Advisory Committee on Data Issues meeting minutes

September 8, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
10 a.m. -12 p.m.

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

Members present

Allison Bailey
Amanda Avalos
Ana Morales
Bruce Brazier
Chandra Hicks
David Mancuso
Hunter Plumer
Jonathan Bennett
Julie Sylvester
Lichiou Lee
Mandy Stahre
Mark Pregler
Russ Shust

Members absent

Jason Brown
Megan Atkinson
Jerome Dugan
Leah Hole-Marshall
Josh Liao

Agenda items

Welcome, Roll call, Agenda Review

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 10:02 a.m.

Approval of Minutes

AnnaLisa Gellermann provided a recap of the May committee meeting, and the committee approved the minutes.

Topics for Today

Topics include the fourth Rand report on hospital prices; Washington hospital costs, price, and profit analysis; a presentation on Washington hospital costs and payment comparisons; and an introduction to the primary care target and measurement.

Rand Report 4: The Public Report

Ross McCool
Washington State Health Care Authority

Ross McCool, HCA's operations research specialist, presented on the fourth round of analysis of Rand's report on hospital prices. The report drew several conclusions: 1) Across all hospital services, payments were approximately 220 percent of what Medicare would have paid. 2) Outpatient services usually lead costs (but not in Washington). 3) Ambulatory Surgical Centers (ASCs) are being paid far less than hospital outpatient departments (HOPDs) for the same services compared to Medicare pricing). 4) Market share correlated significantly with the cost of services. 5) There is no support for a cost-shift theory. 6) There is no support for the theory that quality affects price.
Rand sought to increase transparency into employer health care costs by accessing hospital data through states' All-Payer Claims Database (APCD) claims and voluntary self-reported data for self-insured employers. Rand approached Washington's Health Benefit Exchange (HBE) and the cost board for data from 2018 through 2020. The study included all states except Maryland and covered 4,102 hospitals for a total of $80 million for hospitals and ASCs. The study faced limitations including the inability to distinguish between in-network and out-of-network prices, difficulties with provider assignments (e.g., missing servicing providers), the voluntary nature of data submissions, inappropriate case mix-adjustment weights used for Medicare, and a lack of non-claims-based payment data. Ross McCool reviewed the all-state trends in relative prices for commercial providers and showed that commercial overall paid roughly 220 to 230 percent of Medicare as a basis with a slight increase in 2019 and a decline in 2020. The report also showed relative facility and professional prices by inpatient facility. For Washington, inpatient facilities led prices compared to the trend of the country towards outpatient facilities. Rand explored the correlation between the price and quality of services by comparing hospital quality ratings from low to high. The quality rating was CMS' star rating and prices ranged from less than 150 percent to greater than 250 percent of Medicare. There was not a clear link between price and quality, but the quality measure didn't capture all outcomes that purchasers value, e.g., prevalence and degree of positive health outcomes. The share of discharges from public payers explained less than one percent of price variation which led to the conclusion that cost shifting was not occurring. There was a significant relationship between price and market share where a 10 percent increase in market share was associated with a 0.5 percent increase in relative price. Both Medicare and private insurers paid ASCs at a lower rate. The cost board is the custodian for Rand reporting for HCA. HCA and HBE participated in a contract to release APCD data for reporting which will likely happen again in the next Rand reporting cycle. It is unlikely that this report will go to the board for discussion, but it may be included in the board's index of materials.
Julie asked if one approach could be to use this data to highlight to the board, the Legislature, and HCA that hospitals in Washington are underpaid and facing financial limitations. It was clarified that more information would be needed about the case mix for Medicare and more data on the absolute payments to adopt Julie's suggested approach. Julie asked if the report compared Medicare payments and it was clarified that it was a ratio. Hospital cost challenges have been discussed with the board, especially hospital discharge issues. The Washington State Hospital Association (WSHA) presentation for the board in July also noted low Medicaid reimbursement.

Washington hospital costs, price, and profit analysis

John Bartholomew and Tom Nash

This presentation was given to the board in July but was presented again to the data committee to look at its larger context. John Bartholomew presented initial findings from a review of 2020 Medicare cost reports submitted by Washington hospitals. The findings showed that Washington hospitals, when ranked on price and cost against all other states, are higher than the median in both price and cost per patient. Washington hospitals rank lower than the median in profit, as a measure of margin. Data spanning across time demonstrated that hospital costs are increasing nationally and in the state. Washington, based on its admission rate, was a relatively healthy state with lower admission rates. A review of trends in some key cost metrics showed that trends increased from 2009 to 2014 that largely track national trends. Washington metrics appeared to trend higher beginning in 2014 to the present. Further investigation and analysis might be pursued to verify and identify potential causes. Mr. Bartholomew concluded that identifying hospitals with higher costs should lead to inquiry about what might be driving that cost, which could be a variety of factors.
Julie commented that Harborview is a level 1 trauma center and John Bartholomew replied that this is an example of case mix adjustments that should be made.
AnnaLisa noted that the point is to learn more because hospitals are a large part of what is spent on healthcare. AnnaLisa asked committee members about what reasonable next steps or considerations might be.
Julie mentioned looking at the impacts of the pandemic. AnnaLisa agreed that it would be good to look at the pandemic's impact on service intensity and case mix and labor costs. In the September 21 cost board meeting, Bianca Frogner will present the rest of her presentation on workforce.
Bruce emphasized the importance of case mix and intensity. There are many factors that go into hospital differentiation.

