Health Care Cost Transparency Board's Advisory Committee on Data Issues & Advisory Committee of Health Care Providers and Carriers (Joint Meeting)

January 18, 2024

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board's

Advisory Committee on Data Issues & Advisory Committee of Health Care Providers and Carriers (Joint Meeting)

Meeting Materials

January 18, 2024
2:00 p.m. – 4:00 p.m.

Agenda and Presentations

Agenda 1

Public comments 2

Spending Growth Benchmark Presentation 3

Updates 4

Appendix

1. Response to Questions 5

Tab 1

Washington State Health Care Authority

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JOINT MEETING

Advisory Committee on Data Issues *and*
Advisory Committee of Health Care Providers and Carriers

January 18, 2024
2:00 – 4:00 p.m.
Hybrid Meeting: Zoom with In-Person Availability

AGENDA

Advisory Committee on Data Issues Committee Members:					
☐	Christa Able	☐	Chandra Hicks	☐	Mark Pregler
☐	Megan Atkinson	☐	Leah Hole-Marshall	☐	Russ Shust
☐	Amanda Avalos	☐	Lichiou Lee	☐	Mandy Stahre
☐	Jonathan Bennett	☐	David Mancuso	☐	Julie Sylvester
☐	Bruce Brazier	☐	Ana Morales		
☐	Jason Brown	☐	Hunter Plumer		

Advisory Committee of Health Care Providers and Carriers Committee Members:					
☐	Bob Crittenden	☐	Stacy Kessel	☐	Natalia Martinez-Kohler
☐	Justin Evander	☐	Ross Laursen	☐	Jeb Shepard
☐	Paul Fishman	☐	Eric Lewis	☐	Dorothy Teeter
☐	Jodi Joyce	☐	Todd Lovshin	☐	Wes Waters
☐	Louise Kaplan	☐	Vicki Lowe		

Committee Facilitators:
Theresa Tamura and Mandy Weeks-Green

Time	Agenda Items	Tab	Lead
2:00 - 2:15 (15 min)	Welcome, agenda, roll call and introduction of new member	1	Mandy Weeks-Green Health Care Authority
2:15 - 2:30 (15 min)	Public Comments	2	Mandy Weeks-Green Health Care Authority
2:30-3:30 (60 min)	Benchmark and Analytic Report	3	Vishal Chaudhry Health Care Authority
3:30 – 4:00 (30 min)	Updates - 2024 Workplan	4	Mandy Weeks-Green, Theresa Tamura Health Care Authority
4:00	Adjourn		Mandy Weeks-Green Health Care Authority

Tab 2

Washington State Health Care Authority

Tab 3

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WA Health Care Cost Transparency Board

WA health care spending growth preliminary results

Washington State Health Care Authority

Presentation overview

- Health care cost transparency
  - Spending growth
- Health care cost spending growth preliminary results
  - State
    - Other spending
    - Net cost of private health insurance
  - Market
- Summary
- Next steps

Washington's spending growth

The Health Care Cost Transparency Board established the benchmark for 2022 and the subsequent five years and will evaluate the benchmark annually moving forward

Represents a common goal for payers, purchasers, regulators, and consumers to increase health care affordability

Serves as a starting point from which to align health care spending to ensure that spending growth does not increase at a faster rate than the economy, state revenue, or wages

Performance against the benchmark will be assessed by measuring annual spending growth against each annual benchmark

Washington State Health Care Authority

Washington's Spending Growth Benchmark

- Washington is one of nine states in the nation to adopt a spending growth benchmark
  - Specific rate that carrier and provider expenditure performance will be measured against
    - 2022 and onward
  - Based on a hybrid of median wage and potential gross state product (PGSP)
  - Data sourced from aggregate expenditure data from payers (carriers) and include claims-based and non-claims-based expenditures

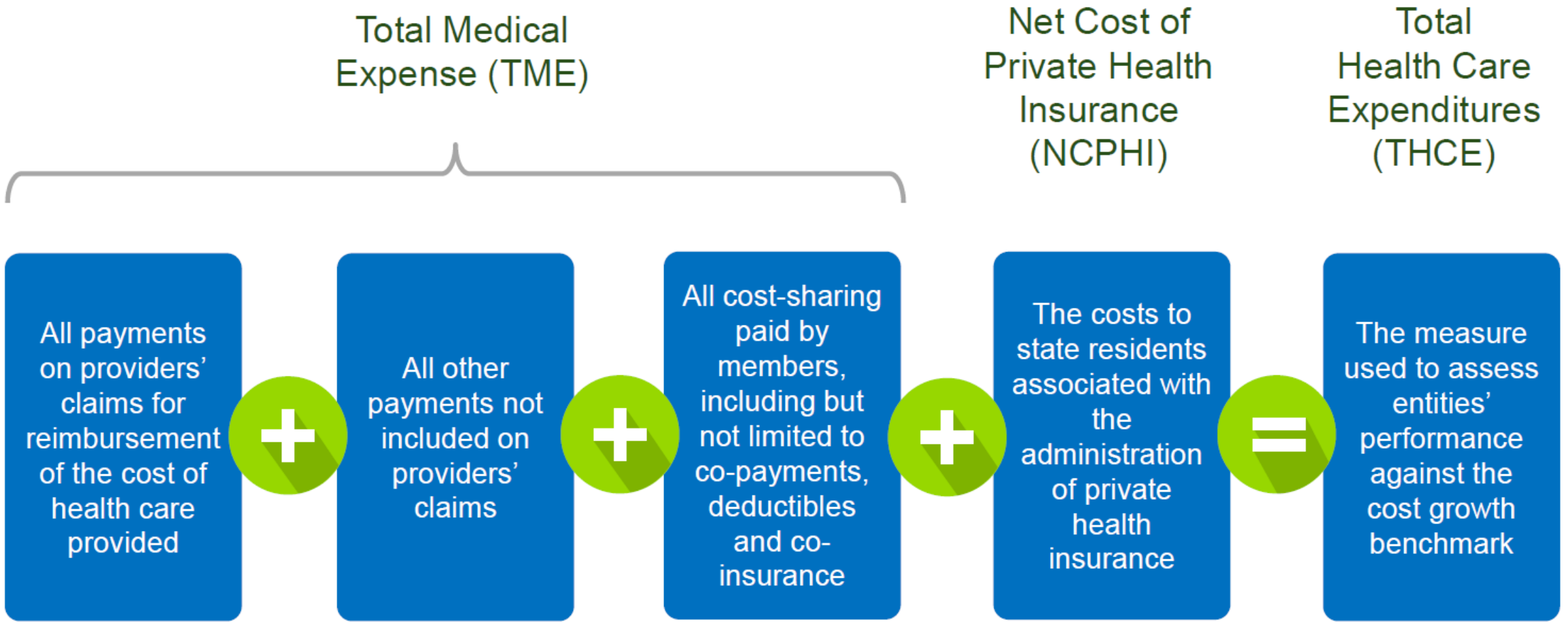
Years	Benchmark
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

Reporting performance against benchmark

Current reporting cycle →

Year of Release	Includes Data from Specified Years	Data Included
Late Fall 2023	2017 – 2019	State and market data only – the board will not publicly report insurance carrier or provider cost growth for this period
Late Fall 2024	2020 – 2022	For large provider entities and carriers – with cost growth target of 3.2%
Late Fall 2025	2022 – 2023	For large provider entities and carriers – with cost growth target of 3.2%
Late Fall 2026	2023 – 2024	For large provider entities and carriers – with cost growth target of 3.0%
Late Fall 2027	2024 – 2025	For large provider entities and carriers – with cost growth target of 3.0%
Late Fall 2028	2025 – 2026	For large provider entities and carriers – with cost growth target of 2.8%

What is being measured?



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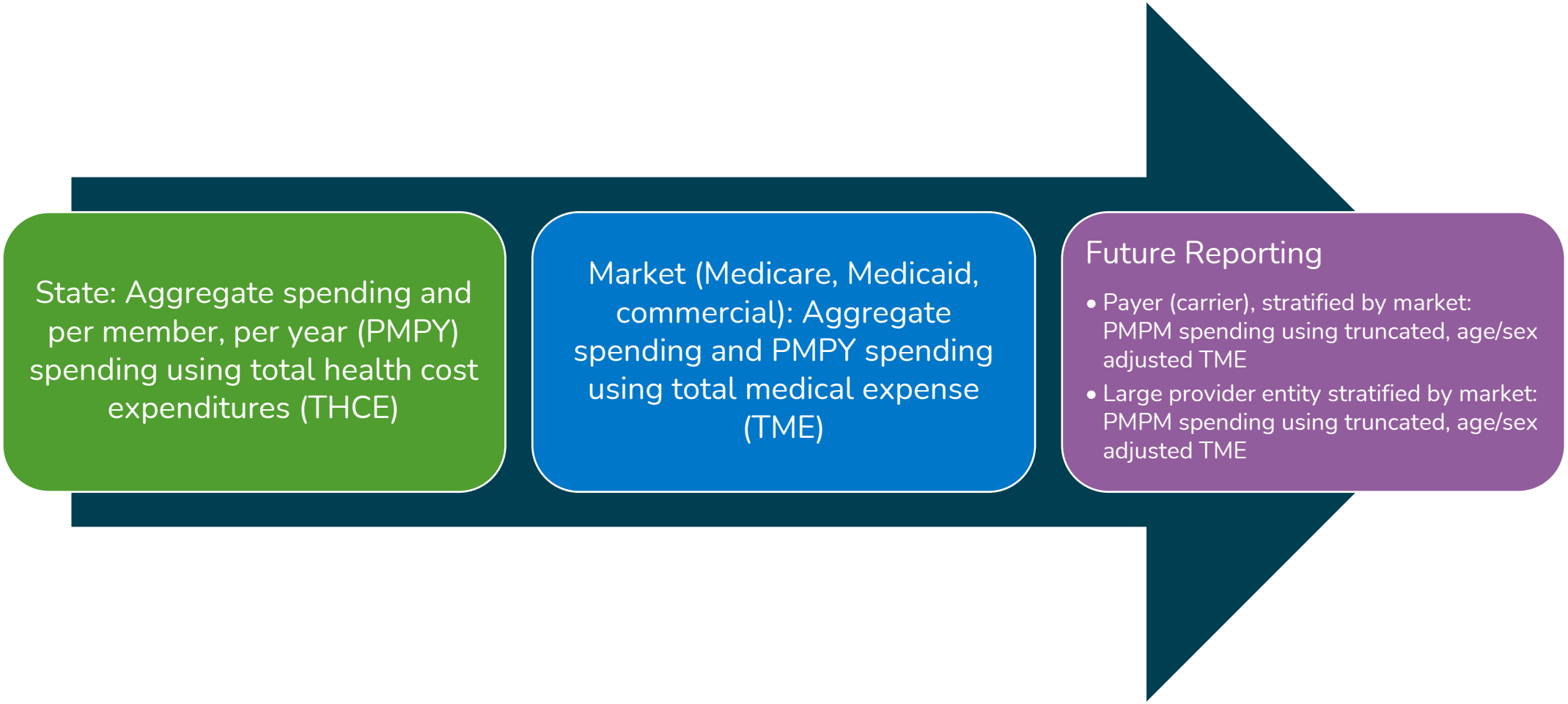
Performance measurement against the benchmark



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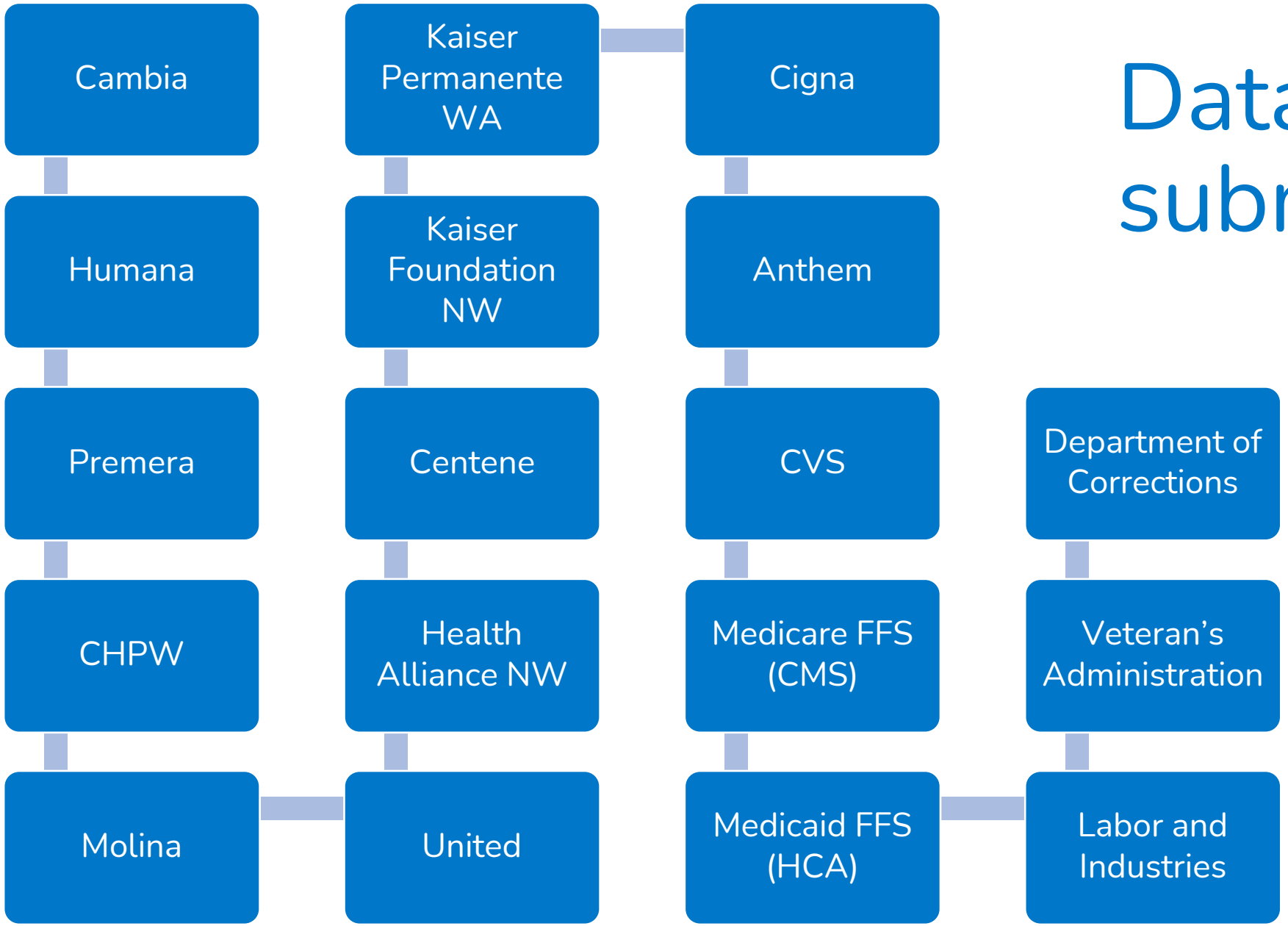
Data submitters



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Service category definitions

- **Hospital outpatient:** Includes all hospital types and payments made for hospital-licensed satellite clinics, emergency room services not resulting in admittance; and observation services
- **Hospital inpatient:** Includes all room and board and ancillary payments for all hospital types and payments for emergency room services when the member is admitted to the hospital
- **Retail prescription:** Includes claims paid to retail pharmacies for prescription drugs, biological products or vaccines
- **Non-claims:** Includes incentives, capitation, risk settlements, direct payments or other non-claims-based payments
- **Claims other:** Includes durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services
- **Long-term care:** Includes skilled nursing facility services, home health service, custodial nursing facility services home- and community-based services including personal care

Service category definitions, continued

- **Professional, other providers:** Includes, but is not limited to licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors, and any fees that do not fit other categories, including facilities fees of community health center services and freestanding ambulatory surgical center services
- **Professional, specialty providers:** Includes services provided by a doctor of medicine or osteopathy in clinical areas other than family practice, geriatrics, internal medicine, and pediatrics
- **Professional, primary care:** Includes care management; care planning; counseling; domiciliary, rest home, or custodial care; FQHC visits; health risk and screenings; home health services; immunization administrations; office visits and preventive medicine visits. Determined by taxonomy and/or services types

Note: Due to Medicare FFS reporting capability, grouping of physicians along with Cost Board categories Primary Care & Specialty Professional

Caveats & limitations

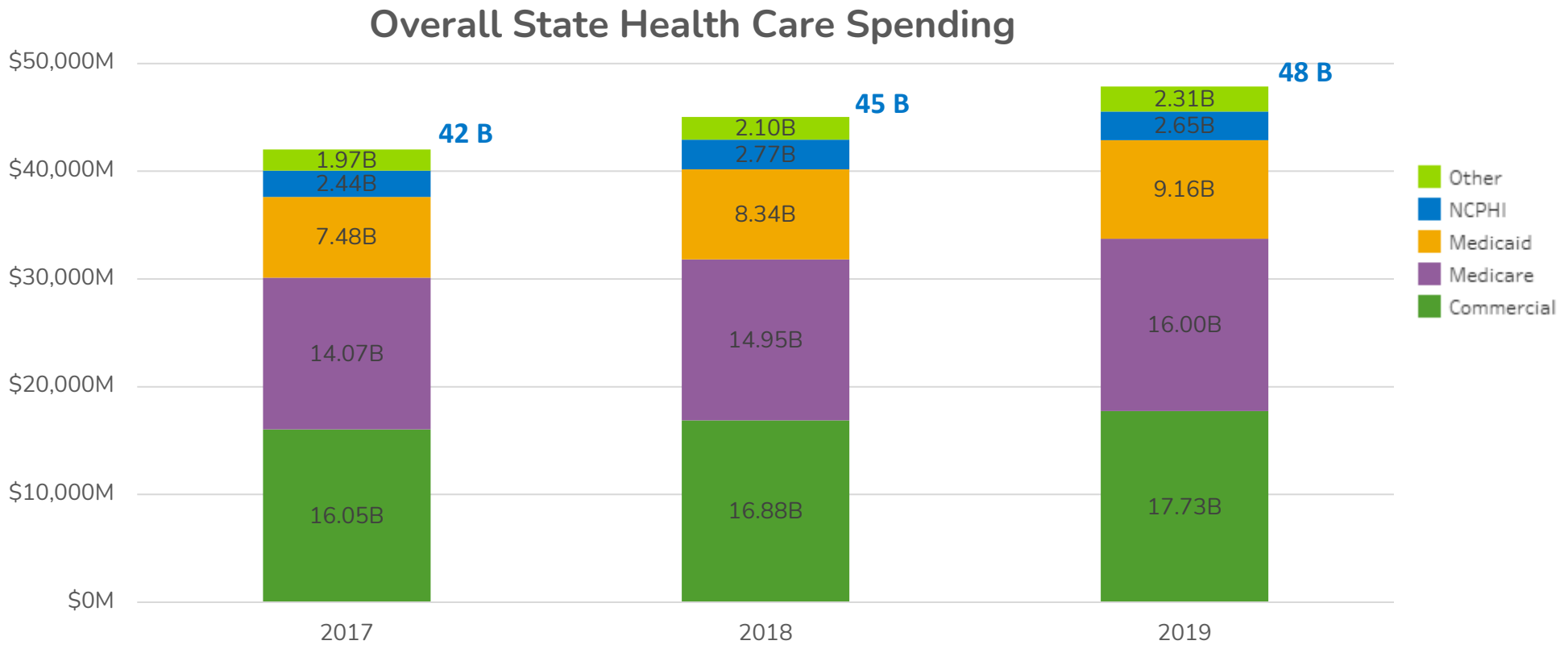
- **Exclusions**
  - Policies offering limited benefits, such as accident, disability, Medicare supplemental insurance, vision or dental stand-alone policies
  - Health care paid through charity care or by customer cash payment
  - Certain non-claims publicly funded behavioral health services
  - Anthem 2017 data
  - Humana Medicare data
  - Custodial nursing facility services, home- and community-based services, and intermediate care facilities and services for persons with developmental disabilities paid by Washington State Department of Social and Health Services (DSHS)
- **All figures are net of prescription drug rebates**
- **Both Medical and Retail Rx Rebates were collected**
  - All rebates (Medical & Retail) subtracted from the Retail Rx category due to the complexity of medical rebates

Highlights

- In 2019, total health care expenditures (THCE) was $48 billion
  - Hospital outpatient services are significant and growing
- Growth between 2017-2019
  - Statewide total health care expenditures increased in 2018 (7.15%) and 2019 (5.81%)
  - Medicare PMPY appears to have slower growth than Medicaid or commercial
  - Medicaid seems to be growing faster than other markets but still has a lower PMPY spending than commercial or Medicare

State

Total health care expenditures (THCE) statewide



NCPHI (Net Cost of Private Health Insurance) are associated with the administration of health insurance.
Other category includes LNI, DoC, & VA health care expenditures.

