Advisory Committee on Data Issues meeting

Washington State Health Care Authority

Washington State Health Care Authority

Advisory Committee on Data Issues
Meeting Materials Book

April 4, 2023
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Agenda and Presentations

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(WA-APCD) Study of Cost Drivers: Specifications for Phase 1 analysis....8

Tab 1

Washington State Health Care Authority

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

Advisory Committee on Data Issues
AGENDA

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

Facilitator: Vishal Chaudhry, HCA Chief Data Officer

Time	Agenda Items	Tab	Lead
2:00 - 2:05 (5 min)	Welcome, call to order, and roll call	1	Vishal Chaudhry Health Care Authority
2:05 - 2:10 (5 min)	Approval of November and February meeting minutes	2	Vishal Chaudhry Health Care Authority
2:10 - 2:20 (10 min)	Public comment	3	Vishal Chaudhry Health Care Authority
2:20 - 2:50 (30 min)	Washington Hospital Costs, Price, and Profit Analysis: Second Level Analysis Methodology • Technical suggestions?	4	John Bartholomew & Tom Nash Bartholomew-Nash & Associates
2:50 – 3:00 (10 min)	Primary Care Committee: Claims Based Measurements	5	Jean Marie Dreyer Health Care Authority
3:00 - 3:15 (15 min)	Benchmark: Historical review of the data collected & methodology	6	Michael Bailit Bailit Health
3:15 - 3:25 (10 min)	Updates to 2023 benchmark data call	7	Ross McCool Health Care Authority
3:25 – 3:55 (30 min)	(WA-APCD) Study of Cost Drivers: Specifications for Phase 1 Analysis Discussion: Cost Driver considerations for 2023 (Phase 2) • Technical suggestions?	8	Amy Kinner OnPoint
3:55 – 4:00 (5 min)	Wrap-up and adjournment		Vishal Chaudhry 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

Advisory Committee on Data Issues meeting minutes

November 1, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
9 a.m. -11 a.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
Bruce Brazier
Chandra Hicks
David Mancuso
Hunter Plumer
Jerome Dugan
Jonathan Bennett
Julie Sylvester
Leah Hole-Marshall
Lichiou Lee
Mandy Stahre
Mark Pregler
Megan Atkinson
Russ Shust

Members absent

Jason Brown
Josh Liao
Ana Morales

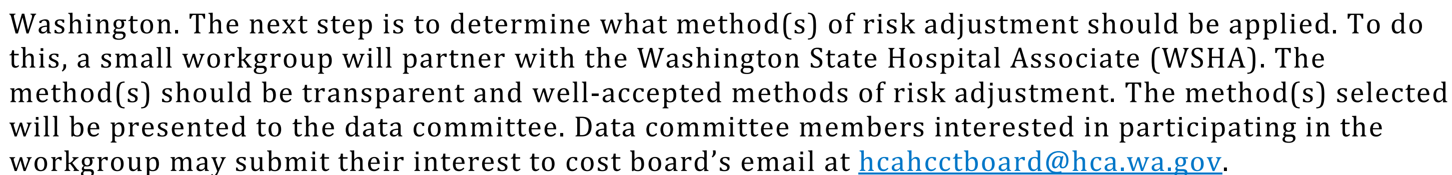
Agenda items

Welcome, Roll call, Agenda Review

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 9:02 a.m.

Recap of September Discussion

AnnaLisa Gellermann, HCA
In September, the data committee heard presentations regarding comparative hospital cost data in



Washington. The next step is to determine what method(s) of risk adjustment should be applied. To do this, a small workgroup will partner with the Washington State Hospital Associate (WSHA). The method(s) should be transparent and well-accepted methods of risk adjustment. The method(s) selected will be presented to the data committee. Data committee members interested in participating in the workgroup may submit their interest to cost board's email at hcahcctboard@hca.wa.gov.

Approval of Minutes

The committee approved the September minutes.

