Health Care Cost Transparency Board meeting

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board Board Book

April 19, 2023
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting materials

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*If time allows

Tab 1

Washington State Health Care Authority

Health Care Cost Transparency Board
AGENDA

April 19, 2023
2:00 p.m. – 4:00 p.m.
Zoom Meeting

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

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome and roll call	1	Sue Birch, Director Health Care Authority
2:05 – 2:10 (5 min)	Approval of February meeting summary	2	Mandy Weeks-Green, Acting Cost Board Dir. Health Care Authority
2:10– 2:25 (15 min)	Public comment	3	Sue Birch Health Care Authority
2:25– 2:30 (5 min)	Data Committee New Member Application	4	Sue Birch Health Care Authority
2:30 – 2:40 (10 min)	Primary Care Committee: Claims Based Measurements	5	Jean Marie Dreyer Health Care Authority
2:40 – 2:45 (5 min)	Data Projects Overview	6	Ross McCool Health Care Authority
2:45– 3:15 (30 min)	Washington Hospital Costs, Price, and Profit Analysis: Second Level Analysis Methodology	7	John Bartholomew & Tom Nash Bartholomew-Nash & Associates
3:15-3:45 (30 min)	Benchmark: Historical review of the data collected & methodology	8	Michael Bailit Bailit Health
3:45-4:00 (15 min)	Updates to 2023 benchmark data call • If time allows: (WA-APCD) Study of Cost Drivers: Specifications for Phase 1 Analysis	9 10	Ross McCool Health Care Authority
4:00	Adjourn		Sue Birch Health Care Authority

Subject to Section 5 of the Laws of 2022, Chapter 115, also known as HB 1329, the Board has agreed this meeting will be held via Zoom without a physical location.

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board meeting summary

February 15, 2023
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 are available on the Health Care Cost Transparency Board webpage.

Members present

Sue Birch, Chair
Eileen Cody
Lois Cook
Bianca Frogner
Leah Hole-Marshall
Molly Nolette
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

Jodi Joyce
Mark Siegel

Call to order

Sue Birch, Board Chair, called the meeting to order at 2:01 p.m.

Agenda items

Welcome, roll call, and agenda review

Chair Birch called the meeting to order and reviewed the agenda. Chair Birch introduced new board member, Eileen Cody.

Approval of November meeting summary

The Board approved the Meeting Summary from the December 2022 meeting.

Topics for Today

The main topics were: Board's analysis of the Cascade Select Public Option: Planning for the Legislative Report; Primary Care Committee recommendation – Primary Care Definition, Discussion, and Vote; Inflation's Impact on Health Care Spending and Implications for the Cost Growth Benchmark Discussion and Vote; and Washington's Cost Growth Driver Analysis: Discussion.

Board's Analysis of Cascade Select Public Option: Planning for the Legislative Report

Mandy Weeks-Green, Coverage and Marketing Strategies Manager, Health Care Authority
Laura Kate Zaichkin, Senior Policy Advisor, Health Benefits Exchange

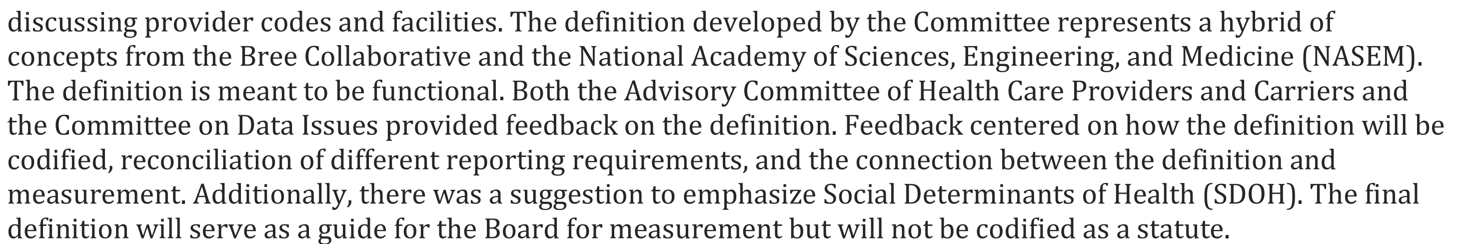
Mandy Weeks-Green presented an introduction to the Board's required report on Cascade Select Plans (CSPs) due in August 2023. CSPs are the public option individual plans available on the Exchange. They have the same standard benefit design as Cascade Care Plans, but also have additional standards and requirements, such as quality measurements and an aggregate reimbursement plan. The goal is to increase availability of quality, affordable health care coverage available to Washington residents. Cascade Select is a three-agency effort with the Health Care Authority (HCA), the Health Benefits Exchange (HBE), and the Office of the Insurance Commissioner (OIC). HBE is the lead agency for benefit design. HCA is responsible for procurement and monitoring. OIC ensures rate review and network access requirements are met. The legislature has required three analyses of Cascade Select Plans: 1) HBE must analyze public option plan rates paid to hospitals for in-network services to see whether they have impacted hospital financial sustainability, 2) the Health Care Cost Transparency Board (Board) must report on the effect of enrollment in the public option on consumers, and 3) HBE must provide recommendations to the legislature on both HBE and the Board's two analyses, with final recommendations due December 1, 2023. The Board's analysis of enrollment in public option plans will include an examination of benefits, premiums paid, and cost-sharing amounts paid. The Board's report won't include general recommendations on the public option or recommendations on procurement, or standard plan design. For the development of the report, HCA and HBE will begin by identifying questions and data. After gathering data and performing initial analyses, HCA and HBE will present their findings at the June Board meeting for review and feedback. In July, HCA and HBE will present the final report.

Laura Kate Zaichkin reviewed anticipated data and analysis necessary for the Board's report on Cascade Select Plans' effect on consumers. The analysis will include Cascade Select premiums from 2021 through 2023; Cascade Care plan design and cost sharing, compared to non-Cascade plans on the Exchange from 2021 through 2023; a description of Cascade Select quality and value contractual requirements and aggregate results; Cascade Select enrollment from 2021 through 2023; and Cascade Select availability from 2021 through 2023. Most of the data will come from the data acquired by the Exchange since the launch of the public option in 2021. There was limited availability across counties in 2021 and only about 1,000 people enrolled. In 2023, there is widespread availability except for five counties. Enrollees total almost 27,000, which is more than 10 percent of the Exchange's total enrollment. HCA and HBE are interested in the Board's reaction to and feedback on data that the Board would like to see included or explored in the report to evaluate the effect enrollment in the public option has had on consumers.

Primary Care Committee Recommendation – Primary Care Definition, Discussion, and Vote

Dr. Emily Transue, Associate Medical Director, Health Care Authority

Dr. Transue updated the Board on the Advisory Committee on Primary Care's (Committee) finalized recommendation for a definition of primary care. The work of the Committee is different from but related to the work done by HCA on the Primary Care Transformation Model (PCTM). Both initiatives share the goal of increasing primary care expenditures while decreasing total health care spending. Dr. Transue reviewed the four main primary care recommendations: 1) a definition of primary care, 2) measurement methodologies to assess claims-based spending, 3) measurement methodology to assess non-claims-based spending, and 4) reporting on barriers to access and use of primary care data and how to overcome them. In October and November 2022, the Committee heard presentations on claims-based measurement from the Primary Care Collaborative and subject matter experts from the University of Washington. At their January 2023 meeting, the Committee made progress



discussing provider codes and facilities. The definition developed by the Committee represents a hybrid of concepts from the Bree Collaborative and the National Academy of Sciences, Engineering, and Medicine (NASEM). The definition is meant to be functional. Both the Advisory Committee of Health Care Providers and Carriers and the Committee on Data Issues provided feedback on the definition. Feedback centered on how the definition will be codified, reconciliation of different reporting requirements, and the connection between the definition and measurement. Additionally, there was a suggestion to emphasize Social Determinants of Health (SDOH). The final definition will serve as a guide for the Board for measurement but will not be codified as a statute.

Board member Eileen Cody moved to approve the definition, which was seconded by Board member Lois Cook. Board member Margaret Stanley asked for clarification on the term "equitable" in the definition. Dr. Transue clarified that equitable refers to whole-person health provision where all populations are able to achieve their respective health goals.

Board member Edwin Wong inquired about the Committee's future work on the methodology to assess non-claims-based spending and asked how that work will affect the definition. Dr. Transue responded that the non-claims-based work hasn't been conducted yet but that the Committee is analyzing work done across the country and should be looking at population-based care in greater depth in the coming months. Edwin Wong asked about how adaptable the definition is. Chair Birch responded that further questions/clarifications would be referred back to the Committee.

Board member Kim Wallace expressed support for the definition and its functional approach. However, the definition doesn't state "to what end" or what the aim is of primary care. There could be a piece added like "supports or promotes a person's experience of their health outcomes" that speaks to the effect of receiving primary care. The current definition says that the point is creating and maintaining a relationship, but there could be language added about health and the benefit a patient receives or experiences because of primary care. Dr. Transue responded that the group could ask the Committee to reexamine the addition of language speaking more directly to health outcomes.

Board member Bianca Frogner noted that the Bree Collaborative initially struggled to distinguish between what was measurable versus what was aspirational. It's hard to connect health outcomes, e.g., quality of life, back to providers, and it's easier to connect processes of care. The Bree Collaborative report on primary care provides background on each concept included. The Office of Financial Management (OFM) discussed other billing codes that might capture coordinated care or SDOH. Have there been increases in those codes? Is there discussion on the committee regarding OFM's approach to team-based care? Dr. Transue noted that there has been an uptick in the use of some SDOH, but most people aren't reimbursing for them yet. As value-based models continue, there may be greater uptake. Uptake is similarly low for collaborative care. The group will discuss this topic when they discuss non-claims-based spending.

Chair Birch noted three pieces of feedback from the Board to bring back to the Committee for consideration: 1) measurable components, 2) what outcomes are being sought, and 3) how the evolution into value-based payment (VBP) expands the definition.

Chair Birch called for a vote to approve the definition and the motion passed.

Public Comment

Sue Birch, Chair

There were no public comments.

