Washington State Health Care Authority

Health Care Cost Transparency Board

June 15, 2022

Health Care Cost Transparency Board
Board Book

June 15, 2022
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only

Meeting Materials — Tab

Meeting agenda 1
May meeting minutes 2
Value-based purchasing part II presentation 3
Community Health and Rural Transformation model presentation 4

P.O. Box 45502
Olympia, WA 98504-5502
hcahcctboard@hca.wa.gov
www.hca.wa.gov

Washington State Health Care Authority

Agenda

TAB 1

Washington State Health Care Authority

June 15, 2022
2:00 p.m. – 4:00 p.m.
Zoom Meeting

Health Care Cost Transparency Board
AGENDA

Board Members:					
☐	Susan E. Birch, Chair	☐	Jodi Joyce	☐	Kim Wallace
☐	Lois C. Cook	☐	Sonja Kellen	☐	Carol Wilmes
☐	John Doyle	☐	Molly Nollette	☐	Edwin Wong
☐	Bianca Frogner	☐	Mark Siegel		
☐	Leah Hole-Marshall	☐	Margaret Stanley		

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome, roll call, and agenda review NOTE: *Chair Birch was unavailable and designated Mich'l Needham to chair this meeting in her absence.*	1	Mich'l Needham, Acting Chair and Chief Policy Officer Health Care Authority
2:05 – 2:15 (10 min)	Approval of May meeting minutes and update on pandemic meeting options	2	AnnaLisa Gellermann, Board Manager Health Care Authority
2:15 – 3:00 (45 min)	Value Based Purchasing Part II	3	JD Fischer, VBP Manager Health Care Authority
3:00 -3:40 (40 min)	Rural Hospitals: Challenges, opportunities, and the Community Health Access and Rural Transformation (CHART) model	4	Theresa Tamura, CHART Manager Health Care Authority
3:40- 3:50 (10 min)	Public comment		Mich'l Needham, Acting Chair and Chief Policy Officer Health Care Authority
3:50 – 3:55 (5 min)	Adjournment		Mich'l Needham, Acting Chair and Chief Policy Officer Health Care Authority

In accordance with Governor Inslee's Proclamation 20-28 et seq amending requirements of the Open Public Meeting Act (Chapter 42.30 RCW) during the COVID-19 public health emergency, and out of an abundance of caution for the health and welfare of the Board and the public, this meeting of the Health Care Cost Transparency Board meeting will be conducted virtually.

Washington State Health Care Authority

May meeting summary

TAB 2

Health Care Cost Transparency Board meeting minutes

May 18, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the board is available on the Health Care Cost Transparency Board webpage.

Members present

Sue Birch, chair
John Doyle
Bianca Frogner
Jodi Joyce
Sonja Kellen
Pam MacEwan
Molly Nollette
Margaret Stanley
Kim Wallace
Carol Wilmes

Members absent

Lois Cook
Mark Seigel
Edwin Wong

Call to order

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

Agenda items

Welcoming remarks

Ms. Birch welcomed the members.

Approval of minutes

The minutes were approved.

Discussion and appointment: Advisory Committee on Data Issues

Two candidates for the Committee were considered by the Board, based on application materials included in the materials and staff recommendation.

Russ Shust was nominated to replace departing member Purav Bhatt. Mr. Shust is the Senior Director of Medical Economics with OptumCare/The Everett Clinic.

Chandra Hicks was nominated to replace departing member Jared Collings. Ms. Hicks is Assistant Director of Delivery System Analytics for Cambia Health Solutions (Regence BlueCross BlueShield).

Both applications were approved.

2022 CMS Actuarial Report

Michael Bailit, Bailit Health

Mr. Bailit presented background and summary information on the Centers for Medicare and Medicaid Services (CMS) national Health Expenditure (NHE) report.

This report is prepared by the CMS Office of the Actuary, has been published annually since 1960, and is often considered the "official" forecast of US health care spending. It includes data on US health care spending by type of service, source of funds, and sponsor.

Mr. Bailit shared the findings that near-term NHE patterns are significantly influenced by the COVID-19 pandemic, and that health care utilization should normalize through 2024. NHE and gross domestic product are both anticipated to grow 5.1 percent per year from 2021-2030, with an average annual NHE per capita growth of 4.3% in 2022 and 2023. He contrasted this to Washington 's cost growth benchmark for those years of 3.2%. He pointed out that the NHE projections were offset by anticipated negative trends in public health dollar spending, related to the reduction in COVID funding. His conclusion was that the benchmark figures would be significantly challenging to achieve in the next few years.

Ms. Birch clarified that expenditure projections by market were national figures, not specific to Washington.

Grant proposal review and discussion

AnnaLisa Gellermann, HCCTB Board Manager
Health Care Authority

Ms. Gellermann provided the Board a draft copy of a proposed grant in development with the Peter G. Peterson Foundation and Gates Ventures. Per Ms. Gellermann, the grant is being developed with the intention of providing data analytic resources and policy development partnership and could form part of a sustainability plan after the end of the Peterson/Milbank sustainability grant which will sunset at the end of December 2022.

Ms. Gellermann described the grant as providing partnership between HCA staff and external data analysts, in support of the Board's charge to perform analyses of cost drivers and provide insight into potential cost mitigation recommendations. Ms. Gellermann shared feedback from the Advisory Committee on Data Issues that use of external partners could cause regulatory barriers.

Board members supported pursuit of the grant, and specifically the additional resources it would provide to build up capacity. One Board member shared that hiring data experts is difficult as they are in demand. One Board member shared that having external partners would add additional perspective, such as the University of Washington or the Washington Health Alliance, would add credibility to the effort. One Board member emphasized that having additional resources and support would be important to bring fully informed recommendations more quickly. In general, the Board strongly supported pursuing the grant.

Primary care expenditures and next steps

AnnaLisa Gellermann, HCCTB Board Manager

Ms. Gellermann shared an overview of the new law establishing a 12% target for primary care spending (RCW 70.390). Her presentation was focused on the preliminary report to the Legislature due December 1, 2022. This report requires recommendations on the definition of primary care, how to achieve the 12% target, and measurement consideration including barriers to access and use of data and how to overcome them.

She shared with the Board a preliminary staff recommendation that an ad hoc committee be formed to examine and provide the required recommendations to the Board. She indicated that staff would return at a future meeting with a more detailed work plan for Board review.

One Board member requested an understanding of the variation of primary care spending by geography, based on a concern that a broad-brush approach would not work related to primary care, and other issues related to cost. Another Board member pointed out that the role of Advanced Registered Nurse Practitioners in rural areas would need to be considered as part of the equation. One member recommended the creation of an ad hoc group including both advisory committee members and other experts. Chair Birch stressed that it was important to create a convergent group recognizing the significant work being done in the state on the issue.

Public comment

Ms. Birch called for comments from the public.

Johnathan Bennet, WSHA: Mr. Bennet provided additional background related to hospital cost studies. He is a member of the Advisory Committee on Data Issues, and as such participated in the May 5 meeting and observed the presentation of the Colorado Hospital Cost Story by John Bartholomew. Mr. Bennet shared that he was puzzled at why this presentation, one among many hospitals cost analyses, was being presented to the Committee and Board. Per Mr. Bennet, Washington has some similarities with Colorado (e.g., low admission rates per capita, lower rates of charity care), but that there were significant differences. He stressed that 44 hospitals in Washington had negative operating margin in 2020, and that he anticipated it would be worse in 2021. He also pointed out that Washington hospitals had significantly lower Medicaid payments (63% of cost) and had not received an increase in a long time. He supported the Board in looking at information outside the All-Payer Claims Database and offered enthusiastic support for guiding the Board's exploration of hospital cost.