Topics for Today

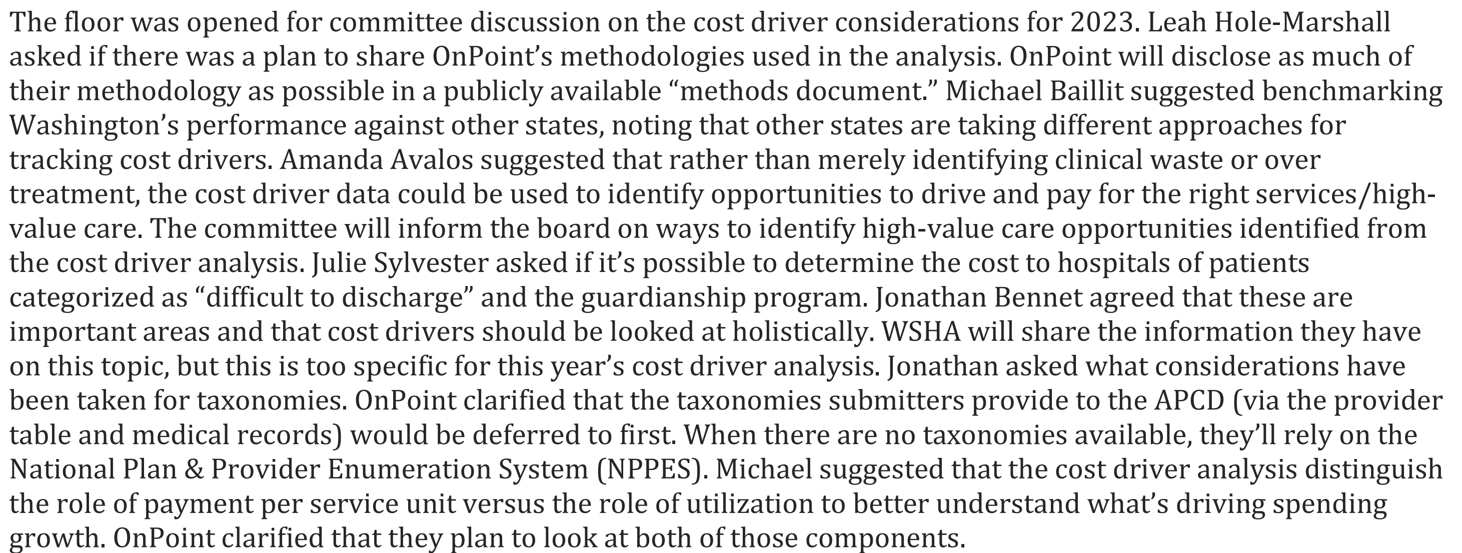
Specifications of the cost driver analysis.

Washington State All-Payer Health Care Claims Database (APCD) study of cost-growth drivers – specifications for year 1 analysis

Amy Kinner
OnPoint Health Data

OnPoint shared specifications for the year 1 cost driver analysis. The analysis will be continuously refined in future years, as analyses will generate additional questions and areas for further investigation. Per statute, the board's cost driver analysis will use APCD claims data to identify costs trends and drivers of cost in the health care system to inform the board's future directions to curb spending growth. APCD claims data will be accompanied by data collected directly from payers for benchmarking work. APCD encounter and claims data can show additional drivers of cost growth, including detailed categories of care, disparities, and high-cost pharmaceuticals. There are several key topics for the baseline analysis, including how spending has changed, if different markets are experiencing different rates of growth, and if there are spending differences by category.

The APCD has some limitations, including gaps and/or lack of data for self-insured commercial plans, Medicaid long-term care, alternative payments, and the uninsured. The analysis will use five years of data (2017-2021) which aligns with the board's cost-benchmarking period. The following payer types will be included in the analysis: commercial, Medicaid, Medicare Advantage, Medicare fee-for-service (available through 2019), Public Employees Benefits Board (PEBB), WA Health Benefit Exchange (HBE), and dual-eligibles (individuals eligible for both Medicare and Medicaid). The categories of care used in the analysis are closely aligned with the benchmarking initiative, including hospital inpatient and hospital outpatient, professional, and retail pharmacy. The analysis will include Washington residents only, and the cost of care will be broken out by region and age group. The board selected several measures from the WA Common Measure Set that represent a broad spread of conditions to help identify unintended consequences for areas of low spending for access and quality. For instance, though primary care and behavioral health are areas of low investment, spending in these areas should *not* be reduced in the board's efforts to curb total health care costs and spending. Capturing annual spend for both primary care and behavioral health is challenging because of the lack of a common definition. To capture primary care spend, the analysis will use Washington's narrow definition of primary care, and taxonomy and procedure codes. Behavioral health spend will include substance use disorder and mental health claims and will be captured using ICD diagnosis codes, CPT/HCPCS procedure codes, rendering taxonomy codes, and National Drug Codes. Not all behavioral health records are contained in the APCD due to federal law. Per a request by David Mancuso, OnPoint will share the detailed logic proposed for non-pharmacy behavioral health service classification. In the next year, OnPoint will develop an interactive tool for the board and HCA staff to track cost drivers.



