HEALTH CARE COST TRANSPARENCY BOARD'S

Advisory Committee on Data Issues Meeting

October 3, 2023

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board's
Advisory Committee on Data Issues
Meeting Materials Book

October 3, 2023
2:00 p.m. – 4:00 p.m.

(Hybrid attendance options)

Agenda and Presentations

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

HEALTH CARE COST TRANSPARENCY BOARD'S
Advisory Committee on Data Issues
AGENDA

October 3, 2023
2:00 – 4:00 p.m.
Hybrid Meeting

Health Care Cost Transparency Board's Advisory Committee on Data Issues Committee Members					
☐	Christa Able	☐	Jason Brown	☐	Hunter Plumer
☐	Megan Atkinson	☐	Chandra Hicks	☐	Mark Pregler
☐	Amanda Avalos	☐	Leah Hole-Marshall	☐	Russ Shust
☐	Allison Bailey	☐	Lichiou Lee	☐	Mandy Stahre
☐	Jonathan Bennett	☐	David Mancuso	☐	Julie Sylvester
☐	Bruce Brazier	☐	Ana Morales		

Facilitators: Mandy Weeks-Greena and Theresa Tamura

Time	Agenda Items	Tab	Lead
2:00 - 2:10 (10 min)	Welcome, agenda, and roll call	1	Mandy Weeks-Green Health Care Authority
2:10 - 2:15 (5 min)	Approval of April and June meeting minutes	2	Mandy Weeks-Green Health Care Authority
2:15 - 2:25 (10 min)	Public Comment	3	Theresa Tamura Health Care Authority
2:25 - 2:55 (30 min)	Washington Hospital Costs, Price, and Profit Analysis: Second Level Analysis Methodology Update • Questions?	4	John Bartholomew & Tom Nash Bartholomew-Nash & Associates
2:55-3:35 (40 min)	Analytic Support Initiative Presentation • Discussion and feedback	5	Joseph L Dieleman, Associate Professor for Health Metrics and Evaluation | University of Washington Mandy Weeks-Geen and Amanda Avalos Health Care Authority
3:35-3:45 (10 min)	Motion from Advisory Committee Member Jonathan Bennett	6	Jonathan Bennett Washington State Hospital Association
3:45-3:55 (10 min)	Presentation on Primary Care Non-Claims Based Measurement Recommendation • Discussion	7	Jean Marie Dreyer Health Care Authority
3:55 – 4:00 (5 min)	Update on Cost Growth Benchmark		Amanda Avalos Health Care Authority
4:00	Adjourn		Mandy Weeks-Green Health Care Authority

Unless indicated otherwise, meetings will be hybrid with attendance options either in person at the Health Care Authority or via the Zoom platform.

Tab 2

Health Care Cost Transparency Board's Advisory Committee on Data Issues meeting minutes

April 4, 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 are available Advisory Committee on Data Issues webpage.

Members present

Amanda Avalos
Allison Bailey
Jonathan Bennett
Bruce Brazier
Lichiou Lee
Ana Morales
Hunter Plumer
Mark Pregler
Russ Shust
Mandy Stahre

Members absent

Megan Atkinson
Jason Brown
Chandra Hicks
Leah Hole-Marshall
David Mancuso
Julie Sylvester

Agenda items

Welcoming, Roll Call, Agenda Review

Vishal Chaudhry, committee facilitator, called the meeting to order at 2:03 p.m.

Approval of Minutes

The committee approved the November 2022 and February 2023 meeting minutes.

Topics for Today

Topics include Washington hospital costs, price, and profit analysis; updates from the Advisory Committee on Primary Care; a historical review of benchmark data collected and methodology; updates to the 2023 benchmark data call; and the cost growth drivers study and specifications for Phase 1 analysis.

Public comment

Katerina LaMarche, Washington State Hospital Association (WSHA), commented that the analyses should be more uniform to ensure consistency between findings. Creating more continuous standardized adjustments by Case Mix Index (CMI), Medicare wage index, and teaching status would improve comparisons between states and hospitals. The hospital cost analysis accounts for year-to-year changes in inpatient and outpatient rates but does not include a discussion of changes in case mix between the years for different treatment for hospitals depending on whether they are low or high-cost compared to peers. There should be a more technical discussion on the appropriate use of analytical exercises to gain a better understanding of how they will be used.

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

John Bartholomew and Tom Nash, Bartholomew-Nash & Associates

John Bartholomew reviewed the two project goals: How the Washington hospital industry looks compared to the nation on costs and margins/profits, and how to identify Washington hospital outliers on cost and margins/profits. The first level analysis provided a high-level review of self-reported Medicare Cost Report data using price per patient, cost per patient, and profit per patient. Hospitals with more than 25 beds were grouped into high price or not high price and the analysis compared cost and profit. For fair and accurate comparisons between hospitals, other measures need to be reviewed, such as case mix, service intensity measures, level of teaching intensity, payer mix, and other financial measures. The goal is to adjust for service intensity, acuity, location, and other differences so that the cost variation can be isolated to business decisions or price discrimination.

The committee heard an overview of the process for the second level hospital financial analysis and the recommendations for methodology enhancement. There are two methodological enhancements and an additional financial review: calculated adjustments to the first level analysis on costs, creating additional groupings beyond bed size, and the using a Washington hospital margin analysis. The margin analysis will review profit and margin compared to the nation. The Hospital-only Operating Expense will be adjusted by applying the Centers for Medicare & Medicaid Services (CMS) wage index files to the salary amounts, while the remaining costs from the Medicare Cost Report will be adjusted for inflation using the C2ER statistic. Salary percentage will be calculated from the Medicare Cost Report. The cost of doing business factors are likely more important than inflation factors. In addition to bed size, one or a combination of teaching intensity, service intensity, and Medicare CMI measures can be utilized. Payer mix will also be reviewed.

A committee member commented that while reviewing factors independently might be helpful, it is also important to combine them together to see the bigger picture from a continuous standpoint. Tom Nash explained that wage index is easy to adjust, which is the adjustments based on hourly and salary information. However, with CMI, there is little correlation between case mix and net patient revenue per adjusted discharge. CMI will be used as one of the pure benchmarking factors when comparing hospitals with similar case mix. Outliers will be identified by grouping similar hospitals across the nation with minimal necessary adjustments to avoid masking information. Making multiple adjustments to a cost or a price measure could obscure the actual amount a consumer is paying. The first step of the second level analysis will be to apply the one cost adjustment and group hospitals to identify outliers. After these steps, other considerations and adjustments can be reviewed and applied.

Advisory Committee on Primary Care: Claims-Based Measurements

Jean Marie Dreyer, HCA

Jean Marie Dreyer provided an update on the primary care recommendations. The Advisory Committee on Primary Care created a high-level definition of primary care which the board approved. The committee is currently working on the second recommendation, an assessment of claims-based spending. The committee is using guiding

principles for code selection, with a focus on ensuring the code set includes services that are predominantly provided by primary care. There were 27 code sets considered for measurement. Vishal Chaudhry reiterated that although the code set will be detailed, the intent is to conduct a high-level aggregate analysis. A committee member asked how the Advisory Committee on Primary Care had decided to balance granular analyses with aggregate-level analyses. The Advisory Committee on Primary Care decided to use a tri-sectional definitional approach using *who*, *what*, and *where*, to generate the provider list. The *what* comes first, then committee members will filter the data with additional subcategories. The data has yet to be fully cemented.