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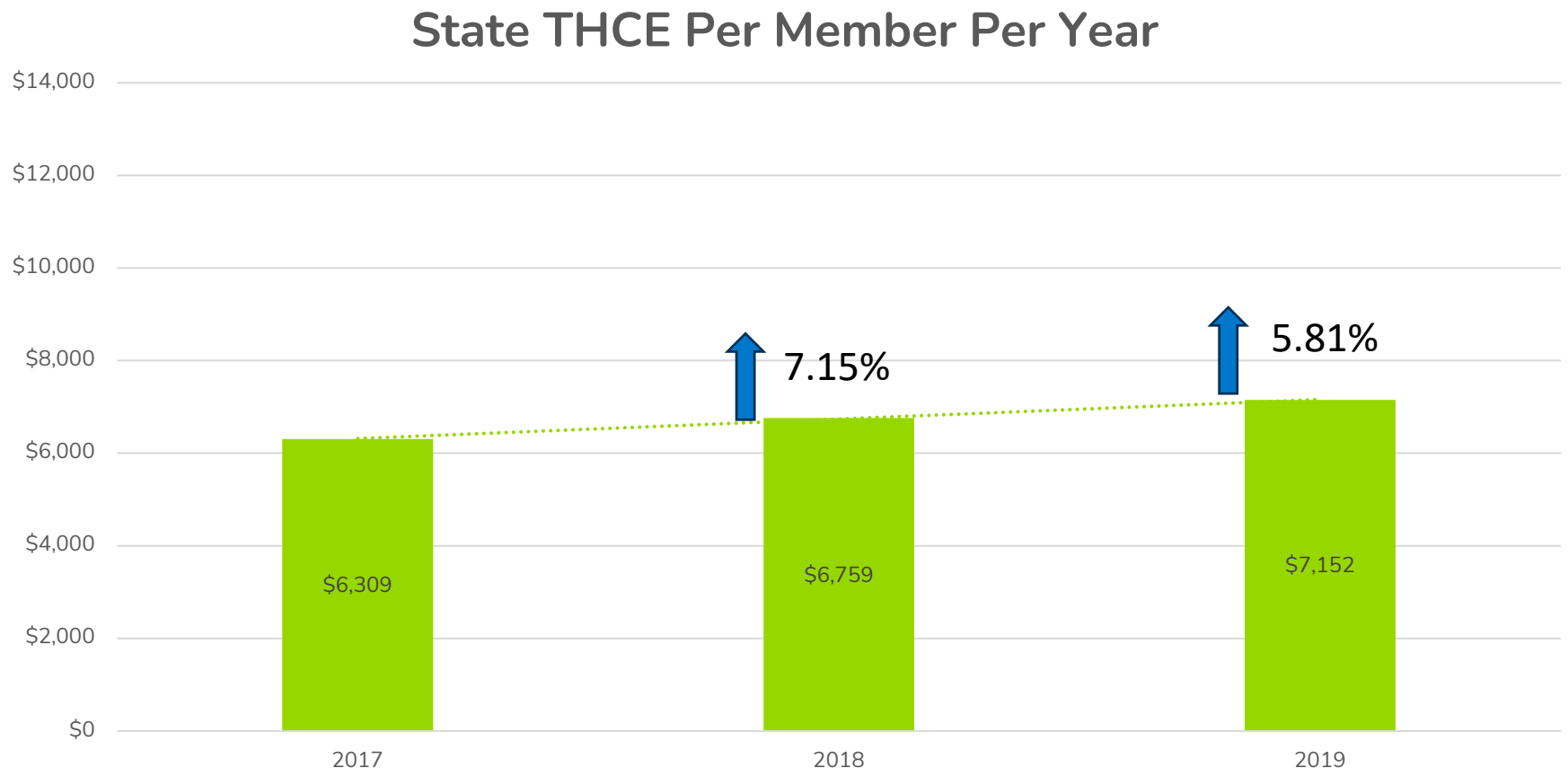
Total health care expenditures for WA



* MA and RI identified 3%-4% annual growth over this period

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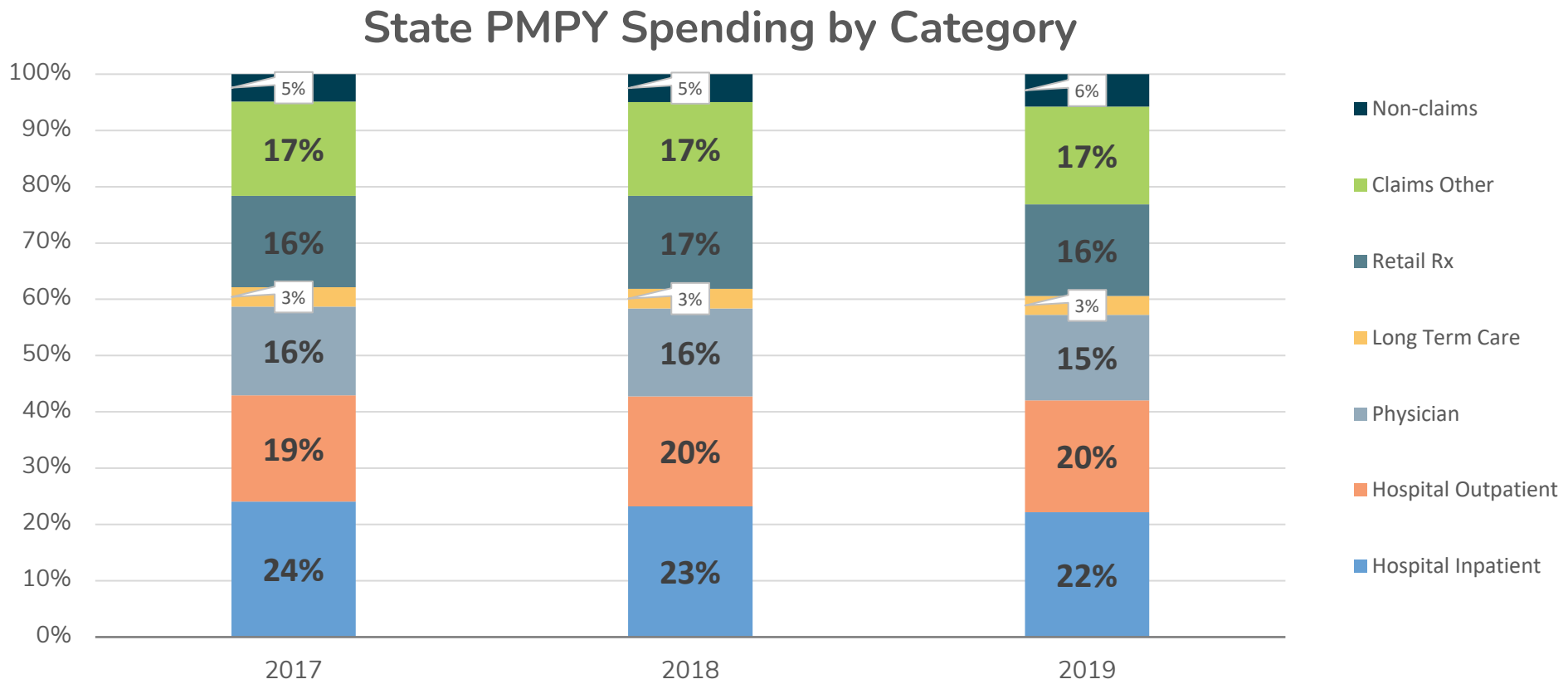
TME, per member per year spending

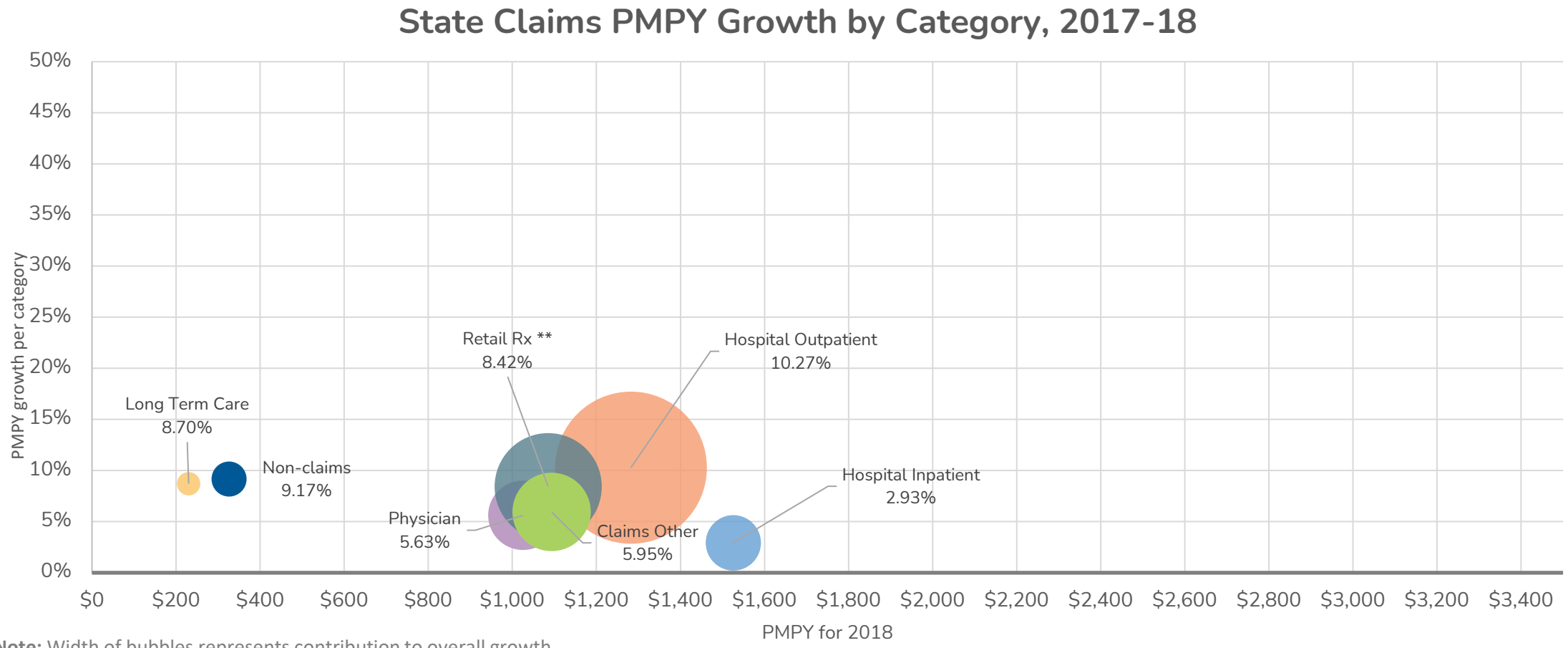


Note: Long term care spending from DSHS is not included

Includes Commercial, Medicaid (MCO & FFS), & Medicare (Adv & FFS).
NCPHI and Other spending is excluded.

Washington State Health Care Authority

Overall service category contribution to cost growth for 2017 - 2018



Note: Width of bubbles represents contribution to overall growth
Includes Commercial, Medicaid (MCO & FFS), & Medicare (Adv & FFS).
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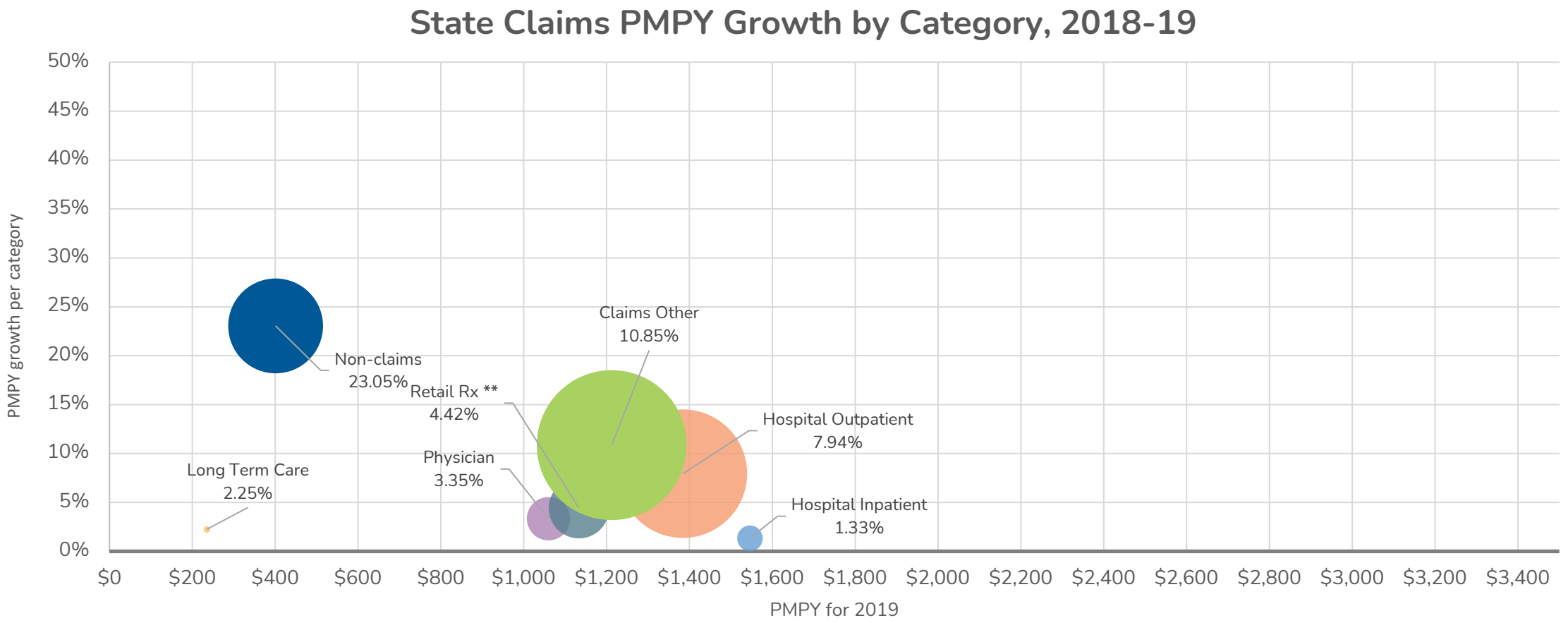
Washington State Health Care Authority

Overall service category contribution to cost growth for 2018 - 2019



Note: Width of bubbles represents contribution to overall growth
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Medicaid

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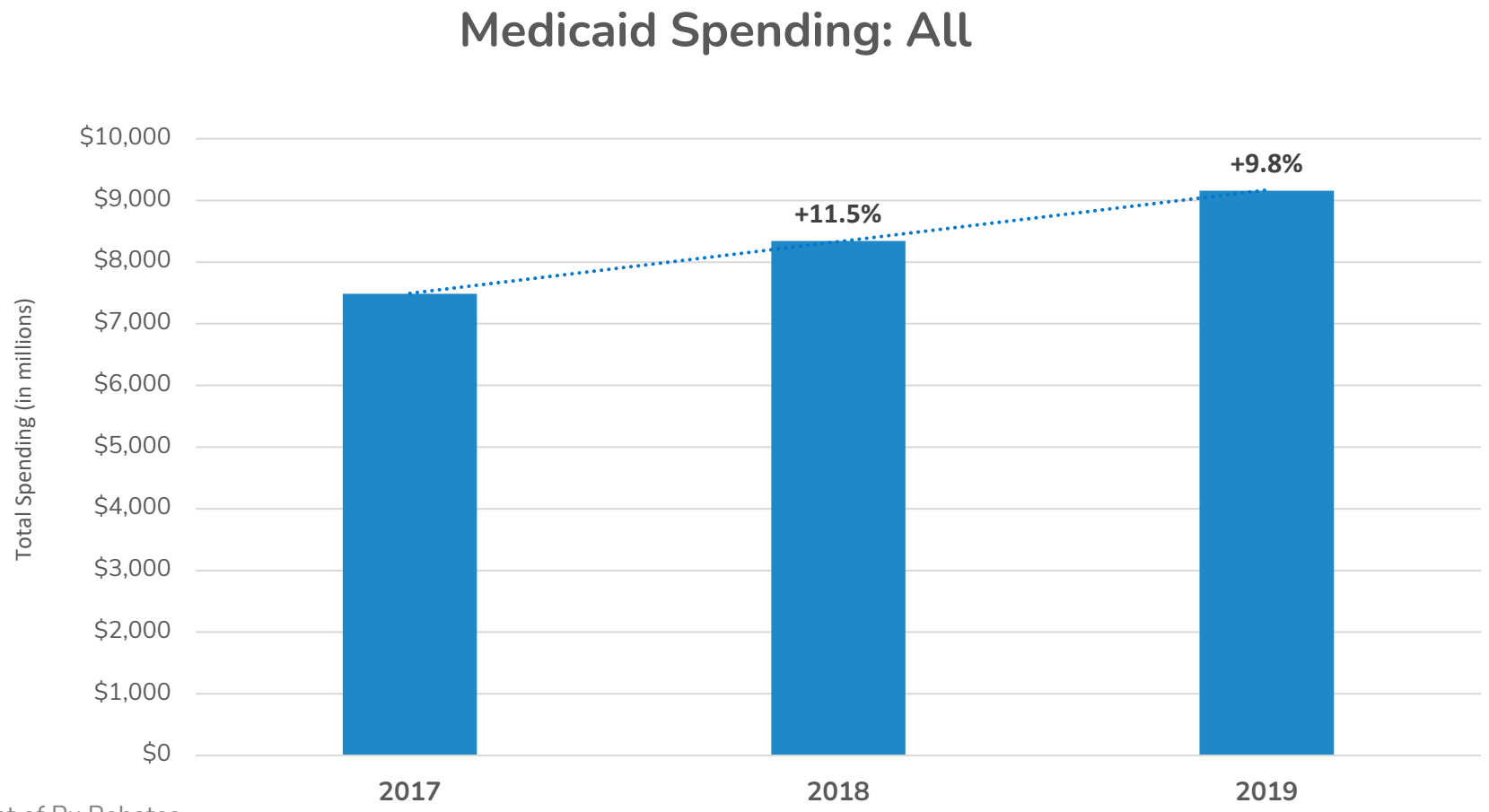
Medicaid growth



* Net of Rx Rebates
Includes Medicaid MC & FFS

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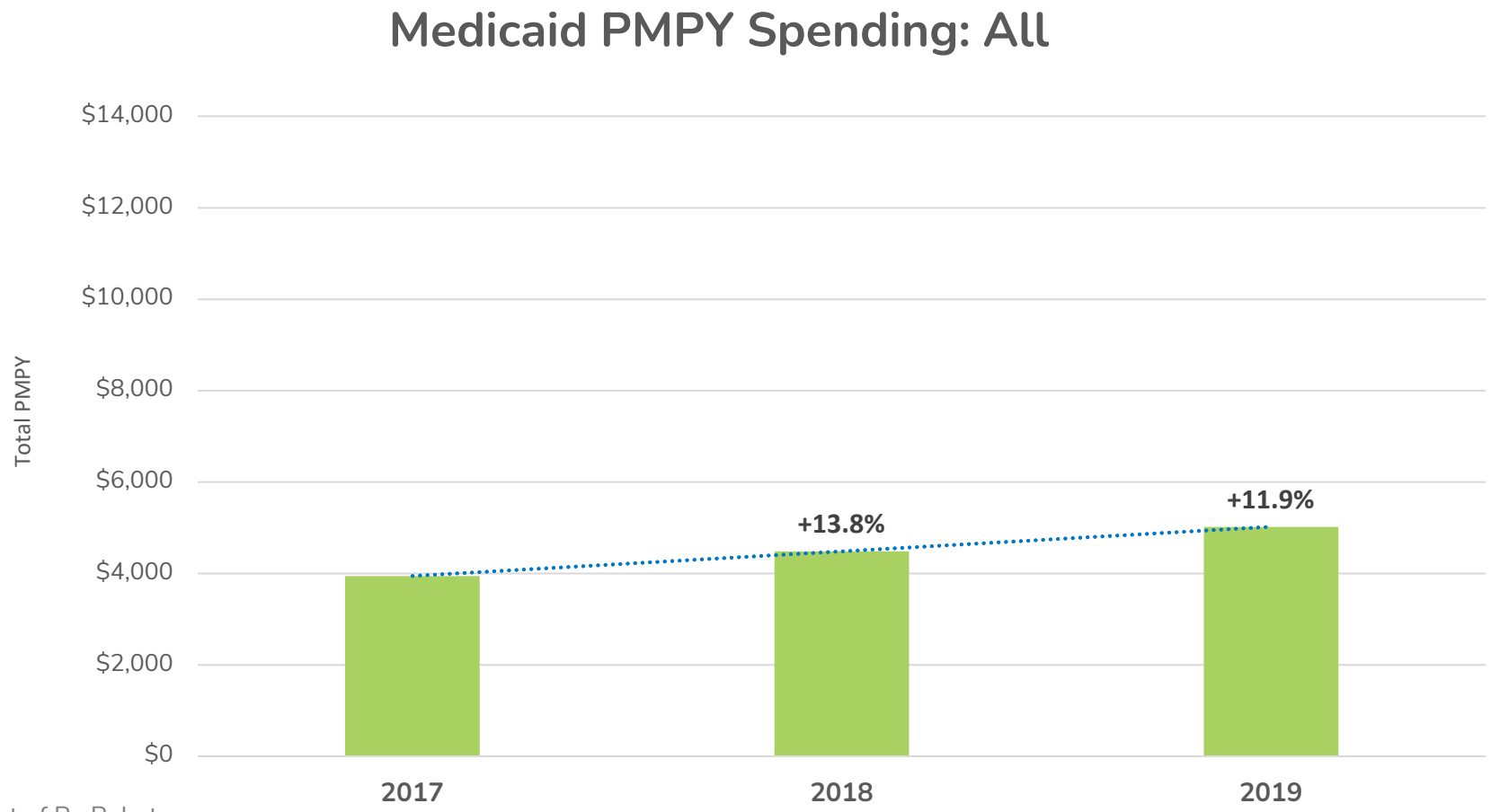
Medicaid PMPY growth