The floor was opened for committee discussion on the cost driver considerations for 2023. Leah Hole-Marshall asked if there was a plan to share OnPoint's methodologies used in the analysis. OnPoint will disclose as much of their methodology as possible in a publicly available "methods document." Michael Baillit suggested benchmarking Washington's performance against other states, noting that other states are taking different approaches for tracking cost drivers. Amanda Avalos suggested that rather than merely identifying clinical waste or over treatment, the cost driver data could be used to identify opportunities to drive and pay for the right services/high-value care. The committee will inform the board on ways to identify high-value care opportunities identified from the cost driver analysis. Julie Sylvester asked if it's possible to determine the cost to hospitals of patients categorized as "difficult to discharge" and the guardianship program. Jonathan Bennet agreed that these are important areas and that cost drivers should be looked at holistically. WSHA will share the information they have on this topic, but this is too specific for this year's cost driver analysis. Jonathan asked what considerations have been taken for taxonomies. OnPoint clarified that the taxonomies submitters provide to the APCD (via the provider table and medical records) would be deferred to first. When there are no taxonomies available, they'll rely on the National Plan & Provider Enumeration System (NPPES). Michael suggested that the cost driver analysis distinguish the role of payment per service unit versus the role of utilization to better understand what's driving spending growth. OnPoint clarified that they plan to look at both of those components.

The next step is for the committee to see the reports from the board's first cost driver analysis.

Adjournment

Meeting adjourned at 9:53 a.m.

Next meeting

February 7, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Advisory Committee on Data Issues & Advisory Committee of Health Care Providers and Carriers
Joint meeting summary

February 7, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2 p.m. -4 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.

Data Committee Members present

Megan Atkinson
Allison Bailey
Ana Morales
David Mancuso
Hunter Plumer
Jerome Dugan
Jonathan Bennett
Julie Sylvester
Lichiou Lee
Mandy Stahre
Mark Pregler
Russ Shust

Members absent

Amanda Avalos
Bruce Brazier
Chandra Hicks
Jason Brown
Leah Hole-Marshall
Josh Liao

Providers and Carriers Committee Members present

Bob Crittenden
Paul Fishman
Jodi Joyce
Louise Kaplan

Stacy Kessel
Ross Laursen
Todd Lovshin
Mike Marsh
Megan McIntyre
Mika Sinanan
Dorothy Teeter
Wes Waters

Members absent

Justin Evander
Vicki Lowe
Natalia Martinex-Kohler

Agenda items

Welcome, Roll call, Agenda Review

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 2:02 p.m.

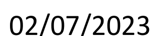
Topics for Today

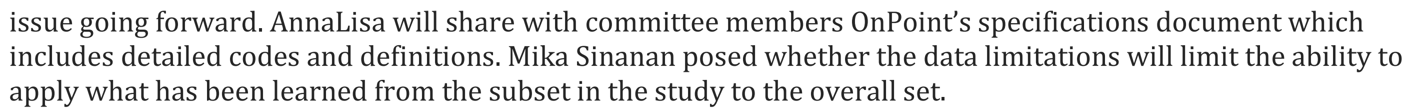
Today's meeting is a joint meeting between the Advisory Committee on Data Issues and the Advisory Committee of Health Care Providers and Carriers. Topics include an introduction to the 2022 cost growth drivers study, discussion and feedback to the Board on the cost growth driver study, a presentation on the Primary Care Transformation Model and Primary Care Definition, and discussion and feedback to the Board on the definition of Primary Care.

2022 Cost Growth Drivers Study: Preliminary Findings

Amy Kinner, OnPoint, Director of Health Analytics

Amy Kinner presented an overview of OnPoint's study of cost growth drivers. The study reviewed cost trends and drivers of cost growth in the health care system by market, geography, health conditions and other demographics, and examined potential unintended consequences to inform the Board on how to curb spending growth.
In quarter one of 2023, OnPoint will begin to examine chronic conditions.
Ross Laursen asked whether the scope of the cost driver analysis includes measuring trends against past discussions regarding the benchmark. AnnaLisa Gellerman clarified that the benchmark is a separate but parallel effort from the cost growth study. Results of the first benchmark measurement (using retrospective data from 2017-2019) will be ready in the summer of 2023.
The study used 5 years of data from 2017 – 2021 to align with the cost-benchmarking period. Products analyzed included commercial (limited data from self-insured plans), Medicaid (managed care only), Medicare Fee-For-Service (FFS) (only available through 2019), Medicare Advantage (MA) (covered by commercial plans), Public Employees Benefits (PEB) (commercial and MA), Washington Health Benefit Exchange (HBE) (commercial). Dual-eligibles were not broken out separately due to missing FFS data beyond 2019. Wes Waters noted that the study's material exclusions in Medicaid could skew the data and asked how assumptions are clarified in the analysis to avoid misinterpretation of the data. It was noted that previously, FFS line-level payments were unusable for cost reporting due to limitations in the way data was submitted, however this issue has been fixed and will not be an