Inflation's Impact on Health Care Spending and Implications for the Cost Growth Benchmark Discussion and Vote

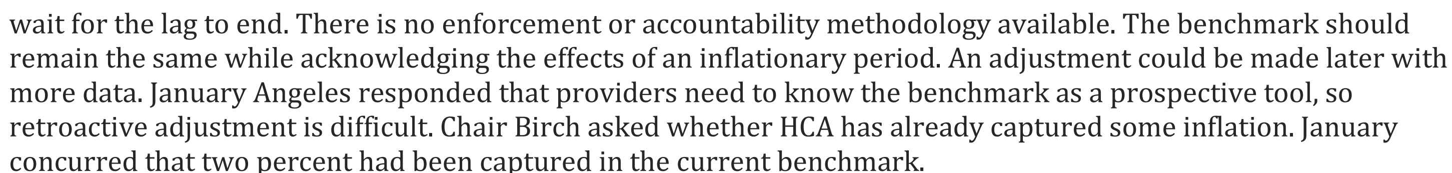
January Angeles, Bailit Health

January Angeles provided an overview of inflation's impact on health care spending. The impact is lagged because rising prices in the general economy don't impact health prices immediately for several reasons: 1) Medicare prices for most services are updated annually based on projected growth in input costs, 2) commercial prices are often defined within multi-year contracts, and 3) Medicaid prices change infrequently and are not specifically linked to input costs. In 2021, the price for goods increased significantly, the price for services increased somewhat, and the price for health care services remained flat. In 2022, the prices for medical care increased at a significantly slower rate than other goods and services. Another analysis by Altarum showed that health care inflation was flat through the end of 2022 despite high and sustained inflation overall.

All six Peterson-Milbank cost growth target states have based target values on economic indicators that are affected by inflation. Washington looks at median wages and income, which are indirectly impacted by inflation. Household income tends to grow when inflation grows. These methodologies were developed under the assumption that inflation would increase at low levels. For a limited time, states should consider whether to allow performance to exceed the cost growth benchmark due to inflation and/or increased labor costs. Making these adjustments would not necessarily mean restating the benchmark, rather, a state could create a temporary allowance when assessing performance against the benchmark. Arguments for adjusting for inflation are: 1) states could lose support from providers and insurers who feel the benchmark value was set using inputs that are completely different from actual experience, 2) the benchmark could be viewed as unrealistic and unfair, leading to lost credibility as a meaningful state policy and a rejection of the benchmark for contract negotiations. Arguments against adjustment for inflation: 1) the benchmark value was purposely set using a methodology intended to provide long-term stability, 2) it is unlikely that the benchmark value or performance against the benchmark would be adjusted if providers were posting record profits or if deflation occurred, and 3) any adjustment could open the door to future calls for benchmark changes. Benchmarks matter because "payers routinely invoke cost growth benchmark values at the negotiating table." They have practical value in constraining spending growth, particularly in the commercial market. Some key policy considerations are: 1) how the state should balance protecting consumers who face slower income growth and a potential recession with being fair to provider organizations and insurers in light of increased costs 2) the precedent that might be set if the state chooses to modify benchmark values, and 3) the basis on which any modification should be made, and for what duration. Several states have their own responses to the rise in inflation. Massachusetts adjusted the 2023 target up by .5 percent, Oregon and Nevada decided to make no adjustment, and Rhode Island adjusted their 2023 through 2025 targets up by 2.7, 1.8, and .2 percentage points, respectively.

Bianca Frogner asked for more discussion of the evidence that inflation influenced healthcare costs. January Angeles clarified that there is a two-year lag and effects from 2020 and 2021 won't show up until 2023. Bianca Frogner also asked for elaboration on goods versus services. Providers are more concerned about wage inflation and the cost of labor. Is inflation happening across the board for all health care labor, or specific occupations? There is very poor data available.

Margaret Stanley noted that the Board received three letters regarding the impact of inflation on consumers, especially those with high deductibles. The Board should also look at unnecessary administrative burden placed on consumers by insurers. There isn't enough data to make a decision on inflation right now and the Board should



wait for the lag to end. There is no enforcement or accountability methodology available. The benchmark should remain the same while acknowledging the effects of an inflationary period. An adjustment could be made later with more data. January Angeles responded that providers need to know the benchmark as a prospective tool, so retroactive adjustment is difficult. Chair Birch asked whether HCA has already captured some inflation. January concurred that two percent had been captured in the current benchmark.

Board member Leah Hole-Marshall emphasized distinguishing between inflation that's been captured already and unexpected inflation. Before an adjustment, it is important to know how the Board will interpret the data and share its context. January Angeles replied that acknowledging inflation upfront suffices for context and used context of Covid as a further example of background information included in reporting. Leah Hole-Marshall expressed that it would be important to use multiple examples.

Board member Eileen Cody asked by what date would the Board need to decide to make a change? Has the Board looked back at past trends to analyze wage increases? January Angeles replied that research hasn't been done yet. For how far ahead to decide, it depends on how the Board views the benchmark e.g., as a point of negotiation for payers and providers. If it is a negotiation tool, it would be best to set it as far ahead as possible.

Bianca Frogner noted that a major challenge is the aggregation of data across many different places. Wages have gone up at other points in time but get lost in the aggregate. While some groups' wages may have gone up, other groups' didn't.

Eileen Cody made a motion to maintain the Board's current benchmark but monitor the need for a change in the future. Bianca seconded. Chair Birch proposed not changing the benchmark now to account for additional inflation not already built into the methodology. Lois Cook expressed agreement with the motion but also felt concerned from a small business owner perspective and shouldn't reduce health care resources in the state. Board member Carol Wilmes also expressed a preference for not making a change after looking after state responses. Those states who decided to make changes have been doing this work longer than Washington. Edwin Wong expressed agreement with the consensus but requested Washington specific measures on Consumer Price Unit (CPU) categories. Margaret Stanley stated the need to acknowledge lack of data to make an adjustment. Eileen Cody amended the motion to say that the benchmark remains unchanged to account for additional inflation as the Board awaits further data. Chair Birch called for a vote on the motion. Bianca Frogner seconded. The motion passed by unanimous approval.

Washington's Cost Growth Driver Analysis

January Angeles, Bailit Health

OnPoint presented its Phase 1 cost driver analysis at the previous Board meeting. OnPoint looked at cost growth from 2017 to 2021 and found that per member per month (PMPM) spending for medical and pharmacy services increased by 25 percent. There were also shifts in relative spending by category with outpatient, "other" professional, and "other" medical spending increasing while inpatient, specialist, long-term care, and primary care decreased as a percentage of total health care expenditures. Hospital outpatient services, pharmacy, and hospital inpatient services were the key cost drivers of commercial spending. Growth in outpatient services was driven by increased utilization, while pharmacy and inpatient were due to price increases. There was significant variation in medical PMPM spending at the individual Washington county level. Across all markers, high-cost members comprise less than one percent of the membership but account for 15 to 21 percent of total spending.

OnPoint also looked at other states' analyses. Connecticut's annual hospital outpatient and pharmacy growth averaged over seven percent in the commercial market between 2015 and 2019. Oregon's commercial cost growth from 2013 to 2019 was driven by professional services. Rhode Island's annual hospital outpatient trend in the commercial market averaged five percent, and pharmacy trend averaged over six percent between 2017 and 2019. Chair Birch asked about Oregon's professional services growth: Was it specialty, primary care, or other? Was this disaggregated? January Angeles clarified it was aggregate.

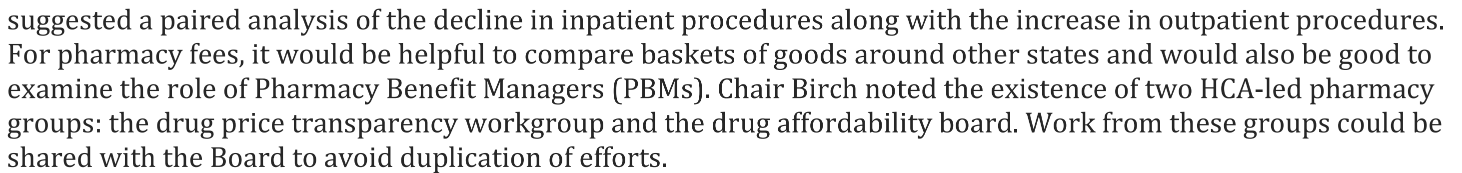
Kim Wallace asked for clarification on Washington's 25 percent growth. Was this over four years, as opposed to annually? This is in contrast to the annual trends from other states. January Angeles affirmed that the growth occurred over four years. Washington's results are generally consistent with other states, particularly with hospital and pharmacy services as key drivers in overall health care spending growth.

For Phase II analysis, there are two types of analyses that could be done for hospital spending: 1) analysis of hospital price growth – overall and by hospital to assess whether price increase is concentrated among specific facilities 2) analysis of procedure and service code movement between inpatient and outpatient settings to determine if inpatient procedures and services shifting to outpatient settings could be driving increases in outpatient utilization and spending.

January Angeles reviewed some of Massachusetts' analyses. Between 2013 and 2018, Massachusetts observed a decline in inpatient stays among commercially insured patients. This was while spending grew about five percent per year during that timeframe. The Health Policy Commission (HPC) looked at procedures commonly performed in either inpatient or outpatient settings. There were 11 surgical procedures that accounted for 21.3 percent of the overall decline in commercial inpatient admissions. Among the 11, HPC narrowed the analysis to spinal fusion, mastectomies, and hysterectomies. Lois Cook noted the lack of placements for people to be discharged. Oregon has a similar issue. How does Washington compare to other states in this regard? January Angeles clarified that proper discharging is an issue in all states. For all three procedures, the percentage of procedures done in inpatient settings declined. Community hospitals showed a greater loss of inpatient volume. HPC looked at the change in inpatient and outpatient volume by hospital system for mastectomies, which showed cross-provider shifts in outpatient care. Most systems experienced declines, but some were able to make up for it more easily with an increase in services in the outpatient setting. Systems that lost volume tended to be lower priced community hospitals. Those that didn't lose volume were higher-priced, academic centers. Eileen Cody asked whether it's correct to assume that outpatient costs less. Outpatient procedures are conducted more often by higher-cost academic centers. It's not just shift in settings, but cross-provider shifts.

The other area of spending to conduct a phase II analysis on is pharmacy. Washington could conduct two analyses: 1) analysis of retail pharmacy spending overall and broken down by generic vs. brand-name drugs and 2) analysis of retail pharmacy spending by drug class or drug category. Rhode Island developed an internal dashboard that shows medical and pharmacy spending PMPM and annual changes in that spending payment per unit and utilization per thousand. Seven categories accounted for almost all 2021 spending. Spending on immunological agents was the top driver, accounting for $152 million. There were very high prices per unit for a handful of drugs. There were high annual price increases, especially for drugs with growing market share.

