

# **Advisory Committee of Health Care Providers and Carriers**

**September 30, 2021**

## Advisory Committee of Health Care Providers and Carriers Meeting Materials Book

September 30, 2021  
10:00 a.m. – 12:00 p.m.

(Zoom Attendance Only)

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# Agenda

# TAB 1

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## Advisory Committee of the Health Care Providers and Carriers

September 30, 2021  
10:00 a.m. – 12:00 p.m.  
Zoom Meeting

### AGENDA

#### Committee Members:

<input type="checkbox"/>	Patricia Auerbach	<input type="checkbox"/>	Louise Kaplan	<input type="checkbox"/>	Natalia Martinez-Kohler
<input type="checkbox"/>	Mark Barnhart	<input type="checkbox"/>	Stacy Kessel	<input type="checkbox"/>	Megan McIntyre
<input type="checkbox"/>	Bob Crittenden	<input type="checkbox"/>	Ross Laursen	<input type="checkbox"/>	Mika Sinanan
<input type="checkbox"/>	Bill Ely	<input type="checkbox"/>	Todd Lovshin	<input type="checkbox"/>	Dorothy Teeter
<input type="checkbox"/>	Paul Fishman	<input type="checkbox"/>	Vicki Lowe	<input type="checkbox"/>	Wes Waters
<input type="checkbox"/>	Jodi Joyce	<input type="checkbox"/>	Mike Marsh		

#### Committee Facilitator:

AnnaLisa Gellermann

Time	Agenda Items	Tab	Lead
10:00-10:05 (5 min)	Welcome, roll call, and agenda review	1	AnnaLisa Gellerman, Board Manager Health Care Authority
10:05-10:08 (3 min)	Approval of meeting minutes	2	AnnaLisa Gellermann
10:08-10:10 (2 min)	Topics we will discuss today	3	AnnaLisa Gellermann
10:10-10:30 (20 min)	Review of Board's decision: benchmark methodology and value	4	AnnaLisa Gellermann
10:30-11:00 (30 min)	Impacts to pursue and to avoid-developing baseline recommendations	5	All
11:00-11:10 (10 min)	Public comment		AnnaLisa Gellermann
11:10-11:30 (20 min)	Introduction to reporting against the cost growth benchmark	6	AnnaLisa Gellermann
11:30-11:55 (25 min)	Methods selected to ensure the accuracy and reliability of benchmark performance measurement	7	AnnaLisa Gellermann
12:00	Adjourn		AnnaLisa Gellerman

*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 Advisory Committee of Providers and Carriers will be conducted virtually.*

# July Meeting Minutes

## TAB 2

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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.

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Advisory Committee of Health Care Provider and Carriers meeting minutes  
07/29/2021



## 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

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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.

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Advisory Committee of Health Care Providers and Carriers meeting minutes

07/29/2021

# Topics we will discuss today

## TAB 3

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## Topics we will discuss today:

1. Recap of Board's September meeting and adoption of benchmark methodology and value
2. Discussion: Impacts to pursue and to avoid-developing baseline recommendations
3. Introduction to reporting against the cost growth benchmark
4. Methods to ensure the accuracy and reliability of benchmark performance measurement

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

## TAB 4

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

## Recap of Board meeting

- As a reminder, the Board originally recommended the following benchmark values:
  - 2022-2023: 3.2%
  - 2024-2025: 3.0%
  - 2026: 2.8%
- This was based on 70/30 blend of historical median wage and potential gross state product, meant to convey that health care should not grow faster than growth in consumer finances and the economy.
- We relayed that the Advisory Committee of Providers and Carriers supported the 3.2% value but expressed desire for a stable (unvarying) benchmark value, and concern about the value going below 3.0%.

## Recap of Board meeting

- After hearing the Advisory Committee's feedback, the Board weighed:
  - The Advisory Committee's desire for an achievable and stable benchmark.
  - The need to drive down cost growth.
- The Board considered 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.