issue going forward. AnnaLisa will share with committee members OnPoint's specifications document which includes detailed codes and definitions. Mika Sinanan posed whether the data limitations will limit the ability to apply what has been learned from the subset in the study to the overall set.
Categories of service were aligned with the benchmarking initiative and include hospital inpatient, hospital outpatient, a narrow definition of primary care providers, non-primary care specialty providers, other providers, long-term care, retail pharmacy, and all other spending (ambulances, durable medical equipment, etc.).
The following are limitations of the study: lack of data for self-insured individuals, no Alternative Payment Model data, no uninsured data, no Medicaid FFS data, and Medicare FFS data being available only through 2019. Long-term care data for Medicaid is not reported but is a significant contributor to spending.
The All-Payer Claims Database (APCD) data represents approximately 4 out of 7 million (the total state population). Between 2017 and 2021, enrollment increased from 3.5 to 4 million (not including Medicare FFS).
Mandy Stahre asked when School Employee Benefits Board (SEBB) plans were added, and it was clarified that SEBB data was identified in 2021. Megan Atkinson added that SEB as a state-operated centralized program began coverage in 2020.
The study compared population growth to membership growth, where population growth was stable at around 1.6 percent, with a ~6.3 percent shift in membership in 2020.
The study examined enrollment by product (Medicare FFS only 2017 - 2019, with all other products ranging from 2017 - 2021). There was significant growth in Medicaid and commercial remained steady. Nationwide, MA plans became more popular. Medicaid lost membership in 2018 and 2019 and then increased during the COVID-19 public health emergency (PHE). The PHE also prompted some growth in the HBE population. Dorothy Teeter asked if the study included about half of Washington's population, and it was clarified that it was.
Inpatient was the highest category of spending in 2017 -2021. There was more growth in outpatient than inpatient, and no significant growth in primary care. Louise Kaplan asked how outpatient differed from primary care, and it was clarified that outpatient is on the facility side, and primary care includes professional fees. Between 2017 - 2021, inpatient spending decreased relative to other spending, as did specialist, long-term care, and primary care. Pharmacy claims expenditures increased from $4.6 billion in 2017 to $6 billion in 2021.
Per member per month (PMPM) spending increased from $271 to $340 between 2017 – 2021. There was an aggregate increase of 25 percent over time, mostly focused in 2021. Pharmacy PMPMs showed the same aggregate 25 percent growth with an increase of $21 per month. For pharmacy spending by product (not including MA due to Part D coverage), spending was slightly higher under HBE. All products increased between 21 and 29 percent.
Regarding increasing costs over time, Jonathan Bennett asked what factors were considered to provide better context and framing for the data, e.g., patients with high-cost needs. Amy Kinner clarified that this topic would be covered later in the presentation.
Regarding total PMPM medical expenditures, Mika Sinanan asked what proportion the exclusions (e.g., Medicare FFS) are of the total, and whether the exclusions would markedly impact the PMPM values. Amy Kinner replied that this question could be taken back to OnPoint and the Health Care Authority (HCA).
Megan Atkinson stated that HCA can easily analyze the impact of targeted program changes on Medicaid spending, but it will be important to try to understand other impacts, e.g., changes in the population, utilization, inflation, etc., across all payers. Without that additional context, it will be difficult to fully understand how well the state is doing compared to the Board's cost growth target. Wes Waters agreed with trying to understand factors that impact spend and trend, noting that commercial products have a different level of member liability at each tier which affects the trend of the product.
The study also analyzed PMPM by category. Most spending was on inpatient and outpatient. Other professional and other medical, while lower than inpatient and outpatient, still saw significant growth.
For inpatient PMPM spending by product, inpatient and outpatient spending for MA was higher than other plans. Commercial showed steadier growth and Medicaid growth remained low.

In examining inpatient, outpatient, and total pharmacy PMPM spending, outpatient PMPM growth was driven by a 32 percent increase in utilization. Pharmacy PMPM spending increased by 25 percent. Inpatient saw a decrease in utilization, but an increase in average allowed amount per service.
There were regional variations in spending. Medical PMPMs ranged from $150 to $1,200. Commercial medical PMPM spending by Accountable Community of Health (ACH) of patient residence was examined.
For medical PMPMs by age and gender in 2021, PMPM was higher for infants and aging populations. There was spending growth across ages for both men and women.
Patients with high-cost needs, or "high-cost members" were defined as individuals with greater than $125,000 in total medical spending. For each product, high-cost members comprised less than 1 percent of membership but 15 to 21 percent of total spending. High-cost members tend to have $20,000 or more in PMPM.
Phase two of the analysis will drill down further into several specifications, e.g., areas of growth by product and region, how chronic conditions impact spending and growth, and if there is a relationship between spending and quality/access to care.
Mike Marsh recommended that this information be made more translatable to various audiences by making sure that the attribution methodology of expenses is clearer. Additionally, PMPM could be made clearer, including how "price makers" such as supply chain, and "price makers" such as utilization, influence the cost of care curve.

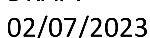
Public Comment

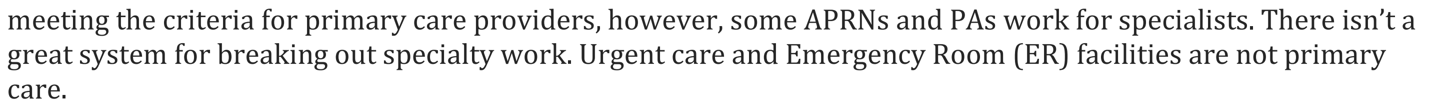
There were no public comments.