January Angeles concluded with a review of other potential phase II analyses identified by HCA and OnPoint. OnPoint would like to know which analyses to prioritize and conduct for the next phase. Margaret Stanley recommended focusing on areas where Washington can have a state impact compared to the federal level. These are areas where purchasers or legislators could effect change. Eileen Cody requested more information about the change in hospital inpatient setting and where it differs e.g., ambulatory surgical centers (ASCs). Bianca Frogner



suggested a paired analysis of the decline in inpatient procedures along with the increase in outpatient procedures. For pharmacy fees, it would be helpful to compare baskets of goods around other states and would also be good to examine the role of Pharmacy Benefit Managers (PBMs). Chair Birch noted the existence of two HCA-led pharmacy groups: the drug price transparency workgroup and the drug affordability board. Work from these groups could be shared with the Board to avoid duplication of efforts.

Leah Hole-Marshall asked when there would be a definition of primary care and primary care spending. It was clarified that there are three more recommendations to go and there is no implementation plan yet. Carol Wilmes emphasized capturing instances of outpatient utilization to see how these affect overall utilization changes in spending impacts.

Chair Birch noted the Board's apparent consensus to focus on outpatient costs and major procedures that have shifted from inpatient to outpatient. Chair Birch also recommended considering high-cost clients for further analysis. OnPoint could look more into chronic conditions and length of stay. January Angeles responded that it's important to focus on what the state has the capacity to address and change. High-cost clients don't have as many policy levers to work with at the state level. Eileen asked whether the high-cost pool is included in the data. Vishal Chaudhry affirmed that if the claims were submitted to the All-Payer Claims Database (APCD), they were included. Bianca Frogner suggested looking at the length of stay. It would be good to look at year by year rather than grouped years due to events like Covid.

Chair Birch identified outpatient services as the first priority and suggested that the second could be high-cost or regional variation. What would the Board like to be its second topic of focus for OnPoint's Phase II analysis? Margaret Stanley suggested looking at PMPM rather than total cost.

Chair Birch summarized that the Board would look at outpatient services and will direct staff to look at existing pharmacy work. Leah Hole-Marshall suggested looking at high-cost patients and the top ten conditions they exhibit to better understand outliers. OnPoint could group patients by condition and spend to see the spread in the one percent group.

AnnaLisa Gellermann announced her departure from the Board and the search for her replacement.

Adjournment

Chair Birch adjourned the meeting at 4:00 p.m.

Next meeting

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

Tab 3

Washington State Health Care Authority

Health Care Cost Transparency Board

Written Comments

Received Since Last Meeting

Written Comments Submitted by Email

1. Washington State Medical Association 1
2. Washington State Hospital Association 2

No Additional Comments Were Received at the February Committee Meeting

- The Zoom video recording is available for viewing here: https://www.youtube.com/watch?v=7mtynGxK0i0

Delivered via e-mail

March 30, 2023

Dear Director Birch and Members of the Health Care Cost Transparency Board (Board),

Please consider the following feedback on the Advisory Committee on Primary Care's definition of primary care as you finalize the Board's legislative report. It is our understanding that the Board voted in favor of the current definition of primary care at its last meeting, but that there is room for additional input.

We appreciate the Board's robust discussion on the definition of primary care. **The current definition only addresses the *what*** – that primary care is team-based care acting as a patient's primary contact with the larger system, providing a comprehensive array of services to create and maintain a continuous relationship. As it stands, **the definition does not address the *why*** of primary care, which is integral for community members to fully understand the purpose of primary care and what this care aims to achieve.

To that end, please accept the below amendment to the definition.

"Team-based care led by an accountable primary care clinician that serves as a person's source of primary contact with the larger healthcare system. Primary care includes a comprehensive array of equitable, evidence-informed services to create and maintain a state of overall health and wellness for each individual, through a continuous relationship over time. This array of services is coordinated by the accountable primary care clinician but may exist in multiple care settings or be delivered in a variety of modes."

Thank you for the opportunity to provide feedback on the definition of primary care in an effort to strengthen it. Please let us know if you have any questions.

Sincerely,

Mika Sinanan, MD, PhD
Past President
Washington State Medical Association

Mike Marsh
President & CEO
Overlake Medical Center & Clinics

Washington State
Hospital Association

March 23, 2023

Dear Members of the Advisory Committee on Data Issues:

We are writing to express our concerns with the HCCTB consultant's proposed methodology for analyzing hospital costs, prices, and profits. The consultant's recommendations are contained, in part, in the slide presentation on Washington Hospital Costs, Price, and Profit Analysis, which we assume is scheduled for the upcoming meeting.

By way of a reminder, in October of last year, Health Care Authority (HCA) staff indicated that the next step in the Board's hospital cost analysis would be to review hospital cost data to better understand differences in spending. HCA staff convened a subgroup to develop a risk adjustment methodology for hospital expenses and revenue so that they are comparable among Washington hospitals and to other states. Albert Froling, WSHA Technical Product Manager and Data Analyst, served on the subgroup along with state consultants John Bartholomew and Tom Nash, Data Advisory Committee member Julie Sylvester, Health Care Consultant Hunter Plumer, and HCA staff.

Under the guidance of the consultant, the subgroup decided to propose the following adjustments for the second level analysis methodology:

1. **Hospital expenses per patient**. These will be adjusted by the Medicare wage index for the salary portion and by a more general cost of living adjustment for non-salary expenses. Comparisons will then be made independently to look at these adjusted costs by bed size, teaching intensity, service intensity (the proportion of costs represented by ICU care), and Medicare Case Mix Index (CMI). There will be no overall adjustment made for case mix.
2. **Patient revenue per discharge**. These will be adjusted only by case mix, using the Medicare case mix index. There will be no adjustment for area differences in wages or other factors such as teaching intensity.
3. **Profit per patient.**

WSHA believes the Board would be better served by creating a continuous standardized adjustment by CMI, Medicare wage index, and teaching status, rather than comparing these measures by peer groups in isolation. A continuous adjustment would facilitate better comparisons between states and hospitals, rather than comparing these measures independently. The methodology we propose is a standard used by non-partisan national experts in hospital payment.

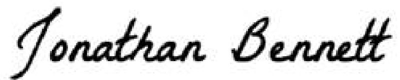
On a smaller issue, we are not sure why the consultant recommends using C2ER as a general cost of living adjustment for non-salary expenses, since this index has no relation to healthcare expenditures for non-operating services.

WSHA recently received the consultant slide deck, with proposed recommendations. It only contains slides related to adjustments for hospital expenses. The subgroup recommended at least one adjustment, case mix, be used for revenue per discharge analysis. WSHA assumes the consultant will also be doing an analysis on revenues since these drive Washington health care expenditures as well as

on hospital profits. As stated above, we believe it is important to not only include case mix as an adjustment for revenue, but also factor in area wage differences and teaching status.

Thank you for your consideration of our concerns as you review the consultant proposal.

Sincerely,



Jonathan Bennett
Vice President, Data Analytics and IT Services
Washington State Hospital Association

Albert Froling, MHA
Technical Product Manager
Washington State Hospital Association

Tab 4

Washington State Health Care Authority

Member	Title	Place of Business
Megan Atkinson	Chief Financial Officer	Health Care Authority
Amanda Avalos	Deputy, Enterprise Analytics, Research, and Reporting	Health Care Authority
Allison Bailey	Executive Director, Revenue Strategy and Analysis	MultiCare Health System
Jonathan Bennett	Vice President, Data Analytics, and IT Services	Washington State Hospital Association
Bruce Brazier	Administrative Services Director	Peninsula Community Health Services
Jason Brown	Budget Assistant	Office of Financial Management
Chandra Hicks	Assistant Director of Delivery System Analytics	Cambria Health Solutions
Leah Hole-Marshall	General Counsel and Chief Strategist	Health Benefit Exchange
Lichiou Lee	Chief Actuary	Office of the Insurance Commissioner
David Mancuso	Director, Research and Data Analysis Division	DSHS, Research and Data Analysis
Ana Morales	National Director, APM Program	United Healthcare
Hunter Plumer	Senior Consultant	HealthTrends
Mark Pregler	Director, Data Management and Analytics	Washington Health Alliance
Russ Shust	Senior Director of Medical Economics	OptumCare Washington
Julie Sylvester	Senior Consultant, Contracting and Payer Relations	University of Washington Medicine
Mandy Stahre	Senior Forecast and Research Manager	Office of Financial Management

From:	Christa Able WA-Tacoma
To:	HCA HCCT Board
Cc:	Katherine Mahoney WA-Tacoma
Subject:	Application for position on the Advisory Committee on Data Issues
Date:	Tuesday, October 25, 2022 8:28:47 AM
Attachments:	image004.png CMA Resume October 2022.docx

External Email

Health Care Cost Transparency Board,

I am writing to apply for a position on the Advisory Committee on Data Issues.

I believe that my healthcare and analytic background could be helpful to the committee. For the past 25+ years I have been involved in healthcare reimbursement for hospitals, professionals and other ancillary services. I have worked in various roles and responsibilities at Franciscan Health System, MultiCare Health System and now Virginia Mason Franciscan Health. The healthcare industry and the process to determine cost drivers from existing data resources is complex. Throughout my career my work has been dependent on analytics, both internally generated and reports provided by the payers.

The work of the cost transparency board is important and the decisions that are made should be based on relevant key drivers. I believe my skills and experience can support this process. Thank you for your consideration.

Please feel free to contact me if you have any questions.

Thank you.

Christa Able

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Christa Able

Division Director Payer Strategy

Payer Strategy & Relationships

Pacific Northwest Division | Virginia Mason Franciscan Health

P: (253) 428-8566

C: (253) 948-6193

1149 Market Street MS 10-09 | Tacoma, WA 98402

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Christa Able

Financial Contracting Director with 25+ years of healthcare contracting in an increasingly complex market. Strong contract negotiation skills with value based contracting joined with leadership experience and the ability to motivate team members to accomplish goals. Career objective is to continue to work in a healthcare contracting position that best utilizes my experience and supports growth in reimbursement, negotiation and management skills.

