Washington State Health Care Authority

Advisory Committee on Data Issues and Advisory Committee of Providers and Carriers

February 7, 2023

Washington State Health Care Authority

Advisory Committee on Data Issues and Advisory Committee of Providers and Carriers Meeting Materials Book

February 7, 2023
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Agenda and Presentations

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

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

February 7, 2023
2:00 – 4:00 p.m.
Zoom Meeting

AGENDA

Data Advisory Committee Members:					
☐	Megan Atkinson	☐	Jerome Dugan	☐	Ana Morales
☐	Amanda Avalos	☐	Chandra Hicks	☐	Hunter Plumer
☐	Allison Bailey	☐	Leah Hole-Marshall	☐	Mark Pregler
☐	Jonathan Bennett	☐	Lichiou Lee	☐	Russ Shust
☐	Bruce Brazier	☐	Josh Liao	☐	Julie Sylvester
☐	Jason Brown	☐	David Mancuso	☐	Mandy Stahre

Health Care Provider and Carrier Advisory Committee Members:					
☐	Mark Barnhart	☐	Stacy Kessel	☐	Megan McIntyre
☐	Bob Crittenden	☐	Ross Laursen	☐	Mika Sinanan
☐	Justin Evander	☐	Todd Lovshin	☐	Dorothy Teeter
☐	Paul Fishman	☐	Vicki Lowe	☐	Wes Waters
☐	Jodi Joyce	☐	Mike Marsh		
☐	Louise Kaplan	☐	Natalia Martinez-Kohler		

Committee Facilitator:
AnnaLisa Gellermann

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome, agenda, and roll call	1	AnnaLisa Gellermann Board Manager, Health Care Authority
2:10 – 2:55 (45 min)	Introduction to 2022 Cost Growth Drivers Study, Questions and Discussion	2	Amy Kinner, Director of Health Analytics OnPoint Health Data
2:55 - 3:10 (15 min)	Cost Growth Driver Study: Discussion and Feedback to the Board		All
3:10 – 3:20 (10 min)	Public comment		AnnaLisa Gellermann
3:20 – 3:40 (20 min)	Presentation on PCTM and Primary Care Definition Recommendation	3	Dr. Judy Zerzan-Thul Chief Medical Officer, Health Care Authority
3:40 – 3:55 (15 min)	Primary Care Definition: Disussion and Feedback to Board		All
3:55 – 4:00 (5 min)	Adjourn		AnnaLisa Gellermann, Board Manager Health Care Authority

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

Tab 2

ONPOINT Health Data

Washington State Health Care Authority

Cost Growth Drivers Study

Preliminary Findings

December 14, 2022

Amy Kinner, *Director of Health Analytics*

ONPOINT Health Data

Washington State Health Care Authority

Overview of Study

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 growth in the health care system to inform the Board as it works to curb spending growth. The study discusses:
  - Spend/trend by market
  - Spend/trend by geography
  - Spend/trend by health conditions and demographics
  - Potential unintended consequences

Key Topics for Phase I Analysis

- How has insurance enrollment changed during the last 5 years?
- How has spending – on a total and per-member basis – changed during the last 5 years?
- How is spending changing for different products (e.g., commercial, Medicaid, Medicare Advantage)?
- Does spending vary by category of service (e.g., inpatient, outpatient, professional, primary care, specialty care)?
- Are there differences in spending by region?
- Are there differences in spending by age and gender categories?
- How do “high-cost members” impact spending?

ONPOINT Health Data

Washington State Health Care Authority

Summary of Methods

Reporting Periods Included in the Analysis

- Study looked at 5 years of data: CY 2017–2021
- This period aligns with the cost-benchmarking period

Product Types & Markets

Product Type	Notes
Commercial	Limited data from self-insured plans
Medicaid	Includes managed care only; FFS members and payments are excluded; FFS data do not include line-level payments (a challenge for some categories)
Medicare Fee-for-Service (FFS)	Only available through 2019
Medicare Advantage	Covered by commercial plans; pharmacy data for these members is not included because many are covered by Medicare Part D (FFS)
Public Employees Benefits Board (PEBB)	Commercial and Medicare Advantage
WA Health Benefit Exchange	Commercial
Dual-eligibles	Not broken out separately in this analysis due to missing FFS data beyond 2019

Categories 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); community health centers and freestanding ASCs also included
Long-term care	SNFs, hospice, home health, personal care services, etc.
Retail pharmacy	Pharmacy claims
Other	All other dollars

Limitations

- Self-insured commercial plans are not required to report data to WA-APCD
- No data is available for the uninsured
- Medicare FFS data (including Medicare Part D pharmacy) is available only through 2019
- Alternative payments (e.g., capitated payments, pharmacy rebates) currently are not reported
- Long-term care data for Medicaid is not reported but is a significant contributor to spending
- Payments for Medicaid FFS data are not included

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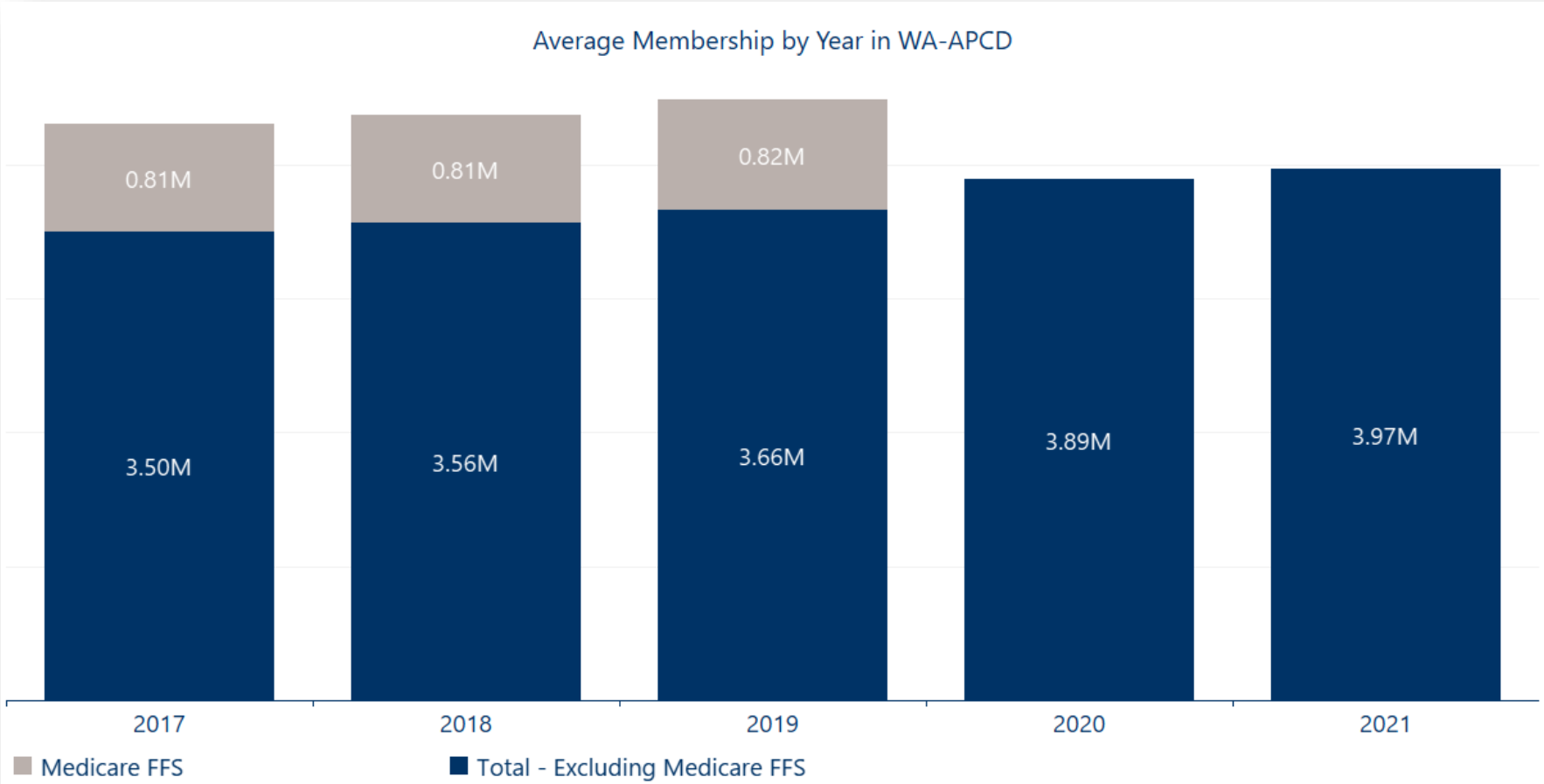
How Has WA-APCD Membership Changed?

Enrollment Trends (2017–2021)

WA-APCD Membership, 2017-2021



Average membership is calculated as number of member months of eligibility/12. This yields a slightly lower total than a count of distinct members during the year because some members have less than 12 months eligibility.

Average WA-APCD medical plan membership increased steadily between 2017 (3.50 million members) and 2021 (3.97 million members).

Medicare Fee-For-Service (FFS) contributed another ~800,000 members annually.

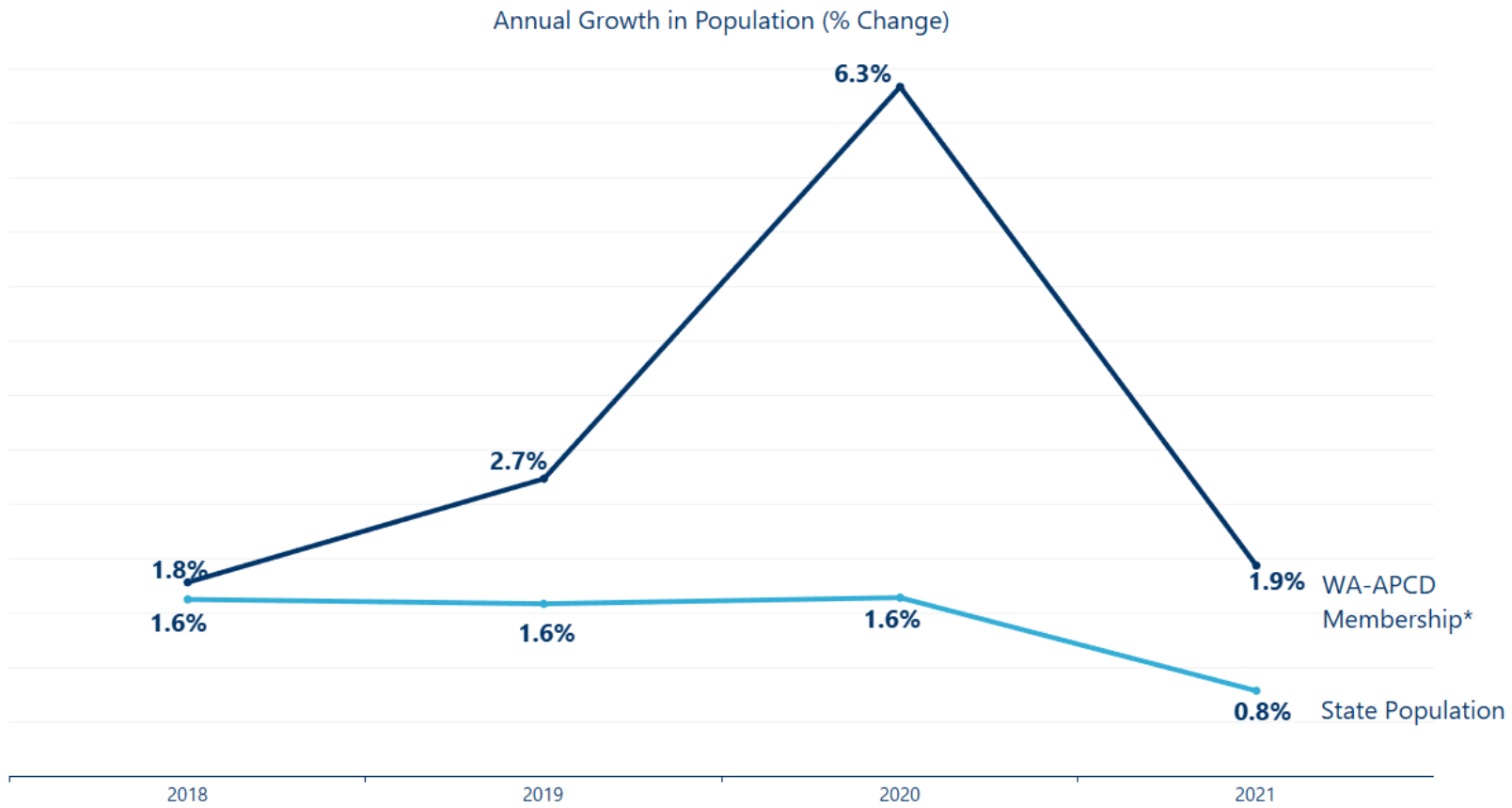
Medicare FFS data are not yet available for 2020 and 2021.

Medicaid FFS members are not included in this analysis.

WA-APCD Membership Growth Exceeded WA Population Growth

Annual percent growth in WA-APCD membership has exceeded the rate of population growth in WA.

In 2020, the WA-APCD grew by 6.3% compared to 1.6% population growth in the state.