Primary Care Recommendation

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

Dr. Judy Zerzan-Thul gave a presentation to the committee that contained an updated on the Primary Care Transformation Model (PCTM) and a recommended definition of primary care formulated by the Advisory Committee on Primary Care (the primary care committee).
Dr. Zerzan-Thul reviewed an updated framework for the PCTM that includes provider, state, payer, and purchaser accountabilities. Dr. Zerzan-Thul compared the PCTM and SB 5589. It will take several years to implement new measurements for primary care spending. Both the PCTM and the primary care spending measurement work aim to increase primary care spending while decreasing total health care spending. There is no date by which the 12 percent spending goal must be attained.
The primary care committee has completed its work to recommend a definition of primary care and has begun its assessment of claims-based spending. In October and November 2022, the Primary Care Collaborative and the University of Washington presented methodologies for measuring claims-based spending to the primary care committee. In January, the primary care committee began a discussion of providers and facilities. The committee used both narrow and broad categories to define providers. The broad category includes Obstetrics and Gynecology (OBGYN) and therapists. The Board will review a final definition of primary care at its February 15 meeting.
Dr. Zerzan-Thul concluded with a review of the primary care committee's finalized definition of primary care. This definition won't conflict with existing statutes. It will be useful for measuring services, e.g., vaccinations but will depend on the who, e.g., family physician versus specialist.
Providers and carriers committee member Louise Kaplan advised settling on something and moving forward rather than debating the definition at length. Why is there a question regarding Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs)as primary care providers? Half of all Medicaid patients receive care from Nurse Practitioners (NPs. Dr. Zerzan-Thul noted that there isn't a debate about them as generally





meeting the criteria for primary care providers, however, some APRNs and PAs work for specialists. There isn't a great system for breaking out specialty work. Urgent care and Emergency Room (ER) facilities are not primary care.
Louise Kaplan recommended a change in the way the data is collected. Dr. Zerzan-Thul responded that the definition used for measurement will be an intersection of who, what, where. The Office of Financial Management (OFM) ended up reporting 60 percent of PAs as practicing primary care. It would be good to have a more defined capability for determination.
Brittney Cherry noted that urgent care is expanding and providing manual wellness visits and other services that would qualify as primary care. Why would urgent care be excluded? Are there any situations where it might be excluded? Dr. Zerzan-Thul clarified that the primary care committee hasn't discussed setting/facilities yet.

Adjournment
Meeting adjourned at 4:00 p.m.

Next Data Committee meeting
April 4, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Next Providers and Carriers Committee meeting
March 7, 2023
Meeting to be held on Zoom
2:00 p.m. –4:00 p.m.

Tab 3

Public comment

Washington State Health Care Authority

Advisory Committee on Data Issues

Written Comments

Received Since Last Meeting

Written Comments Submitted by Email

1. Washington State Hospital Association 1

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

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.

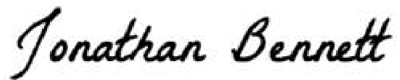
On a smaller issue, we are not sure why the consultant recommends using C2ER as a general cost of living adjustment for non-salary expenses, since this index has no relation to healthcare expenditures for non-operating services.

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 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
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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?