Washington Cost Growth Benchmark Data Collection and Reporting

Michael Bailit, Bailit Health

Michael Bailit reminded the committee of the distinction between the benchmark analysis and the cost growth driver analysis. The benchmark analysis is used to determine the cost growth rate over a given period using payer-collected aggregate data. In contrast, the cost driver analysis provides a more detailed understanding of the trends observed in the aggregate data. The cost driver analysis utilizes granular data from the All-Payer Claims Database (APCD) and provides insight into what is driving overall cost growth.

The benchmark analysis, which measures performance against the benchmark, is reported at four levels: state, market, payer, and large provider entity. Benchmark components include Total Medical Expenses (TME), the Net Cost of Private Health Insurance (NCPHI), and Total Health Care Expenditures (THCE). The committee also reviewed the data sources used to calculate THCE as well as the data specifications for insurer submissions. A committee member asked if college students covered under their parents' plans would be included in the data population. A college student would typically be listed as a dependent and will appear as a state resident even if they are out-of-state. While these students will appear in the aggregate data for benchmark analysis, they will not show up in the APCD for the cost driver analysis since the datasets are different.

To increase confidence in the measurement and reporting of performance at the insurer and large provider entity levels, HCA will risk-adjust by age and sex, truncate spending for high-cost outliers, and use confidence intervals. HCA will not implement clinical risk-adjustment because the work in other states has shown that rising risk scores cannot be verified through independent measurement. There is increasing literature showing that rising risk scores usually reflect increasing intensity of diagnoses on claims rather than population changes. Currently, all states with cost growth benchmarks are not applying clinical risk adjustment due to its highly distortionary effects on performance assessment. An analysis in Rhode Island showed that truncating for high-cost outliers significantly affected the performance of provider entities. Confidence intervals minimize the impact of small numbers. HCA will also report performance for insurers and large provider entities that meet a minimum threshold for attributed lives. The board has recommended deferring the determination of the minimum membership sizes and will revisit the issue.

A committee member asked whether COVID-19 and fewer services being offered has created differences in acuity. There was a change in acuity from 2020 to 2021, but currently, there isn't a good method for measurement because the increasing intensity of diagnostic coding on claims creates distortion, and where the changes in intensity occur cannot be determined. A significant amount of data indicates that applying clinical risk adjustment is not a good approach. Other states use age/sex risk adjustment or no adjustment at all.

2023 Benchmark Data Call

Ross McCool, HCA

Ross McCool provided an update on the 2023 data call, which will include data from 2020, 2021, and 2022. Performance against the benchmark will be calculated using 2021 and 2022 data and the submission process will

be the same as the 2022 data call. The 2023 data call will add a specification for Federal Employee Health Benefits and will associate non-claims spending to providers without age/sex stratification. Changes will be incorporated into the technical manual and submission template. There will be a training webinar to cover updates and show common submissions errors. The training webinar and office hours will begin in July or early August. Submissions for the 2023 benchmark data are due September 1. The benchmark analysis uses aggregate data provided by payers and clinical risk adjustment is not ideal for adjusting at a high level. Clinical risk adjustment, especially based on the individual patient risk characteristics, comes into play in the cost driver analysis but not the benchmark analysis. Clinical risk adjustment needs to be applied within the right context and at the right level.

Study of Cost Drivers: Specifications for Phase 1 Analysis

Amy Kinner, OnPoint

Amy Kinner provided an overview of the cost driver analysis and the APCD. OnPoint reviewed spending and trends by market, geography, health conditions and demographics, and potential unintended consequences. OnPoint has analyzed five years of data (2017-2021). Payer types include commercial, Medicaid, Medicare Advantage, Medicare Fee-For-Service, the Public Employee Benefits Board, the Washington Health Benefit Exchange plans, and dual-eligibles (individuals eligible for Medicare and Medicaid). Categories of care are aligned closely with the benchmarking initiative. The study also includes cost comparisons for different chronic conditions. To capture potential unintended consequences, OnPoint analyzed access and quality measures. Some of the metrics used in the preliminary analysis include member months, eligibility, and expenditures. OnPoint used the primary care definition developed by the Office of Financial Management (OFM). OnPoint will incorporate the Advisory Committee on Primary Care's work moving forward. One committee member noted that significant overlap exists between the definition of primary care from OFM and the definition developed by the advisory committee. Even if the committee makes additional changes to the definition in the future, the cost isn't likely to change significantly.

Wrap Up Questions and Comments

A committee member asked how each of the different analyses and reports will be used and how they fit into the overall picture. Vishal Chaudhry acknowledged that it could be helpful to articulate how the different puzzle pieces fit together and requested that the question be noted for the next meeting. The committee member responded that having common themes and a standardized approach and methodology will benefit the board and its committees.

Adjournment

The meeting adjourned at 3:43 p.m.

Next meeting

June 6, 2023

The meeting will be held electronically through Zoom and in-person at the Health Care Authority

2 p.m. – 4 p.m.

Health Care Cost Transparency Board's Advisory Committee on Data Issues and Advisory Committee of Health Care Providers and Carriers - Joint meeting minutes

June 6, 2023
Health Care Authority
Hybrid Meeting held electronically (Zoom), telephonically, and in person at the Health Care Authority
2 p.m. – 4 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials are available on the Advisory Committee on Data Issues webpage and the Advisory Committee of Health Care Providers and Carriers webpage.

Advisory Committee on Data Issues Members

Present

Christa Able
Amanda Avalos
Allison Bailey
Jonathan Bennett
Bruce Brazier
Leah Hole-Marshall
Lichiou Lee
David Mancuso
Ana Morales
Hunter Plumer
Russ Shust
Mandy Stahre
Julie Sylvester

Absent

Megan Atkinson
Jason Brown
Chandra Hicks
Mark Pregler

Advisory Committee of Health Care Providers and Carriers Members

Present

Bob Crittenden
Justin Evander
Paul Fishman
Louise Kaplan
Stacy Kessel
Ross Laursen
Todd Lovshin

Megan McIntyre
Mika Sinanan
Dorothy Teeter
Wes Waters

Absent
Jodi Joyce
Vicki Lowe
Mike Marsh
Natalia Martinez-Kohler

Agenda items
Welcoming, Roll Call, Agenda Review
Mandy Weeks-Green, committee facilitator, called the meeting to order at 2:02 p.m.

Topics for Today
Topics included an introduction of Christa Able as a new member of the Advisory Committee on Data Issues and the following presentation topics:

- Advisory Committee on Primary Care: Status Update and Claims-Based Measurement Recommendation.
- Institute for Health Metrics and Evaluation (IHME) Analytic Support Initiative.
- Cost Growth Driver Study: Phase II.

New committee member on the Advisory Committee on Data Issues
Christa Able was welcomed as a new committee member. Christa Able is the Financial Contracting Director for Virginia Mason Franciscan Health and has over 25 years of experience in the health care industry.

Public comment
Mandy Weeks-Green, committee facilitator, called for verbal comments from the public.
Katerina LaMarche, Washington State Hospital Association (WSHA), commented that the previous committee meeting in April provided an overview of how providers would be measured against the benchmark. However, the meeting didn't address details critical to providers. There are lingering questions regarding how providers are attributed, how to ensure data is accurate and verifiable, how risk adjustment is handled, and if/how the providers will be able to analyze the data and their performance to undertake reforms. Further clarification would be beneficial to providers for understanding measurements and expectations. There should be more clarity about which providers will be considered large entities subject to the benchmark, how they're being measured, and what adjustments are needed to meet the benchmark in the future.