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Included Medicaid MC & FFS

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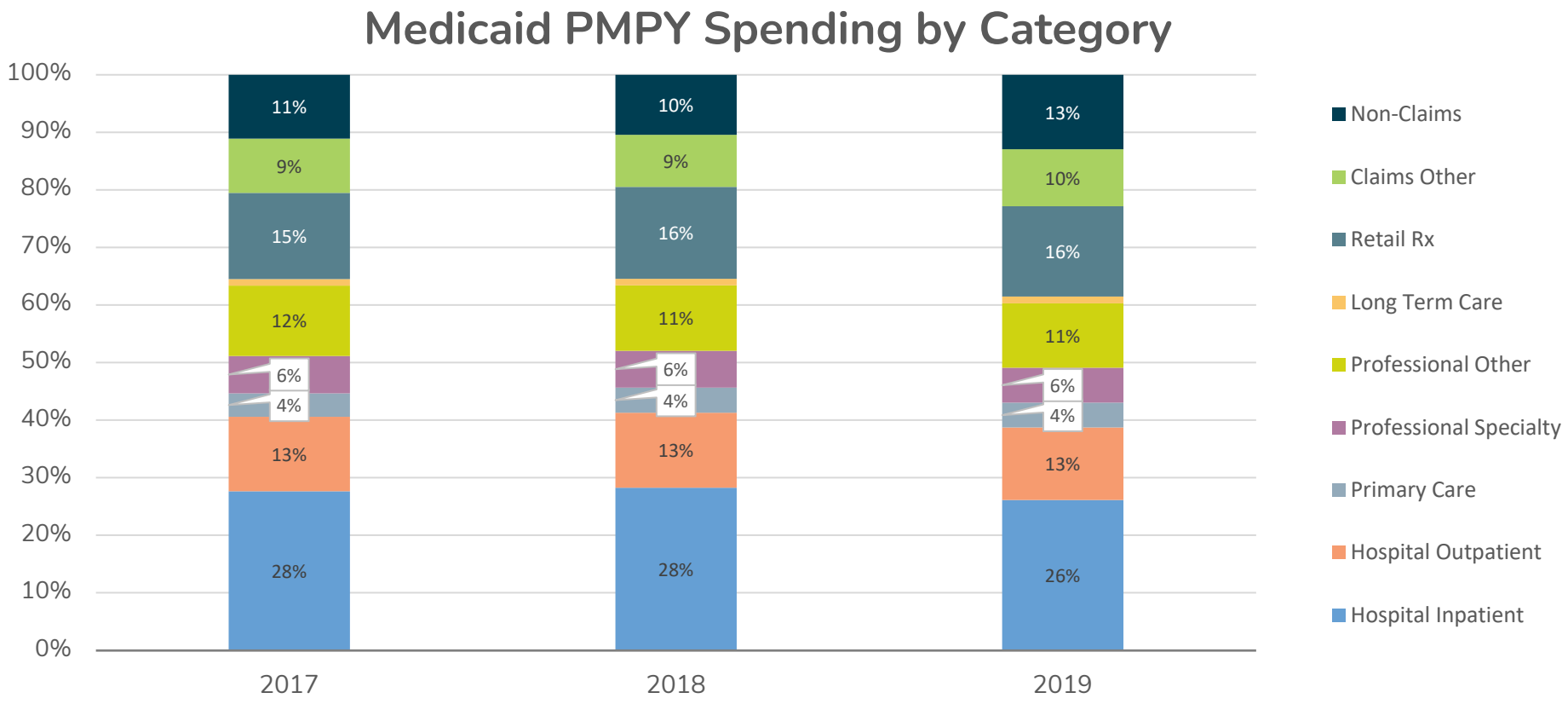
Medicaid TME category PMPY spending



* Net of Rx Rebates
Included Medicaid MC & FFS

Note: Long term care spending from DSHS is not included

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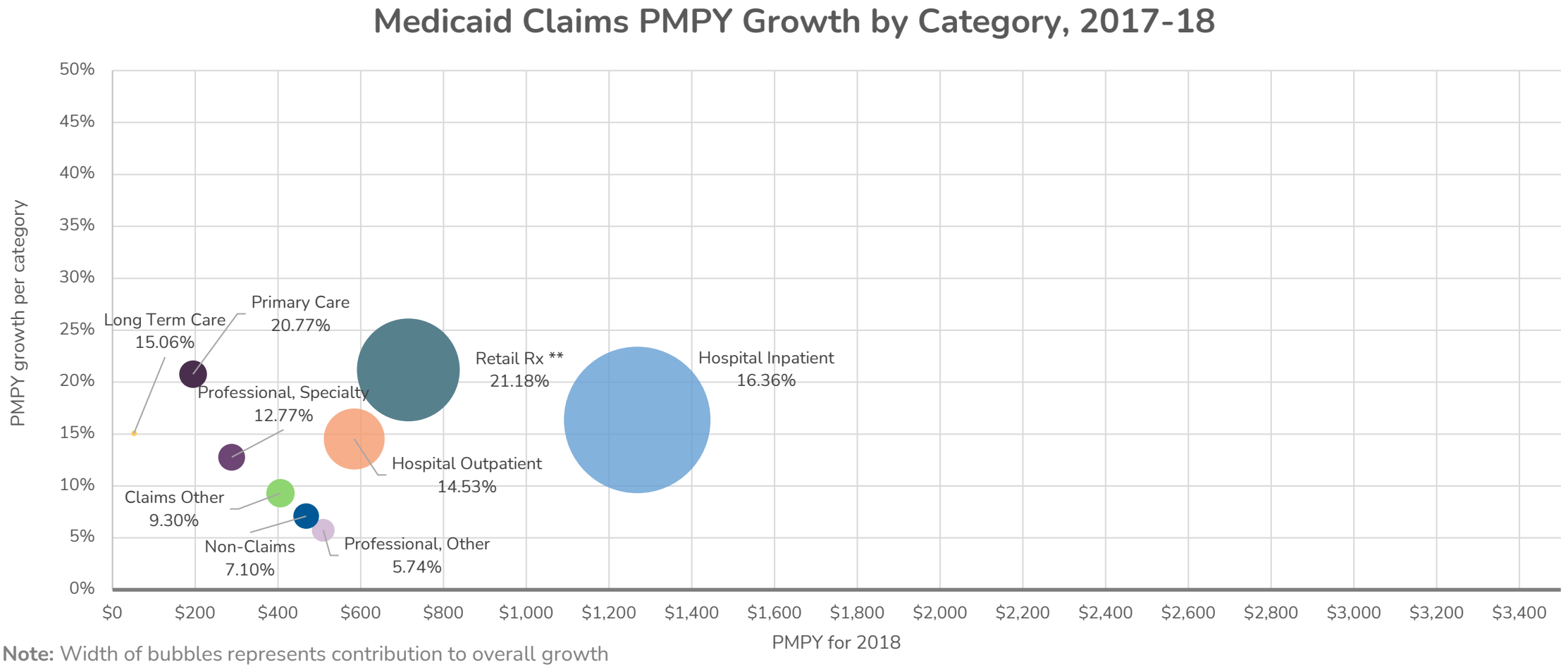
Medicaid service category contribution to cost growth for 2017-2018



Note: Width of bubbles represents contribution to overall growth
Included Medicaid MC & FFS

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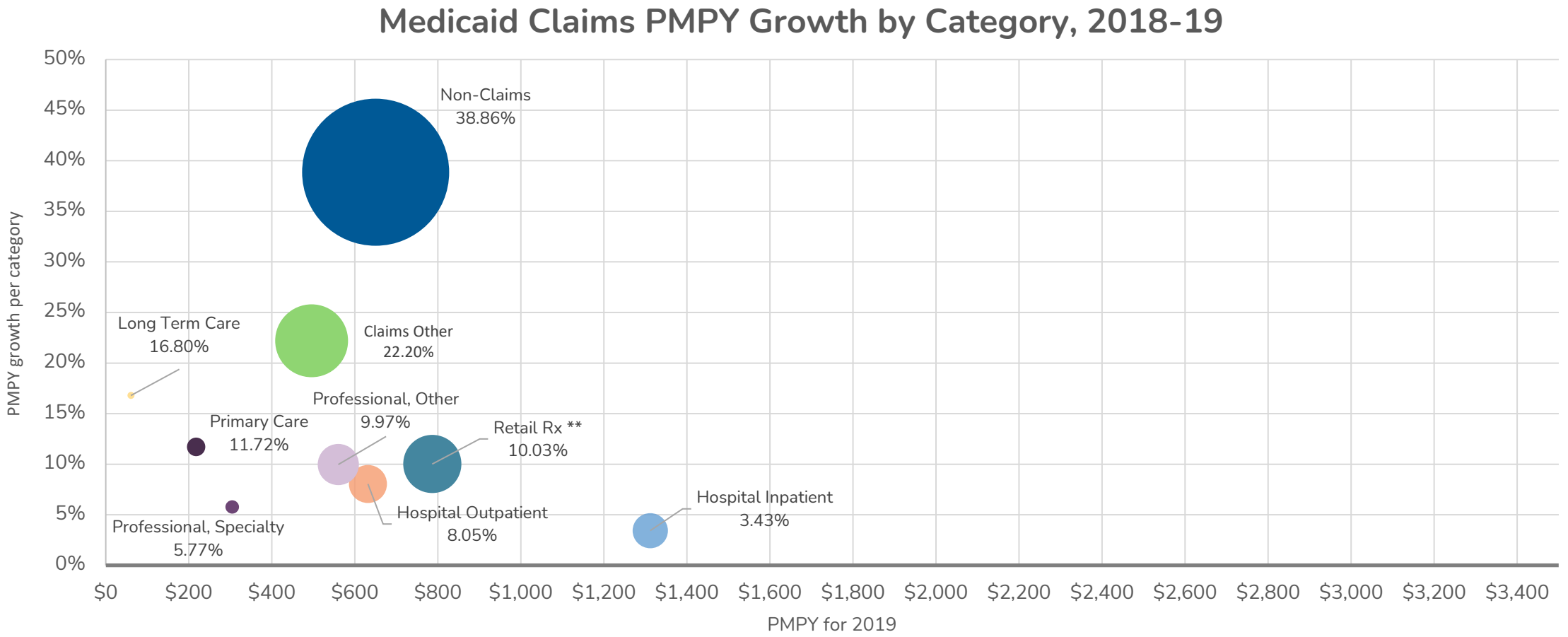
Medicaid service category contribution to cost growth for 2018-2019



Note: Width of bubbles represents contribution to overall growth
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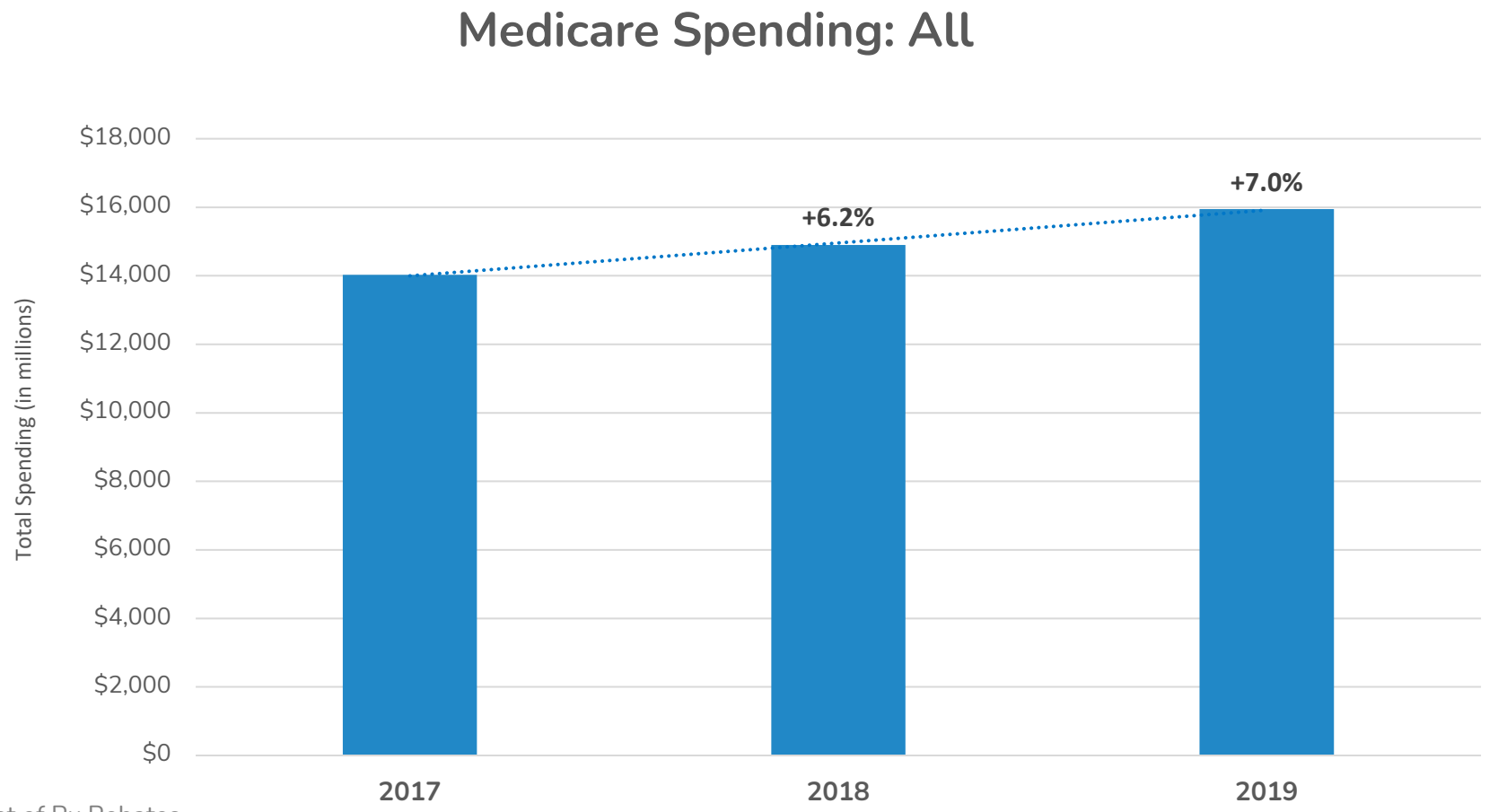
Medicare

Medicare growth



* Net of Rx Rebates
Included Medicare Adv & FFS

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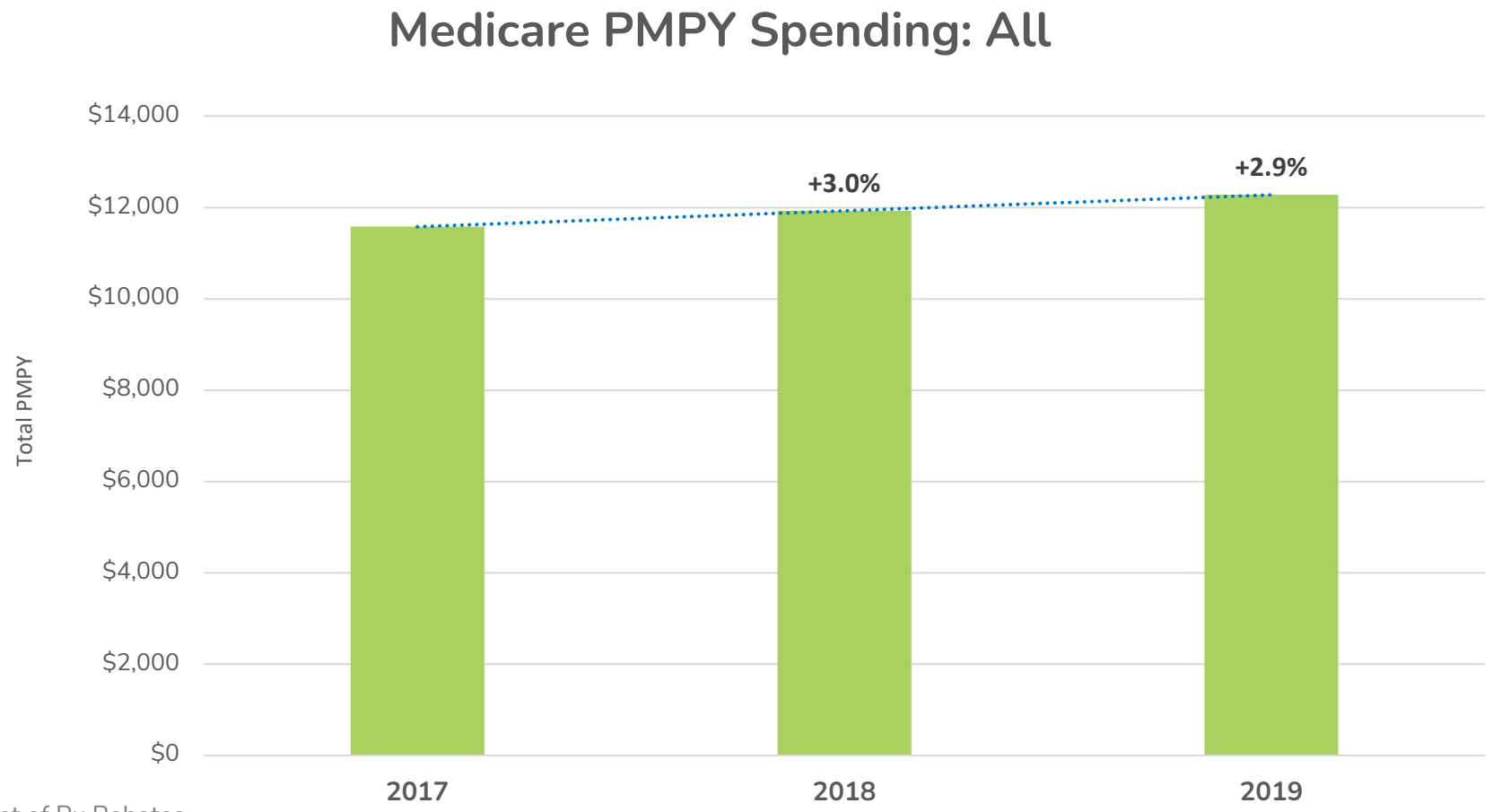
Medicare PMPY growth



* Net of Rx Rebates
Included Medicare Adv & FFS

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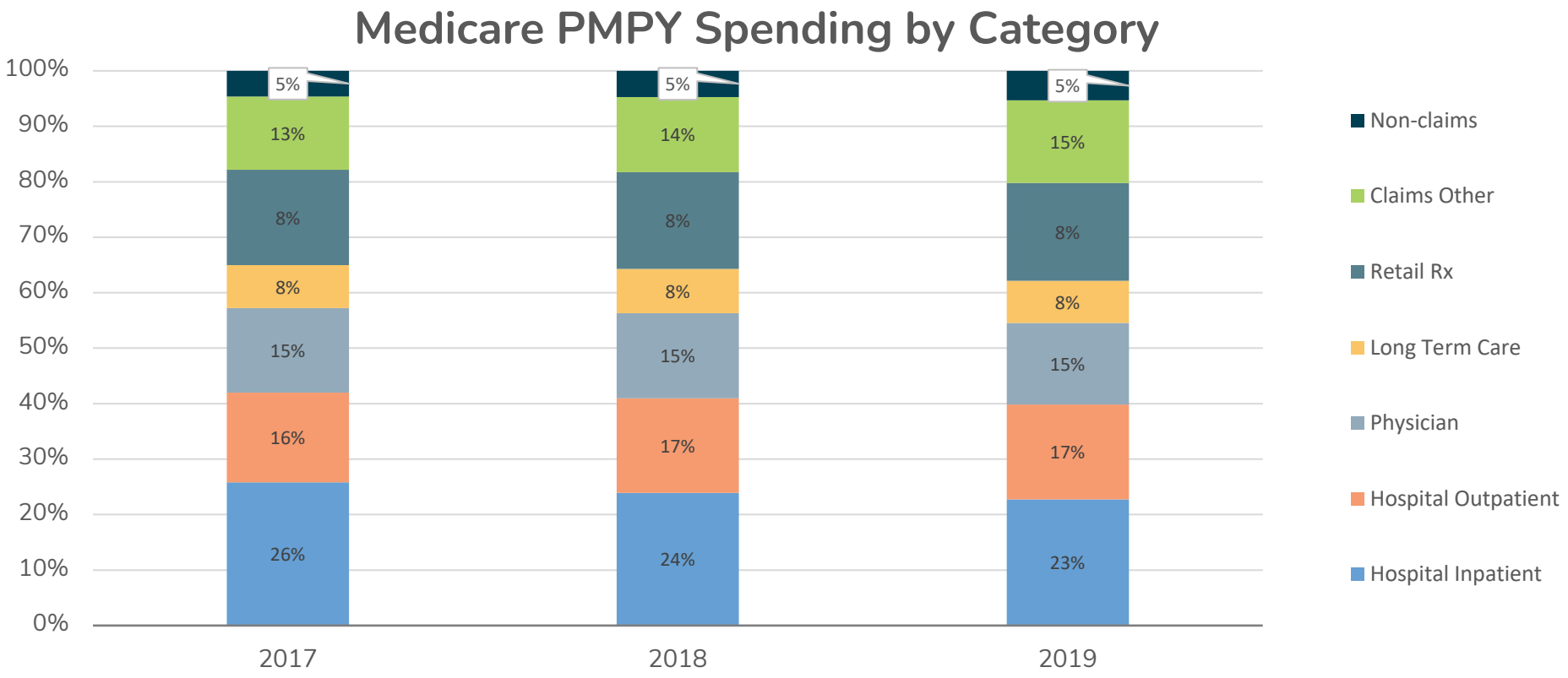
Medicare TME category PMPY spending