Hospital Cost Analysis: The Colorado Story

John Bartholomew and Tom Nash

Mr. Bartholomew and Mr. Nash presented an analysis create by the Colorado Department of Health Care Policy and Financing in response to escalating hospital costs in that state. Per Mr. Bartholomew, Colorado created a hospital provider tax that increased hospital reimbursement for Medicaid services and created a state funding source for the Affordable Care Act Medicaid expansion. The assumption was that higher Medicaid rates and lowered uninsured and bad debt would result in decreased hospital costs. However, analysis showed that Colorado hospital profits grew at 50%+ more than the national average between 2009-2018.

Mr. Bartholomew shared the analysis methodology, based on using Medicare cost report data to observe trends across hospital types and geographic areas. The analysis created metrics based on net patient revenue, hospital-

only operating cost, and net income. He shared both visual exhibits including a scatterplot of Colorado hospitals including net income/profit, and trending reports for cost, price, and profit.

The Board found the methodology interesting and supported the creation of similar analyses using Washington hospital reporting. This will be created and presented to the Board at a future meeting.

Adjournment

Meeting adjourned at 4:01 p.m.

Next meeting

Wednesday, June 15, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Public comment

Washington State Health Care Authority

Value-based purchasing part II

TAB 3

Value-based Purchasing (VBP)

Part II

Health Care Cost Transparency Board
June 15, 2022

Washington State Health Care Authority

Previously on

Value-based Purchasing

Washington State Health Care Authority

Recap

- Payment drives transformation
- VBP should achieve the triple aim
- HCA's VBP Roadmap
- Understanding the impact (and challenges to evaluating VBP)

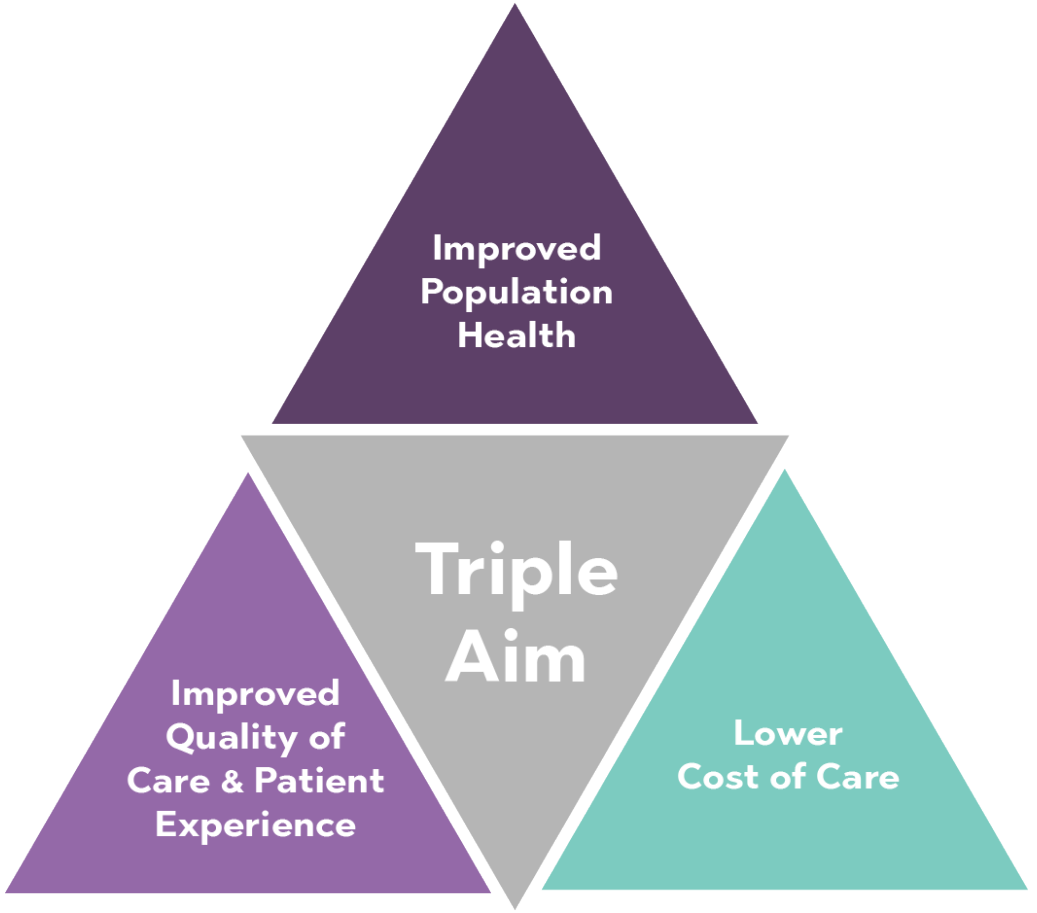
1. What is VBP, why is it important, and how are we doing it?

Washington State Health Care Authority

Why VBP?
Payment drives transformation

VBP should achieve the triple aim by:

- Reducing unnecessary and low-value health care (lower cost)
- Rewarding preventive and whole-person care (better health)
- Rewarding the delivery of high-quality care (better quality and experience)



Washington State Health Care Authority

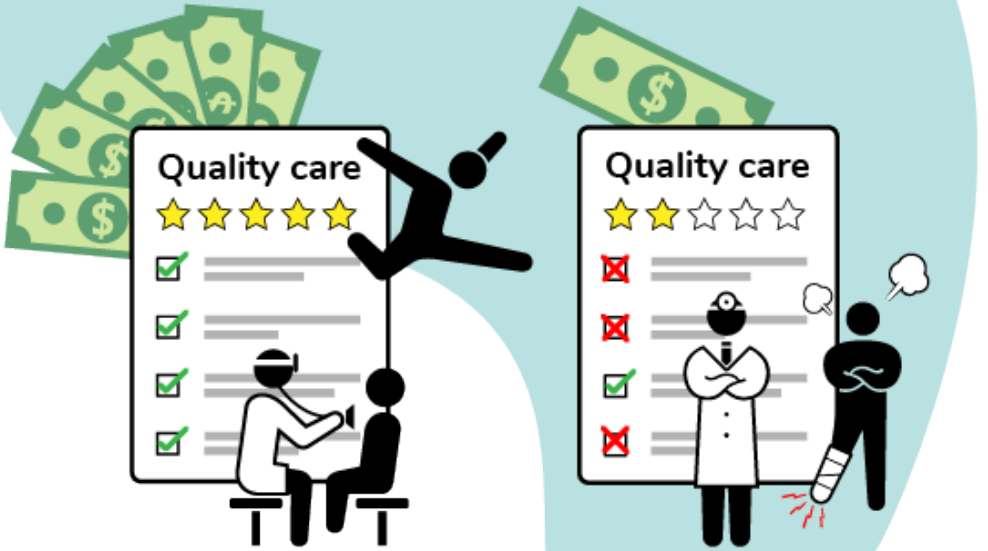
Changing the incentive structure

Fee-for-service

When a health care provider is paid for each service they provide, regardless of the quality or patient's need for that service.