Jeb Shepard, representing the Washington State Medical Association (WSMA), echoed Katerina Lamarche's comments. Jeb Shepard commented that there appears to be a misalignment among stakeholders in terms of understanding the methodologies that will be used in terms of attribution, such as which entities are subject to the benchmark and what measures are in place to ensure data accuracy. WSMA would like to understand these finer points so it can help their members be successful. A benchmark is in effect for this year, but the large provider entities that will be publicly reported against the benchmark have not been informed of that. WSMA requested more detail for public and stakeholder review through presentations and written materials so providers can understand and adjust their performance if needed.

Advisory Committee on Primary Care: Status Update and Claims-Based Measurement Recommendation

Dr. Judy Zerzan-Thul, HCA

The Advisory Committee on Primary Care (primary care committee) has been working on its charges to provide recommendations for the definition of "primary care" and measurement methodologies to assess claims-based and non-claims-based spending.

To determine what counts as primary care, the main framework the primary care committee has used is the *who, what,* and *where.*

- *Who:* Is the provider considered a primary care provider?
- *What:* Is the service considered a primary care service?
- *Where:* Is the facility considered a primary care facility?

If all three of the above criteria are met, then the service or provider counts towards the 12 percent target. As the primary care committee's work continues, changes may be made to the definition - it's not yet clear if the *where* is needed. The committee added a *why* criterion: "to support patients in working toward their goals of physical, mental, and social health and the general wellbeing of each person, through illness prevention and minimizing disease burden."

Dr. Judy Zerzan-Thul discussed the broad versus narrow definitions of primary care, including the lists of clinicians under each category. A naturopath is considered primary care under state statutes and is included in the narrow definition. The primary care committee worked to refine both a broad and narrow definition and the two definitions will be evaluated in the future to determine which to use when measuring progress towards the 12 percent expenditure target. The presentation also discussed the lists of clinicians included under the broad and narrow definitions.

The Advisory Committee of Health Care Providers and Carriers (provider and carrier committee) member Mika Sinanan asked for clarification on the clinicians listed under the broad and narrow definitions. When comparing the lists, there are clinicians listed in the narrow definition, such as pediatric and geriatric, that are not included under the broad definition. Dr. Judy Zerzan-Thul explained that the broad definition includes the narrow definition and acknowledged that the primary care committee had discussed specialists.

Provider and carrier committee member Louise Kaplan commented that under both the broad and narrow definitions, the Advanced Practice Registered Nurse (APRN) and Advanced Registered Nurse Practitioner (ARNP) terms are used. The state licensure is ARNP. ARNP is inclusive of nurse practitioners, nurse anesthetist, nurse midwives, and clinical nurse specialists. The most typical provider of primary care among ARNPs is the Nurse Practitioner. There are some licensure designations that are not primary care. Licensed midwives now have a more expanded scope and provide some primary care services.

Provider and carrier committee member Dorothy Teeter asked why behavioral health was not listed under the narrow definition. Dr. Judy Zerzan-Thul explained that there are billing codes, but the first part is *who*, and the next part is *what.* The National Provider Identifier (NPI) and codes are used to come up with claims-based spending on primary care. There are about 10 to 12 states that measure primary care, which the primary care committee reviewed. Most states have adopted a 12 percent definition of primary care spending.

Dr. Judy Zerzan-Thul also provided an overview of the broad list of the *where* of primary care (e.g., primary care clinics, rural health clinics, ambulatory health clinics, school-based health centers, virtual care). The primary care committee reviewed an extensive list of procedure codes and specific services to include in the primary care

definition which were used by other states and programs in their primary care measurement efforts. Additional data analysis may be conducted to further refine the primary care code list.

The primary care committee has begun to discuss policy recommendations to increase and sustain primary care. The committee developed a ranked list of strategies aligned with preliminary interests. Over the remainder of this year, the primary care committee will address the statutory charges related to data policy. Mika Sinanan asked if the bulleted list in the presentation slide only names the top choices from the ranked list, or if there were more strategies identified, and how these were chosen from the ranked list.

Dr. Judy Zerzan-Thul discussed the committee's policy recommendations to incentivize achievement of the 12 percent target and the recommended specific practices and methods of reimbursement to achieve and sustain the target. The primary care committee used a four-domain framework to explore different strategies for advancing toward a 12 percent spending target to support the goals of access and quality: 1) Direct Investment, 2) Capacity Growth, 3) Patient Behavior, and 4) Reduced Expenditure on Other Services. The list of policy strategies was introduced in order of committee preference.

Advisory Committee on Data Issues (data committee) member Leah Hole-Marshall advised that it might be helpful to have a high-level work plan of the activities the primary care committee intends to work through. Dr. Judy Zerzan-Thul discussed the primary care committee's next steps. The primary care committee has begun to discuss non-claims-based measurements. In the next meeting, the committee will discuss how to measure the different parts, such as quality bonuses that are earned or per member per month payments that aren't tied to claims. The primary care committee will provide further details on implementation.

Mika Sinanan commented that the fourth listed policy under "Patient Engagement" focuses on redirecting patients. This policy may need to be expanded to consider other areas and to think creatively about the ways patients think about the care they receive and how they seek it. Dr. Judy Zerzan-Thul responded that the primary care committee will dig deeper into the policy strategies moving forward.

Dorothy Teeter asked about the percentage of primary care practices in Washington that are still independent as opposed to those that are a part of a larger system – the investment strategies may differ. The Washington State Health Alliance has useful information on this topic.

Louise Kaplan stated that her own practice is a part of a small physician-owned practice that multiple health systems have attempted to purchase. In the news recently, Olympia Obstetrics and Gynecology was bought by Providence Swedish and will now be part of the Providence system. In Olympia, there are few privately-owned independent practices. There are some practices that may be billing nurse practitioner services under physician numbers. The *who* may be an issue to consider in terms of looking at how someone identifies who is providing the primary care.

The HCA and IHME Analytical Support Initiative

Joseph Dieleman, Associate Professor at the University of Washington, IHME

Joseph Dieleman provided an introduction of IHME and the analytical support initiative. IHME is charged with completing work related to measurements and health. IHME's previous projects connect closely with the report, *A Data Use Strategy for State Action to Address Health Care Cost Growth*, funded by the Peterson Center on Healthcare and Milbank Memorial Fund. The report posed the question of what data is needed and how it should be used to curve cost growth. The first part of the project describes all the health care spending in Washington using ten key metrics. The second part uses a trends analysis that compares growth to other states and counties. The analysis reviews which geographic units, health conditions, markets, and service categories have the most growth and how changes in population, disease prevalence, service utilization, and prices contribute to spending growth. The

project, externally funded by the Peterson Center on Healthcare and Gates Ventures, is a partnership with HCA and IHME, with IHME supplying analytical support to HCA. The project is expected to last from June 2023 to July 2025. Joseph Dieleman provided a brief overview of key deliverables and respective due dates.