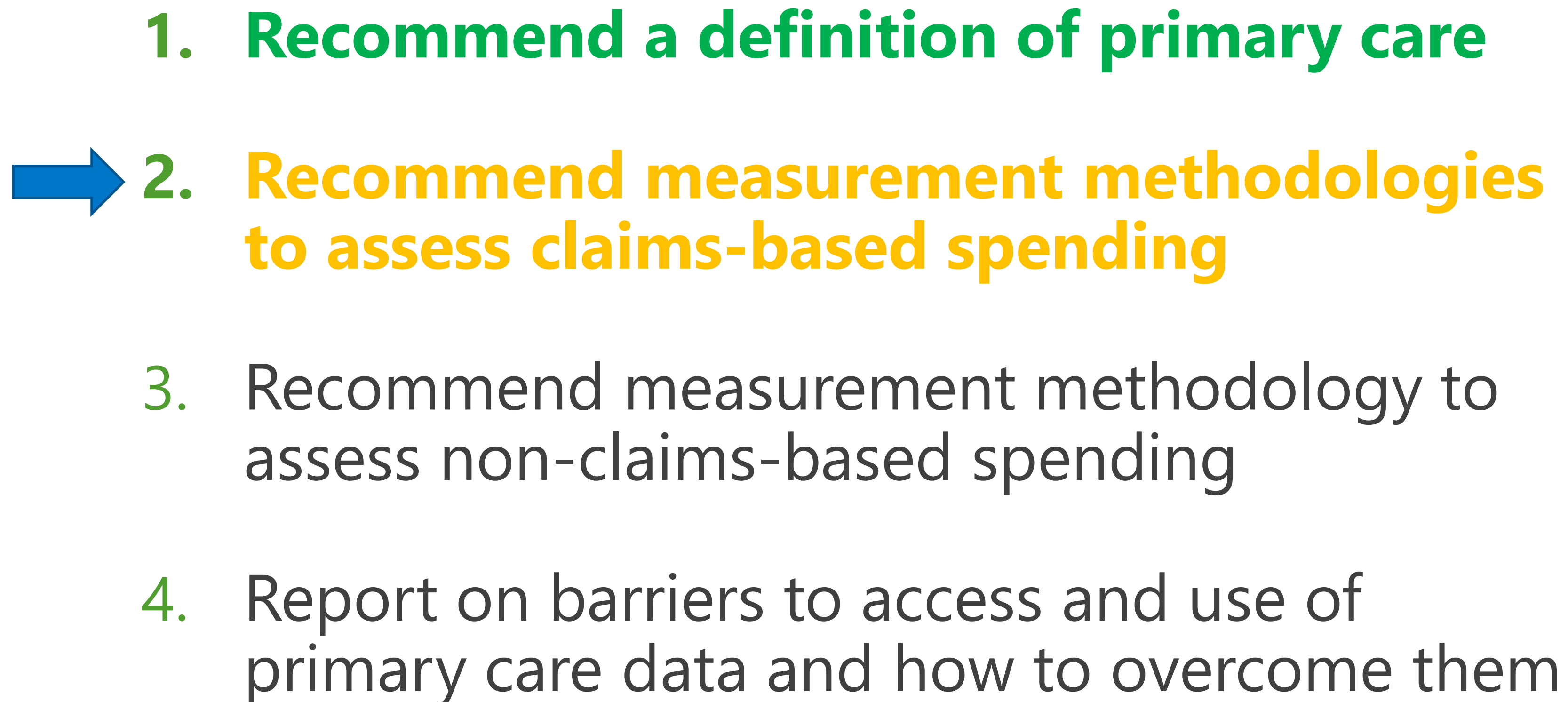
Tab 5

Primary Care Services: Claims-Based Payments

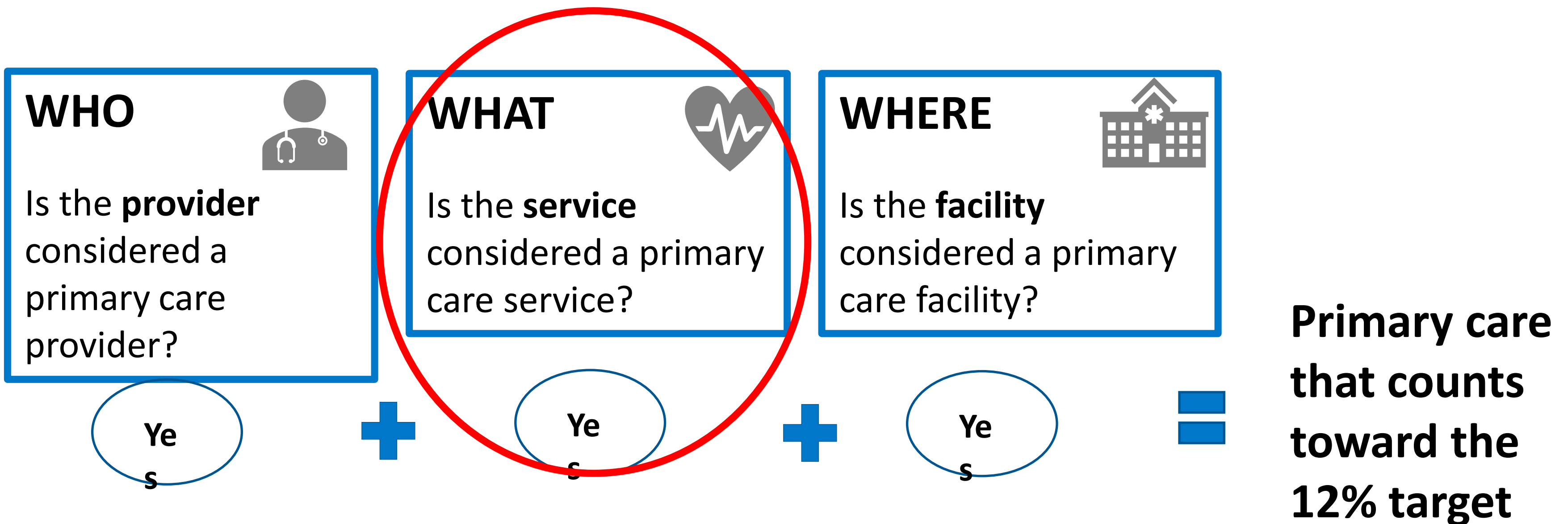
Jean Marie Dreyer, Senior Health Policy Analyst

Washington State Health Care Authority

Primary care recommendations



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.