Value-based Payment

When a health care provider is paid for providing high-quality and high-value care to their patients.

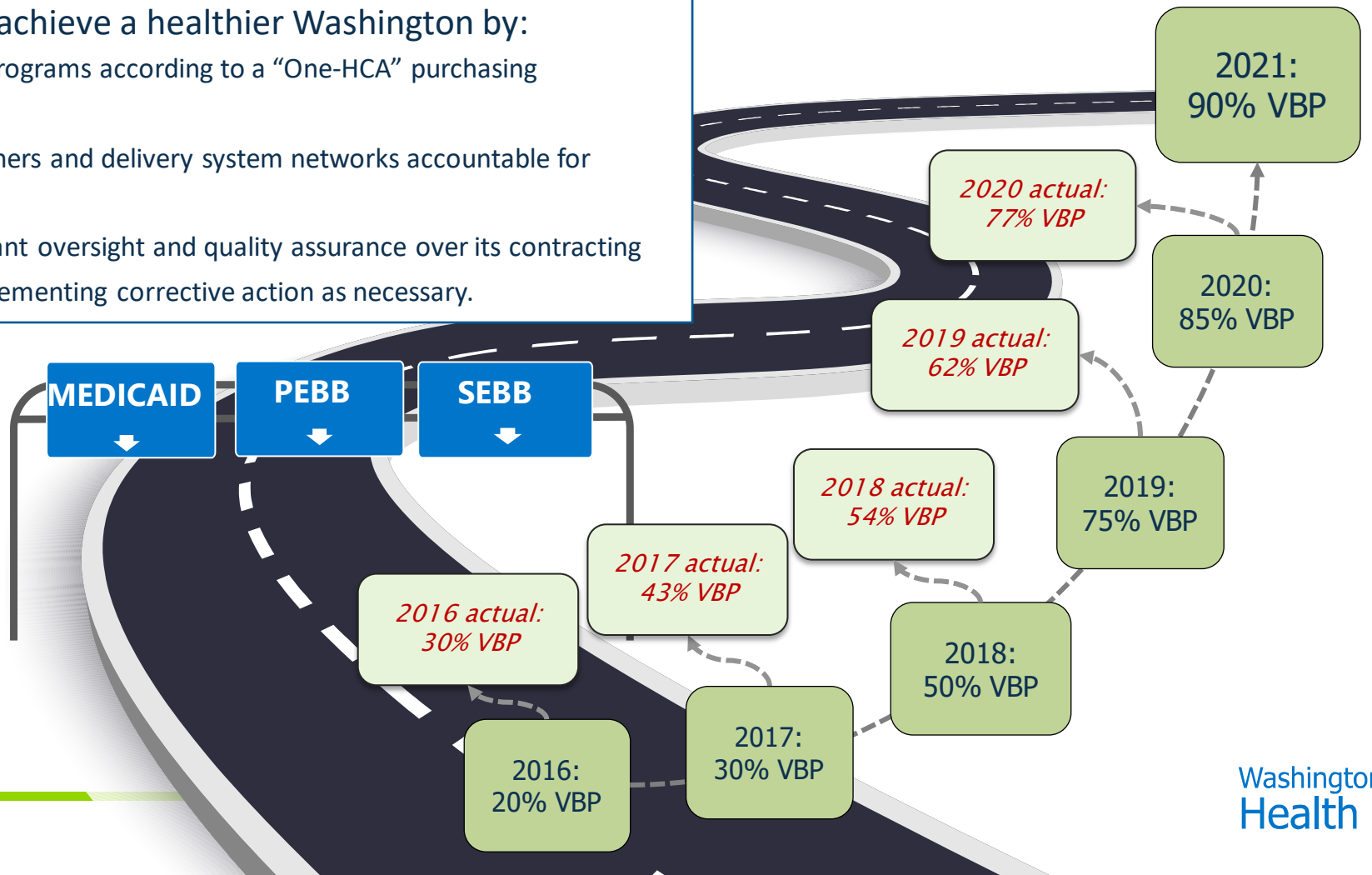


Washington State Health Care Authority

HCA's VBP Roadmap

HCA's vision is to achieve a healthier Washington by:

- Aligning all HCA programs according to a "One-HCA" purchasing philosophy.
- Holding plan partners and delivery system networks accountable for quality and value.
- Exercising significant oversight and quality assurance over its contracting partners and implementing corrective action as necessary.



Washington State Health Care Authority

VBP examples

Public and School Employees Benefits	Apple Health (Medicaid)
• Accountable Care Program: accountable care organization (ACO) model with upside and downside risk to incentivize clinical and quality accountability • Self-insured third-party administrator contract requires Regence to offer substantially similar ACO program to their book of business (risk sharing and care transformation approaches) to spread VBP in the marketplace • Centers of Excellence for Total Joint Replacement and Spine Care • Medical Loss Ratio tied to VBP attainment and quality for SEBB fully insured health plans	• 2% managed care organization (MCO) premium withhold, based on quality and provider VBP arrangements • Behavioral and physical (financial) health integration • Medicaid transformation regional VBP goals tied to incentive payments to Accountable Communities of Health (ACHs) and MCOs • Alternative payment methodology for federally qualified health centers (FQHCs) moves clinics away from encounter-based system

HCA's VBP models in development

- Maternity Episode of Care
- Multi-Payer Primary Care Transformation Model
- Community Health Access and Rural Transformation (CHART) grant
- Alternative Payment Methodology 5 for FQHCs

2. Does VBP work and what do we know about its impact?

Evaluating the impact

- What we can “easily” measure:
  - Health plan quality performance
  - Health plan provider contracting
    - Breadth: total dollars in APMs
    - Depth: total dollars ‘at risk’ or as ‘incentive payments’
  - Member experience for specific models (e.g., COE program)
- HCA currently evaluates:
  - Plan performance on quality and VBP elements
  - HCA’s overall VBP progress
  - Plan and provider experience with VBP (annual Paying for Value Survey)
- State Innovation Model evaluation
  - University of Washington evaluation (including evaluating the Accountable Care Program)

