes to the benchmark

It is unclear if the phrase is referring to "extraordinary circumstances" due to the benchmark or due to other changes outside of the benchmark and request clarifying language.

Impacts to pursue and avoid developing baseline recommendations

Address all cost drivers

The WSMA acknowledges that healthcare in our country is expensive, and that cost containment is an important component of efforts to expand access to healthcare 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 healthcare industry.

According to an article in JAMA², unlike every other industry, the healthcare system in this country has not experienced substantial improvements in productivity over the last 50 years. In 2019, the United States spent an estimated \$950 billion on nonclinical, administrative functions. A typical service industry in the United States has approximately .85 administrative workers for each person in a specialized role (lawyers, teachers, financial agents). In healthcare, there are twice as many administrative staff as physicians and nurses. This includes more than 1 million administrative employees that have been added to the healthcare work force since 2001.

¹ <https://www.kaufmanhall.com/sites/default/files/2021-10/oct.-2021-physician-flash-report.pdf>

² https://jamanetwork.com/journals/jama/fullarticle/2785480?guestAccessKey=7394424b-05bb-437d-b284-4a6c71458f07&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=olf&utm_term=102021

Administrative requirements, and the cost to execute them, are often outside the control of a physician practice. They include industry-agnostic corporate functions: general administration, human resources, nonclinical information technology, general sales and marketing, and finance; but also a financial transactions ecosystem unique to healthcare, which includes claims processing, revenue cycle management, and other industry-specific operational functions, such as insurance underwriting, prior authorization, expensive drugs, administrative clinical support operations such as case management, and customer and patient services such as call centers.

These administrative functions have generated subcomponents of our healthcare industry that are extremely profitable. For example, electronic health record (EHR) vendors, leveraging federal EHR mandates, can charge physician practices exorbitant fees for their products and annual product updates.

There are other important initiatives to consider that also impact the cost of care delivery. The minimum wage in Washington state has steadily increased over the last several years. Starting with \$9.47 in 2015/2016 (the last time the minimum wage remained stable from one year to the next), it has increased steadily to \$13.50 in 2020, and will raise again in 2021 to \$13.69. Local jurisdictions, such as King County, will increase minimum wage for most workers to \$16.69. While minimum wage is an important consideration, rising wages coupled with COVID-19 labor cost distortions will make the current benchmark unachievable. Cybersecurity is another topical example. Physician practices are currently spending millions of dollars to safeguard their patient's protected health information from ransomware and other cyber threats. Albeit costly, we believe this is also an effort the state would support physician practices in undertaking.

Physicians should not be accountable for expenses outside of a practice's control. Blunt and arbitrary tools that do not address all cost drivers will harm many medical groups, potentially putting at risk their overall financial viability. We believe that as a matter of fairness, efforts to contain costs must focus on ALL major cost drivers in healthcare, rather than recommending restraints that will limit patients' access to care.

Small and rural practices

The WSMA is very concerned about smaller practices, especially in rural areas, being adversely impacted by the benchmark, as they have less market share and leverage. Harming these practices in a way that makes them less economically viable will have adverse consequences in terms of patient access to care.

Historically disadvantaged populations

When access to care is cut, it is those who have been historically disadvantaged in their ability to access services who suffer most. People with resources will find ways to access care. The Board must ensure entities subject to the benchmark are not incentivized to reduce costs in a way that worsens inequity in access to care.

Social determinants of health

Long-term investments in our community will have the greatest impact on population health which will eventually lead to lower healthcare costs. We urge the Board to carve investments in social determinants of health out of the benchmark or account for them in a way that does not dis-incentivize these activities.

Slim benefit design

While seeking to aggressively drive down healthcare costs, we urge the Board to avoid incentivizing insurance carriers to stabilize profits by offering slim benefit packages or placing more cost sharing responsibilities on patients.

Ensure patients benefit from reduced costs

The WSMA is not aware of any state working on similar efforts that has successfully lowered premiums and other direct healthcare costs for patients. It appears that the Board has a strong interest in aligning work with these other states but that makes WSMA fear a similar outcome here in Washington; patients not benefiting personally from reduced costs.