* Net of Rx Rebates
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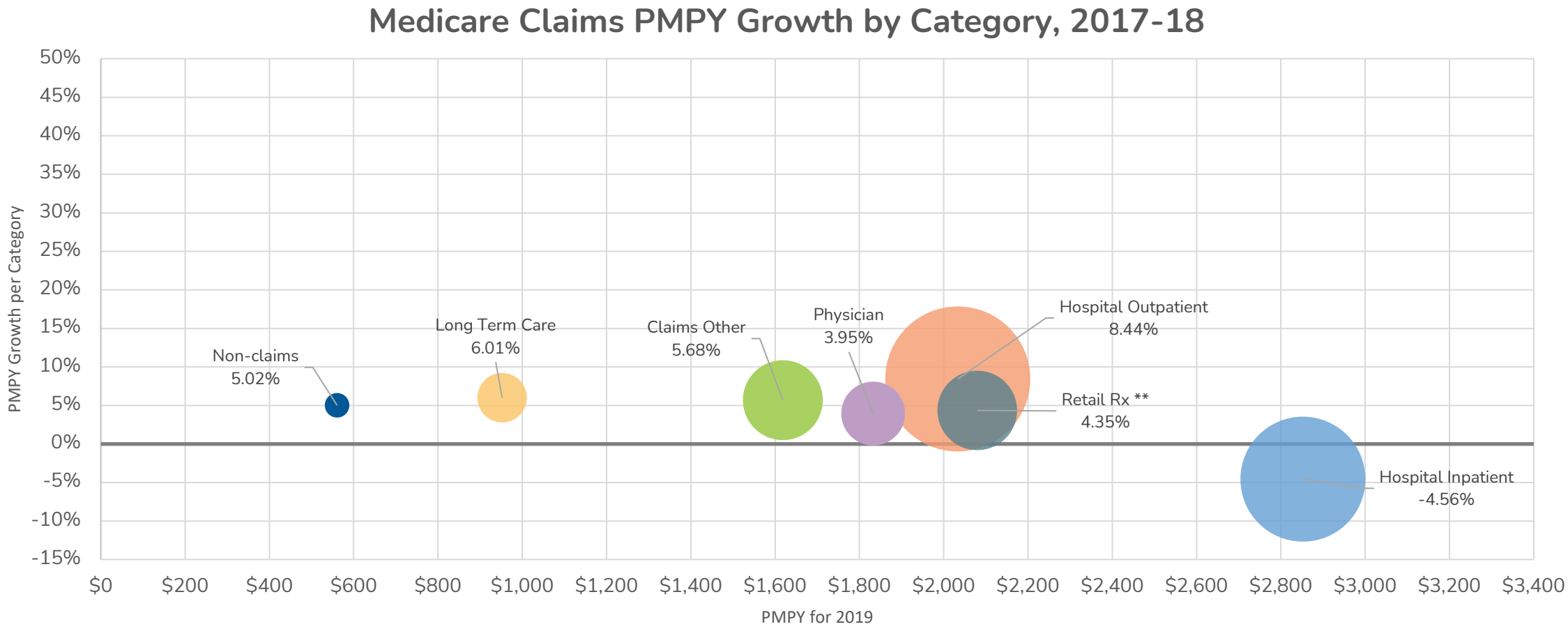
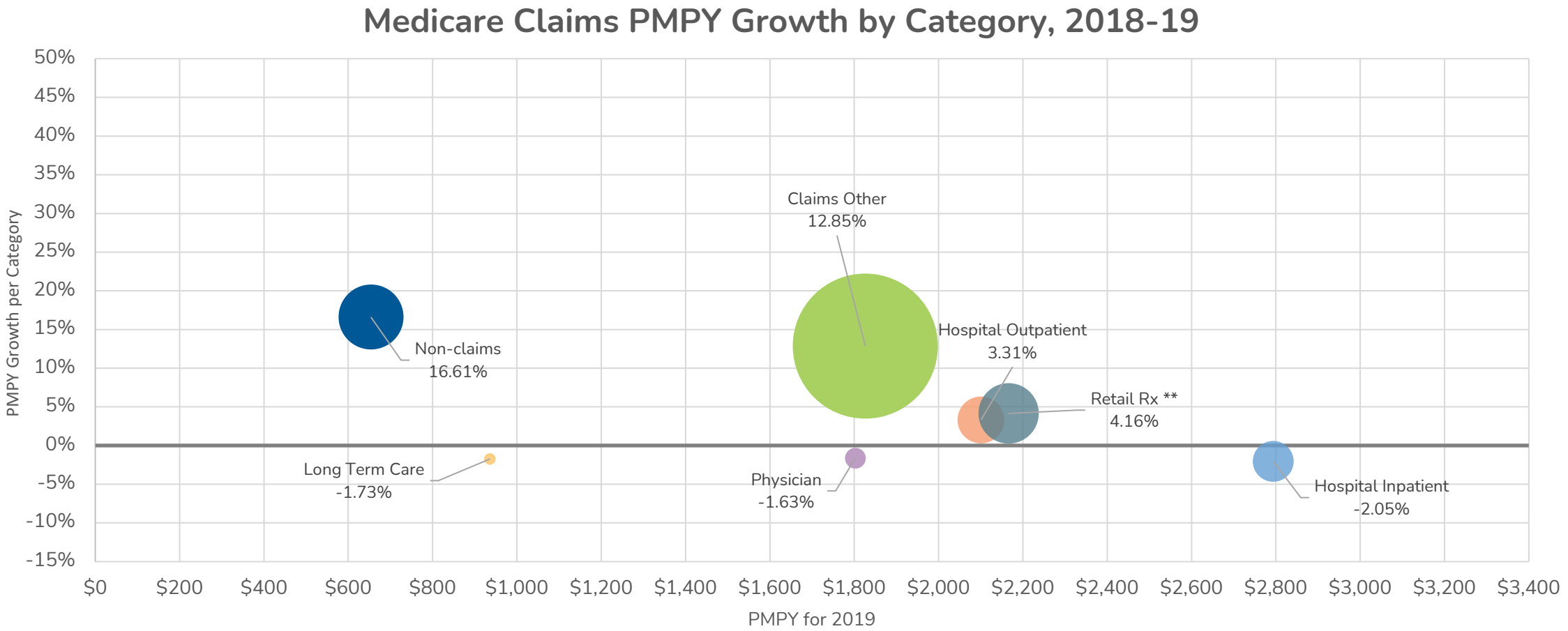
Medicare service category contribution to cost growth for 2017-2018



Note: Width of bubbles represents contribution to overall growth
Includes Medicare Adv & FFS

Washington State Health Care Authority

Medicare service category contribution to cost growth for 2018-2019



Note: Width of bubbles represents contribution to overall growth
Includes Medicare Adv & FFS

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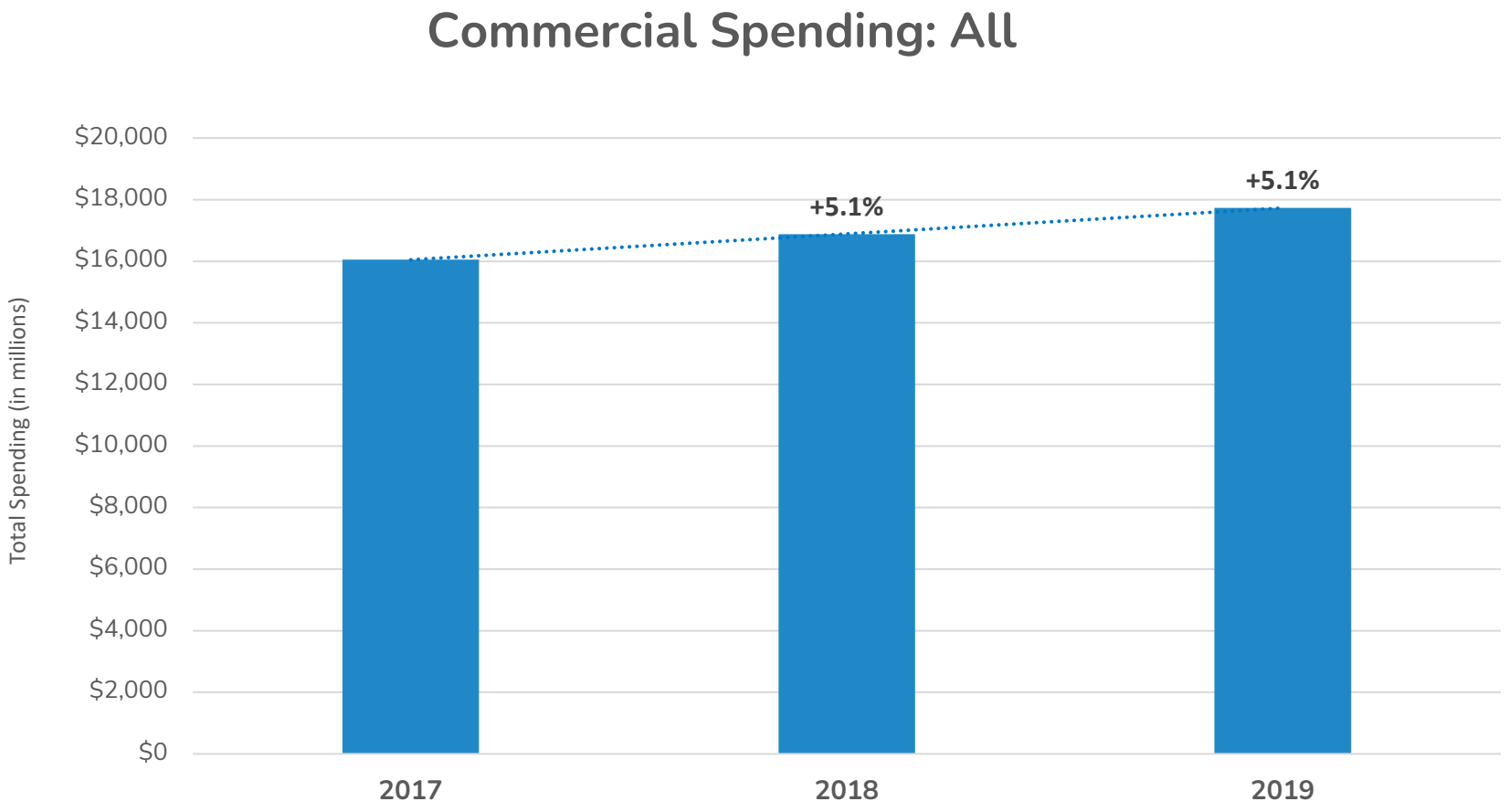
Commercial

Commercial growth



* Net of Rx Rebates

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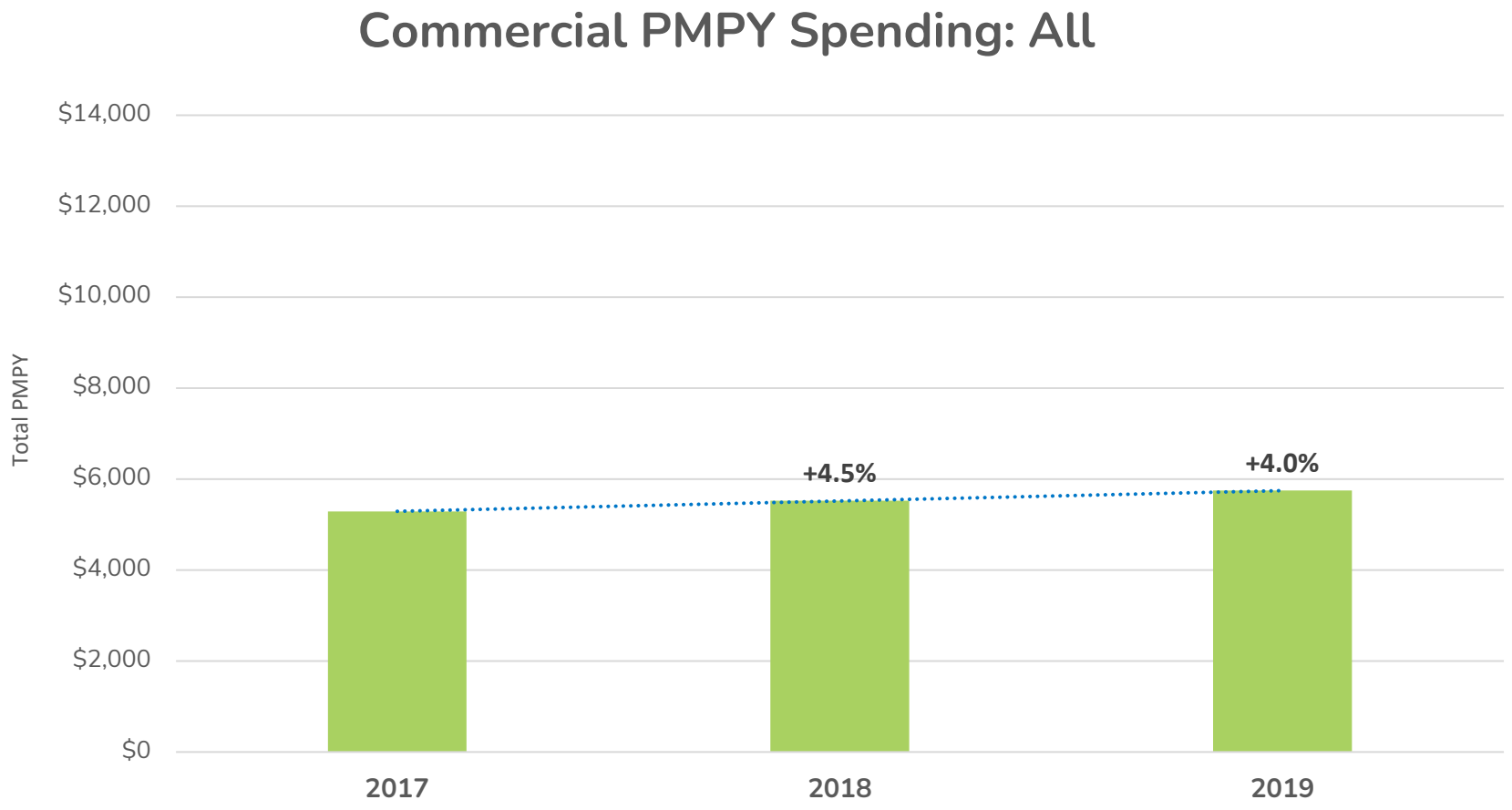
Commercial PMPY growth



* Net of Rx Rebates

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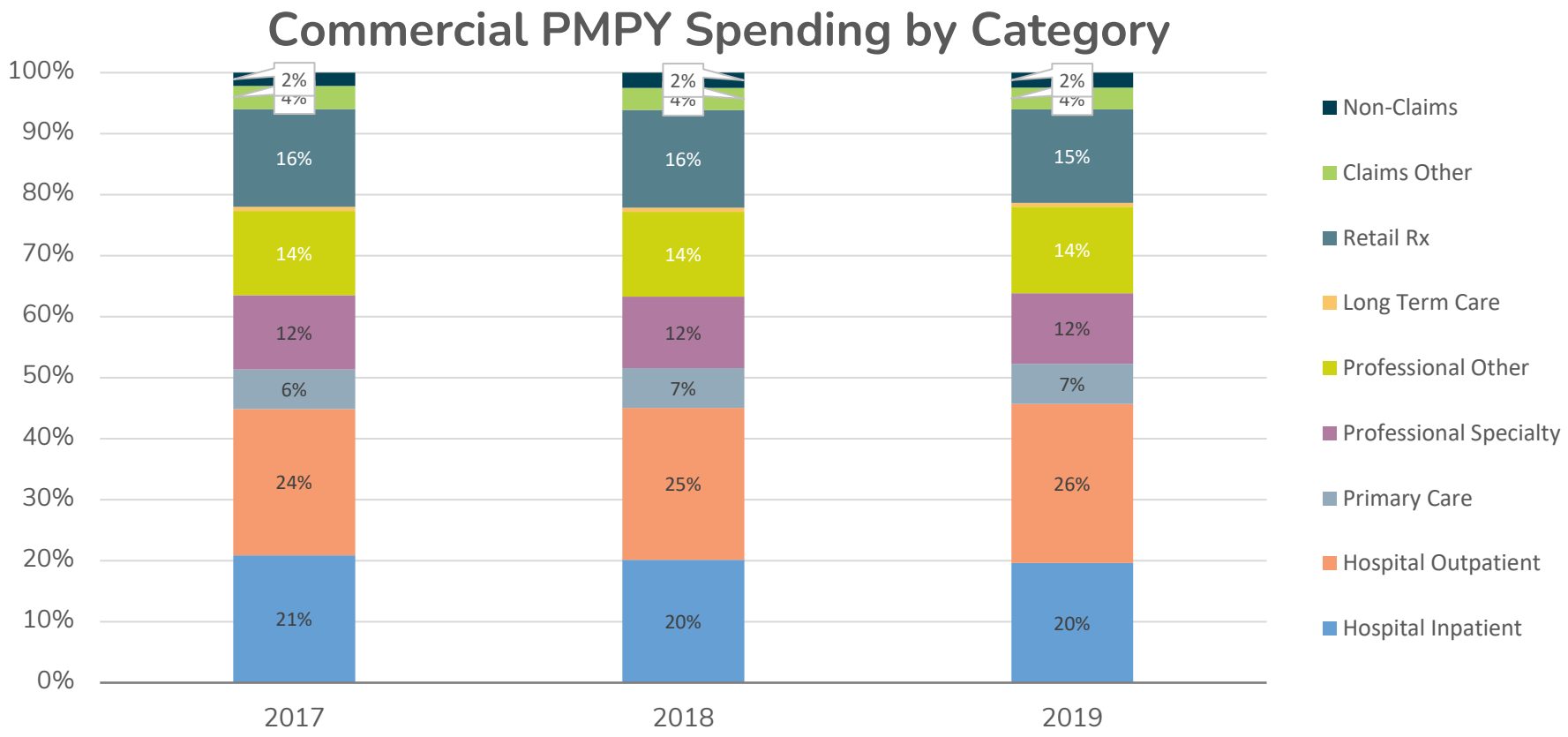
Commercial TME category PMPY spending



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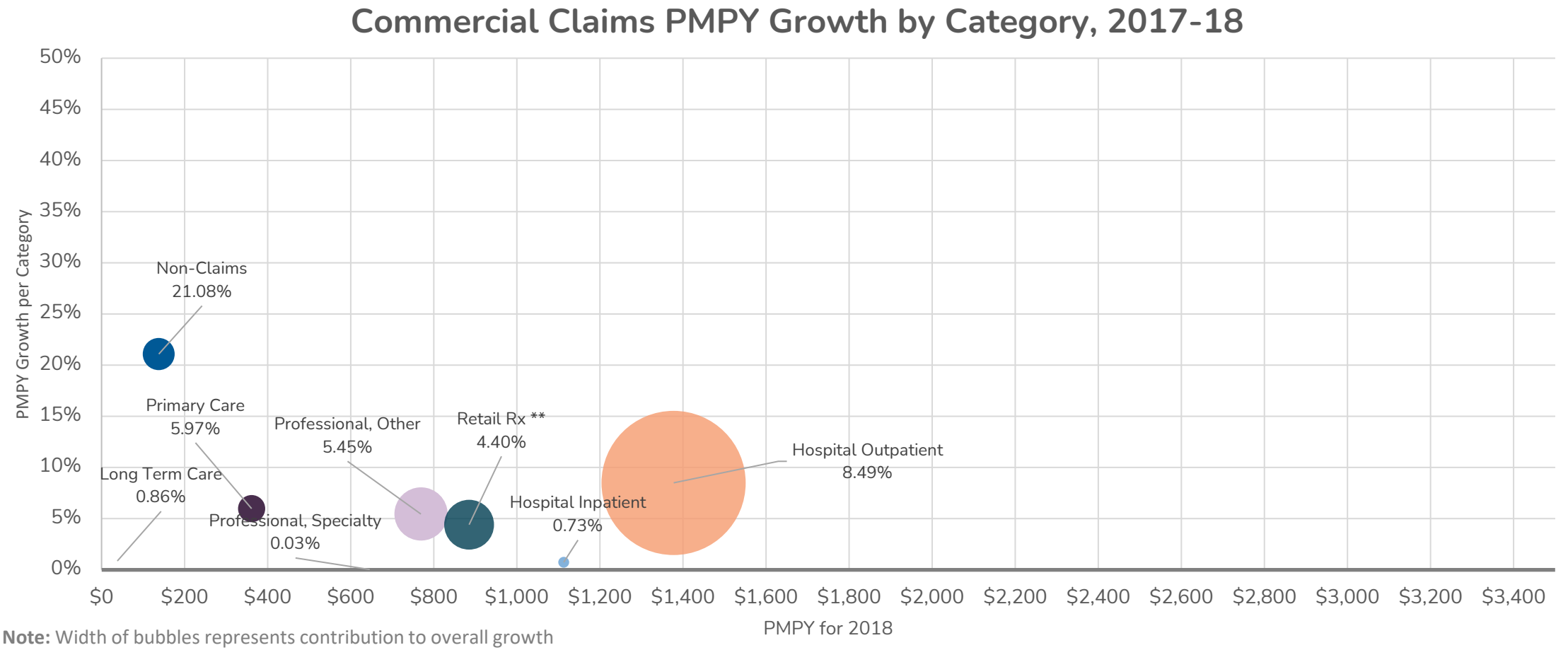
Commercial service category contribution to cost growth for 2017-2018