Core Competencies and Area of Experience:

- *Contract Negotiations, hospital and physician*
- *Value Based Contracting*
- *Payor Relationships*
- *Contract Compliance*
- *Strong analytic and strategic analysis skills*
- *Employee performance and motivation*
- *Integrity and high ethical standards*
- *Demonstrated ability to produce results*

EXPERIENCE

Virginia Mason Franciscan Health (Pacific NW Division of CommonSpirit Health) Tacoma, WA

Virginia Mason Franciscan Health is a leading health system in Washington State, formed by the integration of CHI Franciscan and Virginia Mason. Virginia Mason has more than 18,000 team members and staff, nearly 5,000 employed and affiliated providers, ten hospitals with nearly 1,500 hospital beds and close to 300 care sites throughout the Puget Sound region.

Division Director, Payer Strategy & Relationships (July 2013 - Current)

Responsible for managed care policies, goals and objectives related to contract language and reimbursement, negotiation strategy, and payer relationships. Collects and communicates strategic knowledge to/from the PSR National Payer teams and other key departments across the enterprise. Responsible for fee for service and value-based reimbursement contracts and strengthens CommonSpirit Health's relationships with payers.

- Develops relationships and contracts with local and national payers to drive clear and effective negotiation strategy, reimbursement structure, contract renewal planning process, and contract implementation. Budgeted and forecasted performance are integral to these processes.
- Establishes, builds, and maintains positive, strategic interactions and relationships with payers, employers, providers, and leaders across the ministry.
- Develops and executes communication plans related to payer relationships, negotiations, organizational contractual obligations, and developments in the managed care marketplace including Fee For Service.
- Makes independent decisions and/or exercises judgment based upon appropriate information and objectives. Comprehends and maintains highly detailed information. Accepts and carries out responsibility for direction, control, and planning.
- Stays current with emerging payer trends, new reimbursement methodologies, state specific regulatory issues, plan benefits, payer activity, products and delivery channels including health insurance exchanges, market competition, etc.
- Supports the strategic objectives of population health, and care management initiatives through directly engaging local payers and employer customers.
- Participates in and contributes to CommonSpirit Health's PSR knowledge base through sharing best practices, developing contract performance goals, key metrics, new analytical tools, network development, reimbursement and language guidelines, revenue realization, and other applicable work streams.
- Participates in the dispute resolution and denials processes with local payers. Participates in joint operating committees and denial committees for Division.

- Leads and organizes sub-projects necessary to support local and national payer negotiations.

MultiCare Health System Tacoma, WA

MultiCare is a not-for-profit health care organization with more than 20,000 team members, including employees, providers and volunteers that serve patients primarily from around the Pacific Northwest and Spokane. Multicare includes inpatient care, primary care, virtual care, urgent care, dedicated pediatric care and specialty services including eleven hospitals in Washington State, MultiCare Medical Associates, it's affiliated physicians, and a wide range of community outreach programs.

Director of Payor Contracting **(June 2005 – July 2013)**

Responsible for the oversight and management of all hospital, physician and ancillary contract negotiations and payor strategies including payer relations, payer analytics and contract administration. Cultivates strong partnerships with health plans to advance strategies of value based integrated care models. Assists in the development of operational infrastructure necessary to be successful clinically and financially in these evolving structures. Manages third party payer matters for all MultiCare providers.

- Plans, organizes and directs all contract renewals and rate negotiations with all major payors
- Develops and maintains relationships with key payers
- Assists in development of operational infrastructure necessary to be successful clinically and financially in new evolving value based payment structures.
- Evaluates and reviews market opportunities for value based contract opportunities
- Coordinates the development of a variety of financial analysis to determine profitability and the feasibility of additional opportunities from external payors.
- Coordinates activities and strategies associated with dispute resolution with external payors, including legal action, and data submission requirements.
- Researches trends locally, statewide, and nationally regarding external payor activities
- Follows appropriate legislation and payor trends and appraise as necessary
- Plans and coordinates payor joint operation committee meetings.
- Oversees staff providing direction and guidance, and administering management functions within the provisions of MultiCare policies.
- Contributes to the success of the organization by meeting organizational competency expectations, continuously learning, and by performing other duties as needed or assigned.

Franciscan Health System Tacoma, WA

Reimbursement Manager **(Aug 1997 – June 2005)**

Responsible for payor contracting and all activities involving external payors. Work closely with both clinical and financial managers. Implemented a contractual compliance modeling system and collection process including new software selection and installation. Responsible for all supporting reimbursement functions such as hospital credentialing and reimbursement analysis. Supervised preparation of departmental profitability reports.

Reimbursement Analyst **(Sept 1994-Aug 1997)**

Prepared all financial reports and analysis used to evaluate payor contracts. Prepared departmental financial profitability reports for clinical departments.

Foundation Accountant **(Sept 1992- Sept 1994)**

General ledger accountant for the Franciscan Foundation. Prepared all journal entries, financial statements, budgets, tax returns and reports.

Databar, Inc Tacoma, WA

Controller **(Sept 1990-Sept 1992)**
Responsible for all financial accounting including accounts payable, accounts receivable, payroll, and general ledger. Prepared all tax returns and financial reports. Supervised accounting department.

EDUCATION

BA, University of Washington Foster School of Business, Seattle WA Aug, 1990

Certified CPA March, 1992

Associates Degree, Pierce College Steilacoom, WA June, 1985

Interests: Jogging, Culinary, Golfing, Gardening

Computer and Technology Skills

- Proficient in using Microsoft and Office Products - Word, Excel, Power point and Outlook
- Proficient in financial analytics and the ability to drill down and perform root cause analysis and create focused process improvement

Tab 5

Primary Care Services: Claims-Based Payments

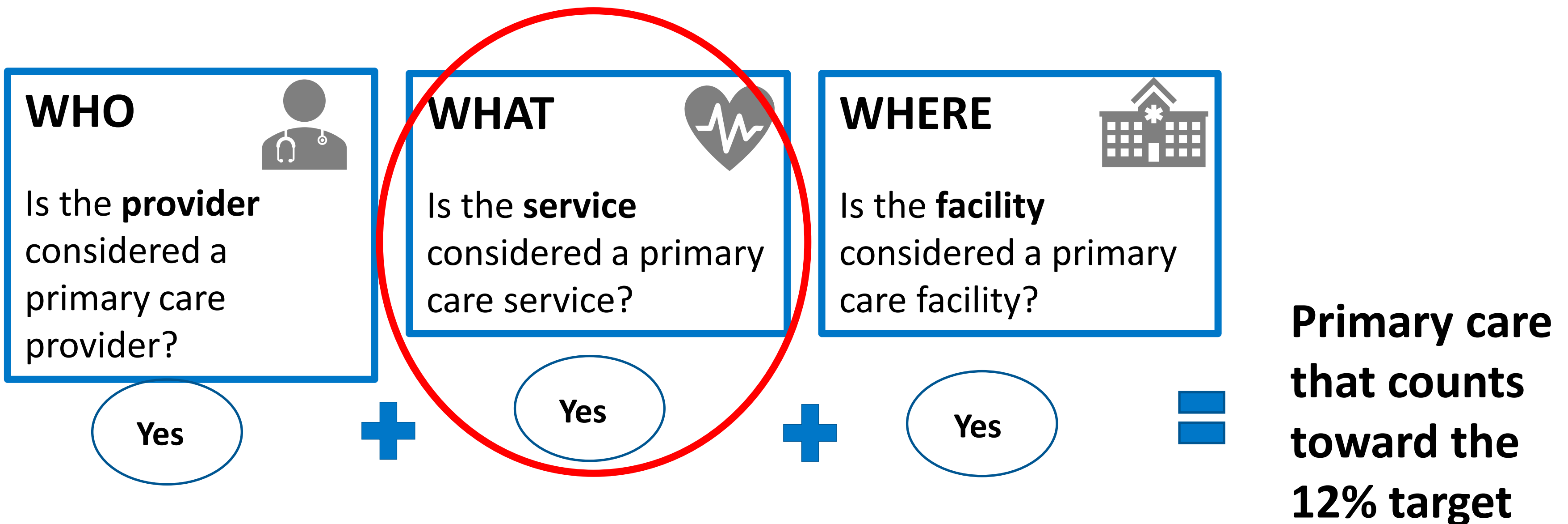
Jean Marie Dreyer, Senior Health Policy Analyst
Washington State Health Care Authority

Washington State Health Care Authority

Primary care recommendations

1. **Recommend a definition of primary care**
2. **Recommend measurement methodologies to assess claims-based spending**
3. Recommend measurement methodology to assess non-claims-based spending
4. Report on barriers to access and use of primary care data and how to overcome them

What Counts as Primary Care?



Guiding principles for code selection and discussion

- No need to capture every possible code that a primary care provider might render.
- Focus is ensuring the code set includes services that are predominantly provided by primary care.
- Future data analyses can identify services for consideration that are frequently provided by approved provider types at approved facilities included in the primary care definition formulated by the committee.

Service code selection process

- Codes drawn from refined list curated by California Health Care Foundation, available on Primary Care Collaborative website.
- Refined list compared service codes used for measurement purposes across multiple states.
- HCA internal clinical staff further refined the code set list to provide recommendations to the committee for consideration.
- Feedback gathered via email and during committee meetings from individual members.
- Center for Evidence-Based Policy created a final list showing the percentage prevalence of individual services across other states, along with the formal recommendation from HCA clinical staff.

Next Steps

- Finalize service code sets for inclusion at April 27 Advisory Committee on Primary Care meeting
- Hearing presentations on non-claims-based payment methodologies from Oregon and possibly Bailit Health at May committee meeting
- Presenting claims-based methodology strategies for feedback at the joint Providers and Carriers and Data Committee meeting on June 6
- Present final claims-based recommendations to the Board for approval on July 18
- Annual report from the Board to be published in August

Tab 6

Washington State Health Care Authority

Health Care Cost Transparency Board Data Projects Overview

	Cost Growth Benchmark	Performance against Benchmark	Cost Driver Analysis / Cost Experience	Primary Care Spend Measurement
What it is	The ceiling/goal for the growth of spending on health care year over year.	Assessment of cost growth against the benchmark target.	Assessment of key drivers of cost growth.	Measurement of expenditure on primary care in relation to overall health care expenditure.
What it represents	Reflects **affordability** for healthcare consumers and purchasers.	Reflects performance of payers and providers against the cost growth benchmark at an **aggregate** level.	Reflects a first- level drill down analysis of factors that are **contributing** to health care cost growth.	Reflects the emphasis on primary care and preventive care as measured through proportion of total health care expenditure spent on primary and preventive care activities.
Analytic basis	**Macro- economic indicators** such as median wage, potential gross state product (PGSP).	**Aggregate** expenditure data, direct from all payers (carriers). Includes claims- based and non- claims-based expenditures.	**Claims based** payment data that Carriers submit to WA- APCD. Includes Individual claims data – enables stratification by geography, risk (list in bill…).	WA-APCD **claims based** payments; plus not yet developed measurement of non-claims payments.
Risk-adjustment consideration	Does not apply. Based on macro-economic indicators.	Age and sex adjustment is being used for analysis of performance against benchmark. Severity-of-illness based risk adjustment is not applicable as data are submitted by payers at an aggregate level and not at a client level.	Risk-adjustment based on severity-of-illness can be applied to WA-APCD data to better assess impact of cost drivers on overall health care cost growth.	Yet to be discussed and developed.