## Recap of Board meeting

- The Board adopted the following language for review of the benchmark:

*The Board will annually review performance against the benchmark and may consider any impact of the cost benchmark on the overall health system, including access to care, quality of care, and impact on the specific populations, providers, or market sectors.*

- The Board adopted the following language to trigger consideration of changes to the benchmark:

*In the event of extraordinary circumstances including highly significant changes in the economy or the health care system, the Board may consider changes to the benchmark or to the benchmark methodology.*

# Finalizing the benchmark methodology and value

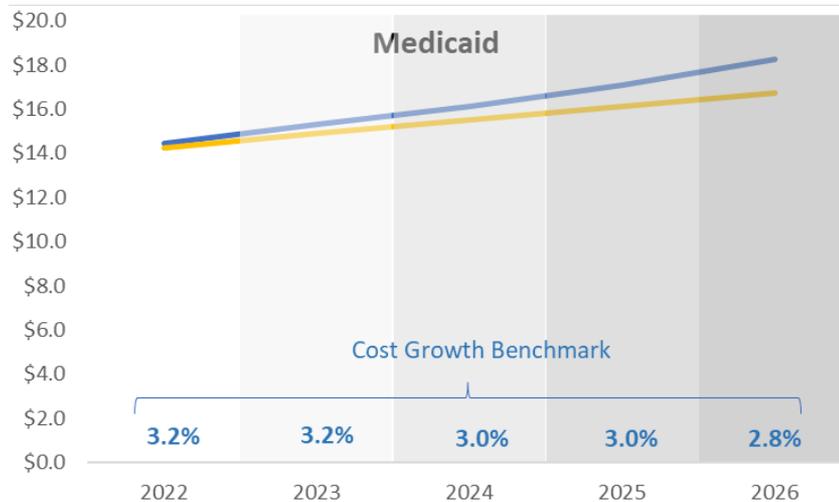
- To inform today's discussion, we modeled the potential savings from implementing a health care cost growth benchmark under three scenarios:

Years	Benchmark Values		
	Option 1	Option 2	Option 3
2022	3.2%	3.2%	3.0%
2023	3.2%	3.2%	3.0%
2024	3.0%	3.2%	3.0%
2025	3.0%	3.0%	2.8%
2026	2.8%	3.0%	2.8%

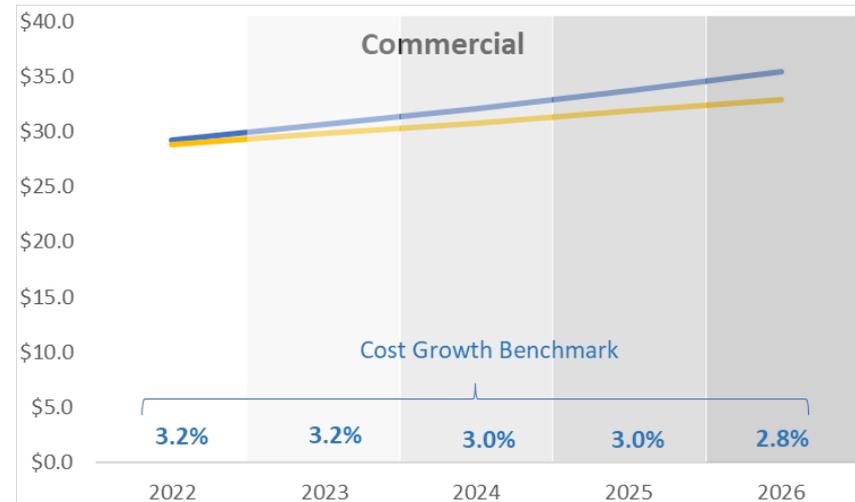
# Projected savings under Option 1

CMS' projected health care cost growth compared to health care cost growth with benchmark Option 1, 2022-2026