For example, it is understood that due to a massive drop in utilization, insurance carriers experienced record profits in 2020. However, those savings did not necessarily result in reduced premiums to consumers.

We strongly urge the Board to ensure savings are passed on to the consumer.

Context is critical

We urge the Board to avoid blunt strategies or recommendations that simply seek to bend the cost curve regardless of service or setting.

As example, not all healthcare cost increases are negative. Many of the newest innovations in medical and surgical care (e.g. investments in telemedicine technology, emerging gene therapy, surgical robotics, etc.) will increase costs but bring treatments that relieve suffering for patients and families across the state. The large insurance carrier Aetna expects that gene therapy alone will add \$45 billion to healthcare costs between 2020 and 2024 if the FDA approves therapies currently in the pipeline. The Board will need to balance the exciting innovations in healthcare treatments with the desire to decrease overall spending.

The Board should be surgical in its evaluation of cost-drivers and where the system could stand to reduce cost while maintaining or even expanding current levels or service.

Unintended consequences

According to Paul J. Feldstein, PhD, professor of healthcare management at University of California in *Health Policy Issues: An Economic Perspective*³, “the United States is undergoing important demographic changes. The population is aging and will require more medical services, both to relieve suffering and cure illnesses. Furthermore, the most important reason for the rapid rise in medical expenditures has been the tremendous advances in medical science. Previously incurable diseases can now be cured, and other illnesses can be diagnosed and treated at an earlier stage. Although cures remain elusive for some diseases (e.g. AIDS and various cancers), life for those with these diseases can be prolonged with expensive drugs. Limiting the growth of medical expenditures to an arbitrarily low rate will decrease investment in new medical technologies and restrict the availability of medical services.”

The Board should track, and include in its report to the legislature, whether the net result of this work is reducing the cost of services or cutting services. If the goal is to cut services, then our concern is that the services that will be lost are those that have the least market leverage – primary care, small practices, rural areas. Loss of access is a loss of value and does not help anyone. It is critical the Board’s data collection process accurately capture whether savings are a result of a reduction in services, or a reduction in cost of those services - so that we can avoid harming patient access to high quality care.

People often represent the largest line item in a budget. We are also concerned that, due to labor costs, non-patient facing clinicians such as those that conduct quality improvement programs at health systems will be eliminated to meet the benchmark. This would have adverse impacts on the quality of patient care, reduction of variation in care, and cause backsliding on progress the healthcare industry has made over the last decade in terms of value-based payments.

³ Paul J. Feldstein, PhD, *Health Policy Issues: An Economic Perspective*. Chicago: Health Administration Press, 2019.

As previously noted, the WSMA believes that for this endeavor to be successful, decisions should be both supported by evidence AND *achievable*, in order to maintain credibility and garner confidence and support from stakeholders.

To ensure that the benchmark is credible and achievable, the WSMA requests the Board recommend to the legislature that it delay application of the benchmark until after the pandemic has subsided. This will give the healthcare system and broader economy a chance to recover and correct the operational distortions that have been outlined above. Alternatively, the Board could adjust the benchmark for 2022-2024 to accommodate both the market distortions created by COVID-19 and the nature of contracting cycles.

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.

Sincerely,

A handwritten signature in black ink, appearing to read "Mika Sinanan MD". The signature is written in a cursive style and is positioned above the typed name.

Mika Sinanan, MD, PhD
President
Washington State Medical Association

cc: Jennifer Hanscom, CEO
Jeb Shepard, Director of Policy
Sean Graham, Director of Government Affairs
WSMA Board of Trustees

Background material

TAB 7

Advisory Committee on Data Issues meeting minutes

October 28, 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

Allison Bailey
Ana Morales
David Mancuso
Hunter Plumer
Jason Brown
Jerome Dugan
Jonathan Bennett
Josh Liao
Julie Sylvester
Leah Hole-Marshall
Lichiou Lee
Mark Pregler
Purav Bhatt
Scott Juergens

Agenda items

Welcome, Roll Call, Agenda Review

J.D. Fischer, committee facilitator, called the meeting to order at 2:02 p.m.