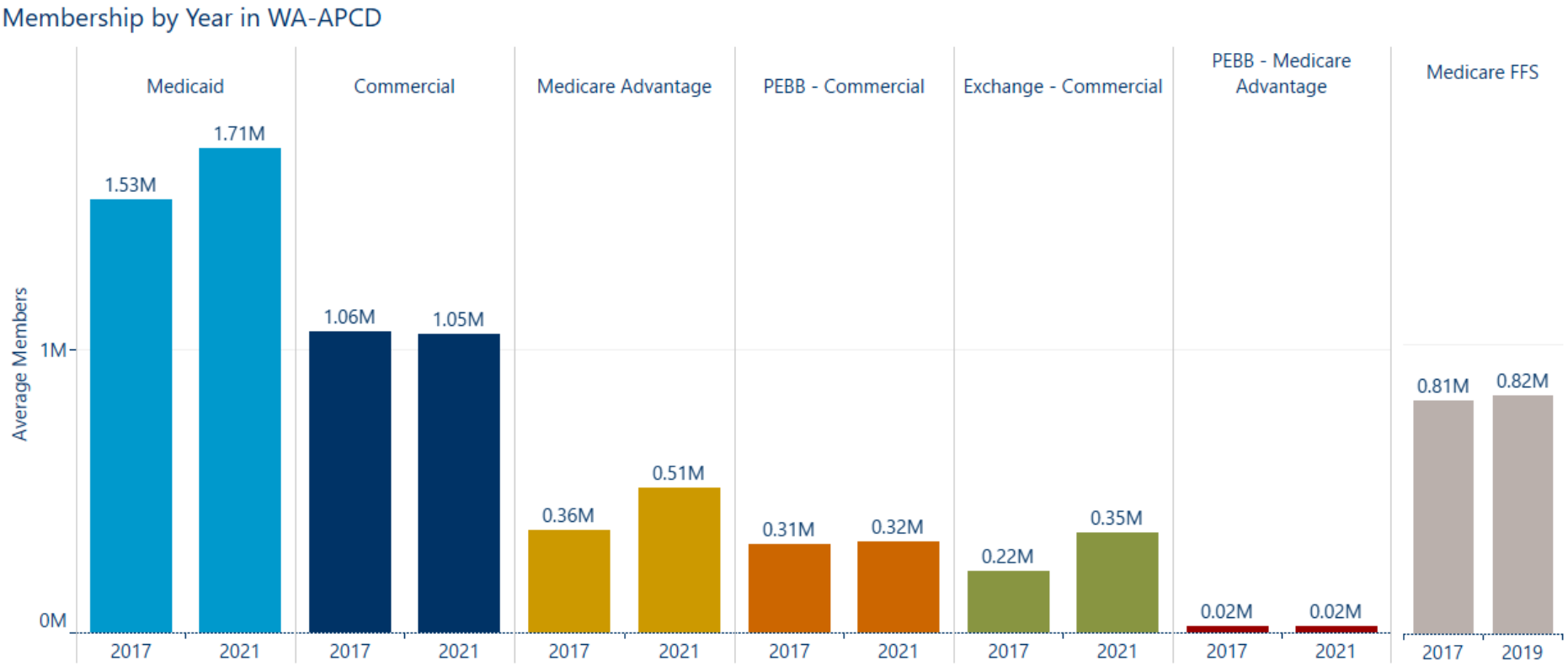


* Excludes Medicare Fee-For-Service (FFS). 2020 and 2021 data are not available for Medicare FFS. Medicaid FFS members are also excluded.

WA-APCD Enrollment by Product (2017 & 2021)

The number of members in Medicaid, Exchange, and Medicare Advantage plans increased significantly between 2017 and 2021 in WA.

Commercial plans and Public Employees Benefits Plan (PEBB) stayed relatively stable during this time.



Notes:

Medicare Fee-For-Service (FFS) data is not available for 2020-2021. Data for 2019 are presented here in place of 2021.

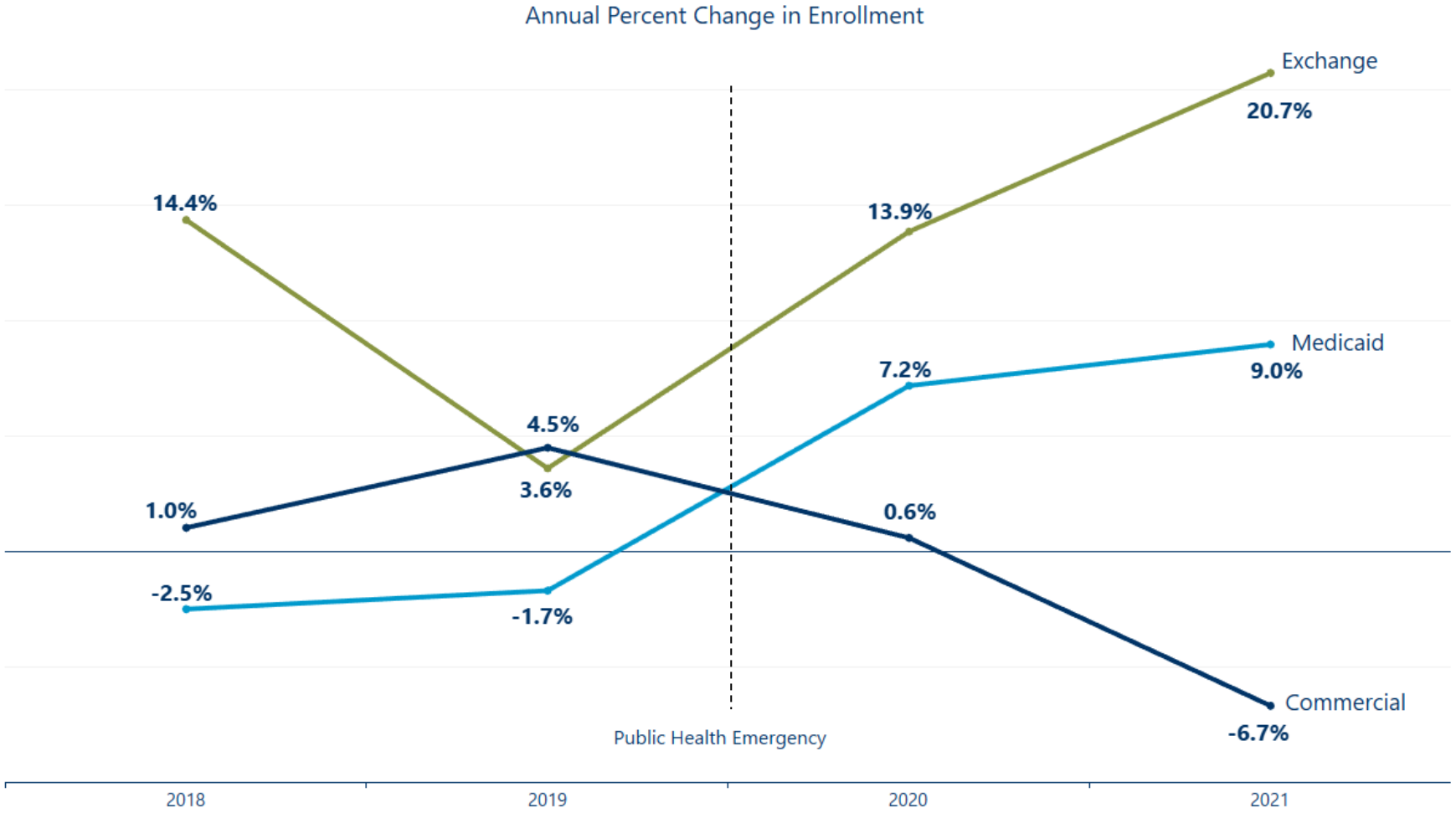
Medicaid data include only members with eligibility under Medicaid Managed Care.

Average membership is calculated as numer of member months of eligibility/12. This yields a slightly lower total than a count of distinct members during the year because some members have fewer than 12 months of eligibility.

Enrollment Trends during COVID-19 Emergency

Enrollment in Medicaid and Exchange plans increased during the COVID public health emergency.

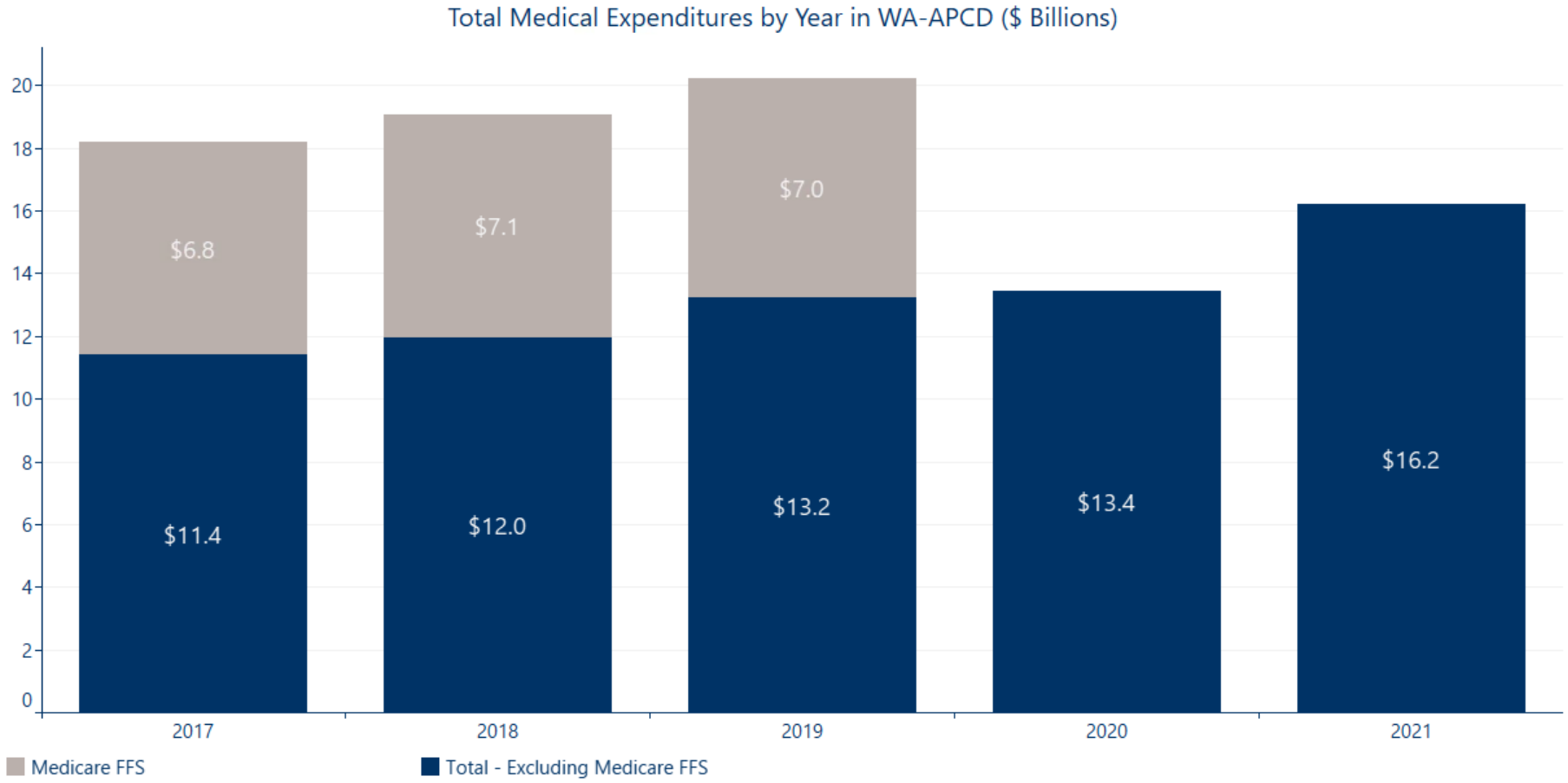
Some members joined or stayed on these plans or stayed on these plans longer than usual, which may have resulted in a downward enrollment trend for commercial payers.



How Have WA-APCD Total Expenditures Changed?

Medical & Pharmacy Claims

Total Medical Claims Expenditures (WA-APCD)



Medical expenditures for claims submitted to the WA-APCD increased from $11.4 billion in 2017 to $16.2 billion in 2021. This includes both plan and member payments.