## Medicaid could save \$3.8b



## Private insurance could save \$7.0b



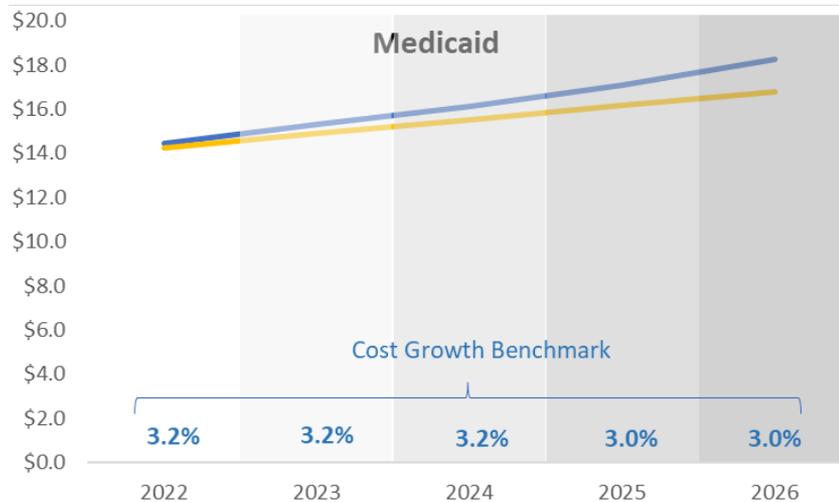
— Spending using CMS's projections of spending growth  
 — Spending using benchmark spending growth

NOTE: Projections were derived by taking state-specific estimates of spending in 2014 using CMS's National Health Expenditures data and projecting them forward using growth in national spending and enrollment (historical through 2018 and projected through 2026). Estimates do not account for COVID-19 impacts. Medicaid estimates only reflect Medicaid and do not include CHIP.

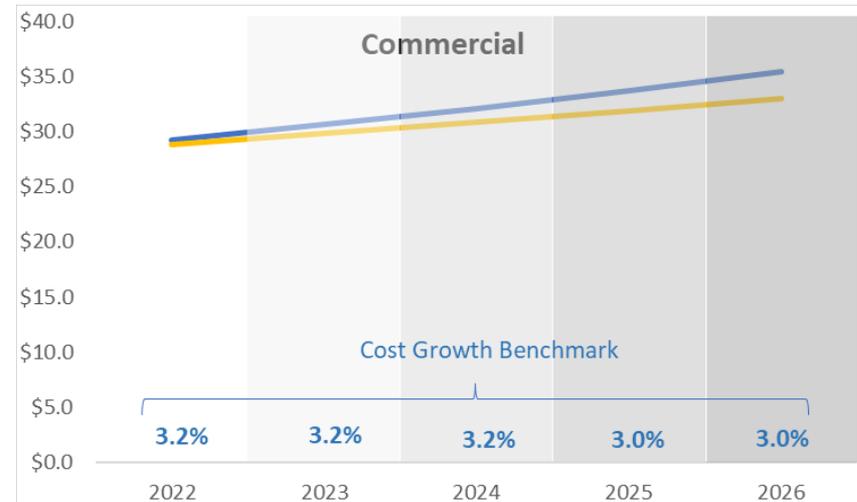
# Projected savings under Option 2

CMS' projected health care cost growth compared to health care cost growth with benchmark Option 1, 2022-2026

## Medicaid could save \$3.6b



## Private insurance could save \$6.8b



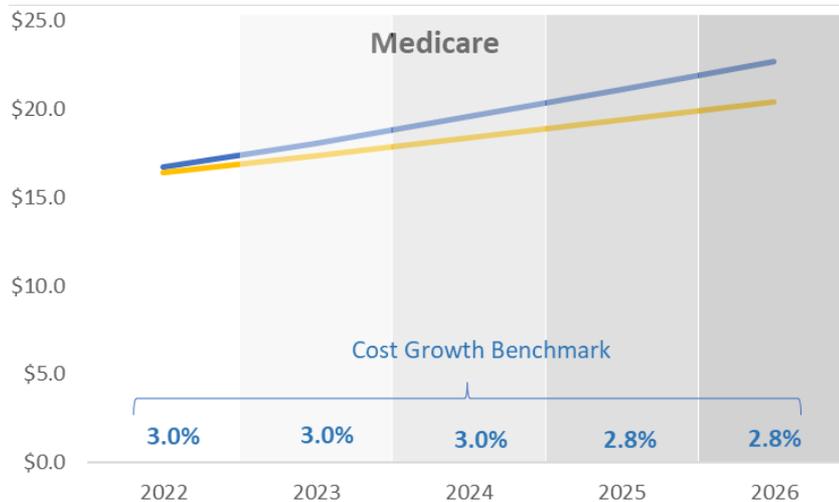
— Spending using CMS's projections of spending growth  
 — Spending using benchmark spending growth

NOTE: Projections were derived by taking state-specific estimates of spending in 2014 using CMS's National Health Expenditures data and projecting them forward using growth in national spending and enrollment (historical through 2018 and projected through 2026). Estimates do not account for COVID-19 impacts. Medicaid estimates only reflect Medicaid and do not include CHIP.