	Cost Growth Benchmark	Performance against Benchmark	Cost Driver Analysis / Cost Experience	Primary Care Spend Measurement
Other considerations		WA-APCD data do not include self-funded plan data; and cannot be used for assessing provider performance against benchmark.	For purposes of cost-driver analyses, risk-adjustment methodology will need to be developed in collaboration with Data Advisory Committee and applied consistently to relevant analyses.	Risk adjustment typically focuses on all aspects of care for an individual. How to appropriately focus on a single category of care will need to be investigated.

Tab 7

Washington State
Health Care Authority

Washington Hospital Costs, Price, and Profit Analysis: Second Level Analysis Methodology

John Bartholomew & Tom Nash
Bartholomew-Nash & Associates

Advisory Committee on Data Issues

April 4, 2023

Project Goal:

1. How does the WA hospital industry look compared to the nation on costs and margins/profits?

2. Can we identify WA hospital outliers on cost and margins/profits?

Refresh: First Level Analysis to Identify Outliers*

- When considering data and findings regarding hospital analytics, you must consider the source.

- This analysis uses self reported Medicare Cost Report data to create metrics on Net Patient Revenue, Hospital-Only Operating Cost, and Net Income by dividing data by adjusted discharges. Calc'ed on Hospitals with 26 beds or greater.
  - Net Patient Revenue divided by Adjusted Discharge = **Price per Patient**
  - Hospital Only Operating Cost divided by Adjusted Discharge = **Cost per Patient**
  - Net Income divided by Adjusted Discharges = **Profit per Patient**

- Observe trends across hospital types and peer groups
  - Health systems, independents, for-profit, not-for-profit, rural, urban, teaching, and by bed size

- Other tools using similar process: NASHP's hospital cost tool

* An appendix is available with data source and formulas used to calculate the First Level financial metrics.

First Level Analysis to Identify Outliers - Summary

Washington Hospital Groupings
Hospitals with > 25 Beds

Price	High price						Not high price								
	15						32								
Cost	National normal cost			High cost			National normal cost			High cost			Low cost		
	3			**12**			23			6			2		
Profit	High profit	National normal profit	Low profit	High profit	National normal profit	Low profit	High profit	National normal profit	Low profit	High profit	National normal profit	Low profit	High profit	National normal profit	Low profit
	0	2	1	2	6	4	4	11	8	0	2	4	1	1	4

Recall First Level Analysis Conclusion:

- A deeper dive would be important to further understand Price, Cost, and Profit variations from the National Median over time.
- But also, for a fair and accurate comparison, we need to look at other measures, such as, case mix, service intensity measures, level of teaching intensity, payer mix, and other financial measures to enable better comparisons between hospitals.
- The goal is to adjust for service intensity, acuity, location, and other differences so the variation in cost is isolated to business decisions or price discrimination. However, there may still be other factors causing variation.
- Engage in a Second Level hospital financial analysis project.

Second Level Hospital Financial Analysis Review

- Process: Conducted a Series of Meetings with State of Washington Subject Matter Experts
- Purpose: Review assumptions to address methodology enhancements for Second Level hospital financial analysis.
- Participants: Members of the Advisory Committee on Data Issues
  - Washington State Hospital Association, HealthTrends, University of Washington Medicine, Washington State Health Care Authority Staff, WA HCA and the consultants.
- Held four meetings on January 11, 2023, January 17, 2023, February 2, 2023, and February 9, 2023
- Summarized into WA HCA consultant recommendations.

Second Level Hospital Financial Analysis: WA HCA Consultant Methodology Recommendations

- There are two types of methodology enhancements and additional financial review:
  - Calculated adjustments to First Level analysis on costs.
  - Creation of additional groupings beyond bed size for comparisons to national database.
  - Washington hospital margin analysis

- Margin Analysis: Complete the review of Washington hospitals profit and margin as compared to the nation, identify outliers.
  - This type of analysis does not require the enhancements above

Second Level Hospital Financial Analysis: WA HCA Consultant Methodology Recommendations

Adjustments to the Cost Data

- Adjustment to Hospital-only Operating Expense: Remove C2ER as a cost-of-living adjustment. Utilize labor wage index information from the CMS wage index files and Medicare Cost Report at the hospital level. Apply labor wage index to the salary amount of costs of each hospital, then apply the C2ER statistic to the remaining costs.
    - Salary percentage will be calculated from the Medicare Cost Report:

Second Level Hospital Financial Analysis: WA HCA Consultant Methodology Recommendations

Additional Groupings – enhanced beyond bed size

- Create more informed peer grouping for hospital comparisons, both within Washington and nationally, using data from the Medicare Cost Report. In addition to bed size, utilize one or a combination of the following measures to further refine the ability to compare 'like' hospitals:
  - Teaching Intensity Measure is a physician resident to bed ratio: this measure identifies the level of teaching at the hospital and is grouped into percentage ranges.
  - Service Intensity Measure calculates intensive care costs as a percentage of total costs: this measure captures the degree to which a hospital offers intensive care services and is grouped into percentage ranges.
  - Medicare Case Mix Index as reported in the Medicare final rule public use files: this index captures the level of acuity at a hospital and is grouped into ranges.

- Additional review: Payer Mix measure, this measure is a ratio of hospital charges from Medicare and Medicaid divided by total charges and is grouped into percentage ranges.

Additional Questions/Comments?

Tab 8

Washington State
Health Care Authority

Washington Cost Growth Benchmark Data Collection and Reporting

Washington State Health Care Authority

Topics for today

- Distinguishing between the cost growth benchmark analysis and the cost growth driver analysis
- What is being measured against the cost growth benchmark
- How performance against the benchmark will be reported
- Data sources for measuring Total Health Care Expenditures
- Specifications for insurer reporting of data
- Adjustments to increase confidence in the measurement and reporting of performance
  1. Risk-adjustment
  2. Truncation of high-cost outlier spending
  3. Use of confidence intervals
  4. Minimum thresholds for reporting

Washington State Health Care Authority

Reminder: cost growth benchmark analysis vs cost growth driver analysis

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

Benchmark Analysis

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

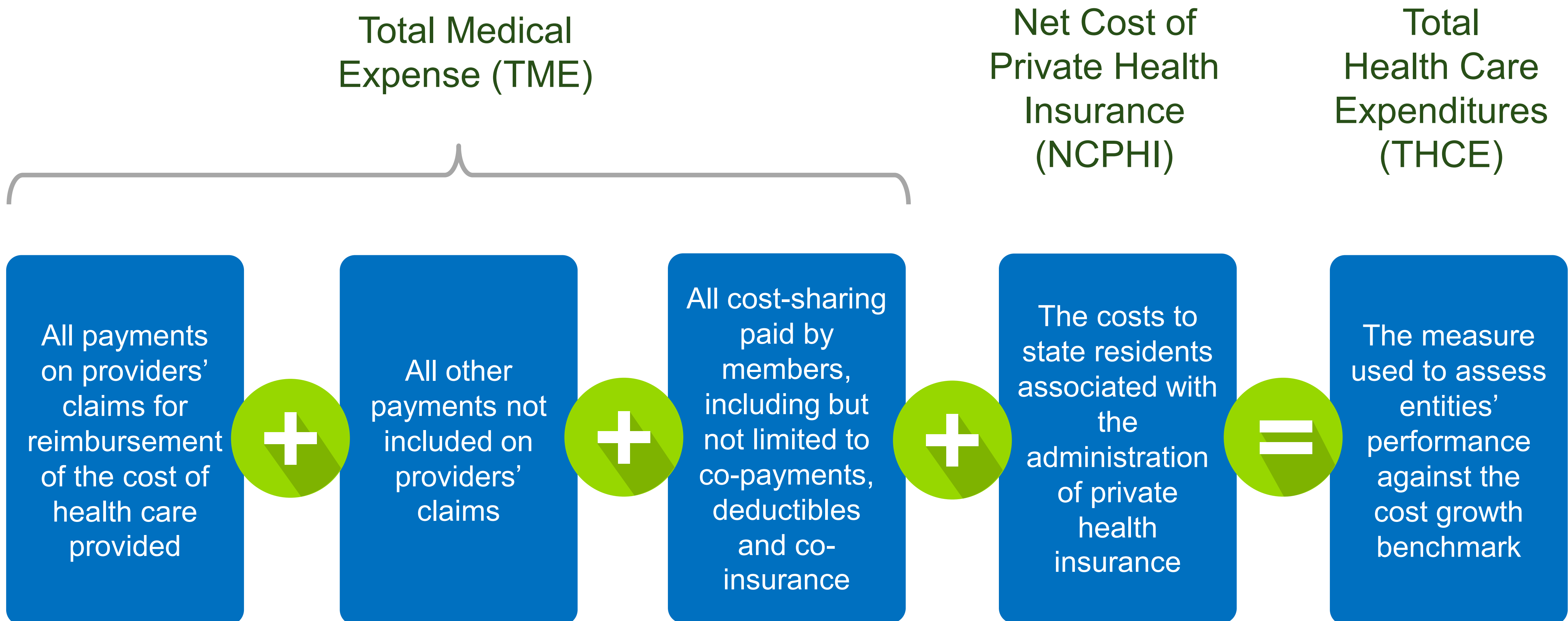
How will we determine what is driving overall cost and cost growth? Where are there opportunities to contain spending?