MCO quality performance

Key: ✓ Criteria Met No Criteria Not Met NA Not applicable/Not contracted

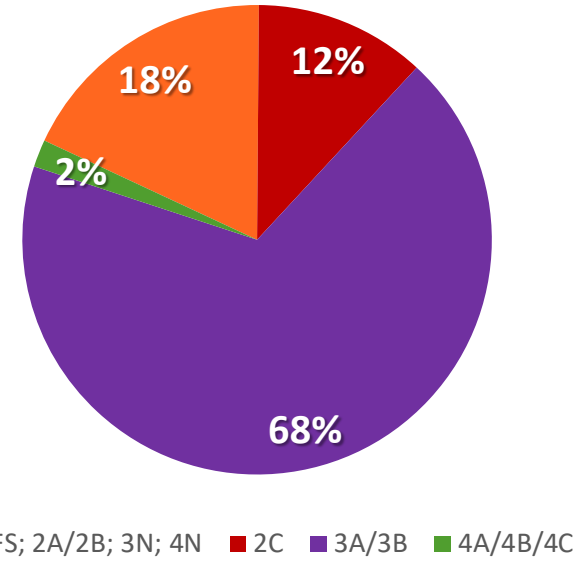
Value-Based Payment Measure		Amerigroup Washington	Coordinated Care of Washington	Community Health Plan of Washington	Molina Healthcare of Washington	UnitedHealthcare Community Plan
Total Percent Achieved		60%	83%	83%	58%	75%
Washington Apple Health Integrated Managed Care (AH-IMC) Shared Measures - *Four shared measures reported by all MCOs*						
Antidepressant Medication Management (AMM)	Effective Acute Phase Treatment	No	✓	✓	✓	✓
	Effective Continuation Phase Treatment	No	✓	✓	✓	✓
Mental Health Treatment (Service) Penetration, Age 6-64, all MCO, excluding BHSO		No	No	✓	No	No
Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care	✓	✓	✓	No	No
	Postpartum Care	✓	✓	✓	✓	✓
Asthma Medication Ratio (AMR), Total		✓	✓	✓	✓	✓
Washington Apple Health Integrated Managed Care (AH-IMC) Plan-Specific Measures - Three quality focus performance measures specific to each MCO						
Substance Use Disorder Treatment Penetration, Age 12-64, all MCO, excluding BHSO		✓	✓	✓	✓	✓
Well Child Visits (WCV), Age 3-11		Data not available				
Follow Up Care for Children Prescribed ADHD Medication (ADD), Initiation Phase		NA	✓	No	NA	NA
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (>9%)		NA	NA	NA	No	✓
Comprehensive Diabetes Care (CDC), Medical Attention for Nephropathy		Data not available	NA	NA	NA	NA

https://www.hca.wa.gov/assets/billers-and-providers/2021-EQR-VBP-Report-Card_Final_11122021.pdf

Washington State Health Care Authority

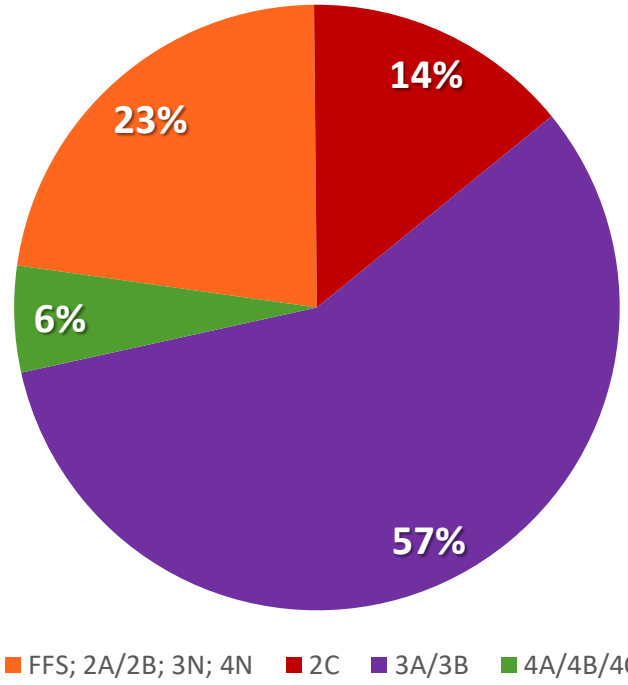
Measuring VBP adoption ('breadth'): CY2020

Medicaid Managed Care



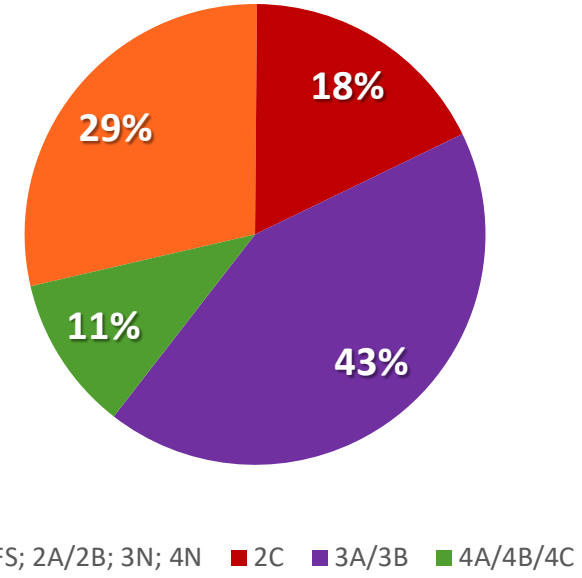
$ 4,561,989,886

HCA TOTAL



$ 7,880,535,034

PEBB & SEBB

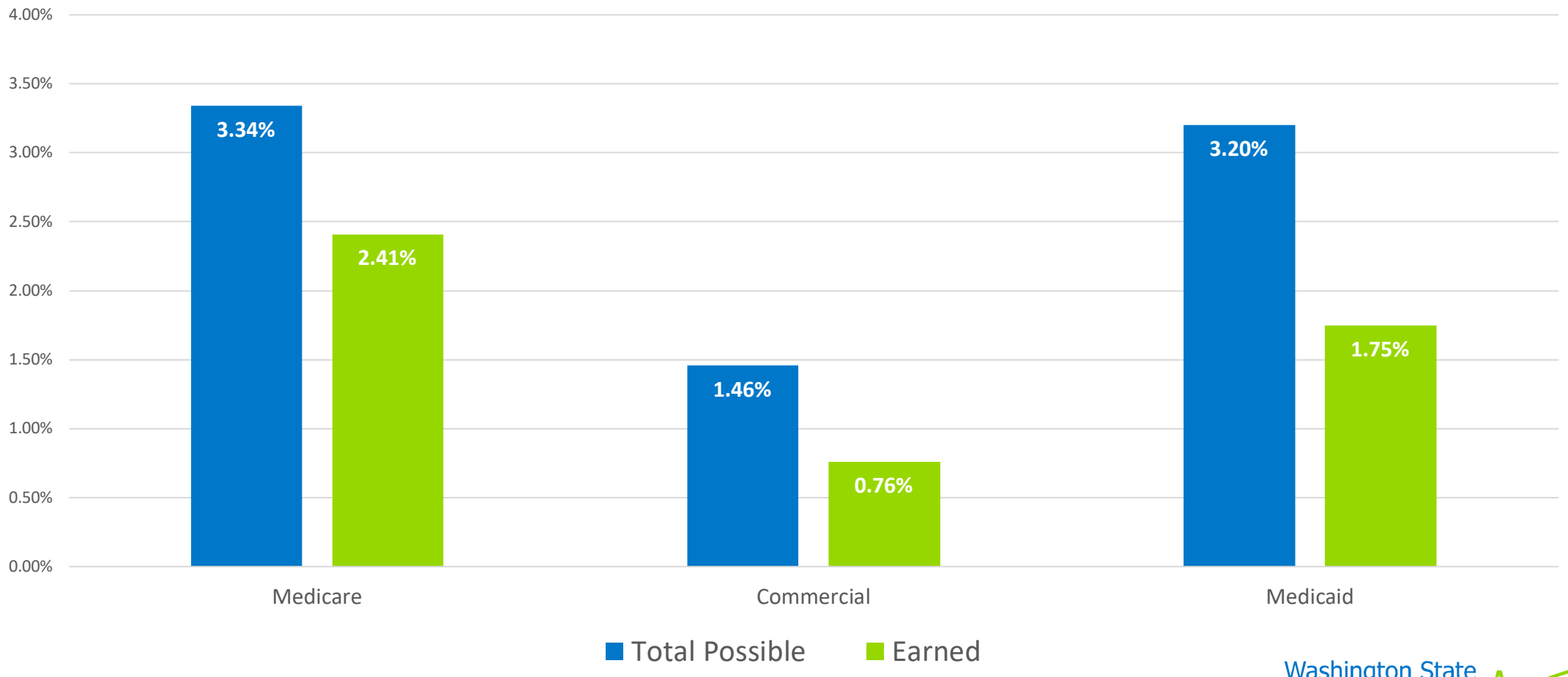


$ 3,318,545,148

2020 state-financed VBP = 77%

Washington State Health Care Authority

Measuring provider incentives ('depth')