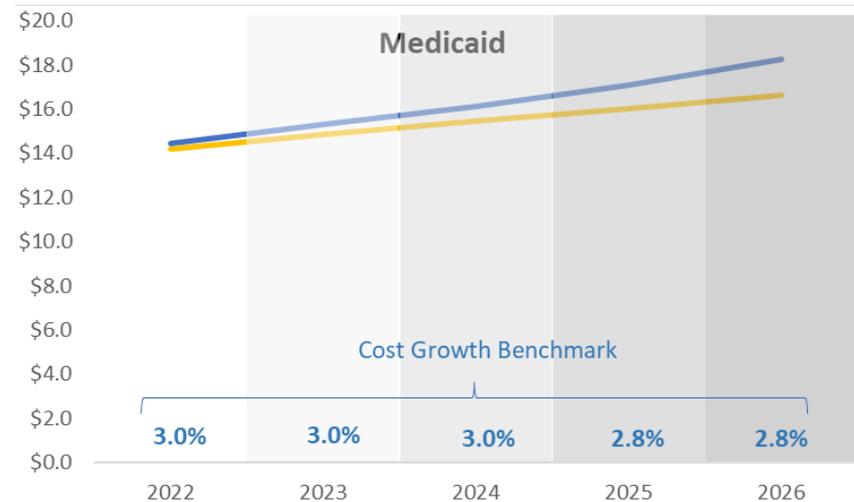
# Projected savings under Option 3

CMS' projected health care cost growth compared to health care cost growth with benchmark Option 1, 2022-2026

## Medicaid could save \$4.1b



## Private insurance could save \$7.7b



— Spending using CMS's projections of spending growth  
 — Spending using benchmark spending growth

NOTE: Projections were derived by taking state-specific estimates of spending in 2014 using CMS's National Health Expenditures data and projecting them forward using growth in national spending and enrollment (historical through 2018 and projected through 2026). Estimates do not account for COVID-19 impacts. Medicaid estimates only reflect Medicaid and do not include CHIP.

# Impacts to pursue and to avoid-developing baseline recommendations

## TAB 5

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Washington State  
Health Care Authority

Impacts to pursue and to avoid-  
developing baseline recommendations





Washington State  
Health Care Authority

Public comment



# Introduction to reporting against the cost growth benchmark

## TAB 6

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Washington State  
Health Care Authority