Public comment

A member of the public asked how to access data used in John Bartholomew's presentation. This data and methodology can be found in the appendix of Colorado's report.

Washington hospitals: adjustments needed for hospital cost and payment comparisons

Jonathan Bennett
Washington State Hospital Association (WSHA)

Jonathan Bennett framed the context and nuances of the board's charge to annually calculate total health expenditures and the additional work needed. An intention of the statute is to consider the intensity of services provided to patients. WSHA recommended using additional lenses when calculating total health care expenditures, including those that take into account regional differences, such as the wage index for hospitals.
Medicare uses two adjustments for all inpatient-based payments. The first is the Medicare Case Mix Index (CMI) which alters payment to account for patients' conditions based on diagnosis or medical procedures performed. Hospitals' case mix (intensity of services) is important in calculating total health care expenditures because hospital costs and prices differ based on the types of patients served. However, the board's consultant has mainly used bed size groupings. WSHA recommended adjusting the data using a diagnosis related group (DRG) based CMI. Hospitals' CMI could then be used as a proxy used for all cases, or the consultant could calculate the CMI using all inpatient data based on the Comprehensive Hospital Abstract Reporting System (CHARS). The committee was asked for thoughts on WSHA's adjustment recommendation. Hunter Plumer suggested using the Medicare CMI for making comparisons across states and using CHARS for analyzing data within Washington. AnnaLisa asked whether using APCD as a data source would be valuable, however APCD doesn't include self-funded cases or a

portion of the commercial population. The Medicare CMI is a great place to start for a perspective on how Washington compares to other states. Mandy Stahre mentioned the Healthcare Cost and Utilization Project (HCUP) database which captures states' CHARS data and could help compare across states. AnnaLisa asked if it would be more valuable to look at in-state comparisons or across-state comparisons to identify areas where the board can encourage bending the cost curve. Agency for Healthcare Research and Quality (AHRQ) captures inpatient ER and ambulatory surgeries from states that collect them and could be used as a source. Mandy suggested keeping comparisons within Washington given different state policies, population demographics, etc.
Medicare's second adjustment is a wage index payment which accounts for geographic differences in labor costs based by hospitals. WSHA recommended using the CMS Area Wage Index for hospital-to-hospital comparisons because it is available for all hospitals and is based on area-equivalent wages for hospital personnel. Mandy agreed with this approach because it accounts for factors outside of the hospital settings. AnnaLisa asked if there were other input price indicators to consider. Amanda Avalos asked for clarification on whether using the CMS Area Wage Index was focused on balancing salaries/wages from the hospital perspective or from the community of patients' perspective and it was clarified that it was for both. A comment in the Zoom chat recommended looking into using ICD9 and ICD10 data to determine how the wage index would align with staffing/workforce levels. Washington is in the top 12 states caring for patients with higher acuity care need and in the top 10 of relative wages. These factors must be taken into consideration and standardized for apples-to-apples comparison with other states and because these types of adjusters bring hospitals' cost of payments up or down. . Information on how WSHA applied these adjusters is publicly available. At their next meeting, the committee will solidify recommendations to the board on 1) next steps and 2) adjustments to hospital costs.

Introduction to primary care target and measurement

AnnaLisa Gellerman, HCA

AnnaLisa shared a condensed version of Dr. Judy Zerzan-Thul's presentation to the board on primary care. Dr. Zerzan-Thul is the chair of the board's advisory committee on primary care which will report to and advise the board on the Legislature's prescribed primary care recommendations, including: 1) a definition of primary care. 2) Measurement methodologies to assess claims-based spending. 3) Measurement methodologies to assess non-claims-based spending. 4) How to overcome barriers to access and use of primary care data. The primary care committee's first step is to review how primary care has been previously defined in Washington including by the Office of Financial Management (OFM) and Bree Collaborative.
Primary care services are typically defined by claims-based and non-claims-based measurement, both of which were briefly described. According to OFM, primary care accounted for about 5.9 percent of total spend (includes broad and narrow definition of primary care) in 2019. "Total spend" was used by OFM, though this is likely different from "total health care expenditures" as defined in the board's statute. Total health care expenditures will be collected as part of the board's data call and differs from the spending currently contained in the APCD, which may or may not impact the total primary care spend percentage. Between 2018-2020, primary care spending in Washington ranged from 5.2 percent to 5.9 percent of total spend. Non-claims-based measurement includes 1) billable services and other primary care-related costs that may not appear on claims such as patient cost-sharing (which will be captured in the board's collection of total health care expenditures), and 2) non-billable services and other costs that may not appear on claims, such as care coordination. The data committee was asked to start thinking about these topics in preparation for future meetings.
Amanda asked for clarification on the scope of primary care recommendations on a definition, i.e., identification of national standards for future comparison across other states. Russ Shust recommended that virtual care and telemedicine be considered for primary care and controlled spend, and to break out "other medical" to get the

professional spend on the facility side. This will make it easier to identify when primary care is a more appropriate modality of care than specialty services and the shrinking of overall costs so primary care represents a larger portion of spend.
Lichiou Lee asked the purpose of including non-claims-based measurement. The primary care committee will need to decide what will be included in primary care spend, i.e., staff salaries. The goal is to increase investments in primary care to reduce overall health care costs. One reason to include non-claims-based measurement is to get credit for all primary care investments, including components that are not captured by APCD.

Adjournment

Meeting adjourned at 11:59 a.m.

Next meeting

November 1, 2022
Meeting to be held on Zoom
9:00 a.m. – 11:00 a.m.