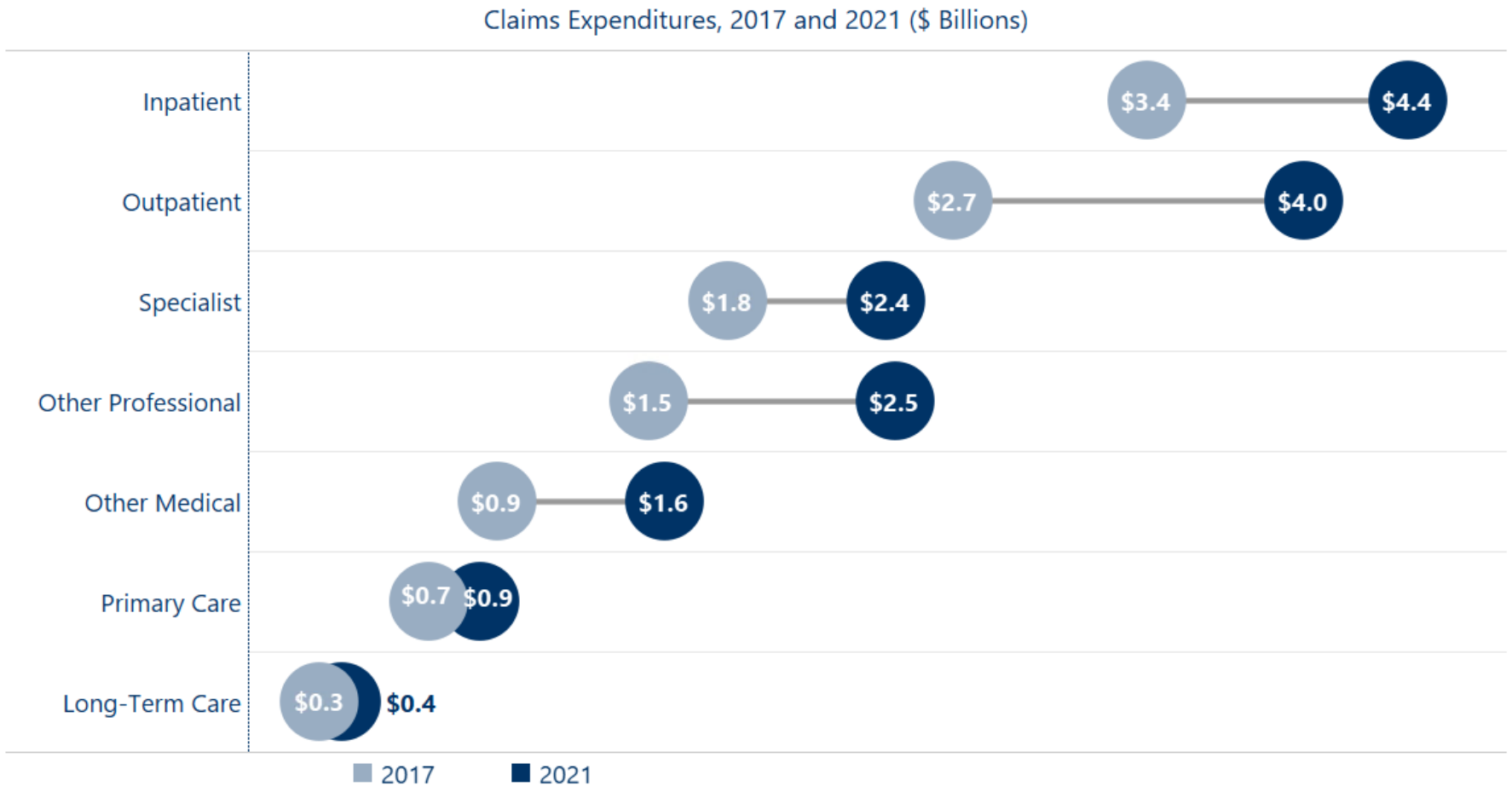
Medicare FFS claims comprised another approximately $7 billion in spending annually.

Note that these data do not include non-claims payments, Medicaid long-term care, Medicaid FFS dollars, or retail pharmacy claims.

Growth in Medical Claims Expenditures, 2017 & 2021

Spending for all medical categories increased between 2017 and 2021. The most significant increases were in outpatient spending ($2.7 billion to $4.4 billion), inpatient spending ($3.4 billion to $4.0 billion), and other professional ($1.5 billion to $2.5 billion).

In 2021, total inpatient spending ($4.4 billion) remained greater than outpatient spending ($4.0 billion), but **outpatient spending has been growing at a more rapid pace.**

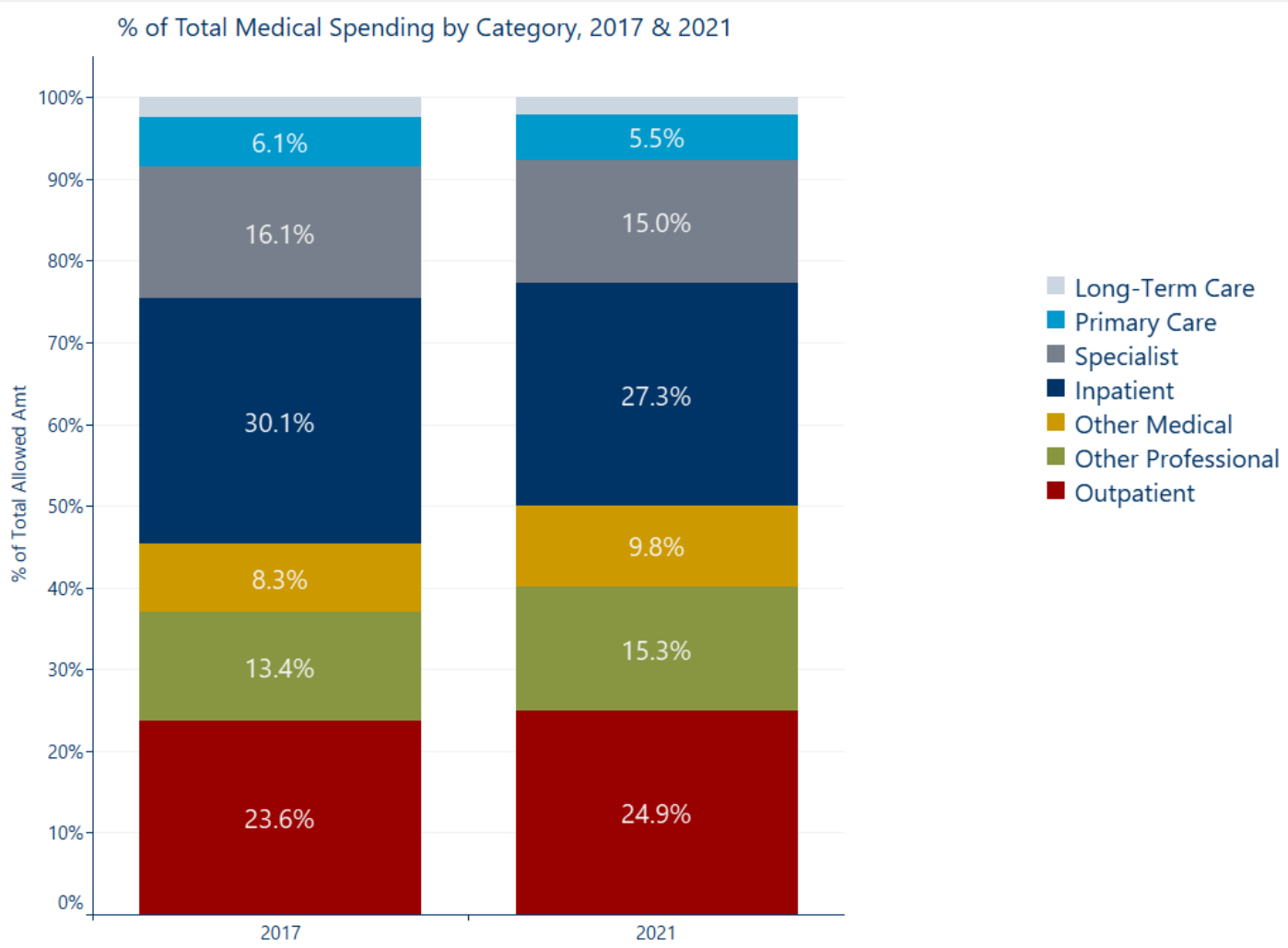


Note that these data do not include non-claims payments, Medicaid long-term care, Medicaid FFS dollars, Medicare FFS dollars, or retail pharmacy claims.

% Medical Spending by Category, 2017 & 2021

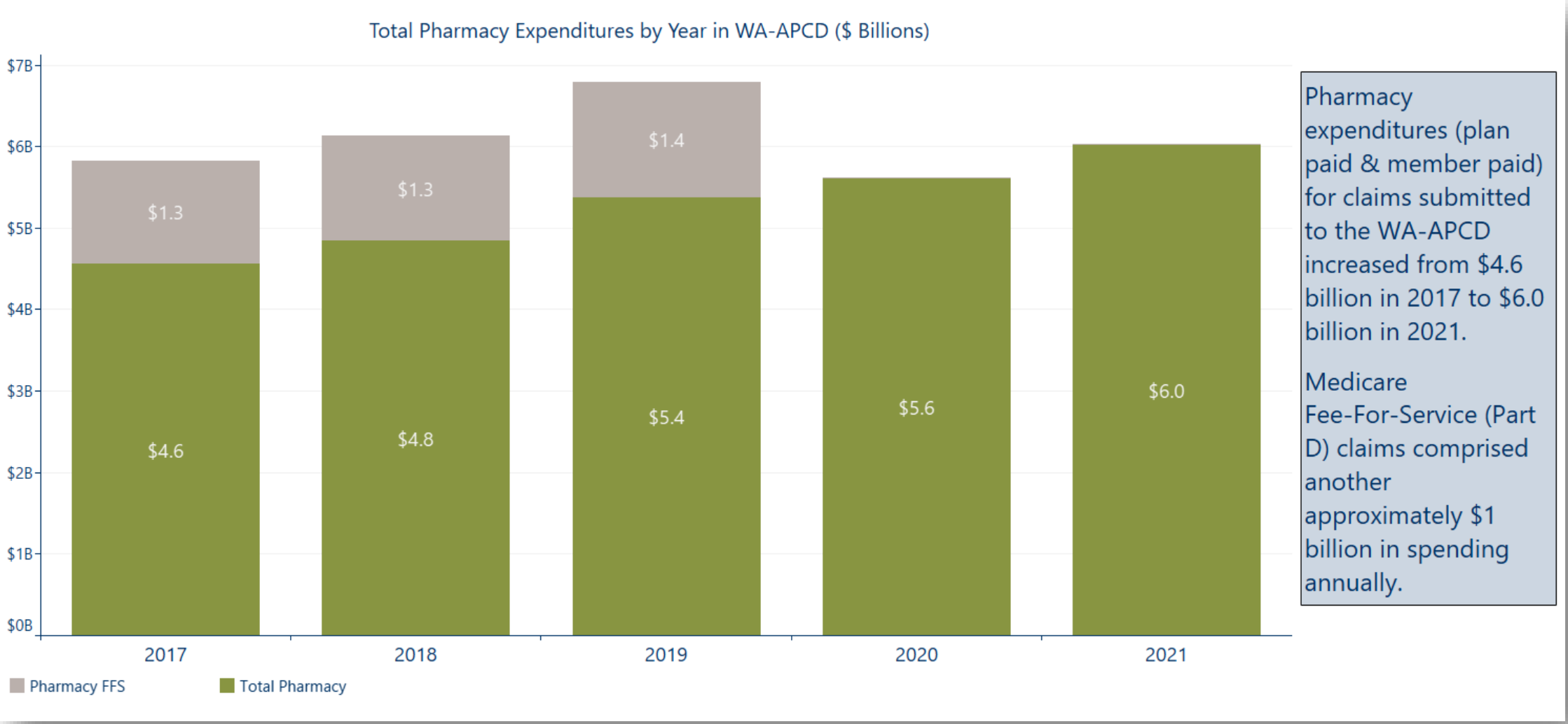
While expenditures for all categories increased between 2017 and 2021, there were some shifts in the relative spending by category.

Outpatient, other professional, and other medical spending categories increased as a percentage of total medical expenditures, while inpatient, specialist, primary care, and long-term care decreased as a percentage of total.



Note that these data do not include non-claims payments, Medicaid long-term care, Medicaid FFS dollars, Medicare FFS dollars, or retail pharmacy claims.

Total Pharmacy Claims Expenditures (WA-APCD)



Pharmacy expenditures (plan paid & member paid) for claims submitted to the WA-APCD increased from $4.6 billion in 2017 to $6.0 billion in 2021.

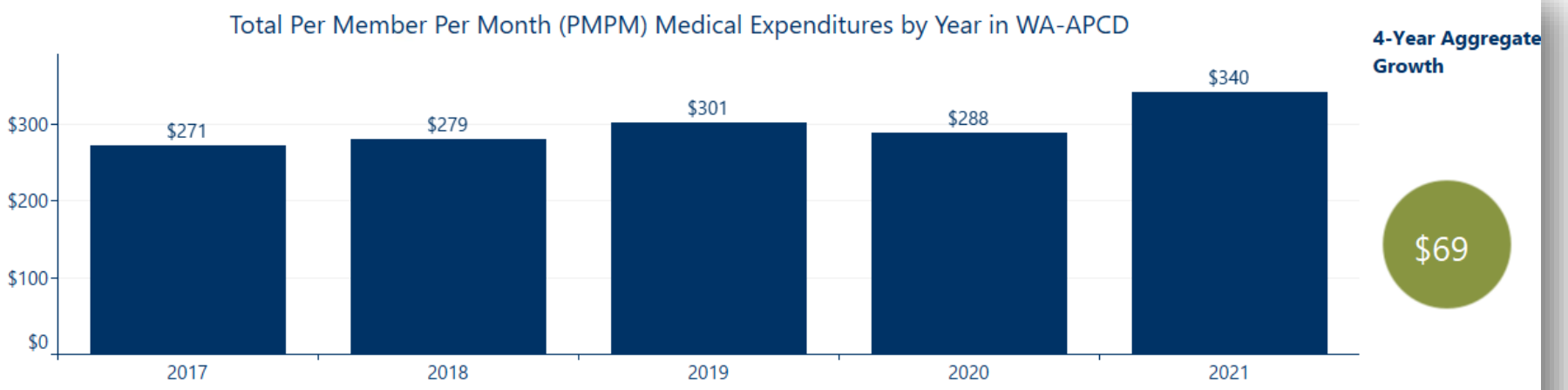
Medicare Fee-For-Service (Part D) claims comprised another approximately $1 billion in spending annually.