# Introduction to reporting 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

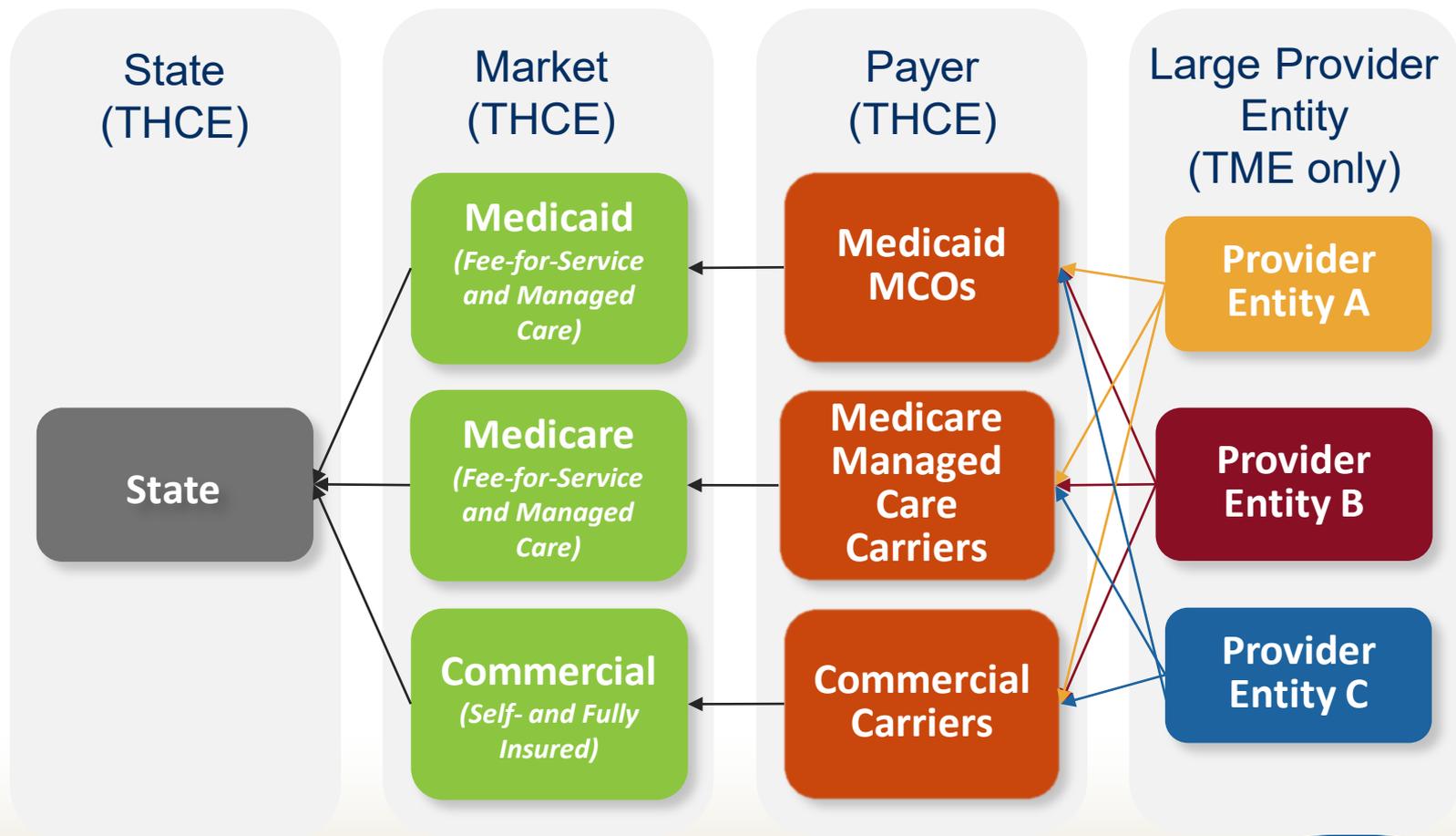
- **What is this?** A plan to analyze cost drivers and identify promising opportunities for reducing cost growth and informing policy decisions.
- **Data Type:** Granular data (claims and/or encounters).
- **Data Source:** APCD.

# Sources for Washington's benchmark data call

In August, the Board approved the following sources for the benchmark data call:

- Medicare (including fee-for-service and Medicare Advantage).
- Medicaid (including fee-for-service and managed care).
- Medicare and Medicaid “duals.”
- Commercial (both fully insured and self-insured).
- Labor and Industries state fund.
- Correctional health system.