Next, the committee heard an overview of the Disease Expenditure (DEX) research project and its findings, which include proportions of national personal health care spending for 161 health conditions and their growth rates over time. IHME conducted an analysis to understand why health care spending has been increasing. At the national level, the analysis reviewed all health care spending, diseases, and age groups and attributed cost growth to one of five categories. The analysis identified the factors driving the increases in spending (such as ambulatory care, pharmaceuticals, nursing facility care, and emergency departments) for specific health conditions. The analysis included spending estimates for race/ethnicity groups, decomposing differences in spending, and health spending attributable to risk factors. For its work with HCA, IHME will take a similar approach to its earlier analyses but with a focus on Washington. The initiative will access the Washington All Payer Claims Database (APCD), begin data landscaping (finding and understanding data sources unique to Washington), learn and receive feedback, and form an analytical strategy to act as guide for the first year on the project.

Mika Sinanan commented that from a provider viewpoint, if a provider entity is exceeding the benchmark, they would want to know which expenditures, practitioners, and clinics need to be looked at and what they should do and recommended greater granularity in the analysis. Joseph Dieleman responded that the project's intent is to be dynamic, collaborative, and receptive to early feedback. The project is meant to be comprehensive for Washington – not an assessment of each provider entity.
Dorothy Teeter asked if IHME can link data analytics with quality of care. Joseph Dieleman stated that linking to quality may not occur in the first year but agreed that it is important and would remain on IHME's radar. Data committee member Jonathan Bennett advised consideration of informational versus actionable information. There needs to be a strategic plan to make available information actionable, especially when looking at large network providers. Joseph Dieleman acknowledged the feedback from the committees about granularity and actionability.
Bob Crittenden agreed with the discussion on actionability, but also mentioned that IHME has data from many other places. There are different ways services are organized and a lot may depend on a system of care. Joseph Dieleman said there has been a push to identify exemplars. Bob Crittenden noted that local comparisons would be helpful, as well as other examples in the U.S. and other countries. IHME should consider examples that seem to fit as the project unfolds, particularly if there are issues where there's a large price increase or problem with the outcomes relative to other places.
Louise Kaplan asked IHME to investigate local and rural access to care issues. Joseph Dieleman replied that much of the data IHME has analyzed in the past was organized to focus on location of residence for the person seeking care rather than where the care is provided. For a service, health condition or type of care, IHME could quantify the number of encounters occurring in a patient's county versus encounters occurring outside a patient's county of residence.

Cost Growth Driver Study: Options for Phase II

Ross McCool, HCA

Ross McCool gave a presentation on additional options for a phase two cost growth driver study. OnPoint presented its initial findings from the cost driver analysis to the board and its committees in December 2022 which covered data from 2017 to 2019. The findings from OnPoint's initial analysis mostly align with other states' cost driver analyses and their presentation was intended to present options and receive feedback from the committees. While OnPoint's analysis showed increased spending in pharmacy, pharmacy related analyses were not presented as there is a newly created Pharmacy Drug Affordability Board that will review pharmacy trends. In previous

committee meetings, the board and its committees expressed interest in chronic condition flags. Additional chronic condition flags can be added from the Chronic Conditions Data Warehouse. Chronic condition flags from other sources can be included but will require additional resources. From 2017 through 2019, there was a slight decrease in spending on inpatient services but an increase in outpatient spending. Further review of overall price growth for both inpatient and outpatient could provide additional information on this trend. This review would include trends in volume of services and price per service and would stratify by facility type and geography. Other cost boards in other states are working on reviewing trends in severity for inpatient and outpatient services. A few states have investigated if an increase in outpatient services is due to inpatient services transitioning to outpatient services. A similar analysis can be done where OnPoint could look at changes in services, case mixes, and diagnosis-related group (DRG). OnPoint could also analyze out-of-pocket spending.

Mika Sinanan commented that looking for transitions from inpatient to outpatient in the data is important, but OnPoint should also consider what providers are trying to accomplish. Ross McCool responded that the data will be used to create talking points to investigate whether there is some consistency across different regions and groups to discuss how to positively affect price growth. Mika Sinanan asked if the phase two cost driver analysis will be included in the proposed report from the board to the legislature later this year. Ross McCool replied that the phase two cost driver analysis will not be complete or ready before the report is due. Mika Sinanan also asked about the data years included in the report. Ross McCool stated that the historical cost driver data is from 2017 through 2019. The benchmark data call includes data from 2017 through 2019 and will have old data as part of its design to provide historical data for review before providing new data.

Ross McCool concluded his presentation with a preview of the cost driver analysis dashboard. The dashboard will be posted to a new section of the Washington HealthCareCompare website and will include links for different resources that use APCD data and will show different studies being conducted in the state.

Wrap Up Questions and Comments

Jonathan Bennett and Mika Sinanan requested to put forward a motion. Mika explained that the motion addresses previously discussed points regarding data actionability and accuracy. Leah Hole-Marshall requested to delay any motion to have the opportunity to hear it. Mandy Weeks-Green stated that the motion could be initially presented at today's meeting and voted on at the next committee meeting.

Mika included the motion in the meeting chat. The motion read as follows: "The joint committees respectfully request that the Board address the following critical operational elements as they relate to the health care cost growth benchmark process at an upcoming board meeting:

1. Methodology – how will we fairly attribute members to providers because providers will be held accountable to the benchmark for those patients.
2. Data Accuracy - how will data be attributed and verified to providers because this will determine compliance with the benchmark.
3. Risk Adjustment - an essential requirement to account for the appropriate healthcare intensity of attributable members because risk adjusted health status will impact the scope and magnitude of services, cost, and outcome and must be fair, equitable, and consistent.
4. Metrics for Provider Performance - what key metrics will be considered the contributors to cost growth because an underperforming provider must be able to understand why and see how to fix it."

Adjournment

Meeting adjourned at 4:04 p.m.

Next committee meetings

Advisory Committee of Health Care Providers and Carriers
September 7, 2023
2 p.m. – 4 p.m.

Advisory Committee on Data Issues
October 3, 2023
2 p.m. – 4 p.m.

The meetings will be held electronically through Zoom, telephonically, and in person at the Health Care Authority.

Tab 3

Washington State Health Care Authority

Washington State Hospital Association

September 20, 2023

Dear Members of Advisory Committee on Data Issues (Advisory Committee):

The Washington State Hospital Association (WSHA) supports the Board's work to address our shared goal in understanding health care spending and promoting affordability while maintaining appropriate, effective, affordable, and accessible care.

During the April 2023 Board meeting, the state's consultants provided an overview of how performance for providers would be measured against the benchmark. The overview was helpful in providing a broad picture understanding but left us with many questions.

We respectfully request that the Advisory Committee consider the following questions and approve the proposed motion to help provide additional clarity and understanding of the performance measurement process.

Advisory Committee representatives from WSHA and WSMA introduced a motion at the June 6 combined Provider and Data Advisory Committee meeting that has been updated and included as an enclosure below for the advisory committee's consideration at the October 3 meeting. We believe it is important to have a comprehensive understanding of the measurement process, including both its strengths and weaknesses, since it is one of the primary tools being used to help control cost growth. The motion reflects the following elements that we hope can be addressed:

1. **Attribution methodology.** Patients are attributed to providers using several methods. Will plans report the numbers of attributions made using each method? Plans will also be attributing primary care providers to large provider entities. Will large provider entities be able to review and vet these specific provider attributions to ensure accuracy?
2. **Risk adjustment for attributable members.** Will the specific adjustment methodology be disclosed and reviewable?
3. **Analysis for specific provider performance.** What information will be given to large provider entities that exceed the benchmark and will that information help inform their practices, e.g., whether exceeding the benchmark was due to increased price of services versus increased use of services? This would better enable providers to make corrections to improve performance. Is there other information that can be provided to inform their practices?
4. **Notice.** Are the large provider entities identified in the technical manual the finalized list of providers that will be compared against the benchmark? How and when will providers be notified that they are subject to the benchmark?