How Have WA-APCD Per Member Per Month (PMPM) Expenditures Changed?

Total PMPM Medical Expenditures (2017–2021)

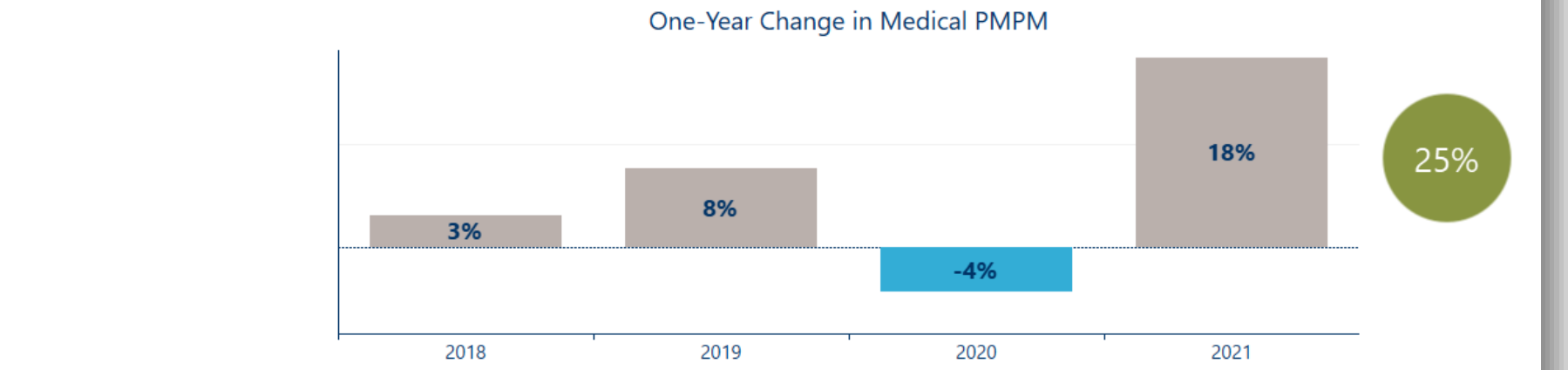
Per member per month (PMPM) is a way to adjust expenditures for the number of patients in the group.

For members in the APCD, total medical PMPMs increased from $271 PMPM in 2017 to $340 PMPM in 2021, a total of $69 PMPM.



There was a dip in PMPM spending in 2020, likely due to less use of medical care during the early days of the COVID pandemic.

Between 2020 and 2021, the rate of spending growth was much higher than other years (+18%). The total increase in medical spending between 2017 and 2021 was 25%.

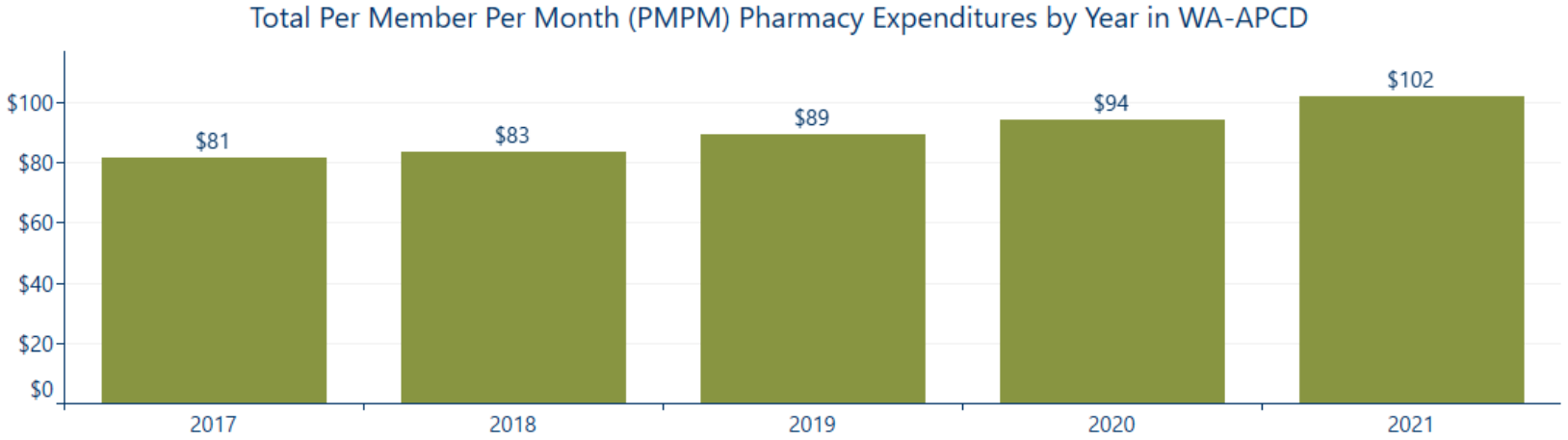


Note that these data do not include non-claims payments, Medicaid long-term care, Medicaid FFS dollars, Medicare FFS dollars, or retail pharmacy claims.

WA-APCD Pharmacy PMPM (2017–2021)

Per member per month (PMPM) is a way to adjust expenditures for the number of patients in the group.

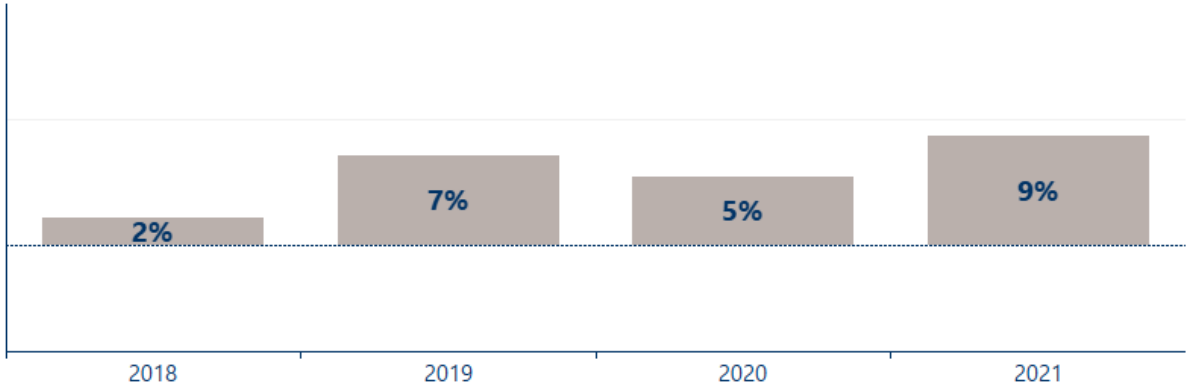
For members in the APCD (excluding Medicare), total pharmacy PMPMs increased from $81 PMPM in 2017 to $102 PMPM in 2021, a total of $21 PMPM.



4-Year Aggregate Growth

$21

Between 2017 and 2021, the rate of PMPM spending growth was 25%, similar to medical spending growth.



25%

Note: These figures do not include spending for Medicare FFS or Medicare Advantage members. Retail pharmacy expenditures in this analysis are gross of rebates.

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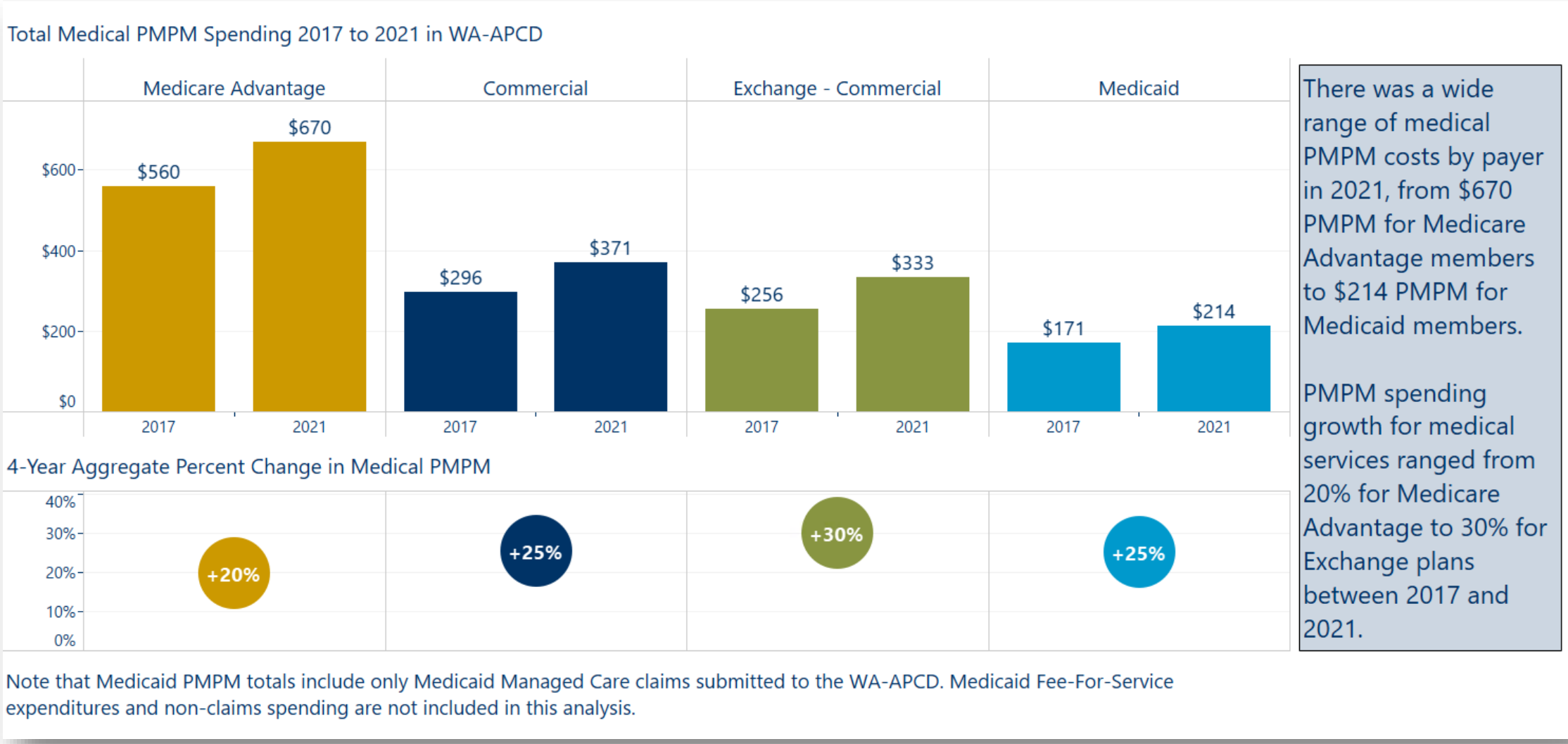
Are Different Products Experiencing Different Rates of Growth?

Medical PMPM Spending by Product (2017 & 2021)

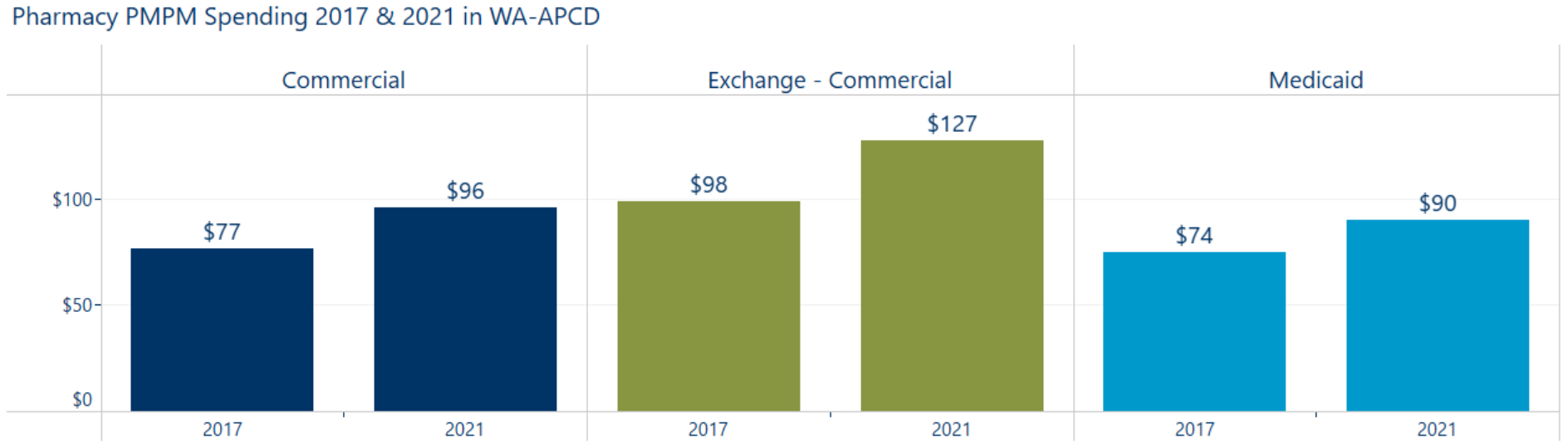


There was a wide range of medical PMPM costs by payer in 2021, from $670 PMPM for Medicare Advantage members to $214 PMPM for Medicaid members.

