Data Call Webinar for Health Care Cost Transparency Board

Washington State Health Care Authority

Welcome

- This training is intended to assist the technical staff of submitting entities who will be responding to the Health Care Cost Transparency Board's 2022 Benchmark Data Call.
- The purpose is to provide an overview of the submission guideline
- Time for questions throughout the presentation and at the end.
- This training is being recorded, and the recording will be posted on the Health Care Cost Transparency Board website
- Landing page is "Benchmark Data Call"
- Links to technical manual, submission template, FAQ's, Office Hours

Agenda

- Overview of Washington's Health Care Cost Growth Benchmark
- Reporting and Attribution
- Data Submission Template Overview
- Q&A and Insights

Overview of Washington's Health Care Cost Benchmark Program

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Washington's Healthcare Cost Transparency Program

- Established by WA SSHB 2457 establishing a **Health Care Cost Transparency Board**, charged with
  - Establishing a health care cost growth **benchmark** or target percentage for growth,
  - Analyzing **total health care expenditure,**
  - Identifying **trends** in health care cost growth, and
  - Identifying **entities that exceed** the health care cost growth benchmark.
- Additional information available online
  - https://www.hca.wa.gov/about-hca/health-care-cost-transparency-board

Washington’s Healthcare Cost Transparency Board

- Governor-appointed agency and purchaser representatives
- Advised by two formal committees:
  - Advisory Committee on Data Issues
  - Advisory Committee of Health Care Providers and Carriers
- Report annually to the legislature in August

Washington's Health Care Cost Growth Benchmark

- The annual rate of growth target for total health care spending in the state.
- Based on a methodology that considers historic median wage and gross state product (PGSP).

Calendar Year	Benchmark Value
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

Annual Health Care Cost Benchmark Cycle

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2022 Filing Submission Schedule

- Filing Opens August 15, 2022
- Final Submission Due October 1, 2022
- Reminder: Leave yourself time for resubmission

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Reporting and Attribution

General

- Washington residents
- Report allowed amounts (i.e., amounts paid by the insurer and member cost sharing) for claims based on date incurred
- Only report spending on claims for which the insurer was the primary payer
- Allow for a claims run-out period and a non-claims reconciliation period of at least 180 days after December 31 of the performance year
- Apply reasonable and appropriate incurred but not reported (IBNR) / incurred but not paid (IBNP) completion factors to each respective TME service category
- Apply reasonable and appropriate estimates of non-claims liability that are expected to be reconciled after the 180-day period

General: Included Policies

Included Policies	
Commercial market policies ✓ Self-insured plans ✓ Short-term health plans ✓ Student health plans ✓ Fully insured individual and group plans ✓ The Washington Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) programs ✓ The Federal Employee Health Benefits Program (FEHB)	The Medicare market policies: ✓ Medicare Advantage Health Maintenance Organization (HMO) ✓ Preferred Provider Organization (PPO) ✓ HMO Point of Service (HMOPOS) ✓ Medicare Medical Savings Account (MSA) ✓ Private Fee-for-Service (PFFS) ✓ Special Needs Plan (SNPs) Medicaid contract ✓ Medicaid and CHIP managed care contracts with the Washington Health Care Authority

General: Excluded Policies

Excluded Policies	
Policies offering limited benefits, including: • Accident policy • Disability policy • Hospital indemnity policy • Long-term care insurance • Medicare supplemental insurance (AKA Medigap) • Stand-alone prescription drug plans	• Specific disease policy • Stop-loss plans • Supplemental insurance that pays deductibles, copays, or coinsurance • Vision-only insurance • Workers compensation • Dental-only insurance

List of Large Provider Entities

Code	Provider Entity
100	Overall Provider Entities
101	Community Clinic Contracting Network (includes Yakima Valley, CHC Snohomish, Columbia Basin, Columbia Valley, International Community Health, Mariposa, Peninsula Community Health, Unity Care, & Sea Mar)
102	Community Health Association of Spokane
103	Community Health Care
104	Community Health of Central Washington
105	Confluence Health
106	Country Doctor Community Health Centers
107	Cowlitz Family Health Center
108	Evergreen Health
109	Family Care Network
110	Family Health Centers
111	Franciscan Health - including Virginia Mason Franciscan Health (part of Pacific NW Division of Common Spirit)
112	HealthPoint
113	Kaiser Permanente of Washington (medical centers in Western WA and Spokane)
114	Kaiser Permanente NW (medical centers in SW WA)
115	Legacy Health
116	Lewis County Community Health Services (Valley View Health Center)
117	Moses Lake Community Health Center
118	MultiCare Health includes Mary Bridge Children's Hospital; Navos
119	Wellfound Behavioral Health Hospitals – partnership with CHI Franciscan and MultiCare
120	NeighborCare Health
121	NEW Health Programs Association
122	North Olympic Healthcare Network PC
123	OptumCare (includes Everett Clinic, Polyclinic, and Northwest Physician's Network)
124	Overlake Medical Center
125	PeaceHealth
126	Providence Health/Swedish Health Services/PacMed/Kadlec
127	Rose Medical
128	Seattle Children's Care Network
129	Seattle-King County Public Health Dept (Health Care for the Homeless Network)
130	The Vancouver Clinic
131	Tri-Cities Community Health
132	UW Medicine (Valley Medical Center, Neighborhood Clinics)
133	Yakima Neighborhood Health Services
999	Unattributed to a Large Provider Entity