Note: Width of bubbles represents contribution to overall growth

* Net of Rx Rebates

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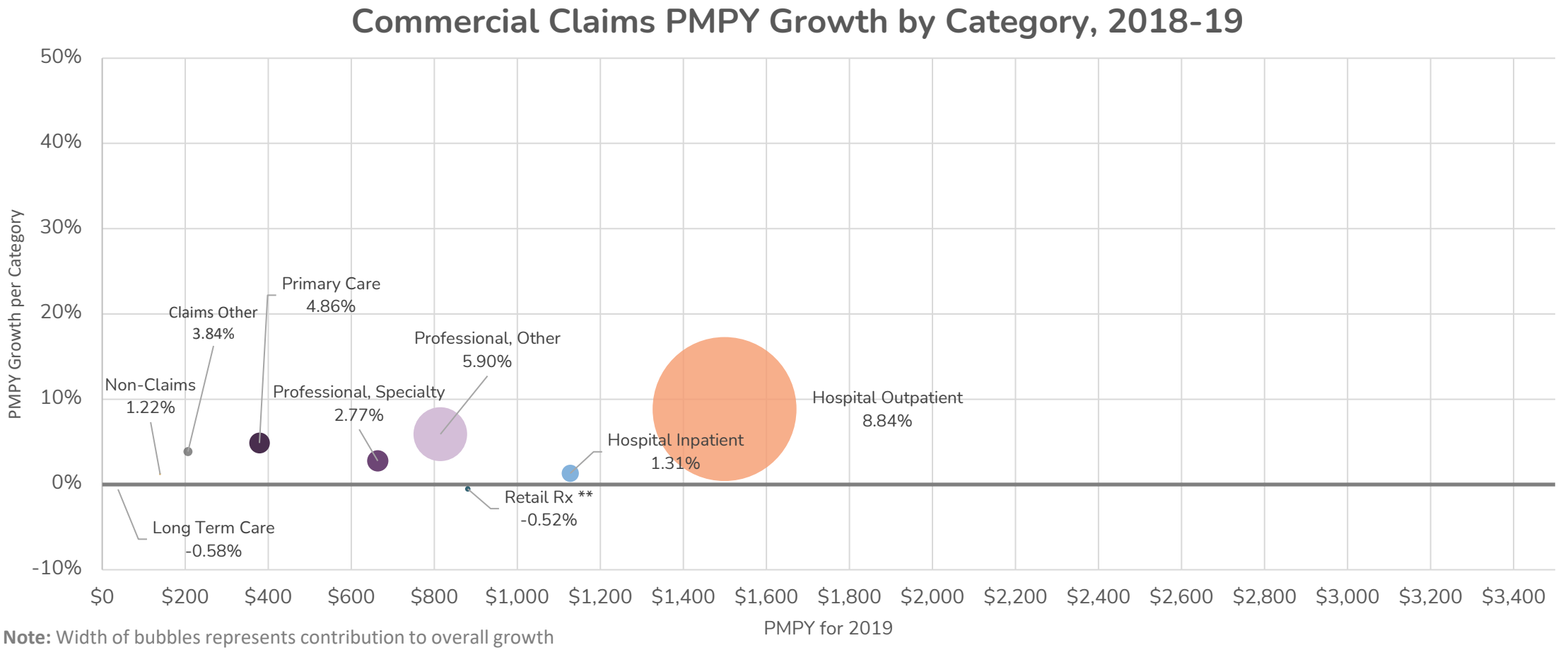
Commercial service category contribution to cost growth for 2018-2019



Note: Width of bubbles represents contribution to overall growth

** Net of Rx Rebates

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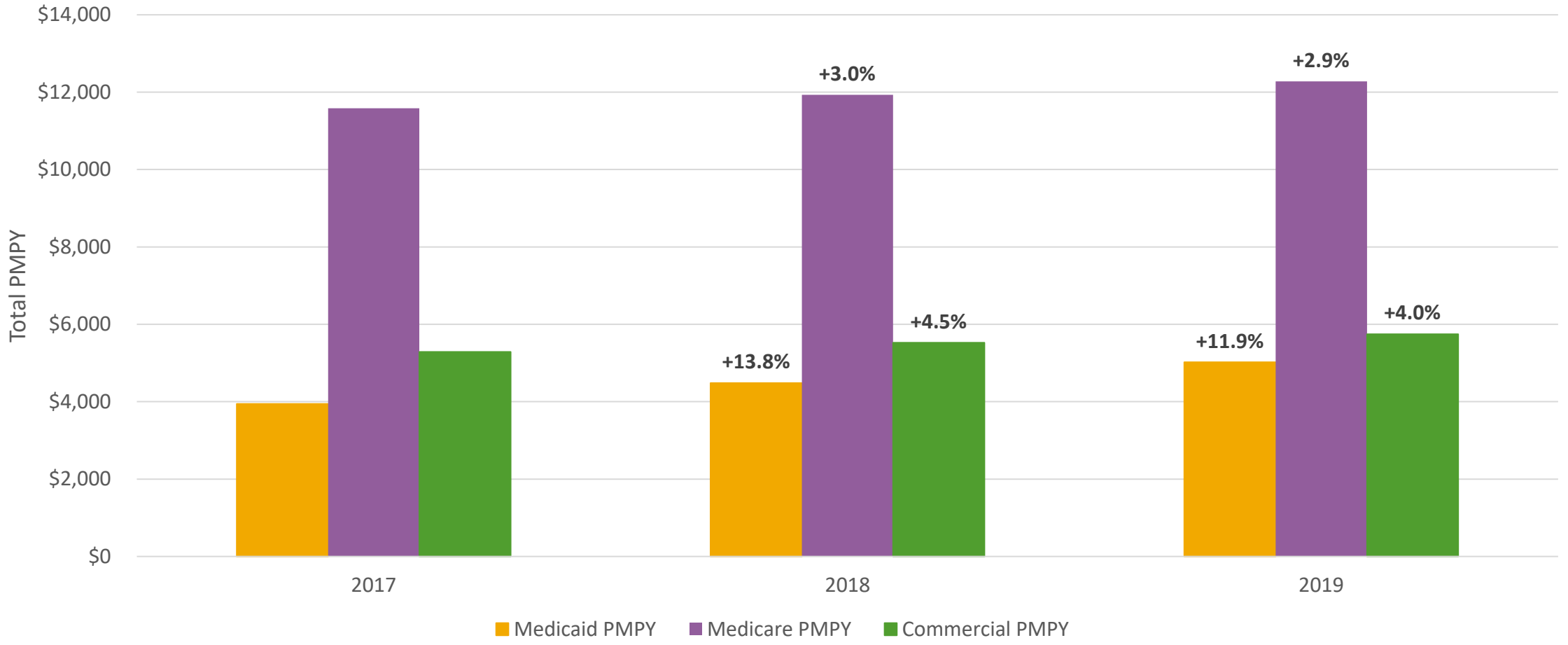
Summary & Next Steps

PMPY growth by market – at a glance



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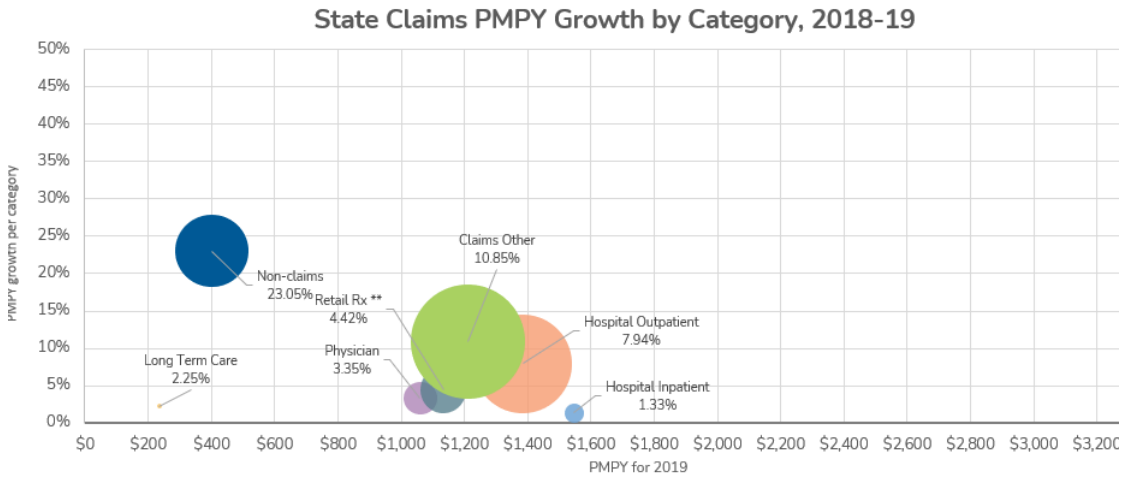
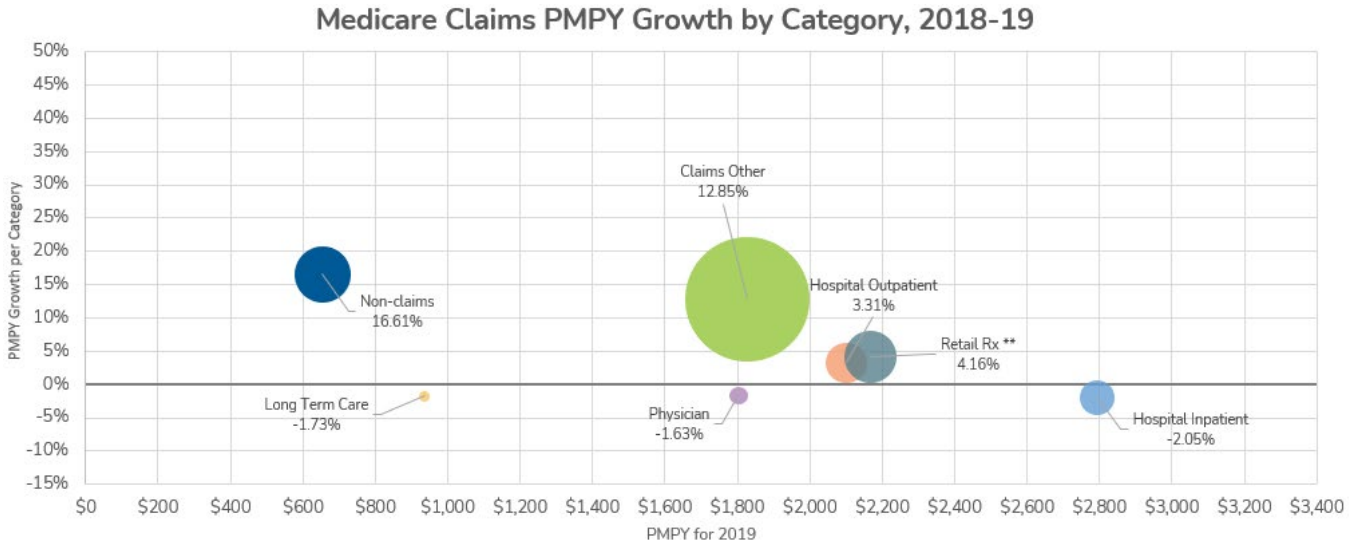
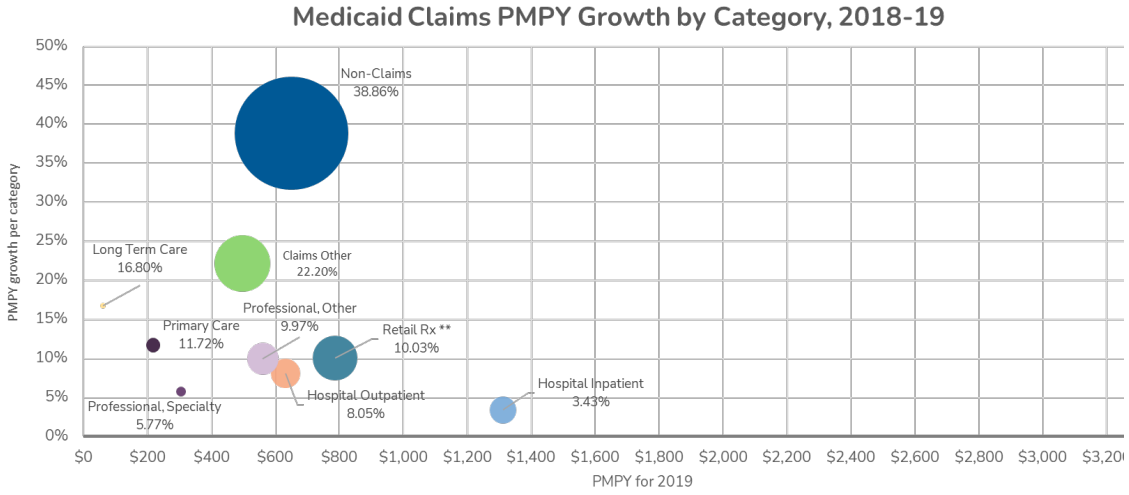
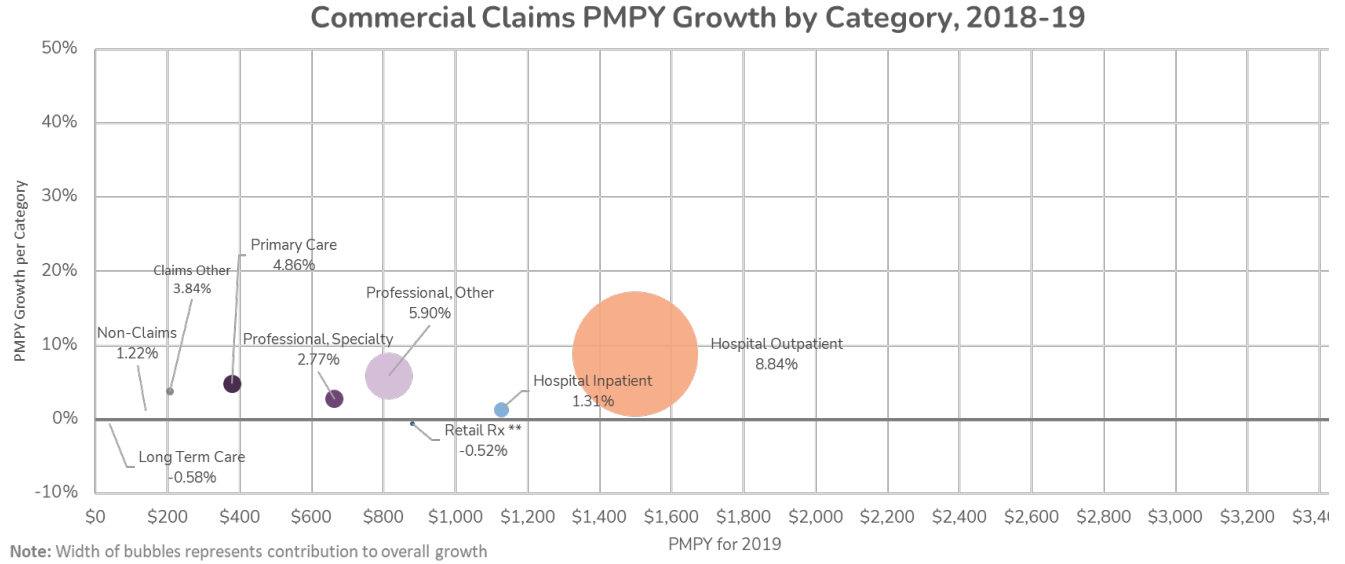
Service category contribution to cost growth – at a glance







Note: Width of bubbles represents contribution to overall growth
Included Medicaid MC & FFS



Note: Width of bubbles represents contribution to overall growth
** Net of Rx Rebates

Next steps

This high-level report sets the stage for the Cost Board's work in 2024

- Next data submission call for carriers
  - Measuring spending against the cost growth benchmark for the first time
    - Explore spending growth from 2021 to 2022, and how that compares to the cost growth benchmark set at 3.2% for 2022
  - Begin reporting on spending at the payer and large health care provider level
- Deeper dives into health care spending
  - Analyze how changes in price and utilization contribute to spending growth
  - Report at the end of 2024 by the Institute for Health Metrics and Evaluation
- Review cost containment strategies to recommend to the legislature

Questions

Discussion

- What additional data would you like to explore to assist with achieving the health care cost growth benchmark in Washington?
  - About these findings or future areas for analysis?

Appendix A: Other spending

Source	2017	2018	2019
DoC	$159,373,434.40	$180,885,549.01	$200,640,533.76
LNI	$400,995,307.95	$397,069,029.47	$445,486,818.21
VA	$1,412,362,918.49	$1,526,068,781.06	$1,665,541,164.18

Tab 4

Washington State Health Care Authority

STATE OF WASHINGTON

HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

Date

Re: Participation in Washington's Payer Reporting of Data for the Cost Growth Benchmark

Dear,

Your organization has been identified for inclusion in Washington's Health Care Cost Growth Benchmark (Benchmark). This letter provides more information about the Benchmark, what it means to be included in the Benchmark program, and upcoming opportunities for your organization to engage. We look forward to sharing more information about the Benchmark and working with your organization in the coming months.

If you have questions or need more information on anything in this letter, please contact us at hcacostboarddata@hca.wa.gov

Sincerely,

Washington Health Care Authority (HCA)

Engagement Opportunities

1. Introductory Webinar

We would like to invite your organization to participate in a webinar on (insert date).

- **What will the webinar cover?**
  The hour-long webinar will provide an overview of Washington's Cost Growth Benchmark program and what it means for provider organizations, including upcoming activities this year and the timeline for next year's data submission, validation, and reporting cycle. We will also brief you on the provider report you will be getting from the Health Care Cost Transparency Board. There will be time for Q&A.

- **Who should participate?**
  The webinar is intended for provider organization leadership, including CEOs, CFOs, and COOs. It may also be appropriate for government relations, compliance, and those working on health care cost issues (e.g., contracting, price transparency). The webinar will be recorded and posted on our website for future viewing.

- **How to join?**
  (Zoom information will be provided here)

2. Individual Meetings

After the introductory webinar, providers will have the opportunity to submit additional Q&A, and if needed, we will schedule a one-on-one (virtual) meeting to review and discuss 2017-2019 data specific to your organization.

3. Health Care Cost Transparency Board and Committee Meetings

We hold regular meetings for the Health Care Cost Transparency Board (Board) meetings and the Board's subcommittee's meetings. Your organization is invited to attend our Board and regular meetings. Information is provided online at https://www.hca.wa.gov/about-hca/who-we-are/health-care-cost-transparency-board or you could also join the Board's email distribution list on this webpage.

About the Cost Growth Benchmark Program

The cost of health care in Washington has grown and is projected to grow faster than both the state's economy and Washingtonians' wages. The Health Care Cost Transparency Board and its Cost Growth Benchmark program was established in 2020 (House Bill 2457) as a vital tool to monitor and contain rising health care costs across the state.

The Cost Growth Benchmark program is a target for the annual per capita rate of growth of total health care spending in the state. Cost increases of health insurance companies and health care provider organizations will be compared to the growth benchmark each year. The program will also evaluate and annually report on cost increases and drivers of health care costs.

What is a Cost Growth Benchmark?

The first step in containing health care costs is establishing an expectation and common goal that costs grow at a sustainable rate which does not outpace the economy or wages. The Cost Growth Benchmark is set using economic data, such as historic and projected gross state product, wages, and income. Washington's benchmark is 3.2% for 2022 and 2023; 3.0% for 2024 and 2025; and 2.8% for 2026.

Who does the Cost Growth Benchmark apply to?

The Benchmark is monitored at four different levels:

1) Statewide
2) Statewide, by market (Medicaid, Medicare, Commercial)
3) Payers (health insurance carriers)
4) Large provider organizations

What does inclusion in the Benchmark program mean for provider organizations?

Provider organizations who have been identified for inclusion in the Cost Growth Benchmark Program will have year-over-year growth in their total medical expenditures calculated and compared to the Cost Growth Benchmark.

Cost Growth Benchmark Program implementation is phased in over the next several years (see timeline below.) In future years, experience or performance relative to the Cost Growth Benchmark will be publicly reported including provider organizations who exceed the Cost Growth Benchmark in a given year.

HCA will not publicly report performance relative to the Cost Growth Benchmark for this initial period for any provider organizations, nor will any accountability measures apply. The initial data gathering of 2017-2019 experience will serve as a historical baseline of post-2019 performance. Performance against the benchmark will start with 2022 data which will be collected from the 2024 data call.

Cost Growth Benchmark Implementation Timeline

Year of Release	Includes Data from Specified Years	Data Included
Late Fall 2023	2017 – 2019	State and market data only – the board will not publicly report insurance carrier or provider cost growth for this period
Late Fall 2024	2020 – 2022	For large provider entities and carriers – with cost growth target of 3.2%
Late Fall 2025	2022 – 2023	For large provider entities and carriers – with cost growth target of 3.2%
Late Fall 2026	2023 – 2024	For large provider entities and carriers – with cost growth target of 3.0%
Late Fall 2027	2024 – 2025	For large provider entities and carriers – with cost growth target of 3.0%
Late Fall 2028	2025 – 2026	For large provider entities and carriers – with cost growth target of 2.8%

Which provider organizations are subject to the Cost Growth Benchmark program?

The Board provided the following parameters for determining which provider organizations will be held responsible for their performance relative to the cost growth benchmark:

Provider organizations that can be accountable for Total Medical Expenditures

Provider organizations that will be held accountable for Total Medical Expenditures include only those organizations that could in theory take on contracts where they are responsible for the total cost of care because they (1) include primary care providers who direct a patient's care, and/or (2) can influence where a patient receives care to promote high value providers and care.