Cost Driver Analysis

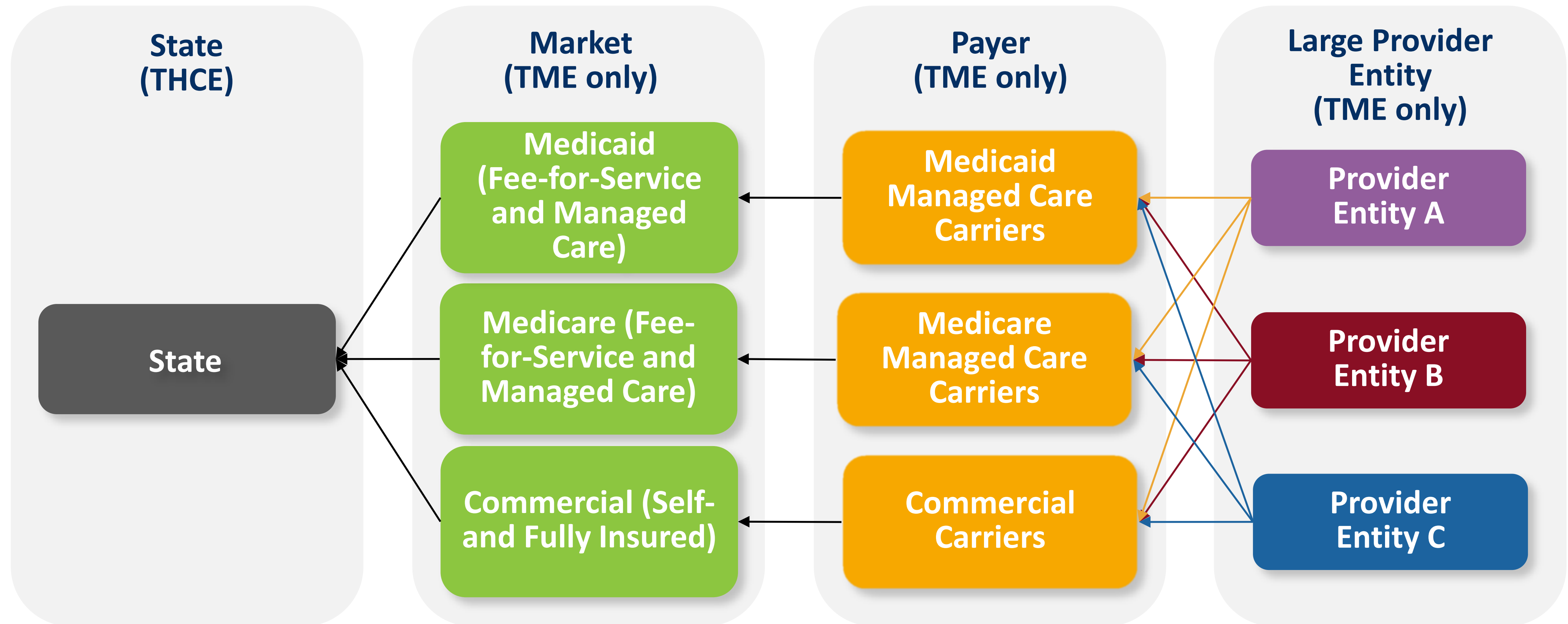
- *What is this?* A plan to analyze cost drivers and identify promising opportunities for reducing cost growth and informing policy decisions
- Data Type: Granular data (claims and/or encounters)
- Data Source: All-Payer Claims Database

Washington State Health Care Authority

What is being measured against the cost growth benchmark?



Performance against the benchmark will be reported at four levels



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Data sources for measuring total health care expenditures

- Most spending data come from payer-submitted reports:
  - Claims and non-claims spending by commercial (both fully- and self-insured), Medicare Advantage, and Medicaid managed care plans
  - Pharmacy rebate information
  - For self-insured plans, “fees from income of uninsured plans” to calculate NCPHI
- Other sources of data include:
  - CMS for Medicare fee-for-service claims and standalone Part D spending
  - State Medicaid agency for non-managed care payments
  - Other sources of public coverage
    - Department of Corrections
    - Department of Labor & Industries
    - Veteran’s Health Administration
  - Regulatory reports to calculate NCPHI

Specifications for insurer submission of data to HCA (1 of 2)

- Population whose data are being reported
  - All members who reside in Washington who have – at a minimum – medical benefits, and for which the payer is primary on a claim
- What data insurers report to HCA
  - Basic carrier identifying information
  - Unadjusted claims and non-claims spending by service category
    - Claims data are reported using allowed amounts, regardless of where services were rendered and the situs of the member’s plan
  - Pharmacy rebates
  - Member enrollment
  - Income from fees of uninsured plans
  - Variance or standard deviation data

Specifications for insurer submission of data to HCA (2 of 2)

- How insurers report spending and membership data to HCA
  - Aggregated by large provider entity and insurance type
  - Aggregated for members not attributable to a large provider entity, byinsurance type
- Other specifications:
  - Run-out period of 180 days
  - Adjustments are made to lines of business for which the insurer does not have all claims information (e.g., carved-out benefits)

Washington State Health Care Authority

Categories of claims- and non-claims-based spending used for reporting

Claims-Based Spending

- Hospital inpatient
- Hospital outpatient
- Professional, primary care
- Professional, specialty
- Professional, other
- Pharmacy
- Long-term care
- Other

Non-Claims-Based Spending

- Capitation or bundled payments
- Performance incentive payments
- Population health and practice infrastructure payments
- Provider salaries
- Recovery

Adjustments to increase confidence in measurement and reporting of performance

- No adjustments are made to the data when reporting spending and spending growth at the state and market levels.
- When reporting at the insurer and large provider entity levels, however, HCA applies the following methodologies:
  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 to determine benchmark performance
  4. Reporting performance only for insurers and large provider entities that meet a minimum threshold (still to be determined) for attributed lives

1. Risk-adjusting aggregate spending data by age and sex

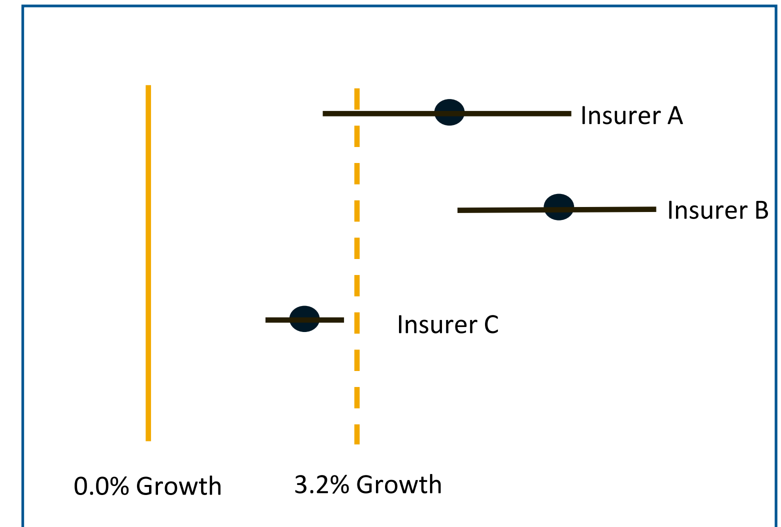
- Other cost growth benchmark states have moved (or recommended moving) away from using clinical risk adjustment.
  - Massachusetts observed steadily rising risk scores that could not be explained by demographic trends or changes in disease prevalence.
  - Rhode Island found similar increase in risk scores that had the effect of raising the benchmark value.
- For the above reasons, HCA will not implement clinical risk-adjustment and will risk-adjust spending using standard age/sex factors.
- To implement this, insurers have been asked to submit aggregate spending and member months data by age/sex cells, which HCA will use to create standardized weights.

2. Truncating spending for high-cost outliers

- In Rhode Island, analyses showed that high-cost outliers significantly affected performance of provider entities.
- Furthermore, total cost of care (TCOC) risk contracts typically remove high-cost outlier spending.
  - The differential treatment of high-cost outliers in the cost growth benchmark program and in TCOC contracts led to confusion and tension around reporting of performance.
- To prevent a small number of extremely costly members from significantly affecting insurers' and providers' per capita expenditures, HCA will not count spending above the following thresholds in calculations of spending growth:
  - Medicare: $125,000
  - Medicaid: $125,000
  - Commercial: $200,000

3. Using confidence intervals around cost growth to determine benchmark performance

- To minimize the impact of small numbers on, HCA will calculate confidence intervals and assess benchmark performance as follows:
  - Performance *cannot be determined* when upper or lower bound intersects the benchmark (e.g., Insurer A).
  - Benchmark has *not been achieved* when lower bound is fully over the benchmark (e.g., Insurer B).
  - Benchmark has been *achieved* when the upper bound is fully below the benchmark (e.g., Insurer C).



Note: Figure is not to scale

Washington State Health Care Authority

4. Reporting performance only for insurers and large provider entities of a minimum size

- With the use of confidence intervals, the issue of determining "sufficient" population sizes has become less pressing.
- When this topic was discussed with the Board, it recommended deferring on determining the minimum membership sizes for reporting insurer and large provider entity performance.
- This issue will be revisited for the 2021-2022 performance year, when cost growth performance will be publicly reported at all four levels.

State	Thresholds for Public Reporting of Provider Performance
DE	For commercial and Medicaid, at least 10,000 attributed lives; for Medicare, at least 5,000 attributed lives
CT and RI	At least 5,000 attributed lives for the market
MA	No published standard for public reporting
OR	Across all markets, provider entities with at least 10,000 attributed lives

Resources

- Washington Benchmark Data Call Technical Manual https://www.hca.wa.gov/assets/program/benchmark-data-call-manual-july-2022.pdf

Tab 9

Updates to 2023 benchmark data call

Health Care Cost Transparency Board

Washington State Health Care Authority

2023 benchmark data call

- Include calendar years 2020, 2021, and 2022 in submission
- The performance against the benchmark will be calculated using 2021 and 2022
- Submission process the same as 2022 data call
  - No changes in what you will need to submit
  - A couple of updates to reference categories to make submitted data more clear

Updates

- Additional insurance category for Federal Employee Health Benefits (FEHB)
  - A couple of payers cover FEHB, but some FEHB beneficiaries are covered by both payers for different aspects of care (hospital vs professional claims)
  - Separated out so we don't count members twice for state and market level PMPM
- Implement a way to associate non-claims spending to providers without age/sex stratification
  - Some bundled or incentive payments are not easily split into those stratifications
  - The trade off is this spending will not be age/sex risk adjusted

Changes to Materials

- These changes will be incorporated into the technical manual and submission template
- Training webinar
  - We'll cover these updates and the most common errors in submissions
- Visit HCA's website
  - hca.wa.gov/about-hca/who-we-are/call-benchmark-data

Timeline for 2023 data call

- The training webinar and office hours will begin in July or early August
- Submissions for 2023 benchmark data are due September 1

Tab 10

Washington State
Health Care Authority

Washington State All-Payer Health Care Claims Database (WA-APCD) Study of Cost-Growth Drivers

Specifications for Phase 1 Analysis

Amy Kinner, Director of Health Analytics

April 4, 2022

Purpose of the Cost-Growth Drivers Study

- Use the Washington State All-Payer Health Care Claims Database (WA-APCD) to identify cost trends and drivers of cost in the healthcare system to inform future directions for the Healthcare Cost Transparency Board to curb spending growth
  - Spend and trend by market
  - Spend and trend by geography
  - Spend and trend by health conditions and demographics
  - Potential unintended consequences

Purpose of the Cost-Growth Drivers Study (cont.)

