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.