These include health systems, hospitals with primary care providers, medical groups with primary care providers, and a subset of specialists that provide care coordination (e.g., some oncologists) or provide a majority of primary care-like services.

Health care cost growth is measured for large provider organizations, not individual clinicians.

Provider organizations that have sufficient patient volume

Provider organizations must have sufficient patient volume to be able to detect accurate and reliable changes in annual per capita Total Medical Expenditures. This helps prevent situations where smaller provider organizations may exceed the health care cost growth target due to a few unusually complex and expensive cases.

To determine sufficient patient volume, we developed an initial list of approximately 50 large provider entities for which benchmark performance could potentially be reported. This initial list was created from several sources including Washington Health Alliance's Community Checkup report, the Washington Association for Community Health's list of Community Health Centers, the Health Resources & Services Administration's Health Center Program Uniform Data System Data, and the Washington State Department of Health's 2019 Year End Hospital reports. Next, carriers were surveyed to gather data on each of their providers' total cost of care contracts and the number of covered lives associated with those contracts. Using this survey data, we further modified the initial list to only include provider organizations who could potentially accumulate 10,000 covered lives across all carriers.[1] During the 2022 data call, we asked carriers to provide data on providers which were included in this preliminary list of providers. After carriers submitted the data (in response to the HCCTB data call), we aggregated the number of covered lives of each provider across all carriers. Provider organizations with at least 10,000 unique covered lives, based on the submitted data, are considered to have sufficient patient volume for benchmark performance to be accurately and reliably measured.

How was my organization identified for inclusion?

Health insurance plans have identified their members who live in Washington and attributed them (where possible) to a primary care provider. All spending incurred by that member is attributed to the primary care provider, and spending is then rolled up to the provider organization level based on primary care provider to organization affiliation.

[1] This threshold is similar to the threshold used in Oregon State's Sustainable Health Care Cost Growth Target Program.

Your organization was identified for inclusion in the Program out of the initial cost growth target data submissions from payers, covering 2017-2019. The list of current payers (data submitters) is available on the Benchmark Data Submission website.

Approximately 26 provider organizations were identified for inclusion in the Cost Growth Benchmark Program from the initial 2017-2019 data. The full list and more details about the attribution and organizational affiliation is available online.

https://www.hca.wa.gov/about-hca/who-we-are/call-benchmark-data.

DRAFT

Provider Report on Respective Health Care Cost Growth Trends, 2017-2019

Provider First-Look at Reporting for the Cost Growth Benchmark

In 2020, Washington State established the Health Care Cost Transparency Board ("Board") under the Health Care Authority (HCA) in House Bill (HB) 2457. In 2022, the Board set the health care cost growth benchmark for 2020-2026 based on a detailed review of Washington's economic data. The spending growth benchmark serves as a starting point from which to align health care spending to ensure that spending growth does not increase at a faster rate than the economy, state revenue, or wages. It represents a common goal for payers, carriers, purchasers, regulators, and consumers to improve health care affordability. As such, the benchmark will be compared to the actual cost growth or performance of provider organizations, carriers and payers.

The Board conducted the first data call in 2022 to gather claims and non-claims cost data from carriers and their respective providers for 2017-2019. This workbook provides providers a first-look at their 2017-2019 aggregated claims and non-claims data from carriers' submitted data. As a reminder, we anticipate that this provider data and results will have similiar trends, but they will not be identical to other provider reports created by carriers or generated internally by the providers due to differences in the population, included costs, and services.

Since there is no growth benchmark set for 2017-2019, this year's provider report will not be compared to a benchmark and will not be publicly reported. The 2017-2019 data will serve as a historical baseline of post-2019 performance. Performance against the benchmark will start with 2022 data which will be collected from the 2024 data call.

Contents of this report

The Table of Contents is under Tab 2 (TOC). Table 1 provides a summary of the growth rate of the risk-adjusted truncated claims expenses per member per month (PMPM) for the provider by market group. The provider will be able to see how provider's own growth rate compares to the overall growth rate in each market and the statewide overall total medical expense PMPM growth rate. Benchmark cost growth is not included for 2017-2019. Starting with data for 2022 that will be collected as a part of the 2020-2022 data, the benchmark cost growth will be added so that providers can compare vis-a-vis the benchmark rate. Table 2 to 8 provides details on the provider's member months, claims and non-claims expenses and other variables by insurance category, carrier and/or market.

Please carefully review the tabs and check that the reasonableness/accuracy of the data.

Provider population size requirements

Only provider organizations with sufficient patient volume (large providers) will receive this report. To determine sufficient patient volume, we developed an initial list of approximately 50 large provider entities for which benchmark performance could potentially be reported. This initial list was created from several sources including Washington Health Alliance's Community Checkup report, the Washington Association for Community Health's list of Community Health Centers, the Health Resources & Services Administration's Health Center Program Uniform Data System Data, and the Washington State Department of Health's 2019 Year End Hospital reports. Next, carriers were surveyed to gather data on each of their providers' total cost of care contracts and the number of covered lives associated with those contracts. Using this survey data, we further updated the initial list to only include provider organizations who could potentially accumulate 10,000 covered lives across all carriers. During the 2022 data call, we asked carriers to provide data on providers which were included in this preliminary list of providers. After carriers submitted the data (in response to the Board data call), we aggregated the number of covered lives of each provider across all carriers. Provider organizations with at least 10,000 unique covered lives (based on the submitted data) are considered to have sufficient patient volume for benchmark performance to be accurately and reliably measured.

Data sources

All data for cost growth target reporting are carrier-reported.

Questions

Should you have any questions on this workbook, please contact us at hcacostboarddata@hca.wa.gov. Should you have any questions on the underlying individual carrier data, please contact the appropriate carrier and copy us at hcacostboarddata@hca.wa.gov on your communications.

Acronyms:

PMPM - Per Member Per Month
FFS = Fee-for-service
HCA = Washington State Health Care Authority
MCO = Managed care organization
THCE = Total health care expenditures
TME = Total medical expense
TOC = Table of contents

Table of Contents

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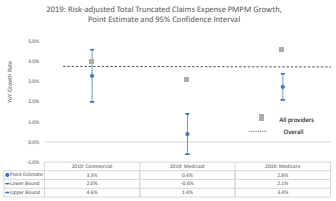
Table 2 Member Months by Insurance Category
Table 3 Member Months by Insurance Category and Carrier
Table 4 Unadjusted Claims Expenses PMPM by Insurance Category and Carrier
Table 5 Unadjusted Non-Claims Expenses PMPM by Insurance Category and Carrier
Table 6 Unadjusted Total Medical Expenses (TME) PMPM by Insurance Category and Carrier
Table 7 Undadjusted Total Medical Expenses (TME) PMPM by Insurance Category and Service Category
Table 8 Risk-Adjusted Total Truncated Claims Expense PMPM by Market

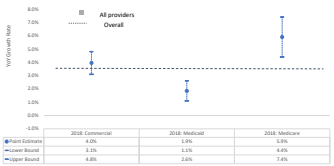
Table 1. Provider Name - Performance Overview: Growth Rate of Risk-Adjusted Total Truncated Claims Expense PMPM by Year and Market a/

	Y-O-Y Growth				
	Provider				
Year and Market	Point Estimate	Lower Bound	Upper Bound	All Providers	Overall
2018: Commercial	4.0%	3.1%	4.8%	5.0%	
2018: Medicaid	1.9%	1.1%	2.6%	2.9%	
2018: Medicare	5.9%	4.4%	7.4%	3.3%	3.5%
2019: Commercial	3.3%	2.0%	4.6%	3.9%	
2019: Medicaid	0.4%	-0.6%	1.4%	3.0%	
2019: Medicare	2.8%	2.1%	3.4%	4.5%	3.7%

Notes:
a/ Numbers are not actual data and are just placed in the template for demonstration purposes. The graphs, while it will contain the same elements, may use a different style in the actual report.
b/ Startine with 2022 data, the benchmark cost erowth will be included.
c/For details on how the numbers are calculated. please see Table 8.



	2019: Commercial	2019: Medicaid	2019: Medicare
Point Estimate	3.3%	0.4%	2.8%
Lower Bound	2.0%	-0.6%	2.1%
Upper Bound	4.6%	1.4%	3.4%



	2018: Commercial	2018: Medicaid	2018: Medicare
Point Estimate	4.0%	1.9%	5.9%
Lower Bound	3.1%	1.1%	4.4%
Upper Bound	4.8%	2.6%	7.4%

Table 2. Provider Name - Member Months by Insurance Category

	Member Months			YOY % Change	
Insurance Category	**2017**	**2018**	**2019**	**2018**	**2019**
Medicare Expenses for Non-Dual Eligible Members					
Medicaid Expenses for Non-Dual Eligible Members					
Commercial: Full Claims					
Commercial: Partial Claims					
Medicare Expenses for Medicare/Medicaid Dual Eligible					
Medicaid Expenses for Medicare/Medicaid Dual Eligible					
All Insurance Categories					

Table 3. Provider Name - Member Months by Insurance Category and Carrier

		Member Months			YOY % Change	
Insurance Category	**Carrier**	**2017**	**2018**	**2019**	**2018**	**2019**
Medicare Expenses for Non-Dual Eligible Members						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Medicaid Expenses for Non-Dual Eligible Members						
	Insurance Company A					
	Insurance Company B					
	Insurance Company D					
Commercial: Full Claims						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Commercial: Partial Claims						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Medicare Expenses for Medicare/Medicaid Dual Eligible						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Medica Expenses for Medicare/Medicaid Dual Eligible						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					

Table 4. Provider Name - Claims Expenses PMPM by Insurance Category and Carrier

		Claims Expenses PMPM			YOY % Change	
Insurance Category	**Carrier**	**2017**	**2018**	**2019**	**2018**	**2019**
Medicare Expenses for Non-Dual Eligible Members						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Medicaid Expenses for Non-Dual Eligible Members						
	Insurance Company A					
	Insurance Company B					
	Insurance Company D					
Commercial: Full Claims						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Commercial: Partial Claims						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Medicare Expenses for Medicare/Medicaid Dual Eligible						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Medica Expenses for Medicare/Medicaid Dual Eligible						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					

Table 5. Provider Name - Non-Claims Expenses PMPM by Insurance Category and Carrier

		Non-Claims Expenses PMPM			YOY % Change	
Insurance Category	**Carrier**	**2017**	**2018**	**2019**	**2018**	**2019**
Medicare Expenses for Non-Dual Eligible Members						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Medicaid Expenses for Non-Dual Eligible Members						
	Insurance Company A					
	Insurance Company B					
	Insurance Company D					
Commercial: Full Claims						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Commercial: Partial Claims						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Medicare Expenses for Medicare/Medicaid Dual Eligible						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Medica Expenses for Medicare/Medicaid Dual Eligible						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					

Table 6. Provider Name - Total Medical Expenses (TME) PMPM by Insurance Category and Carrier

		TME PMPM			YOY % Change	
Insurance Category	**Carrier**	**2017**	**2018**	**2019**	**2018**	**2019**
Medicare Expenses for Non-Dual Eligible Members						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Medicaid Expenses for Non-Dual Eligible Members						
	Insurance Company A					
	Insurance Company B					
	Insurance Company D					
Commercial: Full Claims						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Commercial: Partial Claims						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Medicare Expenses for Medicare/Medicaid Dual Eligible						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					
Medica Expenses for Medicare/Medicaid Dual Eligible						
	Insurance Company A					
	Insurance Company B					
	Insurance Company C					

Table 7. Provider Name - Total Medical Expenses (TME) PMPM by Insurance Category and Service Category

		TME PMPM			YOY % Change	
Insurance Category	**Service Category**	**2017**	**2018**	**2019**	**2018**	**2019**
Medicare Expenses for Non-Dual Eligible Members	**Claims expenses PMPM**					
	Claims: Hospital Inpatient					
	Claims: Hospital Outpatient					
	Claims: Primary Care Provider					
	Claims: Specialty Provider					
	Claims: Other Provider					
	Claims: Long Term Care					
	Claims: Retail Rx					
	Claims: Other					
	Non-Claims expenses PMPM					
	Non-Claims: Capitation PMPM					
	Non-Claims: Performance Incentive PMPM					
	Non-Claims: Recovery PMPM					
	TME PMPM					
Medicaid Expenses for Non-Dual Eligible Members	**Claims expenses PMPM**					
	Claims: Hospital Inpatient					
	Claims: Hospital Outpatient					
	Claims: Primary Care Provider					
	Claims: Specialty Provider					
	Claims: Other Provider					
	Claims: Long Term Care					
	Claims: Retail Rx					
	Claims: Other					
	Non-Claims expenses PMPM					
	Non-Claims: Capitation PMPM					
	Non-Claims: Performance Incentive PMPM					
	Non-Claims: Recovery PMPM					
	TME PMPM					
Commercial: Full Claims	**Claims expenses PMPM**					
	Claims: Hospital Inpatient					
	Claims: Hospital Outpatient					
	Claims: Primary Care Provider					
	Claims: Specialty Provider					
	Claims: Other Provider					
	Claims: Long Term Care					
	Claims: Retail Rx					
	Claims: Other					
	Non-Claims expenses PMPM					
	Non-Claims: Capitation PMPM					
	Non-Claims: Performance Incentive PMPM					
	Non-Claims: Recovery PMPM					
	TME PMPM					
Commercial: Partial Claims	**Claims expenses PMPM**					
	Claims: Hospital Inpatient					
	Claims: Hospital Outpatient					
	Claims: Primary Care Provider					
	Claims: Specialty Provider					
	Claims: Other Provider					
	Claims: Long Term Care					
	Claims: Retail Rx					
	Claims: Other					
	Non-Claims expenses PMPM					
	Non-Claims: Capitation PMPM					
	Non-Claims: Performance Incentive PMPM					
	Non-Claims: Recovery PMPM					
	TME PMPM					
Medicare Expenses for Medicare/Medicaid Dual Eligible	**Claims expenses PMPM**					
	Claims: Hospital Inpatient					
	Claims: Hospital Outpatient					
	Claims: Primary Care Provider					
	Claims: Specialty Provider					
	Claims: Other Provider					
	Claims: Long Term Care					
	Claims: Retail Rx					
	Claims: Other					
	Non-Claims expenses PMPM					
	Non-Claims: Capitation PMPM					
	Non-Claims: Performance Incentive PMPM					
	Non-Claims: Recovery PMPM					
	TME PMPM					
Medica Expenses for Medicare/Medicaid Dual Eligible	**Claims expenses PMPM**					
	Claims: Hospital Inpatient					
	Claims: Hospital Outpatient					
	Claims: Primary Care Provider					
	Claims: Specialty Provider					

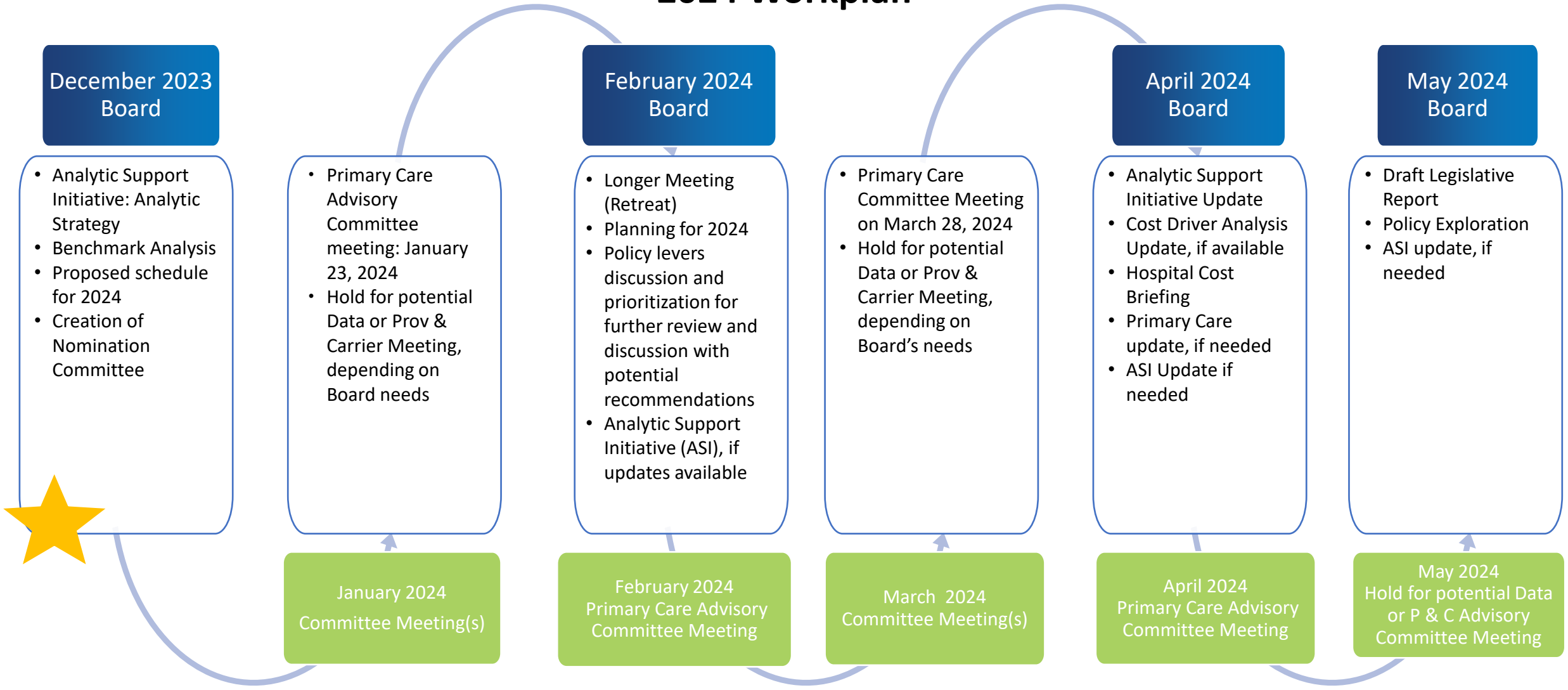
	Claims: Other Provider					
	Claims: Long Term Care					
	Claims: Retail Rx					
	Claims: Other					
	Non-Claims expenses PMPM					
	Non-Claims: Capitation PMPM					
	Non-Claims: Performance Incentive PMPM					
	Non-Claims: Recovery PMPM					
	TME PMPM					

Table 8. Provider Name - Risk-Adjusted Total Truncated Claims Expense PMPM by Market

	Total Truncated Claims Expense PMPM			Risk Score[a/]		Risk-Adjusted Total Truncated Claims Expense PMPM[a/]			Standard Deviation		Y-O-Y Growth					
Market	2017	2018	2019	2018	2019	2017	2018	2019	2018	2019	2018			2019		
											Point Estimate	Upper Bound	Lower Bound	Point Estimate	Upper Bound	Lower Bound
Medicare																
Medicaid																
Commercial																

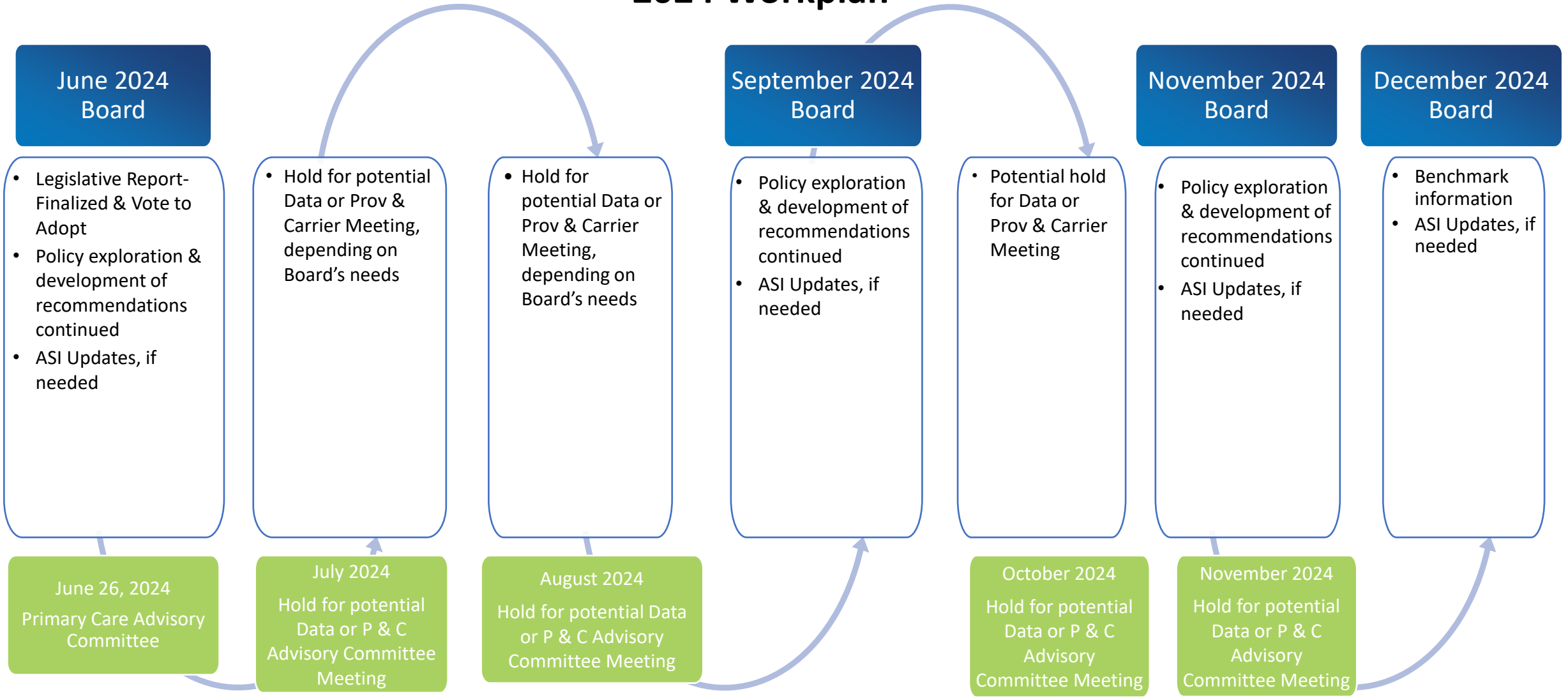
Notes:
a/ [Note on risk-adjustment methodology]

Health Care Cost Transparency Board
2024 Workplan



Workplan will change depending on progress made in each meeting

Health Care Cost Transparency Board
2024 Workplan



Workplan will change depending on progress made in each meeting

Calendar of Board & Advisory Committee Meetings 2024

Health Care Cost Transparency Board

Date	Time
February 9	9am-3pm Retreat
April 10	2-4pm
May 15	2-4pm
June 12	2-4pm
September 19	2-4pm
November 20	2-4pm
December 12	2-4pm

Advisory Committee on Primary Care

Date	Time
January 23	2-4pm
February 29	2-4pm
March 28	2-4pm
April 25	2-4pm
June 26	2-4pm

Advisory Committee of Health Care Providers and Carriers

Date	Time
January 18	2-4pm
March 7	2-4pm
May 29	2-4pm
July 30	2-4pm
August 21	2-4pm
October 24	2-4pm
November 7	2-4pm

Advisory Committee on Data Issues

Date	Time
January 18	2-4pm
March 7	2-4pm
May 29	2-4pm
July 30	2-4pm
August 21	2-4pm
October 24	2-4pm
November 7	2-4pm

Appendix

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board

To ensure health care affordability for all Washingtonians.