Washington State Health Care Authority

3. What is next for VBP?

National context: HCP-LAN APM goals

- Goal statement: “Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk APMs.” i.e., APM Framework categories 3B and up

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%

HCA 2022-25 strategic plan

https://www.hca.wa.gov/about-hca/our-mission-vision-and-values

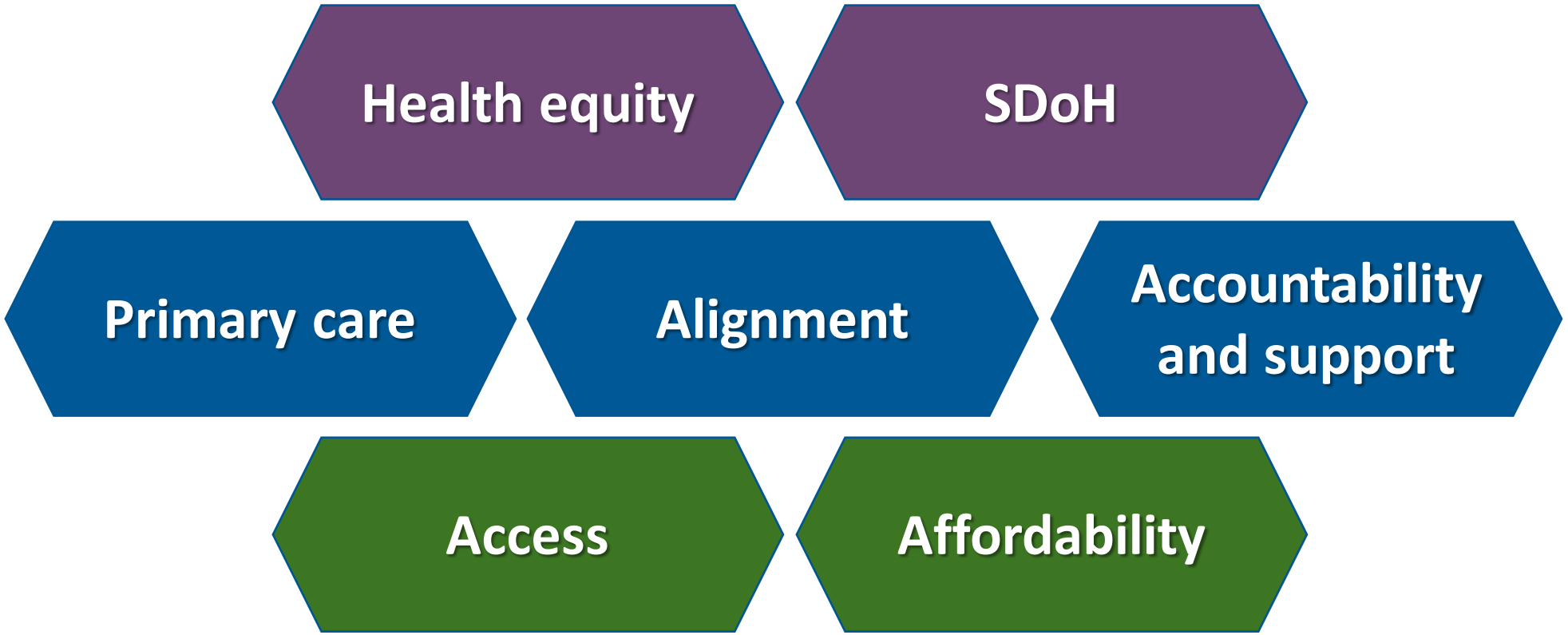
**Refreshed VBP goals in development*

Washington State Health Care Authority

Continue refining and developing APMs

- Multi-payer primary care transformation model
- Community Health Access and Rural Transformation (CHART) Medicaid and Aligned Payer APM
- Medicaid Transformation renewal will continue community-based care and delivery system transformation
- Applying an equity lens to purchasing
- Maternity episode of care
- In development: consolidating and enhancing our measurement and evaluation of VBP efforts

VBP Roadmap: priorities



https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf

Washington State Health Care Authority

VBP: pursuing new goals

- Goal 1: By 2025, HCA will continue working towards achieving 90% of state-financed healthcare, including Medicaid FFS, into HCP-LAN Category 2C or above and drive increased adoption of state-financed healthcare into Category 3B or above.
  - Maintain current progress and increase prevalence of downside risk
- Goal 2: By 2025, HCA will leverage our purchasing power to improve overall health and health equity in Washington
  - Begin with establishing a process to measure and establish a baseline for current disparities

Discussion

- Are there other areas of VBP you are interested in?
  - Deep dive on specific models/strategies?
- From your perspective, does downside risk have significant potential to mitigate cost growth?
- How can HCA help the Cost Board think about VBP in the context of cost drivers?

Questions?

More information:
https://www.hca.wa.gov/about-hca/value-based-purchasing-vbp

JD Fischer, Value-based Purchasing Manager
JD.Fischer@hca.wa.gov

Washington State Health Care Authority

Appendix

Lingo

- Value-based Purchasing

- Value-based Payments & Alternative Payment Models (APMs)

- Value-based Care

Washington State Health Care Authority

Lingo What is value-based purchasing? (VBP)

- VBP is the concept of **paying for quality rather than quantity** of health care.
- In traditional fee-for-service (FFS) payment, each service (exam, procedure, test) has a set price.
  - This creates a system that rewards providing a lot of expensive services, whether they improve patient health.
- Shifting to value-based payment means creating a system where **patients get the care they need, when they need it**…
  - …and *don't* get a lot of expensive, unnecessary care.