PMPM spending growth for medical services ranged from 20% for Medicare Advantage to 30% for Exchange plans between 2017 and 2021.

Note that Medicaid PMPM totals include only Medicaid Managed Care claims submitted to the WA-APCD. Medicaid Fee-For-Service expenditures and non-claims spending are not included in this analysis.

Pharmacy PMPM Spending by Product (2017 & 2021)



Pharmacy PMPM spending ranged from $90 for Medicaid members to $127 for Exchange members in 2021.

PMPM spending growth ranged from 21% in 2017 to 29% in 2021. The growth in pharmacy PMPM spending was similar to the growth in medical spending growth.

Note that Medicaid PMPM totals include only Medicaid Managed Care members in the WA-APCD. Medicaid Fee-For-Service members are not included in this analysis. Medicare FFS and Medicare Advantage are not included in pharmacy reporting for 2021 because Medicare Part D pharmacy data are not available for 2020 and 2021 in the WA-APCD. Retail pharmacy expenditures in this analysis are gross of rebates.

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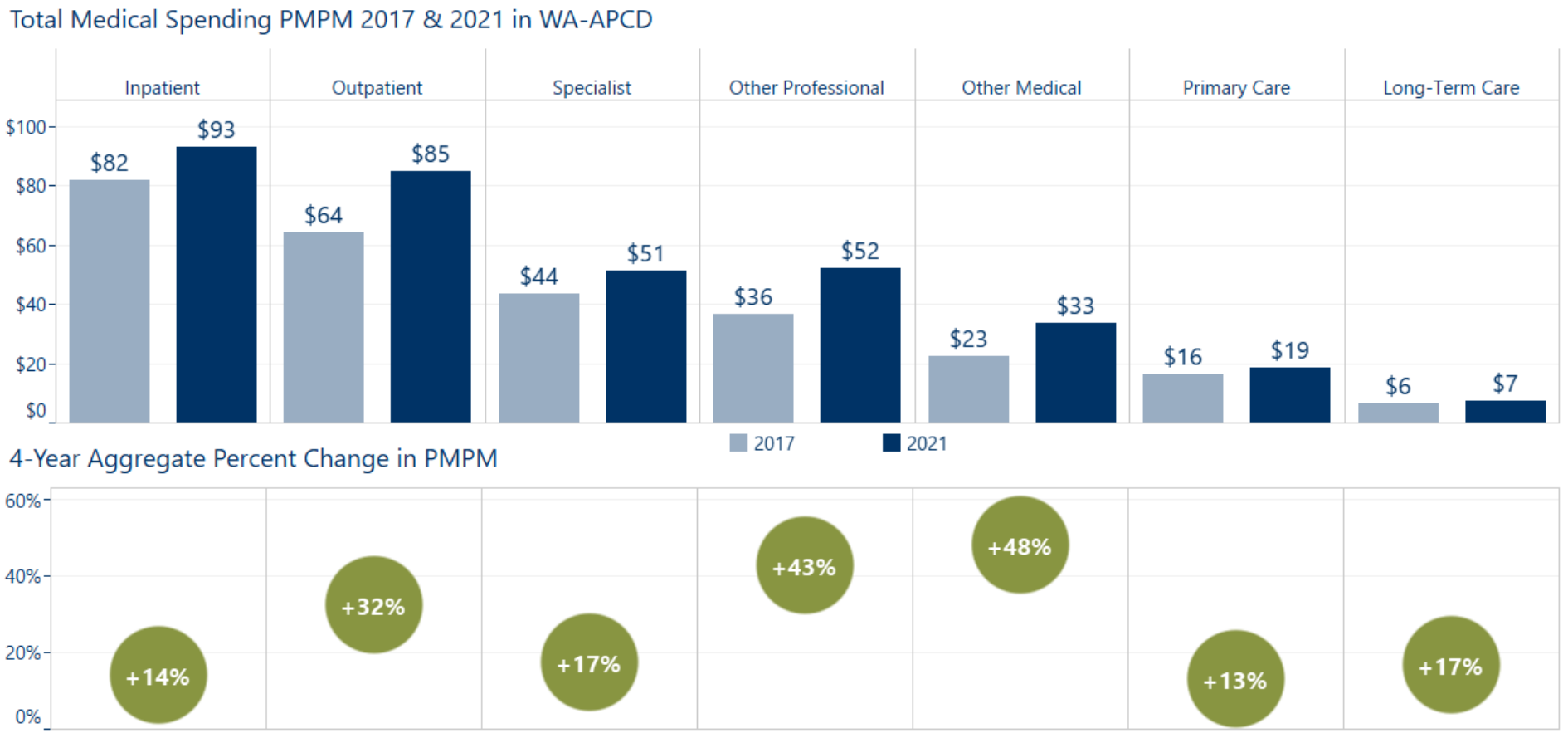
How Does Spending Growth Vary by Category?

PMPM by Category of Medical Service, All Products



Medical per member per month (PMPM) expenditures were calculated by category of spending. In 2021, spending was highest for inpatient ($93 PMPM), and outpatient ($85 PMPM) services.

The four-year aggregate percent growth in PMPM spending ranged from +13% for primary care to +48% for other medical services.

PMPM aggregate spending growth in other professional services (+43%) and outpatient services (+33%) were substantial.

Note that these data do not include non-claims payments, Medicaid long-term care, Medicaid FFS dollars, Medicare FFS dollars, or retail pharmacy claims.

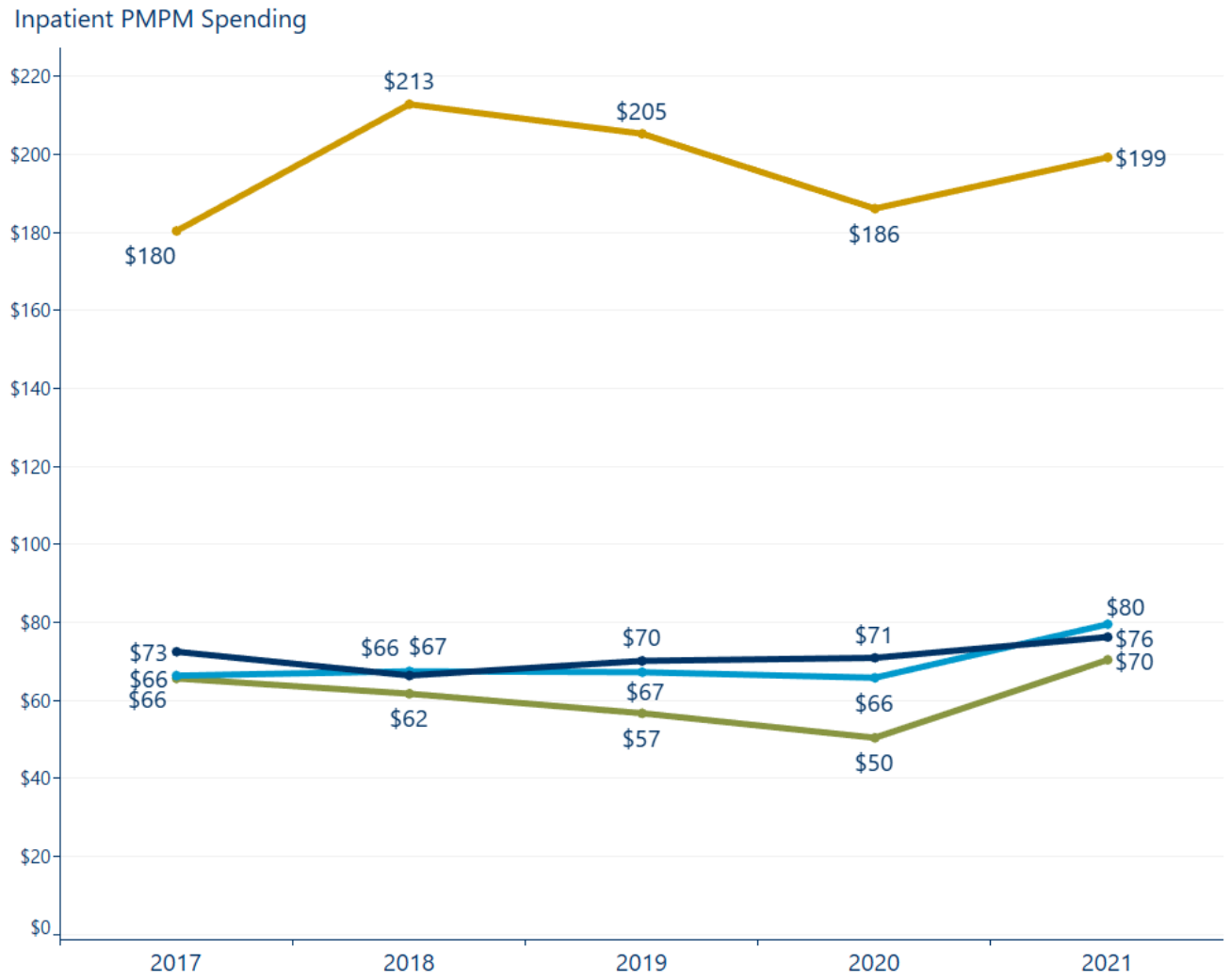
Inpatient PMPM Spending by Product

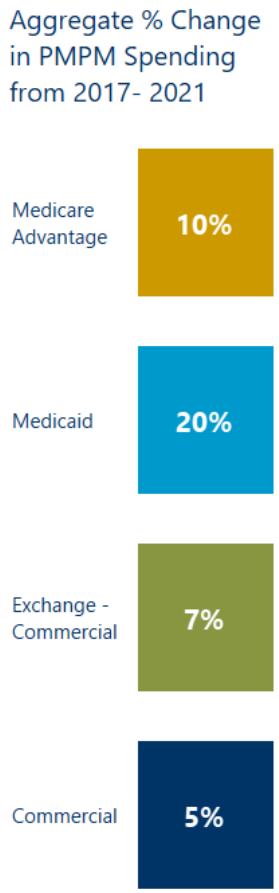
Medicare Advantage patients had the highest inpatient PMPM spending ($199 PMPM in 2021) due to the older population age.

Inpatient PMPM spending for other products ranged from $70 PMPM (Ex-change-Commercial) to $80 PMPM (Medicaid) in 2021.

Inpatient PMPM spending decreased in 2020 during the COVID pandemic but increased again in 2021 across all products.

The 4-year aggregate percent change in PMPM spending ranged from 20% (Medicaid) to 5% (commercial).