Answers to Questions from the Advisory Committee Members

A Member in both the Advisory Committee on Data Issues (Jonathan Bennett with the Washington State Hospital Association) and Advisory Committee of Health Care Providers and Carriers (Mika Sinanan representating the Washington State Medical Association) motioned to request that the Board respond to the questions below. Neither motion passed within the Committees as HCA Staff offered to provide responses to the questions to assist the Committees. Below are the questions and responses.

Important:
The benchmark analysis is currently measuring the baseline year. This means that when this analysis is complete there will only be reporting on state and market level information and includes years 2017-2019. There will be no reporting on carriers or large providers.

Background

The Health Care Cost Transparency Board is responsible for reducing the state's health care cost growth by:

1. Determining the state's total health care expenditures.
2. Identifying cost trends and cost drivers in the health care system.
3. Setting a health care cost growth benchmark for providers and payers.
4. Reporting annually to the Legislature, including providing recommendations for lowering health care costs.

The Board must set a benchmark for the annual rate of growth of total health care spending in Washington State. After establishing the baseline measurement, in future years the Board will identify health care providers and payers that are exceeding the established benchmark. The purpose of the benchmark and reporting is to:

- Reduce the overall trend of health care cost growth in Washington State.
- Make health care costs more transparent to the public and policymakers.
- Encourage providers and payers to keep costs at or below the benchmark.

The Board and its advisory committees have discussed the methodology questions in the past and incorporated the guidance in the data submission technical manual. A summary of each topical area is captured below:

Attribution Methodology

Will plans report the numbers of attributions made using each method? Will large provider entities be able to review provider attributions to ensure accuracy?

Attribution of individual patients to a primary care provider (PCP) follow the following hierarchy:

1. **Member Selection**: Members who were required to select a PCP by plan design should be assigned to that PCP.
2. **Contract Arrangement**: Members not included in #1 and who were attributed to a PCP during the performance period pursuant to contract between the carrier and the provider, should be attributed to that PCP.
3. **Utilization**: Members not included in #1 or #2, and who can be attributed to a PCP based on the member's utilization history should be attributed to that PCP. Carriers may apply their own primary care-based methodology when attributing a member to a PCP based on utilization.

Additional information may be found on page A-2 of the technical manual for the data call. The manual can be found here: https://www.hca.wa.gov/assets/program/benchmark-data-call-manual-july-2022.pdf

Additional relevant information is available in the Health Care Cost Growth Benchmark Value and Methodology document and the Measuring Benchmark Performance document, which are included in this response and available on the Board's webpage.

For the process of reviewing attribution when the Board initiates the provider performance measurement process, please see below in the section on provider performance.

Risk Adjustment

Will specific adjustments made for each of the provider organizations be disclosed and reviewable?

This risk adjustment method was chosen from several options considered by the Advisory Committee on Data Issues (see also the Health Care Cost Growth Benchmark Value and Methodology document and the Measuring Benchmark Performance document). This methodology is utilized by several states engaged in benchmarks and reflects the same methodology used by those other cost boards that use age/sex risk adjustment. The age/sex risk adjustment is straightforward in that it will adjust the overall truncated claims spending based on the carrier/large provider's proportion of those categories based on the overall market.

Risk adjustment does not apply to the baseline benchmark, it will only be applied to the measurement of performance in future years. Milliman is currently proving a secondary review of the methodology and calculations to ensure accuracy. When Milliman's work is complete and the Board begins to collect data to measure performance, the Board will publish additional documentation of the methodology.

Analysis for Specific Provider Performance

What information will be given to large provider entities that exceed the benchmark and will that information help inform their practices, e.g., whether exceeding the benchmark was due to increased price of services versus increased use of services? Is there other information that can be provided to inform their practices on how to make improvements?

Analysis is currently being conducted only to establish the baseline information. These are pre-benchmark years (2017-2019) and will only focus on state and market performance. To date, the Board has not yet initiated the data call to begin measuring performance.

HCA is currently developing a template for payer and large provider reports for future reporting years. This template will be shared for feedback.

After the development of the historical benchmark, and finalization of a reporting template, HCA will work with carriers and large providers to review their growth trends on overall performance as well as individual service categories which are defined in the technical manual. The template will be populated with large provider and carrier information from the baseline years that is not made publicly available, to ensure large providers and carriers have opportunity to review their information and communicate any issues.

Measurement of future years' performance is likely to follow a similar process before public release of the information. There are no performance improvement plans in statute for providers or carriers, therefore the Board does not have the resources, data or staffing to advise providers on their business practices.

Provider Identification and Notice

Are the provider entities identified in the technical manual the finalized list that will be compared against the benchmark? How and when will providers be notified that they are subject to the benchmark?

There is a current list of anticipated large provider entities that may be identified in future years in the data call technical manual on page A-6 here: https://www.hca.wa.gov/assets/program/benchmark-data-call-manual-july-2022.pdf. The list in the manual is based on initial data from carriers. Large providers listed in the manual can expect to have their performance publicly reported if they meet minimum threshold sizes (e.g., 10,000 covered lives). However, this list will be verified with data collected from the benchmark to ensure these entities reach a minimum threshold of covered lives and that all entities have been captured. The Board methodology currently outlines the use of a minimum threshold of covered lives after the historical benchmark analysis that is similar to other cost boards which is a minimum of 10,000 covered lives.

The baseline data and minimum threshold covered lives data are still under review. The current estimated completion date for the minimum threshold analysis is March 2024. At that time, a webinar will be announced for all large provider entities included in the public report for orientation to the report. Public reporting of carrier and large provider experience is not anticipated until late 2024 or early 2025.

When the Board begins measuring performance, HCA will send information to large providers on payers' previously submitted data submissions, which will include the number of attributed members before HCA publishes large provider level cost growth. Large providers and carriers will have the opportunity to review their information and communicate any issues.

Washington State Health Care Authority
Health Care Cost Transparency Board

Health Care Cost Growth Benchmark Value and Methodology

What is a benchmark?

The benchmark is a spending growth rate that carriers and providers should try to stay under to make health care more affordable for individuals, families, states and businesses.

The purpose of Washington's benchmark is to:

- Make health care costs more transparent to the public and policymakers.
- Encourage carriers and providers to keep costs at or below the benchmark.
- Reduce the overall trend of health care cost growth in Washington State.

If you would like more information on the benchmark and how it was created and the process as it was developed, below are descriptions and links to each of the meetings that touched on the benchmark.[1]

Meeting Dates	Topics and Discussions
March 15, 2021 **Health Care Cost Transparency Board**	What is a cost growth benchmark? Why pursue one? How will it impact health costs? Reviewing other states' cost growth benchmark programs.
April 13, 2021 **Health Care Cost Transparency Board**	Beginning the process of defining the methodology.
April 27, 2021 **Advisory Committee of Health Care Providers and Carriers**	Review of the Health Care Cost Growth Benchmark legislation and Massachusetts's Cost Growth Benchmark program experience.
May 13, 2021 **Health Care Cost Transparency Board**	Establishing a benchmark methodology and value: • Economic indicators (e.g., gross state product, mean wage, median wage, consumer price index) • Using historical vs. forecasted values

[1] Written links to meetings materials:
Health Care Cost Transparency Board: https://www.hca.wa.gov/about-hca/who-we-are/meetings-and-materials
Advisory Committee of Health Care Providers and Carriers: https://www.hca.wa.gov/about-hca/who-we-are/advisory-committee-health-care-providers-and-carriers
Advisory Committee on Data Issues: https://www.hca.wa.gov/about-hca/who-we-are/advisory-committee-data-issues

May 25, 2021 **Advisory Committee of Health Care Providers and Carriers**	Benchmark methodology and value: • Economic indicators • Historical vs. forecasted data
June 16, 2021 **Health Care Cost Transparency Board**	Comparing historical health care cost growth in Washington to income growth. Establishing a benchmark methodology and value: • Economic indicators • Historical vs. forecasted values • How long should the initial benchmark value apply for? • Should the benchmark value should adjust over time? • Should there be a trigger to allow the benchmark methodology to be reevaluated? Preliminary decisions: • To set the benchmark value using a 70/30 hybrid of historical median wage and potential gross state products (PGSP), yielding a benchmark value of 3.2%. ○ Based on 20-year historical median wage at 3% and PGSP forecast for 2021-2025 at 3.8%. • To set the benchmark value for an initial period of five years.
June 29, 2021 **Advisory Committee of Health Care Providers and Carriers**	Historic health care cost growth trends in Washington. Benchmark methodology and value: • Economic indicators • Historical vs. forecasted values Adjustments to the benchmark. The committee provided feedback on the benchmark value, how long the initial benchmark value should apply for, whether the value should change over the initial period, and incorporating a trigger.
July 8, 2021 **Advisory Committee on Data Issues**	Introduction and overview of health care cost growth benchmarks.
July 19, 2021 **Health Care Cost Transparency Board**	Feedback from the Advisory Committee of Health Care Providers and Carriers: The Board reviewed feedback on the benchmark methodology – economic indicators, how long the initial benchmark should apply for and if the value should adjust over the initial period, incorporating a trigger to re-evaluate. Recap and discussion on the benchmark methodology and value:

	• Options for a phasedown of benchmark values during the five-year period. • Affirming the rationale for the chosen methodology (70/30 median wage/PGSP) and strong intention to select a benchmark that would provide relief to consumers and employers. The Board discussed phasing down the benchmark value over the five-year period: 2022 – 2023: 3.2% 2024 – 2025: 3% 2026: 2.8%. Trigger for the benchmark methodology.
August 10, 2021 **Advisory Committee on Data Issues**	Overview of preliminary benchmark decisions. Phasing down the benchmark value over a five-year period.
August 17, 2021 **Health Care Cost Transparency Board**	The Board reviewed and approved the proposed trigger language, which included an annual review of performance against the benchmark, and the opportunity to revisit the benchmark value under extraordinary circumstances.
September 14, 2021 **Health Care Cost Transparency Board**	Reviewed feedback from the Advisory Committee of Health Care Providers and Carriers. Options for the benchmark value and methodology and the estimated costs each option would save. The majority voted to approve the following benchmark values: 2022 – 2023: 3.2% 2024 – 2025: 3% 2026: 2.8%
September 30, 2021 **Advisory Committee of Health Care Providers and Carriers**	Review of the Board's decision on the benchmark methodology and value: • Recap of the Board's decision on benchmark methodology and values after receiving feedback from the Advisory Committee of Health Care Providers and Carriers. • Review of Board-adopted language for annual review of performance against the benchmark and for a trigger to consider reevaluation of the benchmark. • Review of projected savings under three selected benchmark scenarios.

	Impacts of the benchmark on the health care delivery systems to consider in terms of access, quality, and cost. The committee discussed unintended potential impacts.
March 16, 2022 **Health Care Cost Transparency Board**	Impact of COVID-19 and rising inflation on the cost growth benchmark: • Impact of COVID-19 on spending trends in 2019 and 2020. • Trend for 2020 and 2021 is expected to be higher. • Rising costs, supply chain issues, labor shortages, and elevated labor costs. • Review of how other states retained their benchmark values and interpret 2020 and 2021 results in the context of the economic impact of COVID-19. The Board determined not to adjust the benchmark, but to monitor the situation closely. Feedback from the Advisory Committee of Providers and Carriers – Impacts to consider: • Possible consequences of transparency and cost reduction efforts and suggestions of areas for monitoring and counter-measurement. • Effects of COVID-19 on spending that will most likely influence benchmark results (rising labor costs, utilization changes, required benefit changes such as vaccines).
April 6, 2022 **Advisory Committee of Health Care Providers and Carriers**	Impact of COVID-19 and rising inflation on the cost growth benchmark: • Impact of COVID-19 on spending trends in 2019 and 2020. • Trend for 2020 and 2021 is expected to be higher. • Rising costs, supply chain issues, labor shortages, and elevated labor costs. • Review of how other states retained their benchmark values and interpret 2020 and 2021 results in the context of the economic impact of COVID-19. • The committee learned that the Board determined not to adjust the benchmark but would continue to monitor and maintain engagement with stakeholders.
October 19, 2022 **Health Care Cost Transparency Board**	Update on the cost growth benchmark in other states. Discussion on possible inflation adjustments: • The data being collected came from a period prior to the inflation spike. • There would be more time to monitor other states' approaches to inflation adjustments before the data call in 2023.

February 15, 2023
 	
Health Care Cost Transparency Board
	Inflation's impact on health care spending for the cost growth benchmark:
	• Recent growth in inflation; goods and services; and health care services.
	  ○ Inflation by product type. While prices of goods and services increased in 2021, health care inflation was constant. Research literature has found macroeconomic changes affect health care spending on a lagged basis.
	  ○ Changes in Consumer Price Index (CPI-U) for medical services compared to other goods and services.
	• Economic indicators used by the six Peterson-Milbank states.
	• Accounting for inflation and increased labor costs when measuring benchmark performance:
	  ○ Whether to allow for performance to exceed the benchmark for a limited time.
	  ○ Making adjustments does not necessarily mean restating the benchmark. A state can set a temporary allowance.
	• Considerations on creating an allowance.
	  ○ Arguments for and against adjusting for inflation and/or labor costs.
	• Key policy considerations.
	• Reviewing other states' responses to rising inflation.
	
	Discussion and Decision: Should there be an adjustment to the benchmark to account for inflation?
	
	A motion was made and approved to maintain the benchmark values as the Board awaits further data.

Washington State Health Care Authority
Health Care Cost Transparency Board

Measuring Benchmark Performance

The Health Care Cost Transparency Board (the Board) will review how the state, markets, health insurance carriers, and large provider entities are performing compared to the benchmark. To collect data needed to measure performance, HCA will conduct the benchmark data call annually for the benchmark analysis.

The technical manual includes details on the data collection process, methodology, data specifications, and calculation methods.

Key Acronyms and Terms

Calculating Spending

Total health care expenditures (THCE): Refers to the spending used to measure performance against the benchmark. THCE is the allowed amount of claims-based and non-claims-based spending from payer to provider plus the carriers' net cost of private health insurance.

- THCE is calculated at the state level.

Total medical expenditures (TME): All payments (total claims and total non-claims payments) to providers incurred for all health care services.

- TME is reported at the state, market, payer, and large provider entity levels.

Net cost of private health insurance (NCPHI): The costs to Washingtonians associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is the difference between health premiums earned and benefits incurred, and consists of carriers' costs of paying bills, advertising, sales commission and other administrative costs, premium taxes, and profits (or contributions to reserves) or losses.

- NCPHI is reported as a component of THCE at the state level.

Methods to Ensure Accuracy and Reliability

Risk adjustment: Accounting for changes of a population that might impact spending growth.

- Risk-adjustment by age/sex will be applied at the provider and carrier levels.

Truncation: Mitigating high-cost outliers on provider and carrier performance against the benchmark.

- Applied at the provider and carrier levels.

Confidence interval: Statistical testing to ensure confidence in calculating cost growth. The confidence interval is a range of values in which we can say with a certain degree of confidence, that our true value lies.

- Applied at the provider and carrier levels.

Meeting Dates and Topics

If you would like more information on how the methodology for measuring performance against the benchmark was developed, the topics and links to the meetings are available in the table below.[1]

Meeting Dates	Topics and Discussions
April 13, 2021 **Health Care Cost Transparency Board**	Defining THCE and TME.
April 27, 2021 **Advisory Committee of Health Care Providers and Carriers**	Massachusetts's cost growth benchmark program structure and experience. This included how the state measured performance against the benchmark using THCE (which includes TME, patient cost-sharing, and the net cost of private health insurance).
May 13, 2021 **Health Care Cost Transparency Board**	Defining THCE and TME. Defining the population for whom TME are being measured: • Sources of coverage. • State of residence and care location.
May 25, 2021 **Advisory Committee of Health Care Providers and Carriers**	Defining THCE and TME. Committee members provided recommendations on additional items to include in the definitions. Determining whose TME to measure. The committee was presented with the Board's preliminary decisions to include spending for all Washington residents, regardless of where they receive their care, and the sources of coverage to include. The committee provided feedback.
July 19, 2021 **Health Care Cost Transparency Board**	Review of the feedback from Advisory Committee of Health Care Providers and Carriers on the definitions for THCE and TME. Feedback included a desire to include additional expenditures. The Board determined these did not meet the definitions due to not representing medical expenditures or not involving payment.
August 10, 2021 **Advisory Committee on Data Issues**	What constitutes THCE when measuring against the benchmark. Overview of data collection and sources for the benchmark analysis. Reporting performance against the cost growth benchmark. • Benchmark performance analysis vs. cost growth driver analysis

[1] Written links to meeting materials:
Health Care Cost Transparency Board: https://www.hca.wa.gov/about-hca/who-we-are/meetings-and-materials
Advisory Committee of Health Care Providers and Carriers: https://www.hca.wa.gov/about-hca/who-we-are/advisory-committee-health-care-providers-and-carriers
Advisory Committee on Data Issues: https://www.hca.wa.gov/about-hca/who-we-are/advisory-committee-data-issues

	• Benchmark performance reported at four levels: state, market, payer, large provider entity.
	• Defining and identifying provider entities whose benchmark performance will be measured will be addressed later.
	
	Methods to Ensure Accuracy and Reliability when measuring performance against the benchmark:
	
	• Statistical testing on data
	  ○ The committee supported the use of confidence intervals. One member supported the use provided there is clear documentation within the reports pertaining to methodology used to construct the confidence intervals.
	• Mitigating the impact of high-cost outliers
	  ○ Most committee members recommend using truncation of high-cost outliers' spending when measuring performance against the benchmark for provider entity and carriers.
	• Accounting for changes in population health status that might impact spending growth.
	  ○ The majority agreed that risk-adjusting by age and sex to assess performance against the benchmark is reasonable. The committee provided feedback and discussed concerns.
	• Determining the minimum population sizes for gathering benchmark data to measure performance against the benchmark.
	  ○ Review of how other states determined the thresholds for payer reporting and public reporting of provider performance. For example, carriers with market share of at least five percent would be required to submit data reports.
	  ○ Many committee members requested additional information about the Washington market to make a more informed decision.

August 17, 2021 **Health Care Cost Transparency Board**	Defining THCE and sources of coverage: Wrap up discussion and review of feedback from the Advisory Committee of Health Care Providers and Carriers. The Board approved the sources of coverage included in the definition of THCE (such as Medicaid, Medicare, and commercial).
September 14, 2021 **Health Care Cost Transparency Board**	Distinguishing between the benchmark analysis (performance against the benchmark) and the cost driver analysis.

	Review of how other states report performance against the benchmark. Typically, states report at four different levels:
	
	1. State.
	2. Market.
	3. Carrier/Payer.
	4. Large provider entity.
	
	The Board was provided feedback from the Advisory Committee on Data Issues on using confidence intervals and truncation to ensure accuracy and reliability of measurement.
	
	Methods and strategies to ensure accuracy and reliability of benchmark performance measurement.
	
	• Statistical testing on benchmark performance data.
	  ○ Confidence intervals.
	• Mitigating the impact of high-cost outliers: using truncation.
	  ○ To not unfairly judge carrier and provider performance against the benchmark when it is influenced by spending on high-cost outliers.
	  ○ Truncation is a common practice to prevent a small number of extremely costly members from significantly affecting providers' per capita expenditures.
	
	Decision: After reviewing feedback from the Advisory Committee on Data Issues, the Board approved the use of confidence intervals and truncation.