Clarification and further explanation will help facilitate a better understanding of measurement and expectation. More broadly, and most importantly, it is imperative that data gathered during this process is accessible, accurate, interpretable, and actionable. Providers' ability to meet the benchmark hinges on these factors so that targeted corrections can be made and improvement can be realized.

Sincerely,

Katerina LaMarche, JD
Policy Director, Government Affairs
Washington State Hospital Association
katerinal@wsha.org

Enclosures: Updated motion for consideration at the October 3 Advisory Committee meeting.

Updated motion for consideration at the October 3 Advisory Committee meeting:

The committee respectfully requests that the Board address the following critical operational elements as they relate to the health care cost growth benchmark process, and as further detailed in the letter above, at an upcoming Board meeting:

- Attribution Methodology: transparency and accuracy of attributed members and primary care providers is important, because large provider entities will be held accountable for those patients and primary care providers.

- Risk Adjustment: adjustment methodology for age and sex should be disclosed and reviewable, because it will better inform primary care providers and large provider entities.

- Analysis for Specific Provider Performance: information and metrics that identify contributors to cost growth should be given to large provider entities, because large provider entities must be able to understand why they exceeded the benchmark in order to improve performance.

- Provider Identification and Notice: identification of large provider entities and the process by which they are notified should be established, because large provider entities must be aware that they are subject to the benchmark.

Tab 4

Washington State Health Care Authority

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

John Bartholomew & Tom Nash
Bartholomew-Nash & Associates

Advisory Committee on Data Issues
October 3, 2023

Project Goal, Second Level Review of Hospital Financial Analysis:

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?

Hospital Financial Analysis – Where Does This Project Fit In?:

1. HCCTB meeting on April 19, 2023 reviewed the Data Projects Overview:
    a) Cost Growth Benchmark
    b) Performance against Benchmark
    c) Cost Driver Analysis/Cost Experience
    d) Primary Care Spend Measurement
    e) NEW: Hospital Cost, Profit, and Price Analysis

Health Care Cost Transparency Board Data Projects Overview: This Project

- What it is
  - Hospital financial analysis to create cost, price and profit trends. Identify Outliers.
- What it Represents
  - Reflects individual hospital financial trends to be compared to 'like' hospitals within Washington and nationally to **identify outliers** in cost and profits.
- Analytic Basis
  - Reflects individual hospital financial trends to be compared to 'like' hospitals within Washington and nationally to **identify outliers** in cost and profits.
- Risk Adjustment Considerations
  - Creating 'like' hospital comparisons requires groupings using Medicare case mix information, hospital specific intensity levels, levels of teaching. As well as adjustments to costs capturing national wage/labor and other cost variations.
- Other Considerations
  - **This endeavor is a companion project to the Cost Driver Analysis/Cost Experience as well as the Cost Growth Benchmark project. Hospital costs comprise of 35-45% of total health care costs, having detailed hospital cost trends and outlier analysis will be insightful to understanding affects on total health care cost growth.**

HCCTB Data Projects: Hospital Financial Analysis as a Complementary Data Project to Other Data Projects

- **Cost Driver Analysis:**
  a) Assessment of key drivers of cost growth.
  b) There are two approaches/perspectives to identifying cost drivers: 1) from the patient or member perspective, and 2) from the provider perspective.
  c) Identifying cost drivers from a provider perspective entails a financial deep-dive review by provider type of the provider's cost of rendering the service they provide as compared to appropriate benchmarks.
  d) When the proposed hospital financial analysis is concluded, HCCTB members will have a deep understanding of the business side of the hospitals operating in their state. HCCTB members will know which hospitals are high cost or normal cost, high price or normal price and which hospitals have high profits or normal profits.

HCCTB Data Projects: Hospital Financial Analysis as a Complementary Data Project to Other Data Projects

- **Cost Growth Benchmark:**
  a) The ceiling/goal for the growth of spending on health care year over year.
  b) Hospital costs comprise 35% to 45% of total health care costs.
  c) Having detailed hospital cost trends and outlier analysis will be insightful to understanding the effects this industry has on total health care cost growth within the state of Washington as compared to the nation and other benchmarks.
  d) When the proposed hospital financial analysis is concluded, HCCTB members will have a cost growth trend measure at the hospital and hospital system level year over year.
  e) HCCTB members will have a deep understanding of the business side of the hospitals operating in their state and know which hospitals are high cost or normal cost trends year over year.

Second Level Hospital Financial Analysis Review

- 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.
  - Net Patient Revenue divided by Adjusted Discharge, adjusted for Medicare Case Mix Index (CMI)* = **Price per Patient**
  - Hospital Only Operating Expense divided by Adjusted Discharge, adjusted for WI and C2ER COLA* = **Cost per Patient**
  - Patient Services Profit Margin = **Patient Profit Percent**
  - Total Profit Margin = **Total Profit Percent**
  - **Medicare Payment to Cost Ratio: an indicator of hospital cost efficiency**

- Create regional medians for benchmarking: regional medians were created for 10 CBSAs: Seattle, WA as compared to St. Louis, MO; Springfield, MO; Denver, CO; Detroit, MI; Chicago, IL; Baltimore, MD; Dallas, TX; Pittsburgh, PA; San Francisco, CA.

- Other tools using similar processes: NASHP's hospital cost tool, St. Louis Business Healthcare Coalition, Colorado Medicaid, and the Colorado Division of Insurance.

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

The Measures: Cost and Price Adjustment Methodology

Adjustment to the Cost Data

- Adjustment to Hospital-only Operating Expense: Utilized labor wage index (WI) information from the CMS wage index files and Medicare Cost Report at the hospital level. Applied labor wage index to the salary amount of costs of each hospital, then applied the Council for Community and Economic Research (C2ER) index to adjust the remaining costs for a cost-of-living adjustment (COLA).
  - Salary percentage was calculated from the Medicare Cost Report.
- Adjusted cost data was then divided by adjusted discharges to express costs on a per patient basis.
  - Adjusted discharges is a measure that encompasses both inpatient and outpatient volume.

Adjustment to the Price Data

- Adjustment to Net Patient Revenue: Net Patient Revenue from the Medicare Cost Report was divided by a Medicare case mix adjusted discharge.
  - Adjusted discharges were multiplied by an aggregate Medicare CMI for each hospital.
  - Medicare CMI is reported in the Medicare Inpatient Prospective Payment System (IPPS) final rule public use files – this index captures the level of acuity at a hospital.

The Measures: Medicare Payment to Cost Ratio

This measure is an additional cost efficiency indicator

- The Medicare payment-to-cost ratio is calculated by dividing Medicare payments by the costs of serving Medicare patients.

