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.