Alignment with the HCP-LAN Alternative Payment Models (APM) Framework

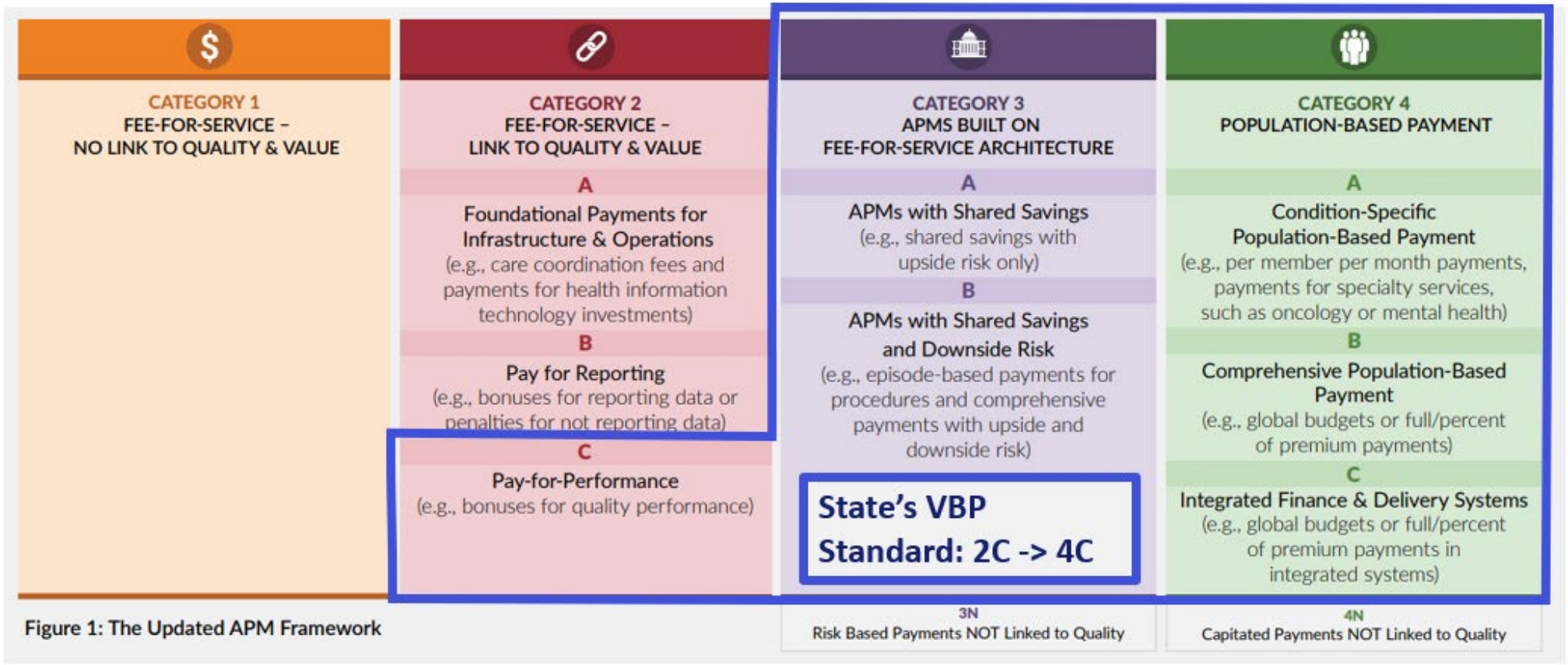
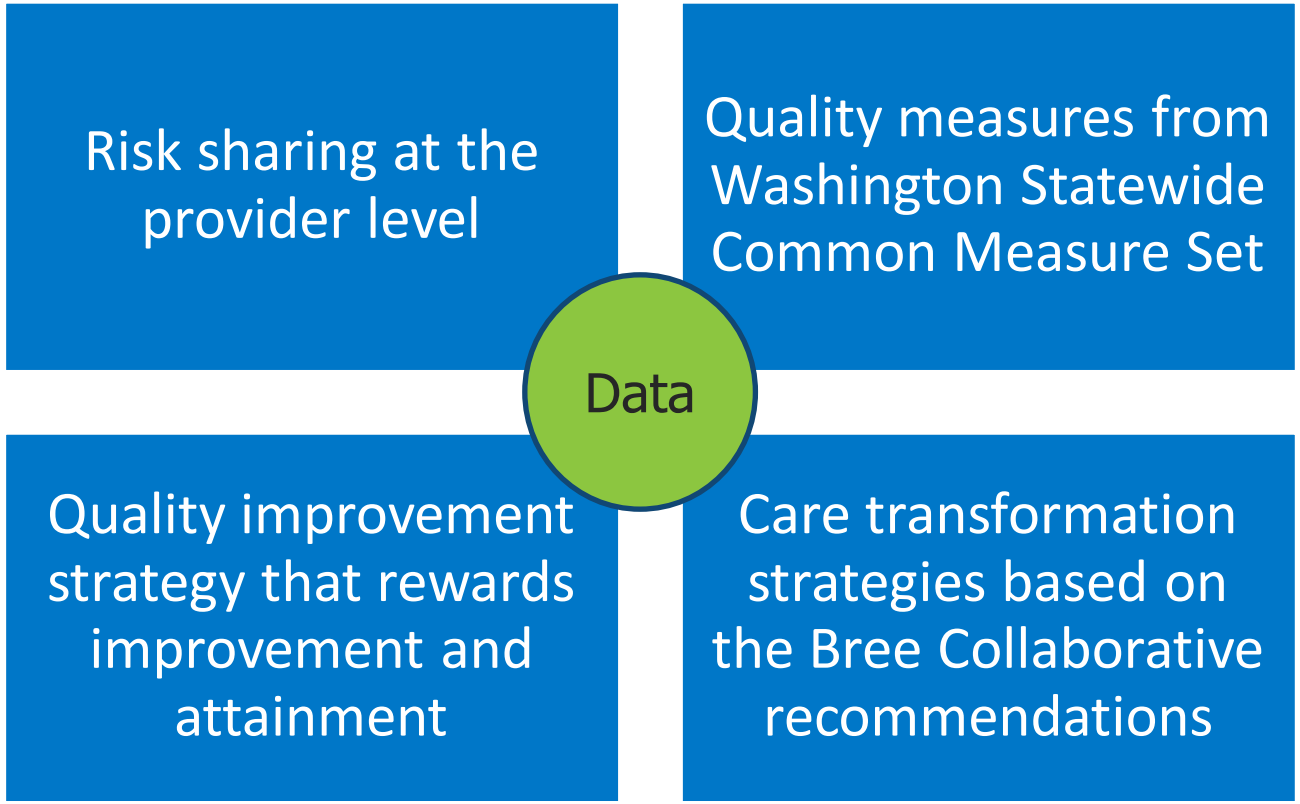