Approval of Minutes

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

Topics for Discussion

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

- Recap of the Committee's September discussion.
- Board responses to Committee recommendations.
- Identification of carriers to report benchmark spending.
- Identification of large providers for whom carriers will report benchmark spending.
- Analysis of risk adjustment options.



Recap of the Committee's September discussion

January Angeles, Bailit Health
PowerPoint presentation

Ms. Angeles presented a summary of the Committee's discussion on patient to clinician attribution methodology and attributing clinicians to large provider entities.

Board responses to Advisory Committee recommendations

January Angeles, Bailit Health
PowerPoint presentation

Ms. Angeles presented a summary of Board responses to Committee recommendations relating to strategies to strengthen benchmark performance assessments. The Board unanimously supported the use of confidence intervals to determine carrier and provider performance against the benchmark and truncation to mitigate the impact of high-cost outliers.

- One Committee member requested that the Committee hear updates on these decisions as more information and analysis is presented to the Board. Ms. Angeles confirmed that those discussions and any decisions will be shared with the Committee.

Identification of carriers to report benchmark spending

January Angeles, Bailit Health
PowerPoint presentation

Ms. Angeles presented to the Committee information pertaining to approaches to identifying carriers that will report total health expenditures to the Board. In the previous Committee meeting, members requested additional information prior to making a recommendation to the Board. Staff produced information to further inform the discussion, including the following:

- Reviewed enrollment data from the state of Washington Office of Insurance Commissioner's "2020 market Information Report." Enrollment data are not available for all plans and staff could not determine enrollment by market.
- Staff developed a list of carriers with at least 10,000 enrolled insured lives, and several for which enrollment data were unavailable but known to be major market players, that would be required to report to HCA and vetted the list with other state staff.

Ms. Angeles recommended not including standalone third-party administrators (TPAs) not affiliated with a licensed insurer and health care benefit managers (HCBMs) at this time. The Committee discussed the significance of the self-funded market in Washington State. One member shared a concern about missing out on a sizeable portion of the market given some large, self-insured employers and union groups (e.g., Boeing, Carpenters Union) not utilizing TPAs affiliated with Washington carriers. Another member shared that the Washington Health Alliance has some information that could be useful in assessing the market share of self-funded employers within the statewide commercial market. Ms. January affirmed the need to conduct additional research on large self-funded employers in the state that contract with non-Washington carrier TPAs.

Ms. Angeles shared the staff recommendation of including 12 carriers with major market share, which collectively account for 96 percent of covered lives in the fully insured individual and group markets. In reviewing the list of



carriers provided to the Committee, one member noted that some of the health plans included were dental-only and/or stop-loss coverage carriers. The Committee discussed the challenge of discerning which plans are dental-only or stop-loss coverage only and discussed the desire to be overly inclusive rather than under-inclusive at this stage. One member recommended requiring carriers to specify enrollment by type of benefit which would allow staff and the Board to identify dental-only type plans.

Ms. Angeles asked the Committee if members believed carriers with major market share were not reflected in the preliminary list. One member asked about the inclusion of Medicare Supplemental coverage, and Ms. Angeles explained the rationale behind excluding this segment due to potential double counting because of the data capture focusing on allowed amounts. One member shared that while the list should provide sufficient representation, there is a concern that self-funded employers may exhibit significant control over what data can be shared and reported, and that some TPAs might need to request permission from the employer to report the self-funded data. Ms. Angeles shared that this has not been a significant issue in other states. In further discussion, one member shared that he estimated that self-funded enrollment in the statewide commercial market exceeds one million lives. In discussing the inclusion of pharmacy data, one member noted that some TPAs may not have pharmacy data from pharmacy benefit managers (PBMs). Ms. Angeles affirmed that this is not unique to Washington and that other states have asked TPAs to estimate the amount of pharmacy spend in their reporting.