- This analysis focuses on the Medicare payment-to-cost ratio, which can also be used as an **indicator of hospital efficiency**. The degree of efficiency on Medicare business can be assumed to be similar across all payers. If a hospital is inefficient on Medicare business, it is likely inefficient on Medicaid and any other public payer business, which can result in a hospital charging higher commercial prices to make up for the poor margins on public payers.

- Medicare payments are adjusted to reflect individual hospital characteristics, such as case mix, teaching intensity, and geographic location, comparing them to the related costs can show how well hospitals are managing expenses and thus serve as a measure of efficiency.

The Peer Group Comparisons Methodology:

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.

Peer Selection Criteria Methodology

WA hospitals will be grouped with 'like' US hospitals

- Initial peers were selected that matched the subject hospital's characteristics as follows:
  - Bed size: 26 to 100, 101 to 300, 301 to 500, 501 to 800, >800
  - Medicare case mix: quartiles 1 through 4 (lowest to highest)
  - Teaching intensity: based on resident to bed ratio quartiles 1 through 4 (lowest to highest)
  - Service intensity: based on intensive care costs as a percentage of total costs quartiles 1 through 4 (lowest to highest)
- The targeted number of peers was between 5 and 20. Selection criteria were narrowed or broadened as necessary to reach this targeted range.

Additional Questions/Comments?

Tab 5

Washington State Health Care Authority

Analytic Support Initiative

WA Health Care Cost Transparency Board's

Advisory Committee on Data Issues

October 3, 2023

HCA & Institute for Health Metrics and Evaluation

Agenda

1. Overview of ASI and role of Data Advisory Committee
2. Discuss proposed analytic products to advance Cost Board discussion
3. Discuss sample use case scenarios for the Cost Board's evaluation

Context

There were several important goals that emerged from the Analytic Strategy Initiative (ASI):

A. Analytic products are in **support of an identified Health Care Cost Transparency Board (Cost Board) need**

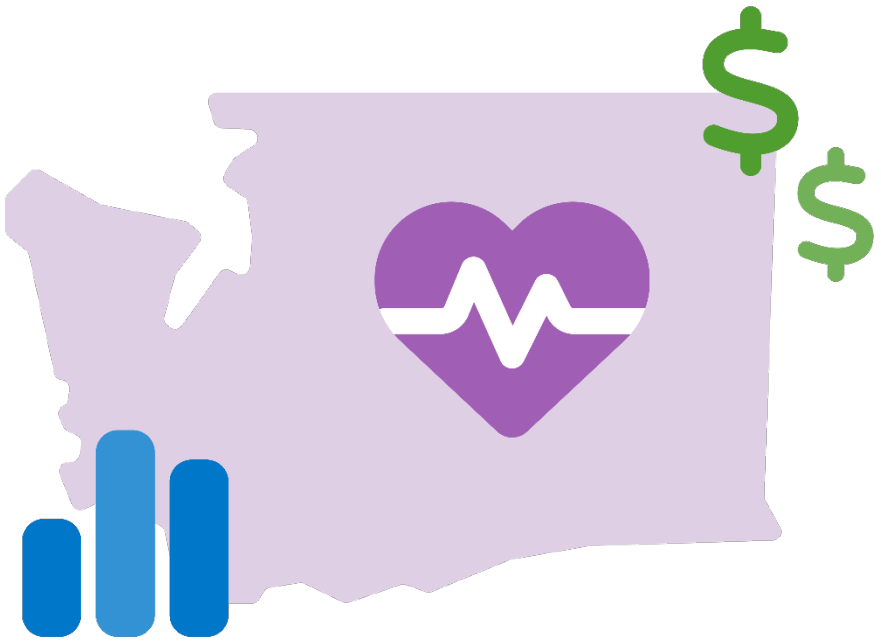
B. Analyses should be **as simple as possible**

C. Results should be presented in a **clear and understandable** manner

D. Results should be appropriately specific and **granular enough for action**

Cost Board's Legislative Mandate

- ❑ Analyze WA's total health expenditure
- ❑ Identify drivers of health care cost growth
- ❑ Establish a benchmark growth rate
- ❑ Identify providers and payers with spending growth rates more than the benchmark
- ❑ Make recommendations to state legislature



Health Care Cost Transparency Board

Data Projects Overview

Cost growth benchmark

The ceiling/ goal for the growth of spending on health care year over year.

Performance against benchmark

Assessment of cost growth against the benchmark target.

Cost driver analysis/cost experience

Assessment of key drivers of cost growth.

Primary care spend measurement

Measurement of expenditure on primary care in relation to overall health care expenditure.

Hospital cost, profit, and price analysis

Hospital financial analysis to create cost, price and profit trends.

Analytic support initiative

Analysis of the drivers of WA health care cost growth by University of Washington's IHME. IHME will use its deep analytic capacity as well as expertise in data integration.

Consumer and affordability

The ability for a consumer to afford their health care insurance.

Health Care Cost Transparency Board's Data Projects

Objectives

To obtain input from the Cost Board's Advisory Committee on Data Issues (Data Advisory Committee) in identifying analytical products (i.e., analyses and results) that advise the Cost Board. Considerations are products that have or are:

a. **high probability of influence** → the proposed analytical product has high probability of being relevant and valuable for the Cost Board's policy considerations

b. **high impact** → the Cost Board's policy considerations that this analytical product is relevant for or has the potential to contribute meaningfully to fulfilling the Cost Board's legislative directive (i.e. cost containment)

c. **novel approach** → as in not duplicative of or is complementary to existing efforts within HCA

IHME background methods applicable to this work

IHME has developed the DEX project which will:

- Estimate **spending**, **spending per capita**, **spending per beneficiary**, **spending per prevalent** (or incident, hereon prevalent) **case**, and **spending per encounter**. These different measures reflect spending and price.
- Estimate **encounters**, **encounters per person**, **encounters per beneficiary**, and **encounters per prevalent case**. These different measures all reflect utilization.

These estimates will exist for

- state and county
- 10 years (2010-2019)
- 36 age/sex groups
- 4 payer categories (Medicare, Medicaid, private insurance, and out-of-pocket)
- 7 types of care
- 161 health conditions

IHME background methods applicable to this work

In addition, IHME has several other resources that are accessible and can be used relatively easily.

- At the county level, we have **cause specific prevalence estimates** for a select set of about 70 health conditions, with **mortality estimates** and **life-expectancy**.
- At the state level, we can attribute health care burden and spending to **modifiable risk factors**, such as high body mass index, high blood pressure, and smoking.
- We have estimates of **hospital market concentration** (a measure of hospital market competition level) for each WA hospital, each Hospital Reference Region, and for the state as a whole. These estimates extend from 2000 to 2020. We also have a measure of insurer concentration at the state level.
- We have developed a peer-reviewed method for estimating **risk-adjusted delivery system value**. This could be calculated for each county.
- We have developed a peer-reviewed method for attributing spending growth to five distinct factors: **population size**, **population age-structure**, **disease prevalence**, **utilization**, and **price** (which includes intensity of care). These analyses can be performed by cause and/or for each county.

Questions for consideration while reviewing the following two slides

- Which of these analytic products would be most helpful for understanding and controlling drivers of cost in Washington?
- How might we consider crafting the data sets to not overlap with existing data projects?
- Is there anything that might supplement these analytic products?