Figure 1: The Updated APM Framework

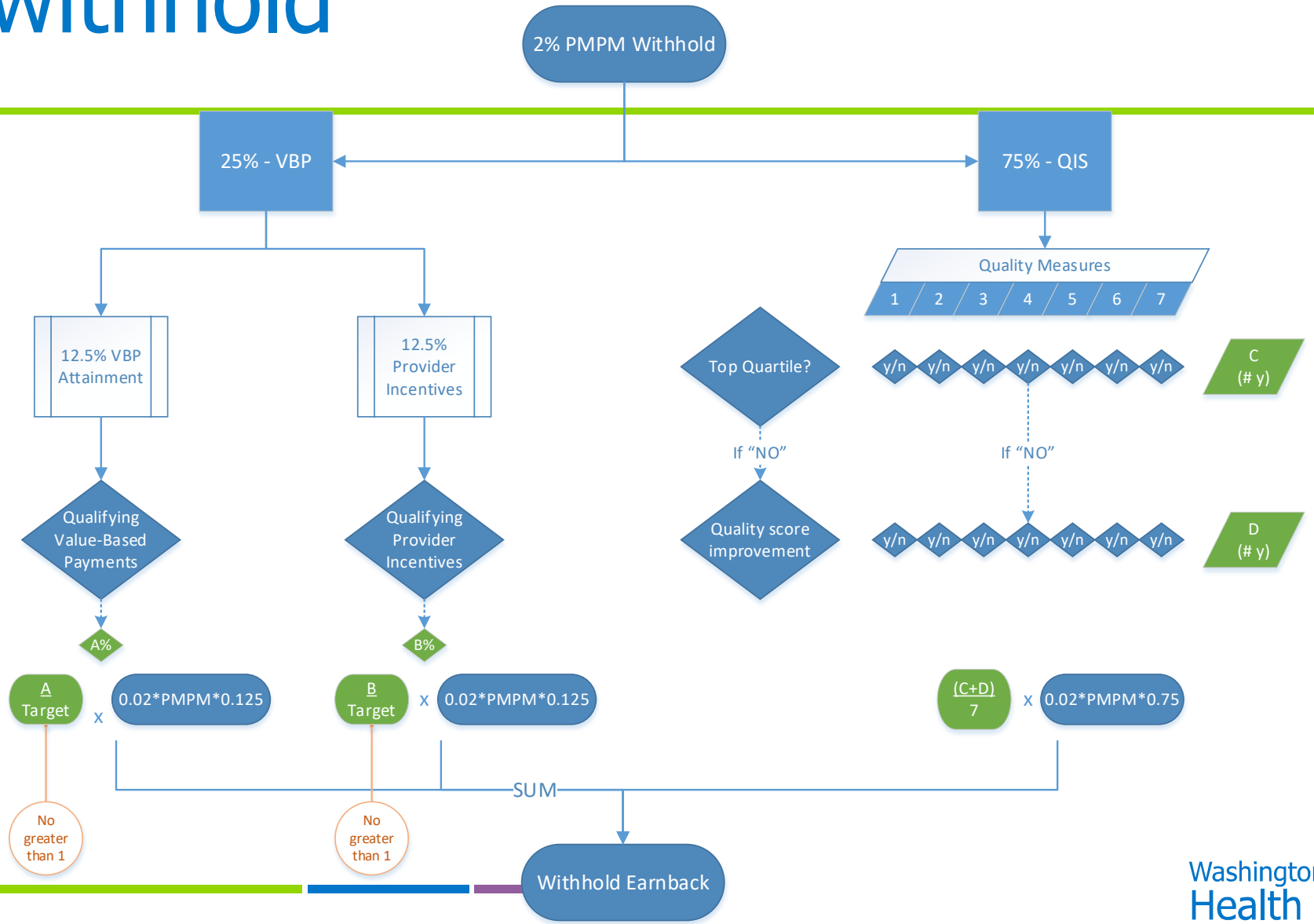
Washington State Health Care Authority

Driving common elements in all HCA's new payment models



Washington State Health Care Authority

MCO withhold



Washington State Health Care Authority

UW evaluation of the ACP

- Assessed the impact of the ACP on utilization, cost, and quality after one year
  - Evaluation funded through the State Innovation Model grant
  - Findings:
    - Small decrease in outpatient hospital visits
    - Members increased primary care utilization
    - No significant decrease in spending, although without price data, evaluators were unable to assess possible cost savings
    - Limited practice transformation
  - As expected, change takes time, and this is not a quick-fix APM strategy

Evaluating patient experience: HCA's Centers of Excellence

- Centers of Excellence for knee and hip replacement and spine care
- Member satisfaction with the knee and hip COE was high in 217 and 2018 :

Feedback question	Rating
My case manager was courteous and helpful	9.8
I felt ready for my surgery	9.6
The travel arrangement met my needs	9.3
My recovery went well	9.3
If I have another joint replacement, I would choose to use this program	9.7
I would recommend this program to family and friends	9.8
Overall satisfaction with your total experience	9.5

- Members saved an average of $988.46 through the knee and hip COE

https://www.hca.wa.gov/about-hca/uniform-medical-plan-ump/centers-excellence#coe-results

Washington State Health Care Authority

Community Health Access and Rural Transformation model

TAB 4

Community Health Access and Rural Transformation (CHART) Model Cost Transparency Board

June 15, 2022

The CHART program is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,998,110 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

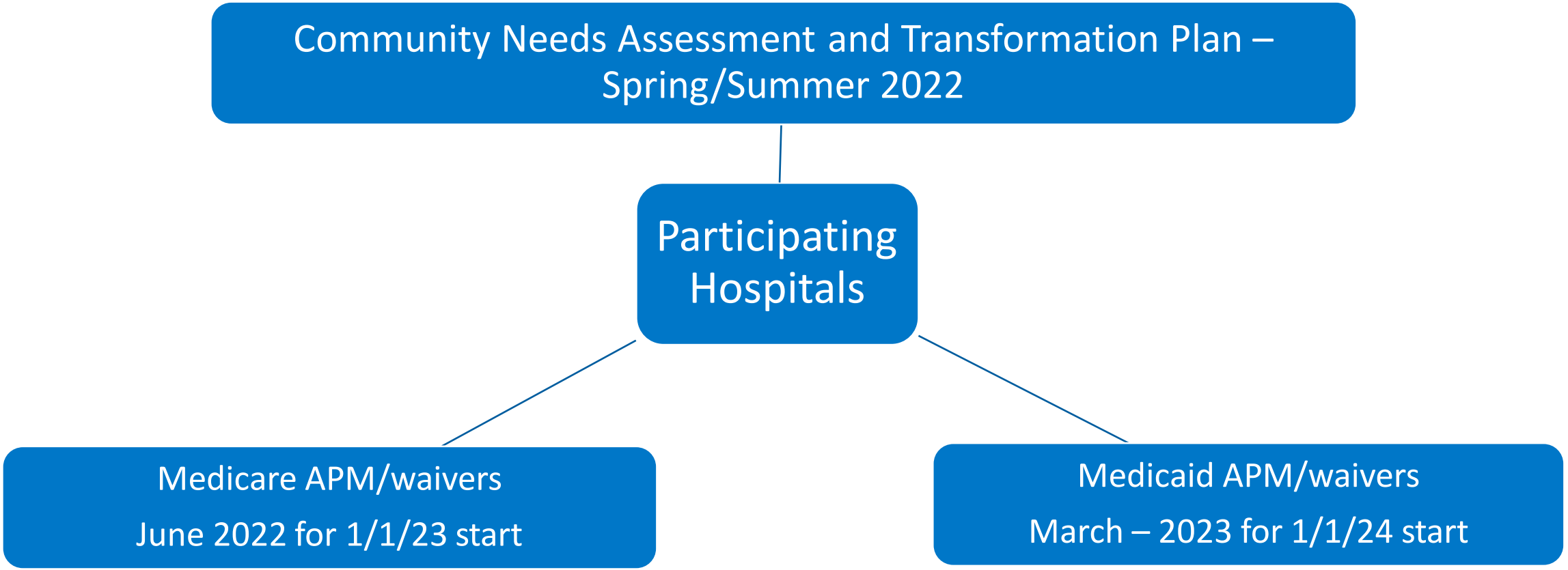
Washington State Health Care Authority

Rural Hospitals: Challenges and Opportunities

Community Health Access & Rural Transformation (CHART) Model Structure and Decisionmakers

Washington State Health Care Authority

CHART Alternative Payment Model (APM)