# States typically report benchmark performance at four levels

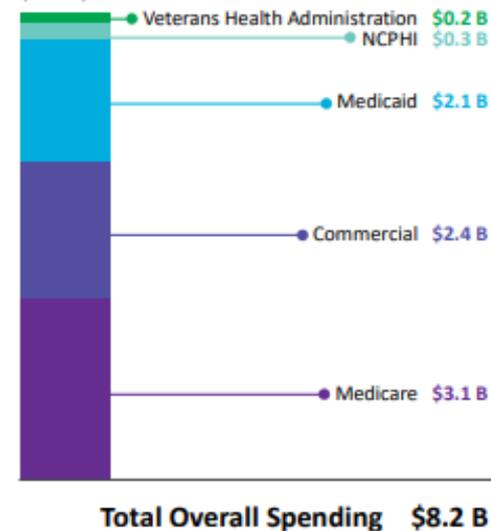


# Reporting at the **state** level: DE example

## 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)



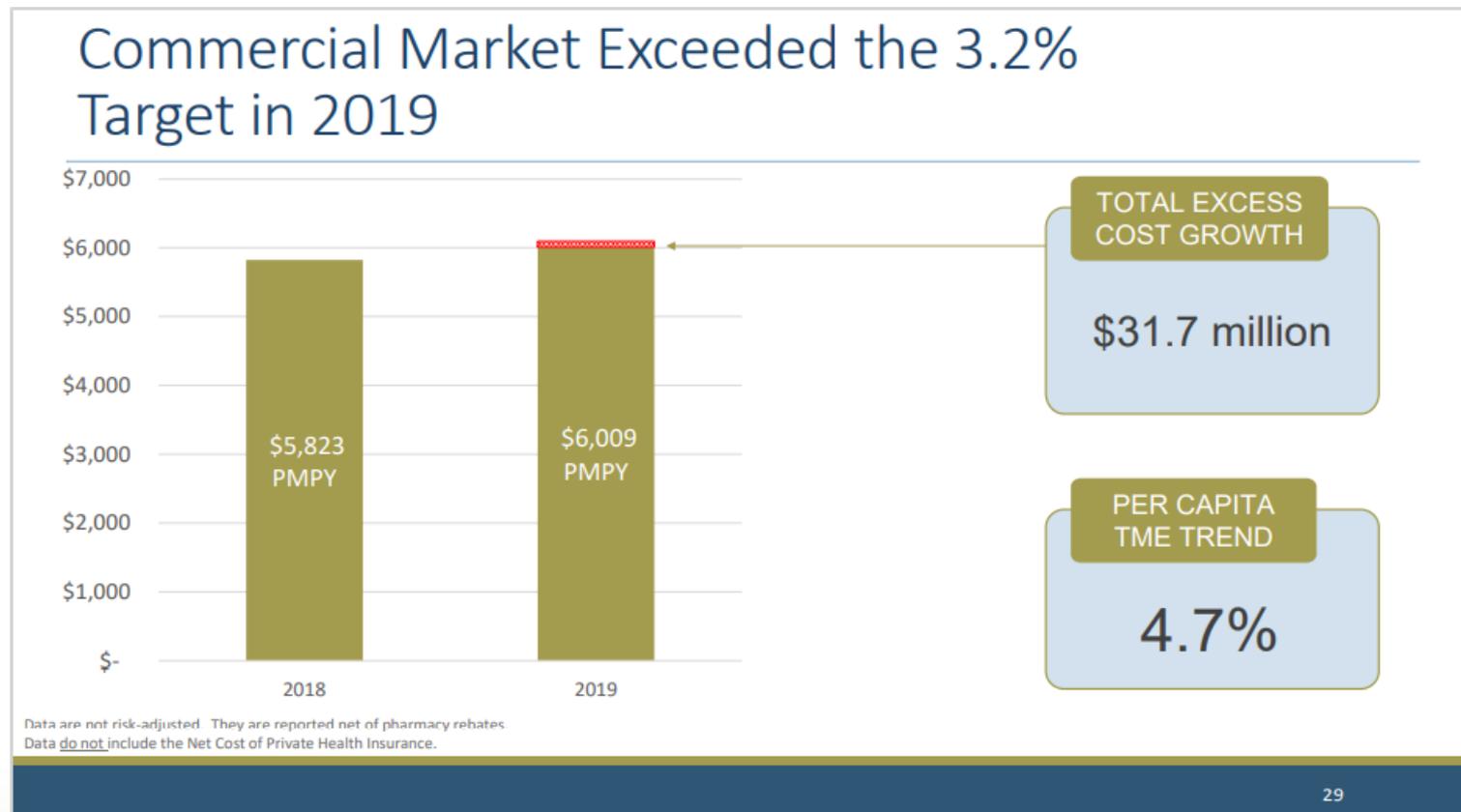
OVERVIEW OF BENCHMARK TREND REPORT: CY 2019 RESULTS

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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>.