Proposed analytic products:

	ANALYTIC PRODUCT	ANALYTIC APPROACH, STRENGTHS, AND LIMITATIONS
A	Spending and price variation and trend reporting	Showing growth rate in spending (by cause, care type, or payer category) for each county with age/sex-standardization and show variation in growth rate by type of care groups for private insurance. The presentation could be in the form of maps, line graphs, etc.
B	Risk-adjusted spending and price reporting	This could look like any of the examples discussed above reporting spending or price growth (maps, line graphs, heatmaps, etc.), but all of the estimates would be risk adjusted. Variation would be reporting by spending utilization, price, across time, and across counties
C	Drivers analysis	We could add drivers such as **type of care mix** and/or **payer category mix**, highlighting where spending is higher or lower because of concentration of care on specific types of care and/or specific payers at the county-level
D	Comparing spending & price growth to “like” counties	Spending, utilization, and price estimates where “like” is defined based on contextual factors such as underlying health, income, education, prevalence of key risks like obesity or smoking. Allows us to highlight where spending, utilization, or price growth is less than, the same as, or greater than similar counties.

Proposed analytic products:

	ANALYTIC PRODUCT	ANALYTIC APPROACH, STRENGTHS, AND LIMITATIONS
E	Reporting and assessing value	**Risk-adjusted delivery system value could be estimated** for each county (and by cause if desired). This would be akin to identifying exemplars of positive (or negative) delivery system performance
F	Reporting and assessing hospital market concentration	The APCD cannot have specific provider reporting, so this could be at the county level and/or could be about illustrating how market concentration in WA is associated with prices (reporting the relationship rather than the specific estimates).
G	Reporting on provider/payer price and price growth variation	Price and trends in prices cannot be reported by provider or payer because of data use constraints, but we can **report information about variation in prices and variation in price growth** by county or by disease
H	Reporting spending effectiveness by cause & county	**Spending effectiveness** is like a cost-effectiveness measure but is measured by cause rather than for a specific intervention. IHME has developed a peer-reviewed method for estimating cause-specific spending effectiveness. This could be repurposed and made specific to WA state and could highlight which diseases are treated with high levels of spending effectiveness.

Discussion of Analytic Products

- Which of these data sets would be most helpful for understanding and controlling drivers of cost in Washington?
- How might we consider crafting the data sets to not overlap with existing data projects?
- Is there anything that might supplement these analytic products?

Potential sample use cases and IHME analytic product capacity

	ASI ANALYTIC FEASIBILITY	ASI Core Analyses
1 **Examine providers and payers** with spending growth rates higher & value growth rates lower than benchmarks		A B D G
2 **Evaluate impact and appropriate criteria for proposed mergers**		A B F G
3 **Identify disease areas** where there may be room to improve preventive / primary care or other opportunities for high-value care delivery mechanisms	**FOCUS OF THE DISCUSSION** ***Potential use cases that add value, are there other cases that could be considered.***	B C G
4 **Identify and evaluate cost containment models**, such as increasing value based care and more		A B C E
5 **Identify use of low-value services to create incentives,** which downside risk of providing low-value care		A B E G H
6 **Evaluate appropriateness and relative value of health insurance offerings** (e.g., network adequacy standards & review)		G
7 **Examine methods to evaluate and curb cost growth of provider prices,** e.g., where growth has not been driven by utilization and commensurate value through imputed burden of disease has not improved		D F G
8 **Examine pricing structures including reference-based pricing**		G

ASI ANALYTIC PRODUCTS

- **A** Spending and price variation and trend reporting
- **B** Risk-adjusted spending and price reporting
- **C** Drivers analysis
- **D** Comparing spending & price growth to “like” counties
- **E** Reporting and assessing delivery system value
- **F** Reporting and assessing hospital market concentration
- **G** Reporting on price variation and price growth variation w/ providers and/or payors
- **H** Reporting spending effectiveness by cause & county

Discussion of Sample Use Case Scenarios

- Which of these sample use cases would be most helpful for understanding and controlling drivers of cost in Washington?

- Is there anything that might supplement these case use scenarios?

Tab 6

Washington State Health Care Authority

Updated motion for consideration at the October 3 Advisory Committee meeting:

The committee respectfully requests that the Board address the following critical operational elements as they relate to the health care cost growth benchmark process, and as further detailed in the letter above, at an upcoming Board meeting:

- Attribution Methodology: transparency and accuracy of attributed members and primary care providers is important, because large provider entities will be held accountable for those patients and primary care providers.

- Risk Adjustment: adjustment methodology for age and sex should be disclosed and reviewable, because it will better inform primary care providers and large provider entities.

- Analysis for Specific Provider Performance: information and metrics that identify contributors to cost growth should be given to large provider entities, because large provider entities must be able to understand why they exceeded the benchmark in order to improve performance.

- Provider Identification and Notice: identification of large provider entities and the process by which they are notified should be established, because large provider entities must be aware that they are subject to the benchmark.

Tab 7

Washington State Health Care Authority

Primary Care Data Collection and Reporting Strategy

Health Care Cost Transparency Board-

Advisory Committee on Data Issues

October 3, 2023

Washington State Health Care Authority

HCCTB Advisory Committee on Primary Care Charges

- Primary Care Definition
  - Recommend a definition of primary care
  - Recommend measurement methodologies to assess claims-based spending
  - Recommend measurement methodologies to assess non-claims-based spending

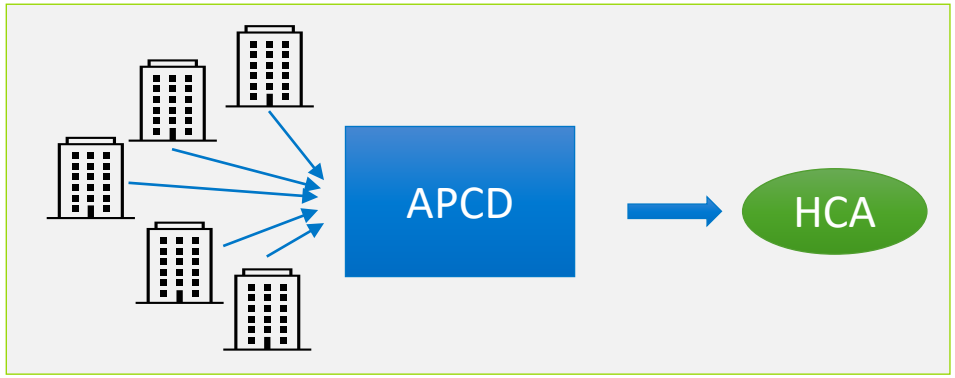
- Data Focused to support primary care
  - Report on barriers to access and use of primary care data and how to overcome them
  - Report annual progress needed for primary care expenditures to reach 12 percent of total health care expenditures
  - Track accountability for annual primary care expenditure targets

- Policies to Increase and Sustain Primary Care
  - Recommend methods to incentivize achievement of the 12 percent target
  - Recommend specific practices and methods of reimbursement to achieve and sustain primary care expenditure targets

How Does Data Collection From Payers Work Today?