- Claims data is accompanied by data collected directly from the payers for benchmarking
- Encounter and claims data from the APCD allows us to explore additional drivers of cost growth (e.g., Diagnosis-Related Groups (DRGs), detailed categories of care, high-cost pharmaceuticals, shifting of services, disparities)

Background on the WA-APCD

- Includes medical, pharmacy, and dental claims data for 5.5 million patients in WA
- Data on Public Employees Benefits Board (PEBB) and WA Health Benefit Exchange (HBE) members
- Limitations
  - Self-insured commercial plans are not required to report data
  - No data is available for the uninsured
  - Medicare FFS data is available only through 2019
  - Alternative payments (e.g., capitated payments, pharmacy rebates) are not currently reported
  - Long-term care data for Medicaid is not reported but entails significant spending

Reporting Periods Included in the Analysis

- 5 years of data: 2017–2021
  - Aligns with the cost-benchmarking period
- Claims attributed based on first service of the claim
- 3 months run-out (adjudication) included in analysis

Product Types & Markets

Payer Type	Notes
Commercial	Limited data from self-insured plans
Medicaid	Includes managed care and FFS plans; FFS does not include line-level payments (a challenge for some categories)
Medicare Advantage	Covered by commercial plans
Medicare Fee-for-Service (FFS)	Available only through 2019
Public Employees Benefits Board (PEBB)	Commercial and Medicare Advantage
WA Health Benefit Exchange	Commercial
Dual-eligibles	Expenditures included, but 2020 and 2021 Medicare FFS not available

Categories of Care - Closely Aligned with Benchmarking Initiative

Category	Notes
Hospital inpatient	Room and board and ancillary payments for hospital inpatient
Hospital outpatient	All hospital types, satellite clinics, and outpatient ED services
Professional – PCPs	WA narrow definition of primary care
Professional – Specialty providers	Non-PCP physicians
Professional – Other providers	Other professionals (e.g., physician assistants (PAs), nurse practitioners (NPs), occupational therapists, counselors)
Long-term care	SNFs, hospice, home health, personal care services, etc.
Retail pharmacy	Pharmacy claims
Other	All other dollars

Note that additional details on definitions are provided in the full Methods document.

Geography

- WA residents only
- Cost of care for in-state and out-of-state services
  - May want to examine out-of-state vs. in-state growth
- Break-outs by region assigned by patient address
  - May want to look at provider address to explore travel and access in the future
  - Out of state claims for inpatient residents are included
- Regions
  - Accountable Communities for Health (ACHs)
  - Counties

Geography - ACHs

Accountable Community of Health	Counties
Better Health Together	Adams, Ferry, Lincoln, Pend Oreille, Spokane, Stevens
Cascade Pacific Action Alliance	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum
Elevate Health	Pierce
Greater Health Now	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima
HealthierHere	King
North Central ACH	Chelan, Douglas, Grant, Okanogan
North Sound ACH	Island, San Juan, Skagit, Snohomish, Whatcom
Olympic Community of Health	Clallam, Jefferson, Kitsap
SWACH (Southwest ACH)	Clark, Klickitat, Skamania

Age Groups

- Modeled on age groups used in WA and other states for benchmarking work
  - 0–1 years
  - 2–18 years
  - 19–39 years
  - 40–54 years
  - 55–64 years
  - 65–74 years
  - 75–84 years
  - 85+ years
- May want to include other groupings in the future based on Medicaid coverage

Gender Categories

- Male
- Female
- Unknown/Other

Chronic Conditions

Chronic Condition	Source Used
Acute Myocardial Infarction	CCW
Alzheimer's Disease	CCW
Anemia	CCW
Asthma	CCW
Atrial Fibrillation and Flutter	CCW
Cancer, Breast	CCW
Chronic Kidney Disease	CCW
Chronic Obstructive Pulmonary Disease (COPD)	CCW
Combined Cancer	Onpoint enhancement flag
Depression, Bipolar, or Other Depressive Mood Orders	CCW
Diabetes	CCW
Heart Failure and Non-Ischemic Heart Disease	CCW
Hip / Pelvic Fracture	CCW
Hyperlipidemia	CCW
Hypertension	CCW
Obesity	CCW Other Chronic Health, Mental Health, and Potentially Disabling Condition Categories
Osteoporosis with or without Pathological Fracture	CCW
Rheumatoid Arthritis / Osteoarthritis	CCW
Stroke / Transient Ischemic Attack	CCW
Substance Abuse (combined Alcohol Use, Opioid Use, Other Drug Use flags)	CCW Other Chronic Health, Mental Health, and Potentially Disabling Condition Categories

Measures of Access & Quality

- Selected measures from WA Common Measure Set
- Are there unintended consequences of low spending for access and quality?

Conditions	
Ambulatory ED Visits (AMB-EDV)	Child and Adolescent Well Care Visits (WCV)
Antidepressant Medication Management (AMM)	Colorectal Cancer Screening (COL)
Asthma Medication Ratio (AMR)	Eye Exam for Patients with Diabetes (CDC-EYE)
Breast Cancer Screening (BCS)	Plan All-Cause Readmissions (PCR)

Metrics: Member Months/Eligibility

- **Distinct members:** The number of unique members in the data for a specific group (not weighted by months of coverage)
- **Member months (medical):** The number of members reported to the WA-APCD with medical coverage during the calendar year expressed in months of membership (restricted to in-state members only and primary insurance plans only)
- **Member months (pharmacy):** The number of members reported to the WA-APCD with pharmacy coverage during the calendar year expressed in months of membership (restricted to in-state members only and primary insurance plans only)

Metrics: Expenditures

- **Expenditures (allowed amount):** Includes the aggregate spending per category of care, including both plan and member payments
- **Plan paid:** Includes the aggregate spending per category of care that was paid by the insurance plan
- **Member paid:** Includes the aggregate spending per category of care that was paid by the member (i.e., coinsurance, copay, and deductible)

Metrics: Other

- **Average allowed amount per service**: The total allowed amount paid by both the plan and member divided by the count of services; this serves as a general measure of “price”
- **High-Cost members**: The number of distinct members in the group with more than $125,000 in total medical and pharmacy claims during the year
- **One-Year percent change:** The percent change from the preceding year
- **Percent behavioral healthcare:** The medical PMPM expenditures for behavioral health divided by the total medical PMPM expenditures (i.e., both behavioral health and non-behavioral health)
- **Percent change from baseline:** The aggregate percent change from baseline year 2017
- **Percent primary care (medical):** The PMPM expenditures for primary care divided by the total medical PMPM expenditures

Metrics: Other, Continued

- **Per member per month (PMPM) rates:** The sum of all dollars paid by the plan and the member divided by the total member months of coverage for the specific population
- **PMPM total expenditures (medical and pharmacy)**: PMPM medical expenditures summed with PMPM pharmacy expenditures
- **Prevalence:** The number of members with a given chronic condition divided by the number of distinct members in the group and presented as a percentage
- **Utilization (per 1,000 members):** Total services multiplied by 12 (for months) and 1,000 (for the per-1,000 member rate) then divided by the total member months of coverage for the population and presented as a rate per 1,000 members

Limitations

- WA-APCD cannot require self-insured plans to submit data and relies on their voluntary participation. Consequently, data from self-insured plans is limited.
- The WA-APCD does not include claims data regarding uninsured residents.
- Medicare FFS data, including Medicare Part D pharmacy data, was available only through 2019.
- Medicaid FFS data was not available.
- While alternative payments (e.g., capitated payments, pharmacy rebates, direct payments to providers) are a growing component of total expenditures, they currently are not reported to the WA-APCD and, therefore, were not available for this study.
- Long-term care data for Medicaid is not reported to the WA-APCD but is a significant contributor to spending.

Thank you.

Reliable data. Informed decisions. Strategic advantage.

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Washington State
Health Care Authority

Prolonged Services

Codes	Description	Prevalence in Other Definitions	Recommendation
99354	Prolonged Service OutPt 60 Min	42%	Include
99355	Prolonged Service OutPt Add 30 Min	42%	Include
99356	Prolonged Service Requiring Unit/Floor 60 Min	17%	Include
99357	Prolonged Service Requiring Unit/Floor Add 30 Min	17%	Include
99358	Prolong Service W/O Contact	67%	Include
99359	Prolong Serv W/O Contact Add 30 Min	67%	Include
99360	Standby Service	42%	Include

Temporary Codes (Part 1)

Codes	Description	Prevalence in Other Definitions	Recommendation
G0008	Admin Influenza Virus Vaccine	92%	Include
G0009	Admin Pneumococcal Vaccine	92%	Include
G0010	Admin Hepatitis B Vaccine	75%	Include
G0101	Cancer Screen; Pelvic/Breast Exam	58%	Include
G0102	Prostate Cancer Screening; Digital Rectal Examination	58%	Include
G0179	Phys Re-Cert Mcr-Covr Hom Hlth Srvc Re-Cert Prd	25%	Include
G0180	Phys Cert Mcr-Covr Hom Hlth Srvc Per Cert Prd	25%	Include
G0181	Home/Nursing Facility Visits W/Out Pt Medicare Approved	25%	Include
G0182	Hospice Facility Visits Medicare Approved	25%	Include
G0396	Alcohol/Subs Misuse Intervention 15-30 Min	67%	Include
G0397	Alcohol/Subs Misuse Intervention 30 Min <	67%	Include
G0402	Welcome to Medicare visit	58%	Include
G0403	Ekg For Initial Prevent Exam	17%	Include