Ms. Angeles affirmed that staff would continue to refine the list.

Identification of large providers for whom carriers will report benchmark spending

January Angeles, Bailit Health
PowerPoint presentation

Ms. Angeles presented to the Committee information pertaining to methodologies for attributing clinicians to large provider entities. Staff developed an initial list of potential providers for whom carriers will report spending and vetted the list with staff from other state agencies. The list identified 50 entities, comprising 24 Community Health Centers (CHCs), 22 health systems, and four medical groups and independent practice associations (IPAs). One member shared the concern about ensuring sufficient capture of covered lives in rural areas. The Committee discussed various provider thresholds used in other states:

- Delaware and Rhode Island publicly report providers with more than 10,000 Medicaid or commercial lives or 5,000 Medicare lives
- Massachusetts has not published their standard for public reporting
- Oregon will report on entities with at least 10,000 attributed lives across all markets, or 5,000 attributed lives in each market

One member noted a specific provider in King County that was missing from the list. Ms. Angeles acknowledged that the list may not capture all providers whose performance would be reported and added that we won't fully know the complete listing until the first data reporting is complete.

One member asked about how the Board will address accountability of large specialty groups that may not provide primary care, but may, through carrier contracts, have attributed patients. Mr. Bailit offered that the concept of accountability may be applied more broadly than just in terms of benchmark performance measurement, and that supplemental analyses of the benchmark performance data may include an assessment of specialty groups and hospitals and their respective influence on cost growth. One member raised the plausible regional impact on cost



growth of factors including labor costs and other operational expenses and asked if the Board had considered regional approaches to the benchmark. Ms. Angeles reiterated the Board's recommendation to institute one benchmark for all markets across the state. No other state has taken a regional approach, although the cost driver analysis could consider regional experience. One member offered that more discussion would be helpful to understand what the minimum size is for providers to have reliable data reported. Mr. Bailit indicated that there is currently research to inform this but that we will know more once we can review the data from other states, and that is best to be over-inclusive at this stage.

Analysis of risk adjustment options

Michael Bailit, Bailit Health
PowerPoint presentation

Mr. Bailit presented to the Committee information pertaining to options for risk adjustment to strengthen benchmark performance measurement. Mr. Bailit recapped information and experience from other states previously reviewed by the Committee. The Committee had discussed and expressed support for adjusting data by age and sex alone. Some members requested additional input from actuaries within their own organizations and some noted the concern that a significant shift in a payer or provider entity's population could yield inaccurate results.

Mr. Bailit shared four options for risk-adjustment developed by staff through additional research and consideration:

1. Age/sex adjustment performed by carriers.
2. Age/sex adjustment performed by the state.
3. Clinical risk adjustment normalization performed by payers.
4. Clinical risk adjustment normalization performed by the state.

Several members voiced support for option 2. One member added that building the capacity for option 4 would be important as part of a larger set of objectives: to build analytical capacity, better conduct cost trend analyses, and assist policy makers and the public discern difference across carriers and benefit plans. One member who supported option 2 recommended option 1 as a back-up and added that the strongest factor influencing health spending increases is price, followed by population growth and age, while disease prevalence and utilization have a minimal impact. Another member who supported option 2 added that options 1 and 3 are difficult to validate and that option 4 would be too costly at this time and may not capture all the requisite data. One member voiced concern for option 2, adding that actuaries and the public health experts at her organization are strongly opposed to age/sex risk-adjustment due to the potential negative impacts on access. One member recommended option 4, adding that while none of the options are perfect, option 4 takes more work but would provide more information on all the moving pieces that contribute to cost growth.

Public Comment

There was no public comment.

Wrap Up and Adjournment

Meeting adjourned at 3:40 p.m.



Next meeting

Thursday, January 27, 2022

Meeting to be held on Zoom

2:00 p.m. – 4:00 p.m.

DRAFT

Advisory Committee on Data Issues meeting minutes

10/28/2021