Code sets considered for measurement

- Preventive Medicine Services (Two parts)
- Immunizations
- Special Services, Procedures and Reports (Two parts)
- Special Evaluation and Management Services
- Care Plan Oversight Services

Code sets considered for measurement: continued

- Consultation
- Home Health Services
- Complex Chronic Care Coordination Services
- Non-face-to-face Physician and Non-Physician Services
- Nursing Facility Services

Code sets considered for measurement: continued

- Domiciliary, Rest Home, or Custodial Care Services
- Osteopathic Manipulative Treatment
- Prolonged Services
- Temporary Codes (Three Parts)
- Lab Testing and Supplies (Two Parts)

Code sets considered for measurement: continued

- Supervision
- Cardiac and Pulmonary Testing/Procedures
- Dermatological
- Newborn Care Services
- Obstetrics
- Otology Services
- Other (Two Parts)

Tab 6

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

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

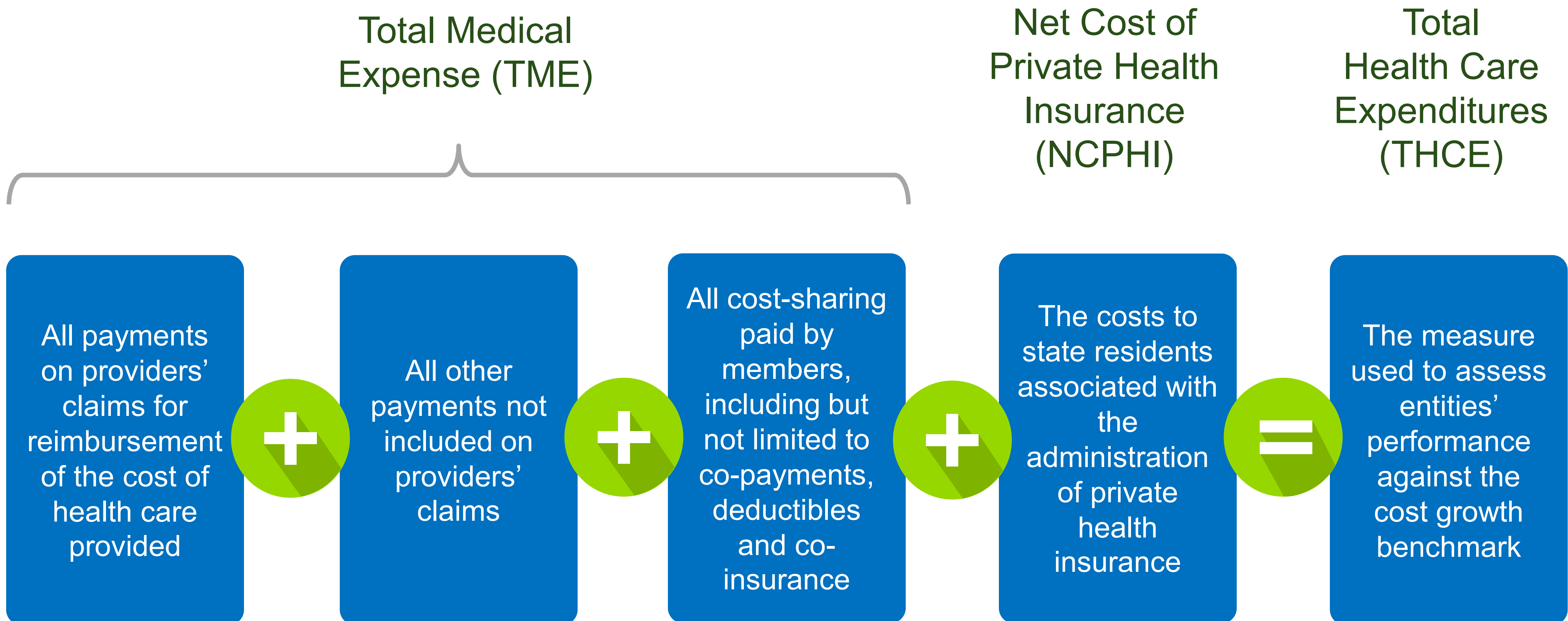
- *What is this?* A calculation of health care cost growth over a given time period using payer-collected aggregate data
- Data Type: Aggregate data that allow assessment of benchmark achievement at multiple levels, e.g., state, region, insurer, large provider entity
- Data Source: Insurers and public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

What is being measured against the cost growth benchmark?