Lab Testing and Supplies (Part 1)

Codes	Description	Prevalence in Other Definitions	Recommendation
*81000	Urinalysis Dip Stick/Tablet Reagnt Non-Auto Micrscpy	0%	Exclude
*81001	Urinalysis Dip Stick/Tablet Reagent Auto Microscopy	0%	Exclude
*81025	Urine Pregnancy Test Visual Color Comparison	0%	Exclude
82044	Urine Albumin Semiquantitative	0%	Exclude
82270	Blood Occult Peroxidase Actv Qual Feces 1 Determination	0%	Exclude
82272	Blood Occult Peroxidase Actv Qual Feces 1-3 Spec Determination	0%	Exclude
82465	Cholesterol Serum/Whole Blood Total	0%	Exclude
82947	Glucose Quantitative Blood Xcpt Reagent Strip	0%	Exclude
82948	Glucose Blood Reagent Strip	0%	Exclude
82950	Glucose Post Glucose Dose	0%	Exclude
82962	Gluc Bld Glucouse Device Spec Home Use	0%	Exclude
83655	Assay Of Lead	0%	Exclude

Lab Testing and Supplies (Part 2)

Codes	Description	Prevalence in Other Definitions	Recommendation
83718	Lipoprotein Dir Meas High Density Cholesterol	0%	Exclude
85013	Blood Count Spun Microhematocrit	0%	Exclude
85014	Blood Count Hematocrit	0%	Exclude
85018	Blood Count Hemoglobin	0%	Exclude
*86580	Skin Test Tuberculosis Intradermal	0%	Exclude
*87205	Smr Prim Src Gram/Giemsa Stain Bct Fungi/Cel	0%	Exclude
*87880	Immunoassay Streptococcus Group A	0%	Exclude

Temporary Codes (Part 2)

Codes	Description	Prevalence in Other Definitions	Recommendation
G0404	Ekg Tracing For Initial Prev	17%	Include
G0405	Ekg Interpret & Report Preve	17%	Include
G0438	Ppps, Initial Visit	92%	Include
G0439	Ppps, Subseq Visit	92%	Include
G0442	Annual Alcohol Screen 15 Min	83%	Include
G0443	Brief Alcohol Misuse Counsel	83%	Include
G0444	Depression Screen Annual 15 Min	75%	Include
G0404	Ekg Tracing For Initial Prev	17%	Include
G0405	Ekg Interpret & Report Preve	17%	Include
G0438	Ppps, Initial Visit	92%	Include
G0439	Ppps, Subseq Visit	92%	Include
G0442	Annual Alcohol Screen 15 Min	83%	Include
G0443	Brief Alcohol Misuse Counsel	83%	Include

Temporary Codes (Part 3)

Codes	Description	Prevalence in Other Definitions	Recommendation
G0463	Hospital Outpt Clinic Visit	58%	Include
G0466	FQHC Visit, New Pt	58%	Include
G0467	FQHC Visit, Established Pt	58%	Include
G0468	FQHC Preventive Visit	58%	Include
G0469	FQHC Visit, Mh New Pt	8%	Include
G0470	FQHC Visit, Mh Estab Pt	8%	Include
G0506	Comprehensive Asses Care Plan Chronic Care Mgmt Services	75%	Include
G0513	Prolong Preventative Services, First 30 Min	67%	Include
G0514	Prolonged Preventive Service Addl 30 Min	67%	Include
*J1050	Injection Medroxyprogesterone Acetate 1 Mg	0%	Exclude
Q0091	Obtaining Screen Pap Smear	33%	Include
*S8100	Holding Chamb/Spacr W/Inhal/Nebulizr; W/O Mask	0%	Exclude
*S8101	Holding Chamb/Spacr W/An Inhal/Nebulizr; W/Mask	0%	Exclude
T1015	Clinic Service All-Inclusive	58%	Include

Supervision

Codes	Description	Prevalence in Other Definitions	Recommendation
99340	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 30 Min	83%	Include
99377	Supervision Hospice Patient/Month 15-29 Min	25%	Include
99378	Supervision Hospice Patient/Month 30 Minutes/>	25%	Include
*99379	Supervision Nurs Facility Pt Mo 15-29 Min	0%	Exclude
*99380	Supervision Nurs Facility Pt Month 30 Min/>	0%	Exclude

Cardiac and Pulmonary Testing/Procedures

Codes	Description	Prevalence in Other Definitions	Recommendation
*93000	Ecg Routine Ecg W/Least 12 Lds W/I&R	0%	Exclude
*93005	Ecg Routine Ecg W/Least 12 Lds Trcg Only W/O I&R	0%	Exclude
*93010	Ecg Routine Ecg W/Least 12 Lds I&R Only	0%	Exclude
*93040	Rhythm Ecg 1-3 Leads W/Interpretation & Report	0%	Exclude
*93268	Xtrnl Pt Activ Ecg Transmis W/R&I </30 Days	0%	Exclude
*93784	Ambl Bld Press W/Tape&/Disk 24/> Hr Alys I&R	0%	Exclude
*94010	Spirometry	8%	Exclude
*94060	Bronchodilation Responsiveness	8%	Exclude
*94640	Pressurized/Nonpressurized Inhalation Treatment	0%	Exclude
*94664	Demo&/Eval Of Pt Utiliz Aersl Gen/Neb/Inhlr/Ip	0%	Exclude
*94760	Noninvasive Ear/Pulse Oximetry Single Deter	0%	Exclude
*94761	Noninvasive Ear/Pulse Oximetry Multiple Deter	0%	Exclude

Dermatological

Codes	Description	Prevalence in Other Definitions	Recommendation
11055	Trim Skin Lesion Single	8%	Exclude
11056	Trim Skin Lesions 2 To 4	8%	Exclude
*11200	Removal Of Skin Tags <W/15	8%	Exclude
*11201	Remove Skin Tags Add-On	8%	Exclude
11719	Trimming Nondystrophic Nails Any Number	0%	Exclude
11720	Debride Nail 1-5	8%	Exclude
11721	Debride Nail 6+	0%	Exclude
11740	Evacuation Subungual Hematoma	0%	Exclude
11900	Inject Skin Lesions </W 7	8%	Exclude

Newborn care services

Codes	Description	Prevalence in Other Definitions	Recommendation
*99460	Initial Evaluation And Management Of Newborn At Hospital	25%	Exclude
*99461	Initial Evaluation And Management Of Newborn Outside Of Hospital	25%	Exclude
*99462	Evaluation And Menagement Of Normal Newborn At Hospital	25%	Exclude
*99463	Evaluation And Menagement Of Normal Newborn Hospital Same Day Admittance And Discharge	25%	Exclude
*99464	Attendance At Delivery And Initial Stabilization Of Newborn	25%	Exclude
*99465	Delivery/Birthing Resuscitation	25%	Exclude

Obstetrics

Codes	Description	Prevalence in Other Definitions	Recommendation
*59400	Obstetrical Care	36%	Exclude
*59410	Veginal Delivery + Postpartum Care	25%	Exclude
*59425	Antepartum Care Only 4-6 Visits	17%	Exclude
*59426	Antepartum Care Only 7< Visits	17%	Exclude
*59430	Postpartum Care Only	17%	Exclude
*59510	Routine Ob Care	36%	Exclude
*59515	Cesarean Delivery Only + Postpartum Care	27%	Exclude
*59610	Routine Obstetric Care After Prevs C-Section	30%	Exclude
*59614	Vaginal Delivery Only After Prevs C-Section + Postpartum Care	27%	Exclude
*59618	Routine Ob Care Post Vaginal Delivery After Prev C-Section	36%	Exclude
*59622	C-Section Only, After Attempted Vaginal Delivery After Prev C- Section + Postpartum Care	27%	Exclude

Otology Services

Codes	Description	Prevalence in Other Definitions	Recommendation
*69200	Clear Outer Ear Canal W/Out Anesthesia	8%	Exclude
*69210	Remove Impacted Ear Wax Instruments	8%	Exclude
*92551	Pure Tone Hearing Test Air	8%	Exclude
*92567	Tympanometry	8%	Exclude

Other (Part 1)

Codes	Description	Prevalence in Other Definitions	Recommendation
*36415	Routine Venipuncture	8%	Exclude
*36416	Capillary Blood Draw	8%	Exclude
11976	Remove Contraceptive Capsule	8%	Include
11981	Insert Drug Implant Device	33%	Include
11982	Remove Drug Implant Device	33%	Include
11983	Remove W/ Insert Drug Implant	33%	Include
15851	Removal Sutures Under Anesthesia Other Surgeon	0%	Exclude
16020	Dressings&/Dbrdmt Prtl-Thkns Burns 1St/Sbsq Small	0%	Exclude
17110	Destroy B9 Lesion 1-14	8%	Exclude
17111	Destroy B9 Lesion 15 Or More	8%	Exclude
*24640	Closed Treat Radial Head Sublx Child	0%	Exclude
*30300	Removal Foreign Body Intranasal Office Procedure	0%	Exclude
*51702	Insj Temp Indwellg Bladder Catheter Simple	0%	Exclude

Other (Part 2)

Codes	Description	Prevalence in Other Definitions	Recommendation
*54150	Circumcision W/Clamp/Oth Dev W/Block	0%	Exclude
57170	Fitting Of Diaphragm/Cap	33%	Include
58300	Insert Intrauterine Device	33%	Include
*95115	Prof Services Allergen Immutherapy Single Injection	0%	Exclude
*95117	Prof Services Allergen Immutherapy Multiple Injection	0%	Exclude
96372	Ther/Proph/Diag Inj Sc/Im	50%	Include
*A4627	Spacr Bag/Resrvor W/Wo Mask W/Metrd Dose Inhal	0%	Exclude
*A6448	Light Comprs Bandge Elast Wdth < 3 In Per Yard	0%	Exclude
*A6449	Light Comprs Bandge Elast Wdth >/= 3 & <5 In Per Yd	0%	Exclude
*A7003	Admn Set Sm Vol Nonfiltr Pneumat Nebulizr Dispbl	0%	Exclude
*A7015	Areo Mask Used W/ Dme Neb	0%	Exclude
99495	Trans Care Mgmt 14 Day Disch	92%	Include
*97597	Debridement Open Wound 20 Sq Cm/<	0%	Exclude
*97602	Rmvl Devital Tiss N-Slctv Dbrdmt W/O Anes 1 Sess	0%	Exclude