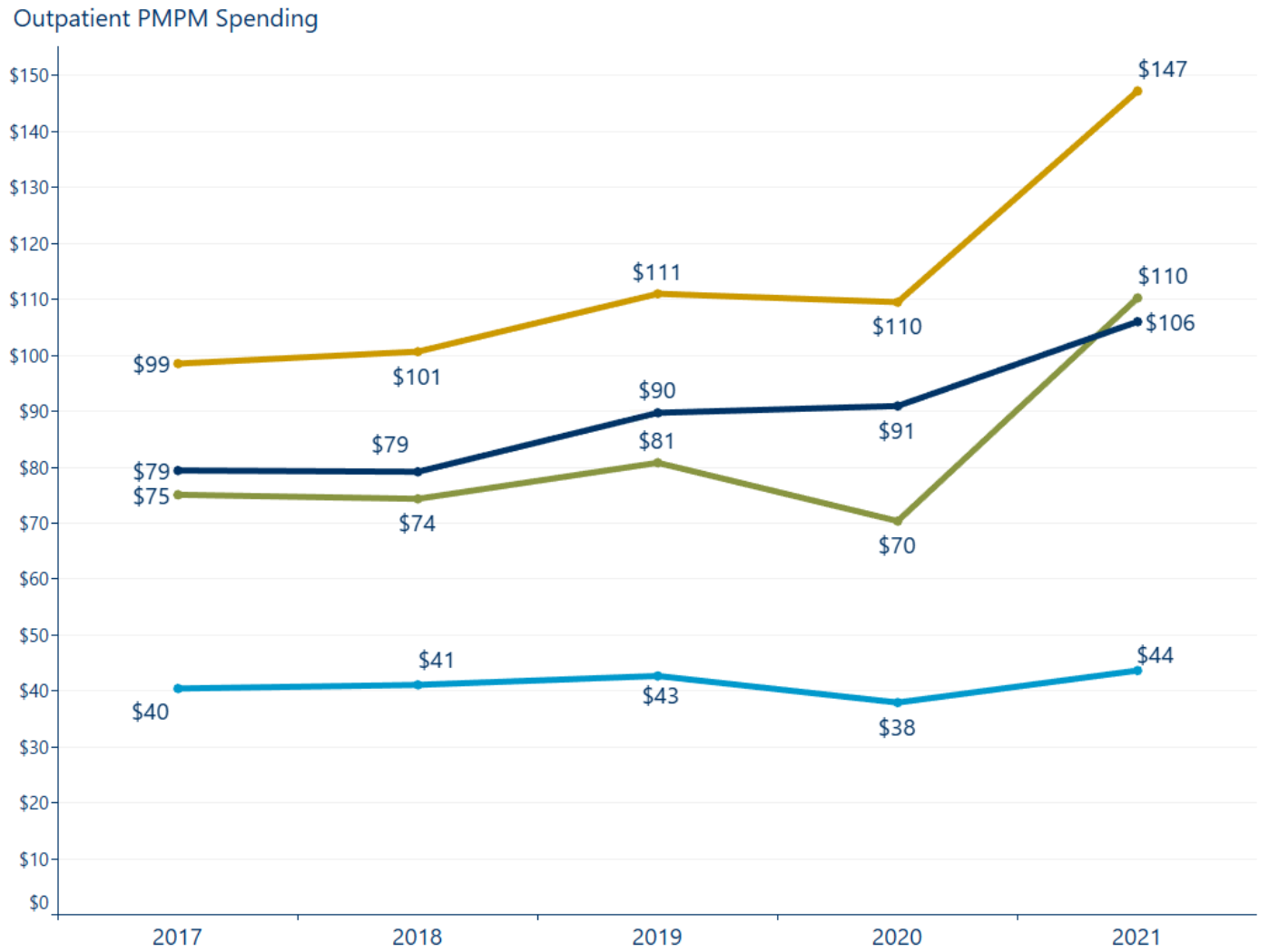


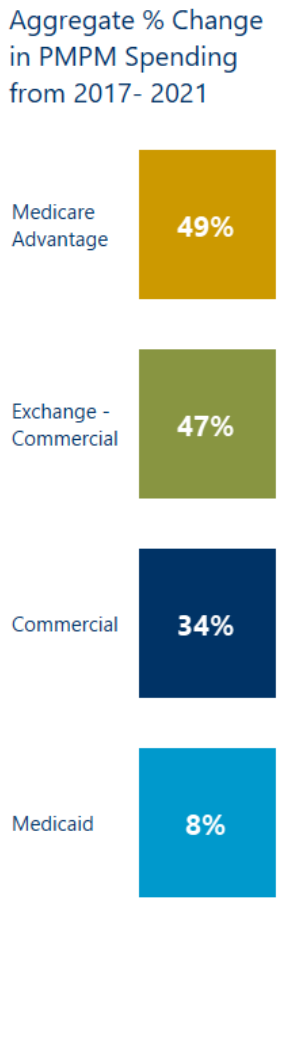


Outpatient PMPM Spending by Product

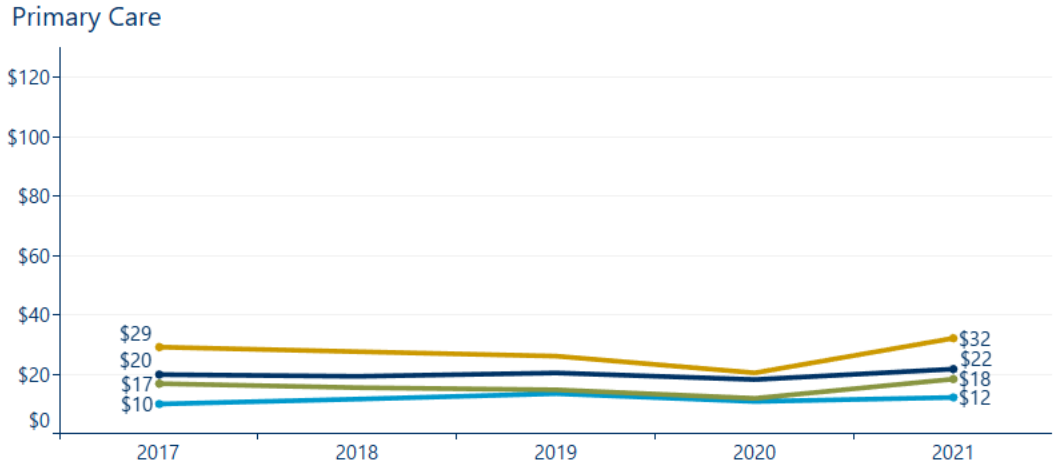
Medicare Advantage patients had the highest outpatient PMPM spending ($147 in 2021) due to the older population age. Outpatient PMPM spending for other products ranged from $44 (Medicaid) to $110 (Exchange-Commercial) in 2021.

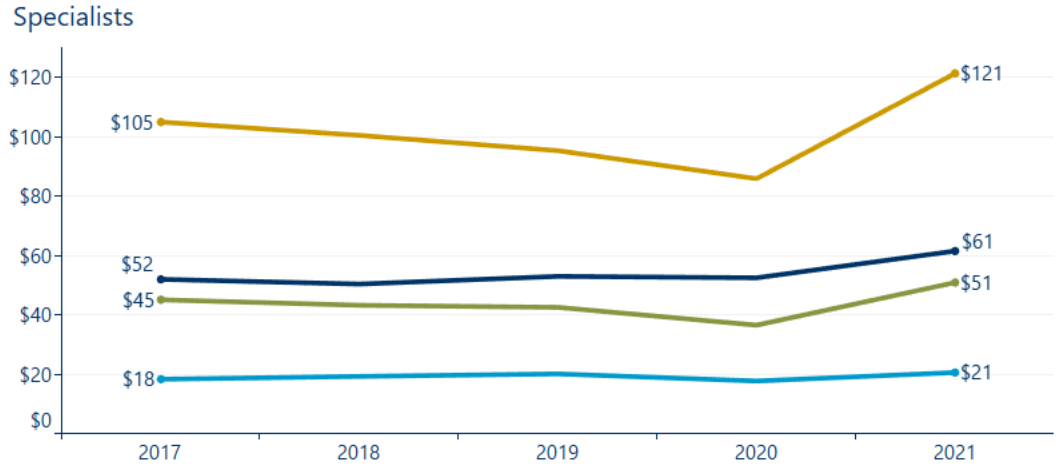
The 4-year aggregate percent change in outpatient PMPM spending ranged from 49% (Medicaid) to 8% (Medicaid).

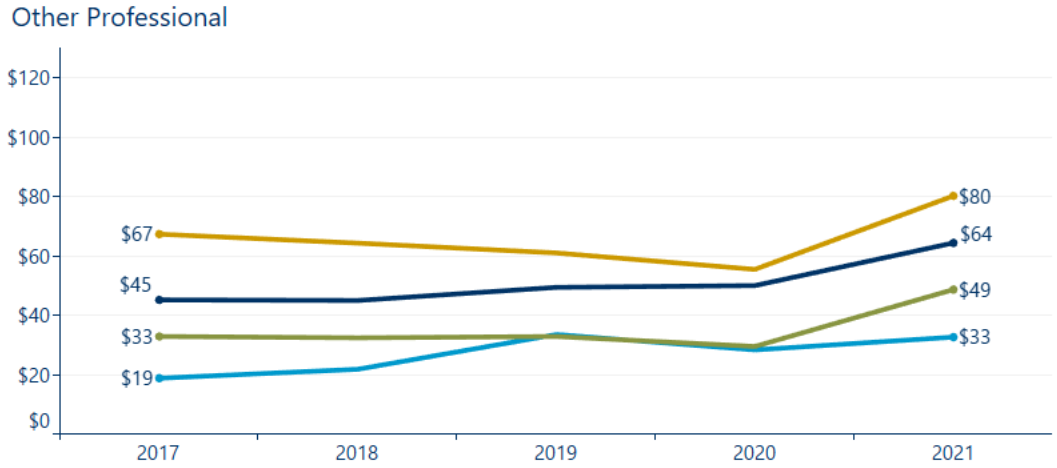




Professional PMPM Spending by Product





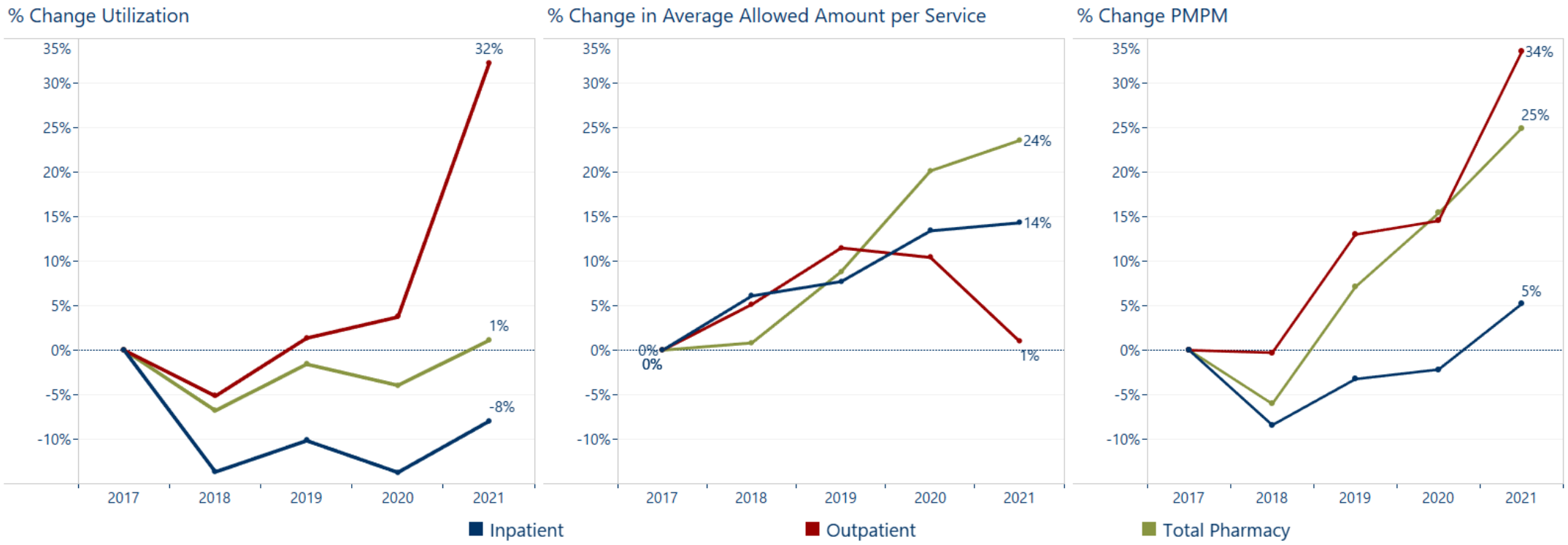


PMPM spending on the specialist and other professional categories was significantly greater than spending on primary care for all products. Fee-for-service PMPM spending for primary care services did not increase much between 2017 and 2021.

Note that the other professional category includes a diverse set of providers, including nurse practiftioners, physicians assistants, occupational therapists, counselors, etc. Facility fees for community health centers and free-standing ambulatory surgery centers also are bucketed into this category.

Medicare Advantage Commercial Exchange - Commercial Medicaid

Changes in Commercial Cost Drivers (2017–2021)



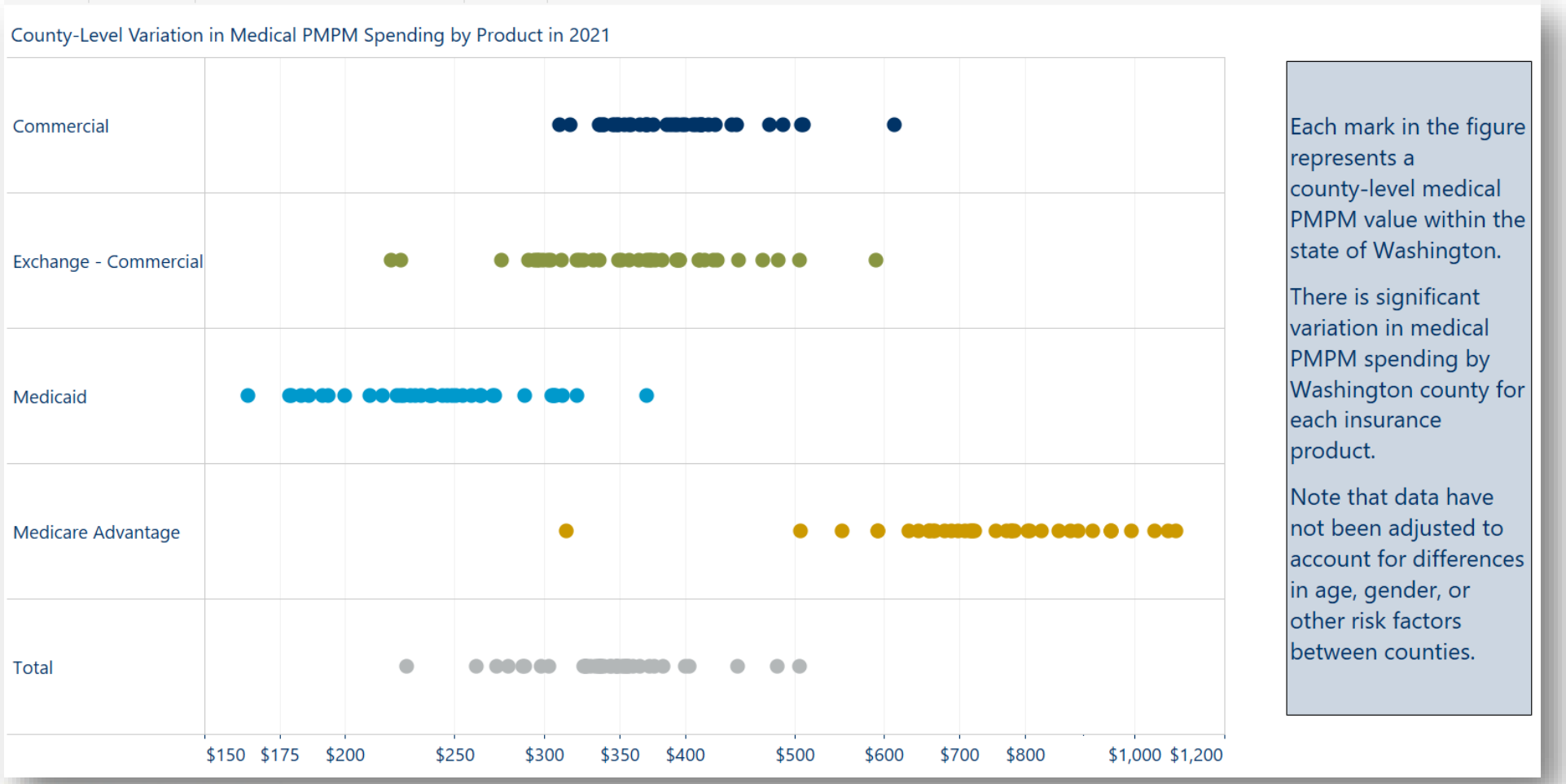
In the commercial population, outpatient spending PMPM grew by 34% between 2017 and 2021 (see graph on far right). This was driven by a 32% increase in outpatient services per 1,000 members during that time, while the average allowed amount per service grew by only 1%.