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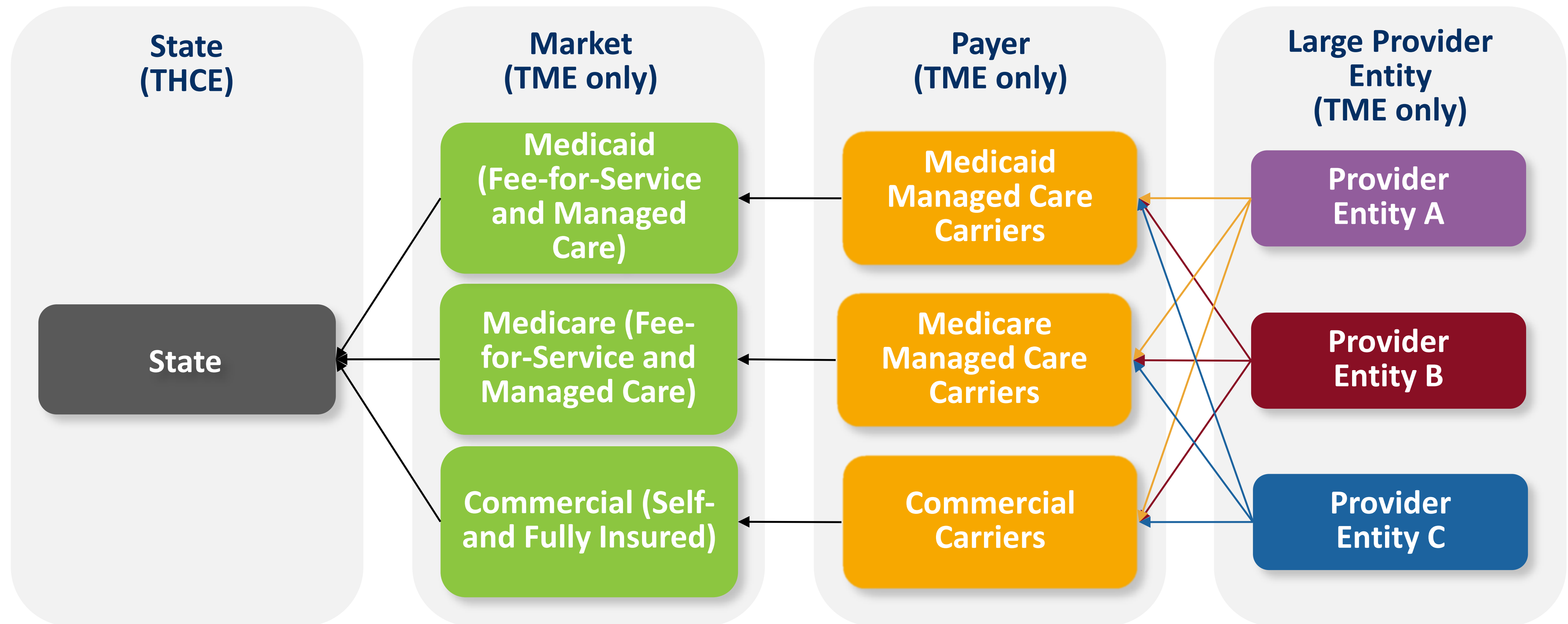
Performance against the benchmark will be reported at four levels



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

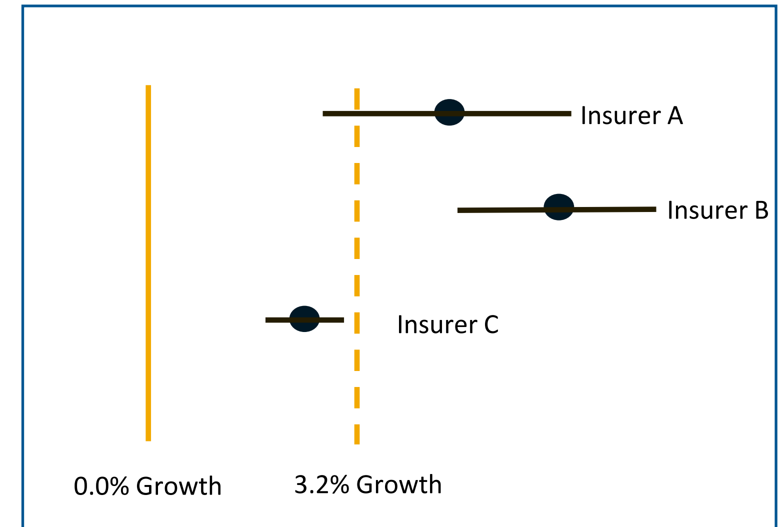
- Other cost growth benchmark states have moved (or recommended moving) away from using clinical risk adjustment.
  - Massachusetts observed steadily rising risk scores that could not be explained by demographic trends or changes in disease prevalence.
  - Rhode Island found similar increase in risk 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

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

Washington State Health Care Authority

Resources

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

Tab 7

Washington State
Health Care Authority

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 8

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, 2023

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.

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