Washington State Health Care Authority

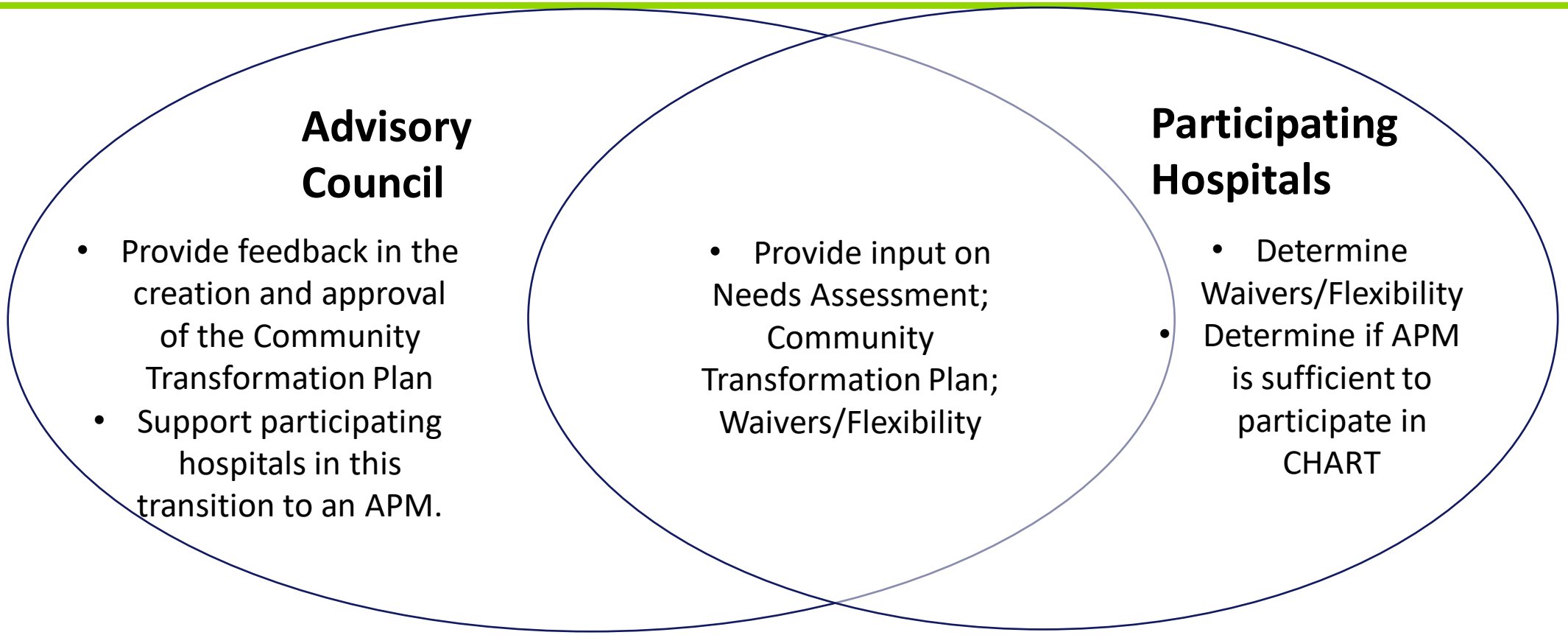
CHART team and partners

- CHART focuses on North Central WA counties:
  - Chelan, Grant, Douglas, and Okanogan
- Executive Sponsors:
  - Mich'l Needham, Chief Policy Officer, HCA
  - Dr. Judy Zerzan-Thul, Chief Medical Officer, HCA (also co-chair of Advisory Council)
  - John Schapman, Acting Executive Director, North Central Accountable Community of Health
- Advisory Council:
  - Made up of 24 hospital Chief Executive Officers
  - Active community leaders and providers
  - State agency division leaders

CHART team and partners

- Partners:
  - North Central Accountable Communities of Health
  - Center for Evidenced Based Policy
  - Mathematica
- CHART HCA Team:
  - Theresa Tamura, Project Director
  - Kahlie Dufresne, Special Assistant for Health Policy and Programs
  - J.D. Fisher, Value-based Purchasing Manager
  - Mark Dansby, Project Manager
  - Jean Marie Dreyer, Senior Policy Analyst
  - Data and finance staff

CHART input and decisions



Washington State Health Care Authority

Timeline and major milestones

June 2022

- Hospitals receive estimated Medicare CPA* @ end of June
- CMS provides feedback on Initial Transformation Plan

*Capitated Payment Amount

July 2022

- Hospitals review CPA
- Community Transformation Plan w/revisions based on feedback due 7/19
- Advisory Council mtg July 12th

Q4 2022

- Hospitals receive final Medicare CPA in October
- Hospitals sign up for Medicare CPA with CMS for 1/1/23 start date
- Advisory Council mtg Sept. 27

2023

- March Medicaid CPA to hospitals.
- Payments to hospitals participating in Medicare APM begins
- Work on Community Transformation Plan begins

What does success look like? What are the concerns?

What would CHART success look like?

- Financial stability for hospitals in North Central.
- Sustainable payment model that:
  - Provides flexibility to invest where needed.
  - Reduces unnecessary services.
  - Focuses more on prevention and wellness.
- Improved care coordination of services throughout region.
- Framework to address underlying health-related issues in the region, such as transportation.

Motivation for hospitals to join CHART

- Commitment to and history of serving the North Central community.
- Personal and professional interest in developing a sustainable payment model that will provide financial stability for hospitals and their employees.
- Provide a voice and specific perspective related to payment reform to support rural care.
- Support high-quality care that includes a holistic look at social needs.

CHART primary concerns

- Razor thin margins makes risk aversion real.
- Transition from fee-for-service (FFS) or Accountable Care Organization models.
  - Model has to be better than current state.
  - Need sufficient time to demonstrate return on investment in social needs.
  - Reduction in payments when service lines eliminated.
- Move beyond discussion to actual implementation.
  - Design sustainable and actionable payment model.

CHART primary concerns (continued)

- Building trust and engaging all key partners, including public hospital district boards.
- Lack of staff/bandwidth capacity, including:
  - Providers
  - Hospital finance staff
  - Advisory Council members
  - HCA staff

Strategic Priorities for Community Transformation Plan

Strategy priority #1

- **Strategic Priority**
  - Improve the ability to share data across North Central Region partners (e.g., hospitals, community) while protecting patient information.
- **Action steps**
  - Assess the need for an interoperability tool that integrates hospital electronic health records enabling providers to access a unified health record.
  - Create provider agreements.
  - Evaluate existing data sharing repositories.

Strategic priority #2

- **Strategic priority**
  - Increase transportation options to move patients to/from hospital and follow-up visits to community options or home.
- **Action steps**
  - Develop list of patients in need of transport for a target population.
  - Identify services that can be moved to a patient's home thereby reducing the transportation needs.
  - Identify mechanisms to increase transportation options.

Strategic Priority #3

- **Strategic priority**
  - Improve care coordination for high-cost, high need patients with chronic comorbidities through telehealth appointments, and care management interventions.
- **Action steps**
  - Improve collaboration with managed care organizations and their care managers for both primary care and behavioral health.
  - Increase number of telehealth visits and remote monitoring devices by identifying and addressing barriers (e.g., lack of/challenges with cell service and broadband).
  - Evaluate North Central best practice care coordination and patient engagement.

Observations/Questions

More info contact:

theresa.tamura@hca.wa.gov

Washington State Health Care Authority