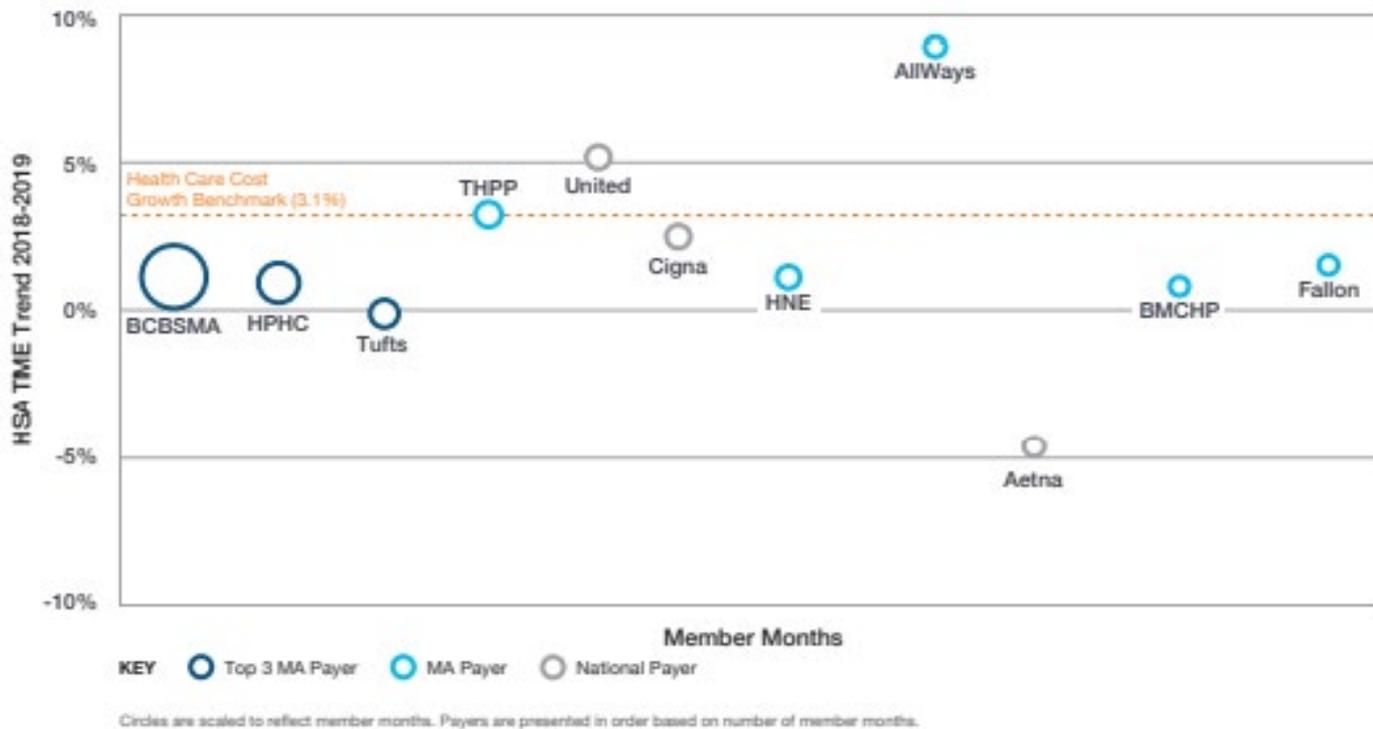
# Reporting at the **market** level: RI example (commercial)



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

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

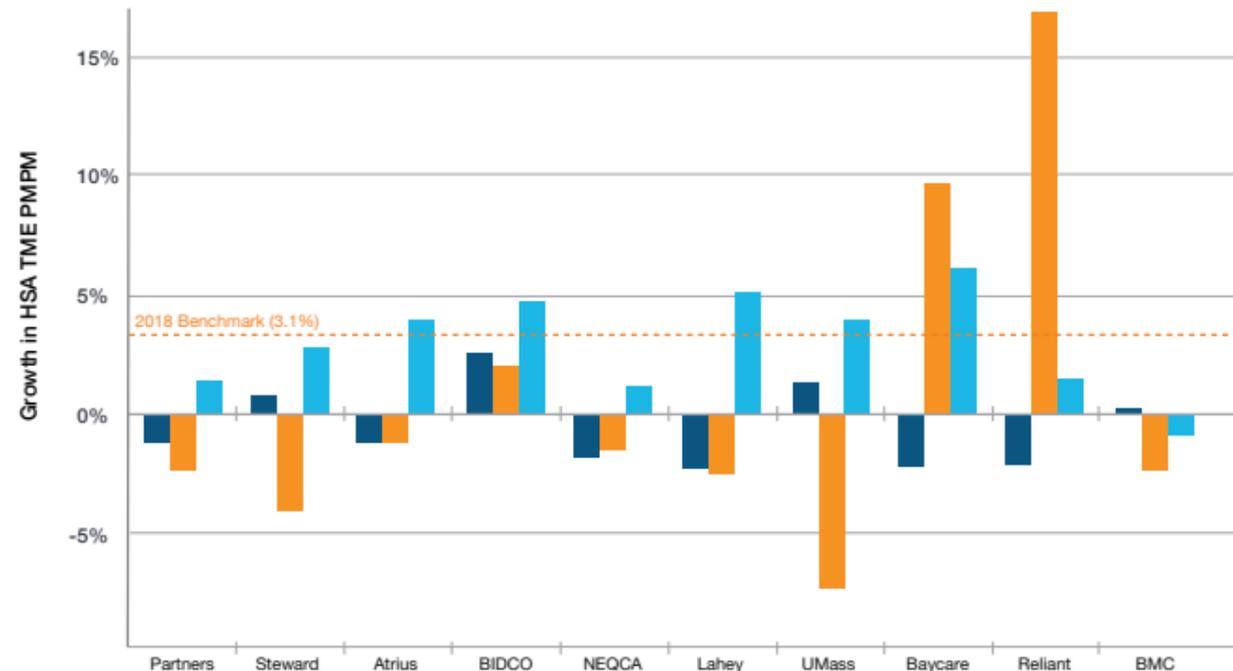
## Change in Preliminary Commercial HSA TME by Payer, 2018-2019