The pattern for pharmacy was much different. Pharmacy spending PMPM increased by 25% between 2017 and 2021, but this was primarily driven by an increased average allowed amount per service (24% increase), while pharmacy use per 1,000 members increased by only 1%.

Inpatient spending PMPM grew by 5% between 2017 and 2021. Allowed amounts per inpatient discharges increased by 14%, while inpatient discharges per 1,000 members decreased by 8%.

Are There Regional Differences in Spending?

Medical PMPM Spending Varies Widely by Patient County of Residence



Each mark in the figure represents a county-level medical PMPM value within the state of Washington.

There is significant variation in medical PMPM spending by Washington county for each insurance product.

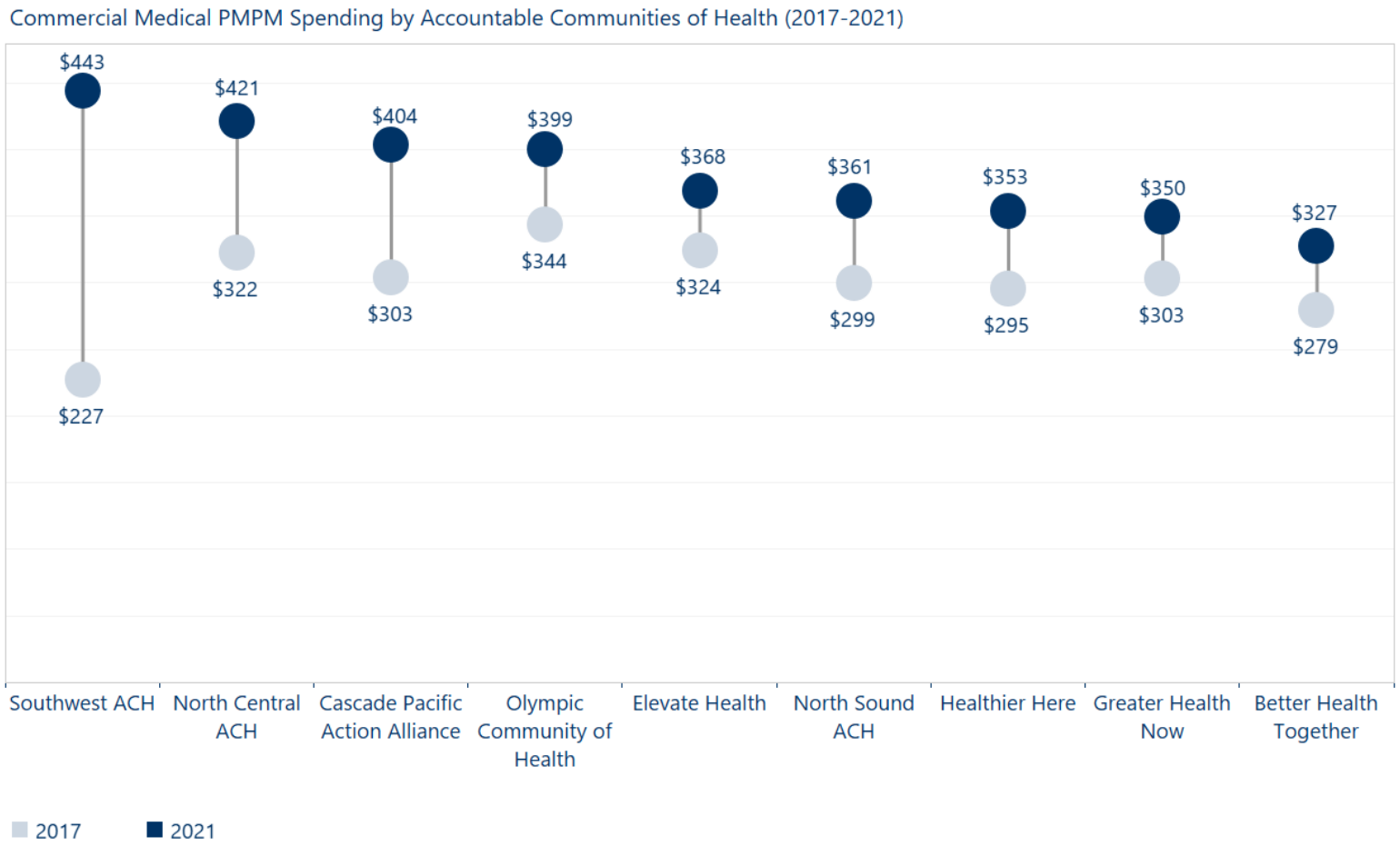
Note that data have not been adjusted to account for differences in age, gender, or other risk factors between counties.

Commercial Medical PMPM Spending, Stratified by ACH of Patient Residence, 2017 & 2021

There is significant variation in medical PMPM spending by region in Washington. For the commercially insured population, in 2021, medical PMPM spending ranged from $443 in the Southwest Accountable Communities of Health (ACH) to $327 PMPM in the Better Health Together ACH.

Regional spending may vary due to pricing as well as the age, gender, and other population risk factors.

Spending growth varied by ACH. For example, commercial spending almost doubled between 2017 and 2021 in the SW Regional Alliance Area.



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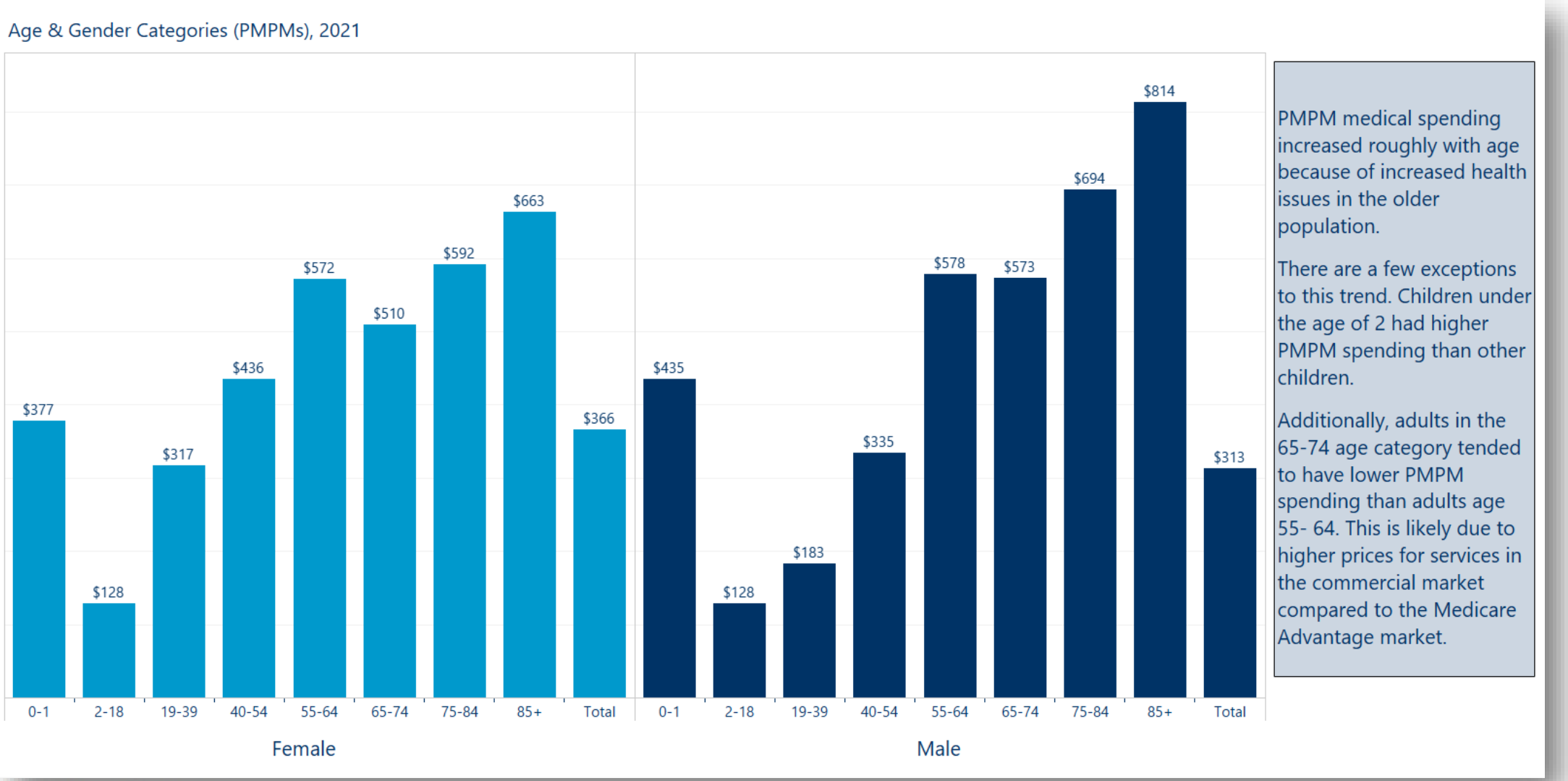
How Does Spending Vary by Age & Gender?

Medical PMPM Totals by Gender & Age (Years), 2021

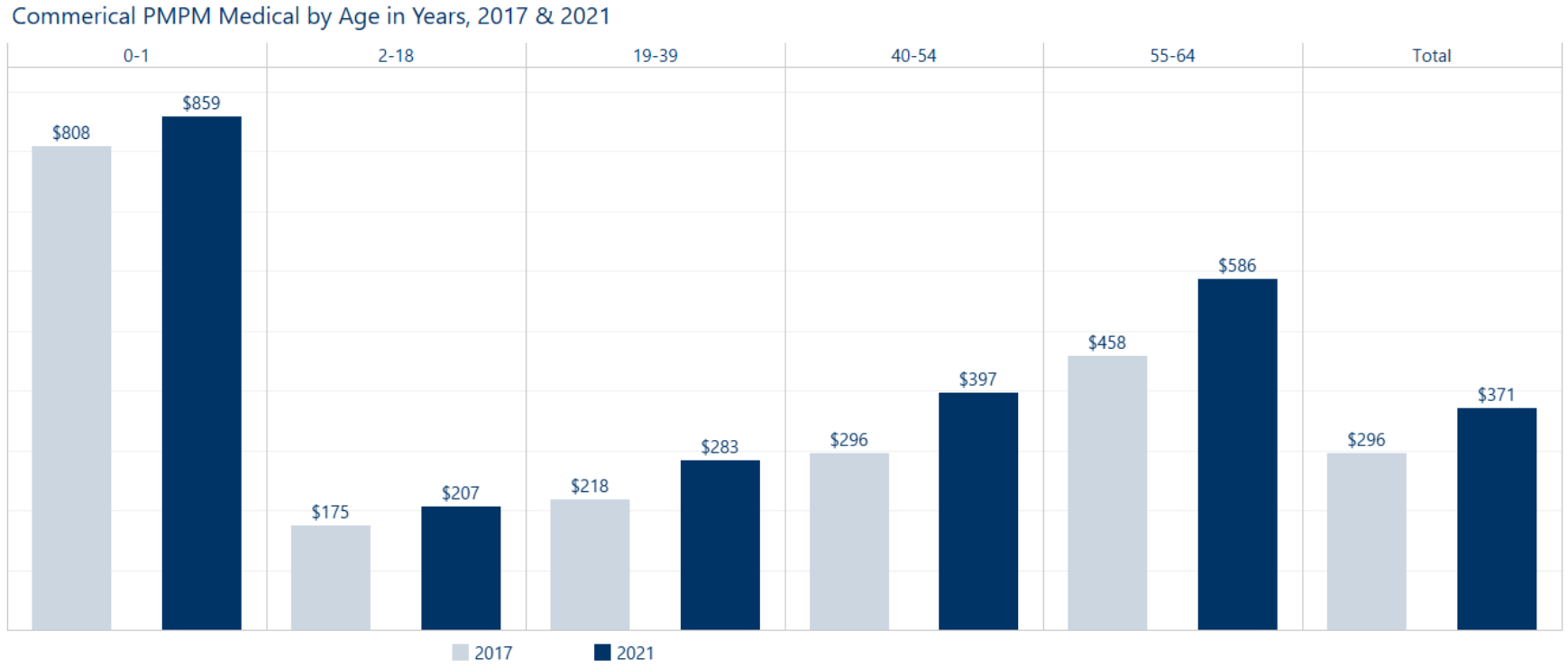


PMPM medical spending increased roughly with age because of increased health issues in the older population.