September 30, 2021 **Advisory Committee of Health Care Providers and Carriers**	Introduction to reporting performance against the benchmark: Cost growth benchmark analysis vs. cost driver analysis: what they are, what data type will be used, and the data sources. Sources of coverage for the benchmark data call. Provider level reporting: Limited to provider entities that are large enough to accurately and reliably measure and have responsibility for meeting all a patient's needs. Methods selected to ensure the accuracy and reliability of benchmark performance measurement. The Board's activities related to developing the benchmark data call was shared. The Board's intent is to use best practices to ensure accurate, valid, and consistent data to support confidence in the results. Larger decisions will be made by the Board with recommendations from the Advisory Committee on Data Issues. Some will be made by HCA staff.

	The committee was presented with information on the use of confidence intervals (a range of values in which we are fairly sure our true value lies) and truncation (mitigating the high-cost outliers when assessing provider and carrier performance against the benchmark). The committee also heard how other states use these strategies to ensure the benchmark performance data is reliable.
October 28, 2021 **Advisory Committee on Data Issues**	Defining the list of carriers that will report THCE for the cost growth benchmark. • HCA staff researched and developed a list of carriers with at least 10,000 enrolled lives that would be required to report data. The list was vetted with other state staff. ○ Staff recommended 12 carriers with substantial market share. Together, the 12 carriers account for 96% of covered lives (after excluding limited benefit plans). • Discussed recommendation to not include standalone third-party administrators (TPA) and health care benefit managers at the time. • Discussed how to account for members on self-funded employer plans. Identifying large provider entities for whom carriers will report spending. • Review of methodologies for attributing clinicians to large provider entities. • Staff developed an initial list of potential providers. The committee provided feedback. Risk adjustment options. The committee reviewed strengths and weaknesses on four options for risk adjustment and provided recommendations.
September 8, 2021 **Advisory Committee on Data Issues**	Key questions to address for provider-level reporting: • How members should be attributed to clinicians. ○ Comparing two methodologies for attributing member to clinicians. • Discussion on how to organize clinicians into large provider entities. The committee did not recommend mandating a specific methodology, but felt it was important to have material consistency in attribution methodologies and to have documentation of those methodologies

	from payers. The committee recommended allowing payers to use their own attribution methodology based on the following hierarchy: 1. Member selection 2. Contract arrangement 3. Utilization
October 28, 2021 **Advisory Committee on Data Issues**	Defining the list of large provider entities for whom the carriers will be reporting THCE on. • Methodologies for attributing clinicians to large provider entities. • Review of the process and considerations for identifying providers. • Staff conducted research and developed an initial list of 50 entities, which was vetted with staff from other state agencies with knowledge of the provider landscape. • Review of provider thresholds used in other states. For example, public reporting of providers with more than 10,000 Medicaid or commercial lives or 5,000 Medicare lives.
November 17, 2021 **Health Care Cost Transparency Board**	Using risk adjustment when determining performance against the benchmark. The Board reviewed four options to risk adjust health data: • age/sex adjustment performed by the payers • age/sex adjustment performed by the state • clinical risk adjustment normalization performed by payers • clinical risk adjustment normalization performed by the state Feedback from the Advisory Committee on Data Issues • Most supported age/sex performed by the state. Some supported that the state performs clinical adjustment normalization on all payer data; however, this option was not feasible within current resources. The Board decided to select age/sex risk adjustment using standard weights developed by HCA based on current resources. The Board directed that staff explore the future ability to perform clinical risk adjustment normalization using data from the Washington State All Payer Claims Database (APCD). Key questions to address for provider-level reporting: preliminary discussion on provider attribution methodology. • How members can be attributed to clinicians

	• How clinicians should be organized into larger entities for reporting. Review of approaches, including methodologies used in other states. The Board also reviewed feedback from the Advisory Committee on Data Issues.
December 15, 2021 **Health Care Cost Transparency Board**	Attribution in Health Care Authority programs. To achieve the mandate to report cost trends at the provider level, payers would need instructions on how to do to levels of attribution: member to clinician and clinician to large provider entity. The Board was informed that all other states were allowing carriers to use their own attribution methodology, either with or without a recommended hierarchy. The Board reviewed about attribution methodology of the Washington Health Alliance (WHA), which uses primary care provider (PCP) based attribution. Staff recommended allowing insurers to use their own PCP-based attribution methodology, within the following hierarchy: member selection, contract arrangement, and utilization. This would be in line with recommendation by the Advisory Committee on Data Issues. Decision: Member attribution methodology. The Board approved the recommendation of allowing carriers to use their own PCP-based attribution methodology, based on a hierarchy that prioritizes member selection, then contract arrangements, then utilization. Presentation and discussion: Provider entities accountable for total medical expenditures. The Board was provided information related to how to attribute clinicians to large provider entities and discussed concerns. The Board revisited research investigating the feasibility of existing state directories. Staff recommended pursuing use of the Washington Health Alliance (WHA) directory and asking issuers to do attribution based on contracting arrangements as a fallback option should a WHA contract not prove feasible. Decision: Clinical Attribution. The Board accepted the recommendation to pursue use of WHA's directory, and then to ask carriers to do attribution

	based on contracting arrangement as a fallback option. HCA staff was directed to explore whether there were other large entities in the state who do not employ PCPs that would be appropriate for inclusion. Cost growth benchmark accountability. The Board reviewed the legislative language on benchmark accountability, as well as Massachusetts's accountability process. The presenter asked the Board several questions to consider, including the process(es) that should be in place for reporting against the benchmark, how performance should be reported, types of communication that should accompany the cost trends report, and any other activities that should accompany the release of the cost trends report.
January 31, 2022 **Advisory Committee on Data Issues**	Pre-benchmark data collection process and timeline. The Board will adopt the technical manual to collect data. The Board expects the committee will have the opportunity to comment prior to adoption. Payer survey of provider entity contracts A payer survey will be issued confirming total cost of care contracts. The purpose of the survey is to confirm the list of provider entities that will be subject of the benchmark reporting data are correctly identified. Benchmark Performance Assessment Proposed truncation thresholds, consistent with Rhode Island's approach: Commercial: $150,000. Medicaid: $250,000. Medicare: $100,000. Truncation amounts would be valued at the member level, cumulatively (rather than treatment level), and applied to provider entities and carriers by market. The committee provided feedback and recommendations including having an approach that permits reviewers to understand what had been excluded (either through the ability to "toggle" the truncation on and off, or through an ad-hoc report).
February 1, 2022	Pre-benchmark data collection process and timeline.

Advisory Committee of Health Care Providers and Carriers	The Board will adopt the technical manual to collect data. The Board expects the committee will have the opportunity to comment prior to adoption.
	
	Payer survey of provider entity contracts
	
	A payer survey will be issued confirming total cost of care contracts. The purpose of the survey is to confirm the list of provider entities that will be subject of the benchmark reporting data.
	
	Accountability – reporting performance against the benchmark
	• Review of accountability processes adopted by other states.
	• Draft principles:
	  ○ Accountability process (including preparation, review, reporting, and recommendations) will be transparent and predictable.
	  ▪ The benchmark analysis report will identify the entities who are reported on, permitting comparison between them.

March 1, 2022
 	
Advisory Committee on Data Issues
	Benchmark Performance Assessment.
	• Risk Adjustment of benchmark data.
	  ○ Future measurement of carriers and large provider entity performance against the benchmark will be risk-adjusted by age/sex.
	  ○ Carriers will submit aggregate spending and member months data by age/sex cells.
	  ○ Proposed age bands: 0-1, 2-18, 19-39, 40-54, 55-64, 65-75, 77- 84 and 85+. Rhode Island was the first state to use age/sex risk adjustment, and this was the method used.
	• Truncation analysis update.
	  ○ The Board contracted with OnPoint to perform an analysis of truncation level impacts in Washington.
	  ○ A truncation dashboard, created by a committee member, was shared. The dashboard was based on MEPS data.

April 20, 2022 **Health Care Cost Transparency Board**	Benchmark attainment: Feedback from the Advisory Committee of Health Care Providers and Carriers on criteria the Board adopted for selecting strategies to support benchmark attainment.

May 5, 2022 **Advisory Committee on Data Issues**	Truncation report and recommendations. • Specifications for the truncation analysis and the approaches used. • Results of the truncation study prepared for the Board upon recommendation by the committee. • Staff recommended to adopt truncation points removing the top ~5% of spending: Commercial: $200,000. Medicaid: $125,000. Medicare: $125,000. • Truncation was used where it would most impact reporting: at the carrier and provider levels. Truncation is used in other states as change of frequency or incidence of high-cost outliers would be greater at the provider and carrier levels due to smaller population sizes and shifting year-to-year. • The purpose of truncation is to ensure high-cost outliers would not unduly shift the appearance of spending growth to one carrier or provider entity. The goal is to hold provider entities and carriers accountable fairly for spending trends. Benchmark data call technical manual and updates. Technical manual: • Which carriers are required to submit data. • Large provider entities for which insurers will submit spending data (tentative). • Data specifications. • Data submission process. • Data submission template. Washington's data specifications compared to other states. HCA will conduct a data validation process including: • Early review of submissions. • An initial analysis of trends across service categories and from year to year looking for anomalies. • A series of validation calls with submitters to ensure data was submitted correctly. It was noted that ensuring the quality of submitted data often required back-and-forth communication with submitters. The process needs

	extensive one-on-one engagement and learning to respond was an iterative process.

June 2, 2022
Advisory Committee of Health Care Providers and Carriers
	Update on large provider entities subject to attribution by carriers for the benchmark analysis report.
	• Draft list of provider entities was presented, along with the rationale.
	  ○ While patients are attributed to a specific provider, the reporting for TME falls to the large entity provider, not the individual clinician.
	  ○ Reportable provider entities include those that could take on the total cost of care contracts because they:
	  ▪ Include primary care providers who direct a patient's care.
	  ▪ Can exert influence over where a patient receives care.
	• There will be no public reporting on carriers and providers in the first benchmark analysis report.

April 4, 2023
Advisory Committee on Data Issues
	Benchmark data collection and reporting.
	• Distinguishing between the cost growth benchmark analysis and the cost growth driver analysis.
	• What is measured against the cost growth benchmark? (TME, THCE, NCPHI).
	• Performance against the benchmark will be reported at four levels:
	  ○ State (THCE).
	  ○ Market (TME only).
	  ○ Carrier (TME only).
	  ○ Large provider entity (TME only).
	• Data sources for measuring THCE:
	  ○ Carrier-submitted reports.
	  ○ Other data sources such as:
	  ▪ Center for Medicare and Medicaid Services (CMS).
	  ▪ State Medicaid agency for non-managed care payments (fee-for-service).
	  ▪ Other public coverages: Department of Corrections, Department of Labor & Industries, Veteran's Health Administration.
	  ▪ Regulatory reports to calculate NCPHI.
	• Specifications for carrier-submitted data:
	  ○ Population the data is reported on.

- What data the carriers will report (such as member enrollment, income from fees of uninsured plans, variance or standard deviation data, pharmacy rebates).
- How carriers report spending and membership data.
- Other specifications.

- Categories of claims and non-claims-based spending.
- Adjustments to increase confidence and measurement and reporting performance:
  - State and market levels: No adjustments to data.
  - Carrier and large provider entity levels:

    Risk-adjusting aggregate spending data by age and sex. Overview of how other states have moved (or recommended moving) away from using clinical risk adjustment. The Board will risk-adjust by age/sex factors. To implement this, carries were asked to submit aggregate spending and member months data by age/sex cells, which will used to create standardized weights.

    Truncating spending for high-cost outliers. To prevent a small number of extremely costly members from significantly affecting carrier and provider per capita expenditures, truncation will not count spending above certain thresholds:

    Commercial: $200,000.

    Medicaid: $125,000.

    Medicare: $125,000.

    Using confidence intervals around cost growth rates. The Board will calculate confidence intervals (a degree of uncertainty or certainty) to minimize the impact of small numbers.

    Reporting performance only for carriers and large provider entities[2] that meet minimum threshold for attributed lives. Using confidence intervals will help the issue of determining "sufficient" population sizes to become less pressing. The Board previously recommended deferring the determination of the minimum membership sizes for carrier and large provider entity performance.

Updates on the 2023 benchmark data call.

- Calendar years: 2020 – 2022. Performance against the benchmark will be calculated using 2021 and 2022.

[2] The definition of a "large provider entity" will be determined after the benchmark analysis is completed.

	• Additional insurance category for the Federal Employee Health Benefits (FEHB). • Implementing a way to associate non-claims spending to providers without age/sex stratification. • Changes to materials such as the technical manual and submission template.

April 19, 2023
Health Care Cost Transparency Board
	Data projects overview:
	• Cost growth benchmark.
	• Performance against the benchmark.
	• Cost Driver Analysis.
	• Primary Care Spend measurement.
	
	What they are, what they represent, the analytic basis, risk adjustment considerations, and other considerations.
	
	Benchmark data collection and reporting:
	• Reminder: Distinguishing between the cost growth benchmark analysis vs. the cost growth driver analysis.
	• What is measured against the cost growth benchmark?
	  ○ TME, NCPHI, THCE: What they are and what is included in the calculations.
	• Performance against the benchmark will be reported at four levels:
	  ○ State (THCE).
	  ○ Market (TME only).
	  ○ Carrier (TME only).
	  ○ Large provider entity (TME only).
	• Data sources for measuring THCE.
	• Specifications for carrier-submitted data:
	• Categories of claims and non-claims-based spending.
	• Adjustments to increase confidence and measurement and reporting performance:
	  ○ State and market levels: No adjustments to data.
	  ○ Carrier and large provider entity levels:
	  1. Risk-adjusting aggregate spending data by age and sex.
	  2. Truncating spending for high-cost outliers.
	  3. Using confidence intervals around cost growth rates.

	4. Reporting performance only for carriers and large provider entities that meet minimum threshold for attributed lives. Updates on the 2023 benchmark data call.

Washington State Health Care Authority
Health Care Cost Transparency Board

Cost Driver Analysis

What is the cost driver analysis?

A first-level drill down analysis of key drivers of health care cost growth. Identification of cost drivers provides the greatest opportunities for mitigating cost growth by creating targeted policies that help Washingtonians by better understanding and controlling these key drivers of costs.

To develop the cost driver analysis, the Health Care Cost Transparency Board (the Board) contracted with OnPoint, a data vendor, to utilize the All-Payer Claims Database (APCD) to examine drivers of health care cost in Washington.

The first year of cost driver analysis included a high-level review of:

- Trends in price and utilization.
- Spend and trend by market and geography.
- Spend and trend by health conditions and demographics.

If you would like more information on the cost driver analysis, how it was created and the process as it was developed, below are descriptions and links to each of the meetings that touched on the cost driver analysis.[1]

Meeting Dates	Topics and Discussions
September 14, 2021 **Health Care Cost Transparency Board**	A general overview of two separate analyses: • Benchmark analysis – Data call from insurance carriers and public payers at an aggregate level to allow assessment of benchmark achievement at multiple levels. • Cost driver analysis – A plan to analyze cost drivers and identify opportunities for reducing cost growth and informing policy decisions using granular claims and/or encounters from data sourced from the APCD.
November 17, 2021 **Health Care Cost Transparency Board**	The Board determined to address the legislative mandate to account for utilization, service intensity, and regional pricing differences in the cost growth driver analysis.
January 19, 2022	Discussion of analyses of cost and cost growth drivers:

[1] Written links to meeting materials:
Health Care Cost Transparency Board: https://www.hca.wa.gov/about-hca/who-we-are/meetings-and-materials
Advisory Committee of Health Care Providers and Carriers: https://www.hca.wa.gov/about-hca/who-we-are/advisory-committee-health-care-providers-and-carriers
Advisory Committee on Data Issues: https://www.hca.wa.gov/about-hca/who-we-are/advisory-committee-data-issues

Health Care Cost Transparency Board	• Distinguishing between the cost benchmark analysis and cost driver analysis. • Purpose and framework. • Two types of cost driver analyses: Phase I and Phase II. • HCA's recommendation and proposed plan for Phase I. • Data sources and types of analyses to include. • Proposed process for conducting and vetting the analyses.
January 31, 2022 **Advisory Committee on Data Issues**	Discussion of analyses of cost and cost growth drivers: • Distinguishing between the cost benchmark analysis vs. the cost driver analysis. • Purpose and framework. • Two types of cost driver analyses: Phase I and Phase II. • HCA's recommendation and proposed plan for Phase I. • Data source and types of analyses to include. • Proposed process for conducting and vetting the analyses. • Recommended Phase II analyses to identify opportunities to reduce cost growth. Committee members asked questions and provided feedback.
February 1, 2022 **Advisory Committee of Health Care Providers and Carriers**	Discussion of analyses of cost and cost growth drivers: • Distinguishing between the cost benchmark analysis vs. the cost driver analysis. • Purpose and framework. • Two types of cost driver analyses: Phase I and Phase II. • HCA's recommendation and proposed plan for Phase I. • Data source and types of analyses to include. • Proposed process for conducting and vetting the analyses. • Recommended Phase II analyses to identify opportunities to reduce cost growth. The committee provided feedback and recommendations.
March 16, 2022 **Health Care Cost Transparency Board**	Review of feedback and recommendations from the Advisory Committee on Data Issues on the cost growth driver analysis and the Advisory Committee of Health Care Providers and Carriers on

	potential unintended consequences of transparency and cost reduction efforts.
November 1, 2022 **Advisory Committee on Data Issues**	The APCD study of cost growth drivers – specifications for Year 1 cost driver analysis. • Purpose, data source (APCD), and scope of the study. • Key topics for the baseline analysis. • Background on the APCD data – what is included and its limitations. • Five years of data: 2017 – 2021. • Payer types and markets. • Categories aligned with the benchmarking initiative. • Geography, age groups, and chronic conditions. • Measures of access and quality. • Primary care. • Behavioral health. Cost driver considerations for 2023: Discussion and feedback.

December 14, 2022
Health Care Cost Transparency Board
	Introduction to the 2022 cost growth drivers study – preliminary findings.
	• Purpose, data source (APCD), and scope of the study.
	• Key topics to consider for Phase I analysis.
	• Summary of methods.
	  ○ Five years of data: 2017 – 2021.
	  ○ Types of coverage and markets.
	  ○ Categories aligned with the benchmarking initiative.
	  ○ Data limitations.
	• Enrollment trends.
	• Trends in medical claims expenditures (medical and pharmacy).
	• Spending by category of service (e.g., primary care, inpatient, specialist).
	• Trends in Per Member Per Month (PMPM) expenditures.
	• Spending growth rate trends for different types of coverage and by categories of service.
	• Regional differences in health care spending.
	• Spending by age and gender.
	• Impact of high-cost members.
	Discussion and feedback on the cost growth drivers study.

February 7, 2023 **Joint committee meeting:**	Introduction to the 2022 cost growth driver study – preliminary findings.

Advisory Committee on Data Issues
 	
Advisory Committee of Health Care Providers and Carriers
	• Purpose, data source (APCD), and scope of the study.
	• Key topics to consider for Phase I analysis.
	• Summary of methods.
	  ○ Five years of data: 2017 – 2021.
	  ○ Types of coverage and markets.
	  ○ Categories of service.
	  ○ Data limitations.
	• Enrollment trends.
	• Trends in medical claims expenditures (medical and pharmacy).
	• Spending by category of service (e.g., primary care, inpatient, specialist).
	• Trends in Per Member Per Month (PMPM) expenditures.
	• Spending growth rate trends for different types of coverage and by categories of service.
	• Regional differences in health care spending.
	• Spending by age and gender.
	• Impact of high-cost members.

February 15, 2023
 	
Health Care Cost Transparency Board
	Cost driver analysis:
	• Key takeaways from the Phase I analysis.
	• Cost growth analyses findings in other states.
	  ○ Washington's findings were generally consistent with other state and national findings. Hospital and pharmacy services are driving overall health care spending growth.
	• Potential Phase II "drill-down" analyses to consider for:
	  ○ Hospital spending.
	  ○ Retail pharmacy spending.
	• Other potential Phase II analyses identified by HCA and OnPoint.
	
	Discussion: What types of drill-down analyses does the Board wish to prioritize?

April 4, 2023 **Advisory Committee on Data Issues**	The APCD study of cost growth drivers – specifications for Phase 1 cost driver analysis. • Purpose, data source (APCD), and scope. • Background on the APCD data – what is included and its limitations. • Reporting periods. • Product types and markets. • Categories of care. • Geography, age groups, and gender categories.

	• Chronic conditions.
	• Measures of access and quality.
	• Metrics:
	  ○ Member months/eligibility.
	  ○ Expenditures.
	  ○ Other metrics.

April 19, 2023 **Health Care Cost Transparency Board**	Data projects overview: • Cost growth benchmark. • Performance against the benchmark. • Cost Driver Analysis. • Primary Care Spend measurement. What they are, what they represent, the analytic bases, risk adjustment considerations, and other considerations.
June 6, 2023 **Joint Committee Meeting:** **Advisory Committee on Data Issues** **Advisory Committee of Health Care Providers and Carriers**	Cost Driver Analysis: Options for Phase II. Options presented were inspired by other states' Phase II analyses. The analyses on pharmacy spending are intentionally left out as a newly created Prescription Drug Affordability Board (PDAB) will review pharmacy trends. • Adding more chronic condition flags. • Inpatient and outpatient descriptives: Overall inpatient/outpatient price growth, trends in inpatient/outpatient severity. • Inpatient to outpatient services: Looking to see if an increase in outpatient services is due to transitions from inpatient services and looking at changes in services, case mixes, and/or diagnostic-related groups (DRGs). • Out-of-pocket spending.