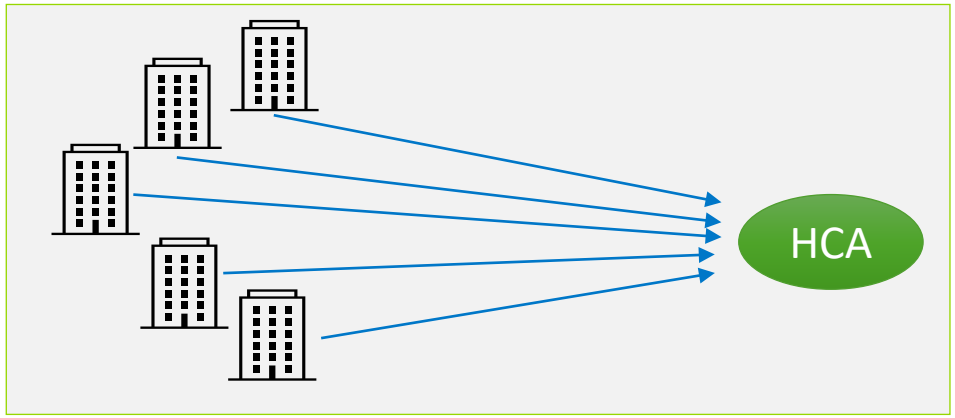
All Payer Claims Database

- **Detailed data** submitted by **subset of payers** to APCD
- APCD detailed data can be queried by HCA
- **Does not** include ERISA plans
- **Does not** include non-claims-based expenditures



HCA Aggregate Data Call

- **Aggregate data** submitted by all payers directly to HCA
- **Includes** ERISA plans' data
- **Includes** non-claims-based expenditures
- HCA updates reporting specifications to meet current policy needs regularly.

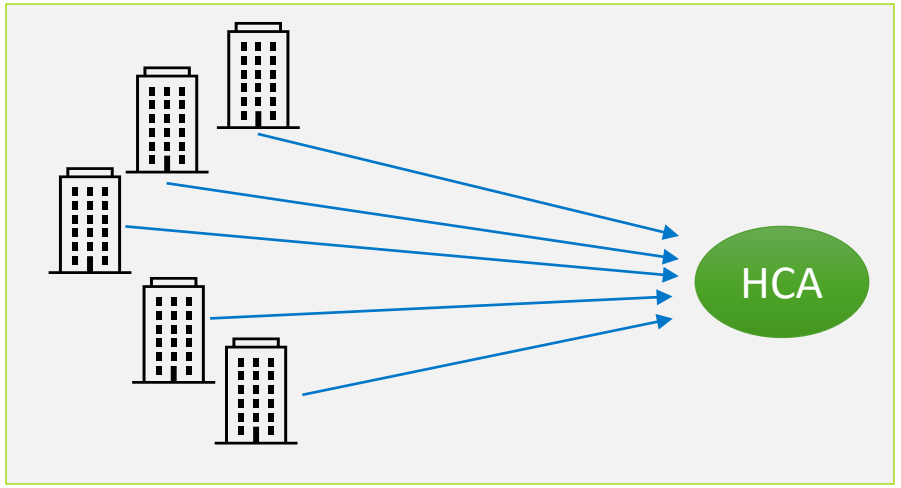


Washington State Health Care Authority

Data Collection Mechanism

Existing aggregate data call that can be modified to incorporate the Board-approved primary care definition and to solve for missing data elements in the APCD. However, there are several persistent challenges:

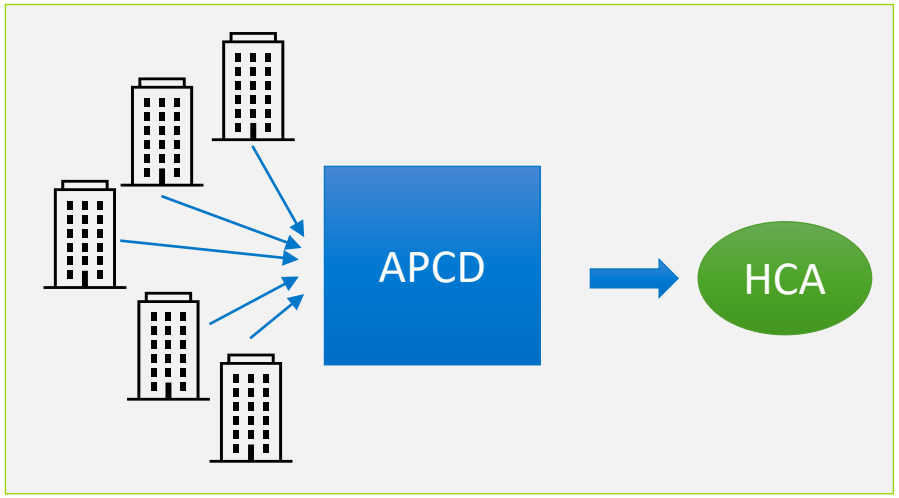
- Multiple entities calculate PC expenditures based on state-provided specifications = opportunity for inconsistent application of the specifications.
- Self-reported aggregate data reduces accountability and transparency
- The process is administratively burdensome and partially duplicative with APCD reporting by plans.



Washington State Health Care Authority

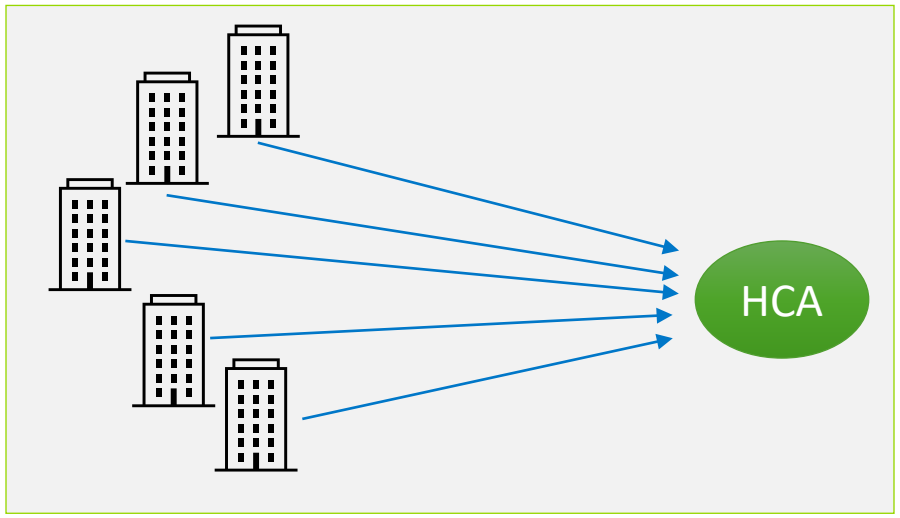
HCA Proposal – A Hybrid Solution

Claims-based Expenditures



- Standardization of reporting and interpretation
- Increased process transparency
- Leverage existing infrastructure

Non Claims-based Expenditures



- Solution for APCD data gaps
- Customizable for reporting under value-based purchasing or other categorical frameworks

Washington State Health Care Authority

Tab 8

Washington State Health Care Authority

Benchmark Schedule

Year of Release of Report	Includes Data from Specified years	Data included
Fall 2023	2017-2019	State and market data only – the board will not publicly report insurance carrier* or provider cost growth for this period
Summer 2024	2020-2022	For large provider entities and carriers** - with growth target of 3.2%
Summer 2025	2022-2023	For large provider entities and carriers – with growth target of 3.2%
Summer 2026	2023-2024	For large provider entities and carriers – with growth target of 3.0%
Summer 2027	2024-2025	For large provider entities and carriers – with growth target of 3.0%
Summer 2028	2025-2026	For large provider entities and carriers – with growth target of 2.8%