There are a few exceptions to this trend. Children under the age of 2 had higher PMPM spending than other children.

Additionally, adults in the 65-74 age category tended to have lower PMPM spending than adults age 55- 64. This is likely due to higher prices for services in the commercial market compared to the Medicare Advantage market.

Commercial PMPM Medical by Age, 2017 & 2021



For the commercially insured population (<65 years), medical PMPM spending varied from $859 in the 0-1 age group to $207 in the 2-18 age group. With the exception of the 0-1 age group, spending increased with age.

Spending growth between 2017 and 2021 was moderate in the pediatric population and ranged from 28%-34% growth in the adult population groups.

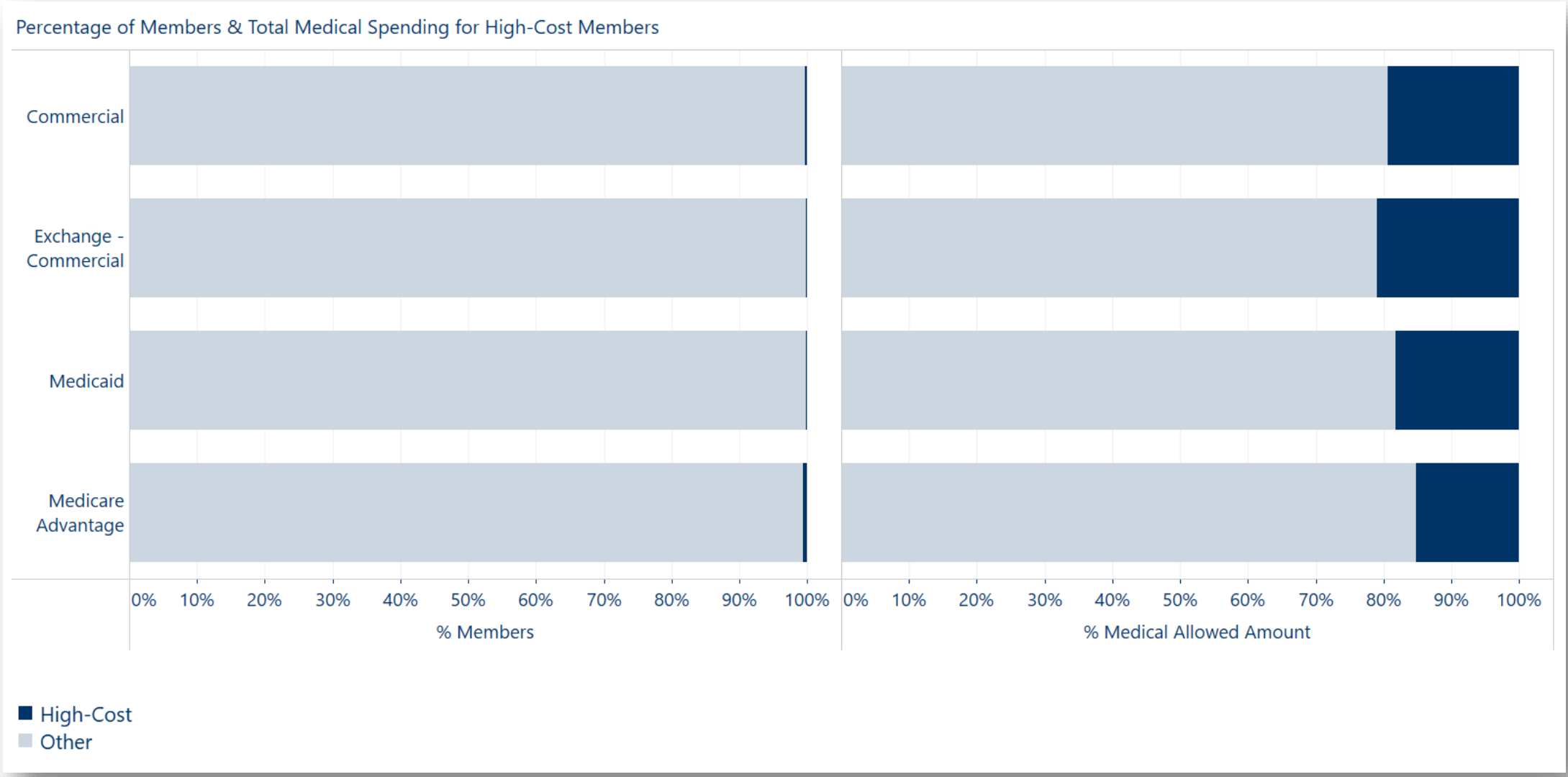
What is the Impact of High-Cost Members?

Impact of High-Cost Members on Spending, 2021

- High-cost members (>$125K medical spending) comprised less than 1% of the membership but 15% – 21% of total spending

Product	Members		Total Medical Spending		Medical PMPM	
	High-Cost	Other	High-Cost	Other	High-Cost	Other
Commercial	0.28%	99.72%	19.41%	80.59%	$22,837	$300
Exchange - Commercial	0.26%	99.74%	21.01%	78.99%	$22,907	$264
Medicaid	0.16%	99.84%	18.21%	81.79%	$24,530	$175
Medicare Advantage	0.57%	99.43%	15.23%	84.77%	$17,828	$571

Impact of High-Cost Members on Spending (cont.)



Next Steps

Next Set of Analyses – Phase II

- Drill down further into areas of growth by product, region, etc.
- How do chronic conditions impact spending and spending growth?
- How does spending for primary care and behavioral health vary across the state?
- How has out-of-pocket spending changed?
- Are there relationships between spending and quality/access to care?
- How are utilization changes impacting spending?
- How are price changes impacting spending?

Thank you.

Reliable data. Informed decisions. Strategic advantage.

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Public comment

Washington State Health Care Authority

Tab 3

Washington State Health Care Authority

Primary Care Transformation Model: update and primary care definition recommendation

Dr. Judy Zerzan-Thul, Chief Medical Officer
Washington State Health Care Authority

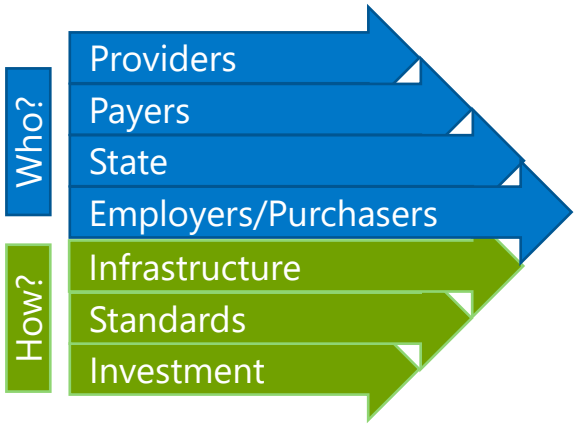
Washington State Health Care Authority

Primary Care Transformation Model (PCTM) purpose

- Multistakeholder approach
  - Payers
  - Purchasers
  - Providers
- PCTM was one of the key solutions collectively developed to improve and support primary care
- HCA has a critical role, but not the only one

Updated WA Multi-payer Primary Care Model Framework

Comprehensive system alignment



Provider accountabilities

1) Whole person care
2) A team for every patient
3) Appropriate resource allocation
4) Behavioral health screening and follow-up
5) Patient support
6) Care coordination strategy
7) Expanded access
8) Culturally attuned care
9) Health literacy
10) Data informed performance management

State accountabilities

Single standardized evaluation to establish common understanding of provider capabilities

HCA Program Alignment

Performance standards

Model participation/Financing

Practice Supports

Contract Alignment

Payer accountabilities

Aligned Practice Supports

Shared Quality Standards

Aligned Payment Models
Transformation Funding
Prospective Comprehensive Care Payment
Quality Incentives

Purchaser accountabilities

Aligned Payer Contractual Expectations

Performance standards

Model participation

Practice Supports

Alignment Through Direct Contracting

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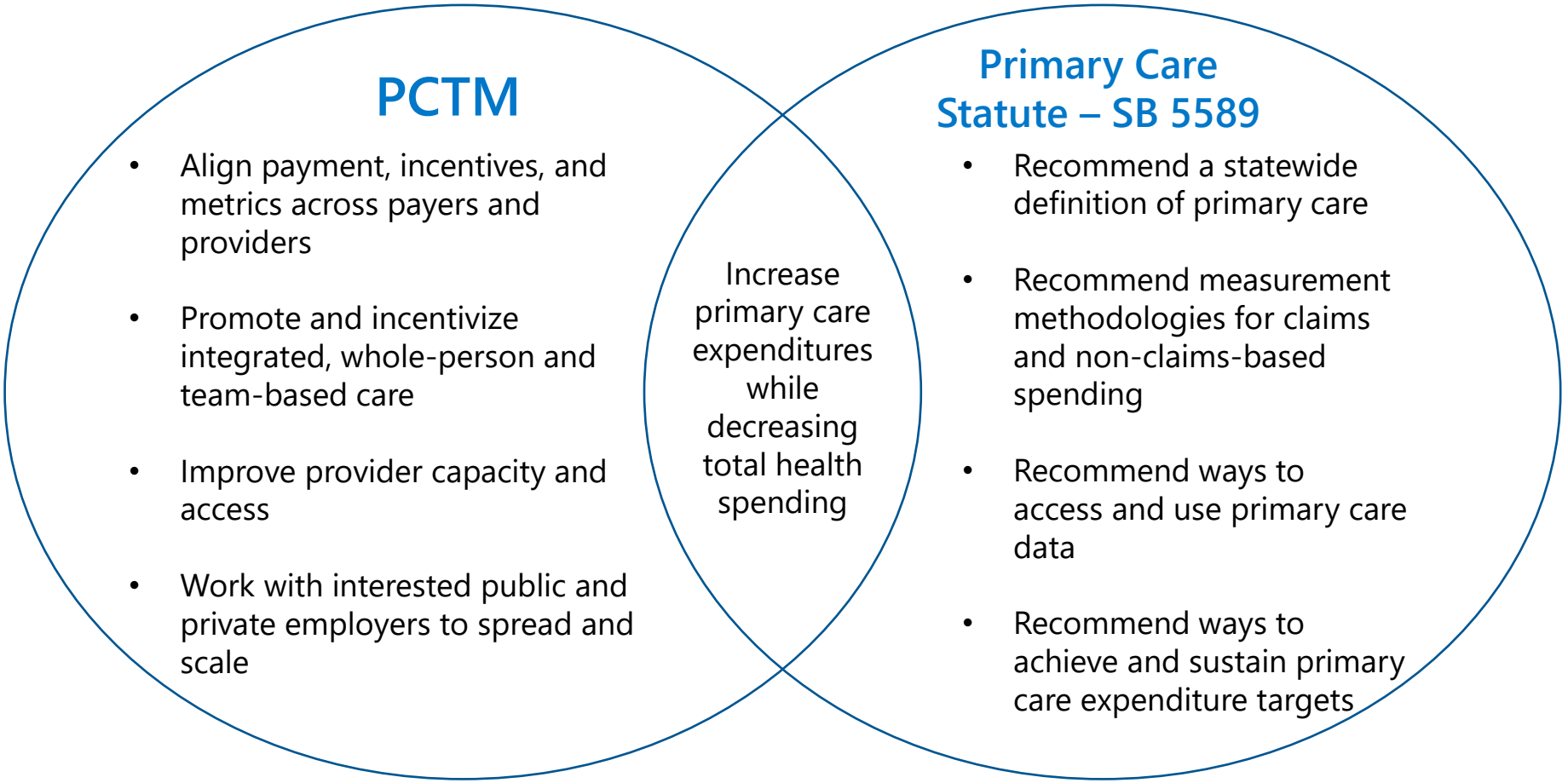
PCTM funding update

- Did not receive funding for Medicaid transformation and rate increase for the PCTM in the most recently released budget
- Work on primary care and the provider certification workgroups continues
- Final budget has not been released
- HCA has multiple efforts in progress to support primary care

PCTM and Advisory Committee on Primary Care



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

Progress update

- Advisory Committee on Primary Care heard presentations on claims-based measurement methodologies at its October and November meetings
  - October 25, 2022
  - November 21, 2022
- Discussed provider codes and facilities to include in claims-based measurement at January 31, 2023 meeting
- Proposing final definition to the Health Care Cost Transparency Board at February 15, 2023 meeting

Primary care 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 **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."

Feedback on definition

- Clarification requested for:
  - How the definition will be codified
  - Reconciling different reporting requirements
  - Connection between definition and measurement
- Proposal to add emphasis on SDOH

Final proposal

- The definition will serve as the Board's guide for measurement but will not be codified as a statute
  - Already have PC definition in statue
  - No change to current operations
- Claims-based measurement will be conducted in a manner similar to OFM's proposed methodology
  - Will preserve narrow and broad definitions of claims-based payments
- The definition's reference to equity helps address SDOH considerations
  - Non-claims-based measurement could also address SDOH

Thank you for attending the meeting!

Washington State Health Care Authority