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 discuss later.

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

## TAB 7

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

# Developing the Benchmark Data Call

- Adopt best practices to ensure accurate, valid, and consistent data to support confidence in the results.
- Current Process for design decisions.
  - Problem identification
  - Proposed methodology
  - Data Committee review and feedback
  - Board decision
- September design decisions.
  - Confidence Intervals
  - Truncation of high-cost outliers

## Problem: small numbers

- Random variations 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 more likely to be impacted by such random variation are not unfairly assessed.

# Strategies for ensuring that benchmark performance data are reliable

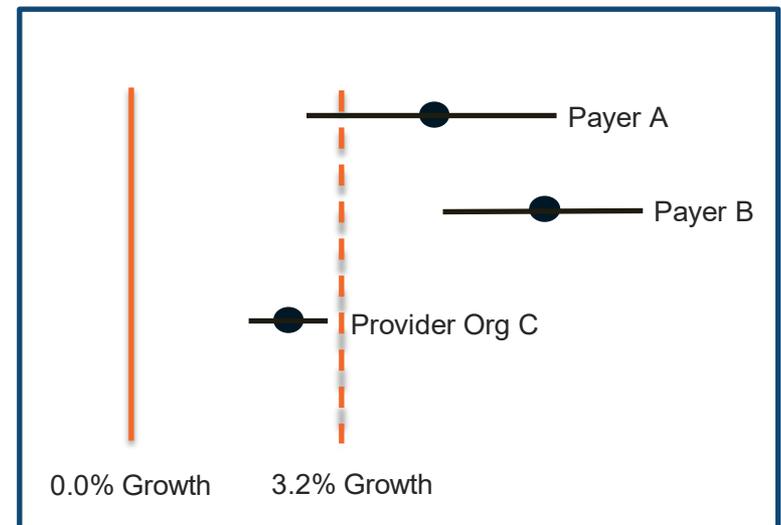
- There are some strategies we can implement to reduce the chance that random variation plays a significant part in a carrier or provider entity's performance and increase our confidence in HCA's performance assessment:
  1. Perform statistical testing on benchmark performance data.
  2. Mitigate the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

# 1. Performing statistical testing on benchmark performance

- Washington could develop confidence intervals around benchmark performance.
- The confidence interval would show 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 the assessed entity.

# 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, CT, and RI will be the first states to use confidence intervals in determining benchmark performance.
  - OR developed the methodology, which CT and RI then adopted.
  - All three states are now collecting or analyzing data with plans to use this methodology.
- MA's methodology is defined in statute and cannot be changed without legislation.
- DE thus far has 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.

## 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 accountable care organization, including high-cost outlier spending raised the trend rate by several percentage points.
- Furthermore, differential treatment of high-cost outliers in the cost growth benchmark program and in total cost of care contracts led to confusion and tension around reporting of performance.
- As a result, RI is truncating 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.

## Preview of Next Steps

- Board will consider risk adjustment and minimum population size.
- Begin development of cost driver analysis.