Note: This list may be revised in future years of data collection

Reporting on Large Provider Entities and Attribution

Attribute individual patients to a primary care provider (PCP) and those PCPs to a large provider entity. To attribute member to a PCP, carriers should follow the hierarchy below:

- Member Selection
  - Members who were required to select a PCP by plan design
- Contract Arrangement
  - Members not included in the above and who can be attributed to a PCP during the performance period pursuant to contract between the carrier and the provider
- Utilization
  - Member not included in the above who can be attributed to a PCP based on the member's utilization history

Data Submission Template Overview

Data Submission Template - Contents

Tab Name	Contents
1_Cover Page	Payer info, attestation, and data submission confirmation
2_TME	Total Medical Expenses for all of the payer's members by insurance category, regardless of attribution, by large provider entity and age/sex band.
3_SD	Standard Deviations on per member per month claims spending by market for the payer overall for each large provider entity.
4_LOB_ENROLL	Payer's member months by line of business.
5_RX_REBATE	Pharmacy rebates data by insurance category code.
6_Reference Tables	Lookup Tables for Codes for Tabs 2-5.

Data Submission Template - Cover Page

- Contact information
  - Name of individual who should be contacted with data validation questions
- Data completeness and estimates
  - What is potentially missing from the data and what estimate methodologies were used
- Attestation
  - Confirm that the data submitted is current, complete, and accurate to the best of their knowledge

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Data Submission Template – TME Data Stratification

TME01 code Carrier Code	TME02 year Reporting Year	TME03 code Insurance Category Code	TME04 code Large Provider Entity Code	TME05 code Age Band Code	TME06 code Sex Code

- These codes can be found in the Reference Tables tab

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Data Submission Template – TME
Data Stratification – Insurance Category Code

- Insurance Category Codes are mutually exclusive categories that indicate for which business the carrier is reporting data
- Commercial has two categories:
  - Full claims – for when the carrier holds the entire medical benefit and has all the data
  - Partial claims – for when the carrier holds part of the benefit, and another part is carved out (e.g., pharmacy or behavioral health). Carriers should estimate partial claims data for which it does not have access.

Insurance Category Code	Description
1	Medicare expenses for non-dual eligible members
2	Medicaid expenses for non-dual eligible members
3	Commercial: Full Claims
4	Commercial: Partial Claims
5	Medicare Expenses for Medicare/Medicaid Dual Eligible
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible

Data Submission Template – TME Data Fields

TME07 non-negative integer Member Months	TME08 - 15 non-negative number Claims Based Spending	TME16 - 21 non-negative number Non-claims Based Spending	TME22 non-negative number Truncated Claims Spending	TME23 non-negative integer Count of Members with Claims Truncated

- Only TME22 should have truncated claims spending
  - The threshold to truncate is found in the manual
- EXCEPTION: TME20 Non-Claims: Recovery should be a non-positive number

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Data Submission Template – TME Claims Based Spending Fields

Hospital Inpatient

- Sum of the allowed amount from the claims for hospital inpatient services. Includes all room and board and ancillary payments for all hospital types. Includes payments for emergency room services when the member is admitted to the hospital, in accordance with the specific Carrier's payment rules. Does not include payments made for observation services, payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician, or inpatient services at non-hospital facilities (e.g., residential treatment facilities).

Hospital Outpatient

- Sum of the allowed amount from the claims for hospital outpatient service. Includes all hospital types and payments made for hospital-licensed satellite clinics, emergency room services not resulting in admittance; and observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

Data Submission Template – TME Claims Based Spending Fields

- Professional, Primary Care Providers
  - Sum of the allowed amount from the claims paid to primary care providers for primary care services using the provider taxonomy and procedure codes in Appendix A of the Implementation Manual. Attachment 1 includes the taxonomy codes for primary care providers. Attachment 2 includes services that are defined as primary care services. This definition is based on the narrow definition of primary care outlined in the Office of Financial Management's (OFM) Primary Care Expenditures Report.
- Professional, Specialty Providers
  - Sum of the allowed amount from the claims paid to physicians or physician group practices that are not defined as a PCP. Includes services provided by a doctor of medicine or osteopathy in clinical areas other than family practice, geriatrics, internal medicine, and pediatrics as defined above using OFM's narrow definition of primary care.

Data Submission Template – TME Claims Based Spending Fields

- **Profession, Other Providers**
  - Sum of the allowed amount from the claims paid to a licensed practitioner other than a PCP or specialty provider. Includes, but is not limited to, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors, and any fees that do not fit other categories, including facilities fees of community health center services and freestanding ambulatory surgical center services.
- **Long-Term Care**
  - Sum of the allowed amount from the claims paid to health care providers for skilled or custodial nursing facility services, intermediate care facilities and services for persons with developmental disabilities, hospice, and providers of home- and community-based services including personal care (e.g., assistance with dressing, bathing, eating, etc.), homemaker and chore services, home delivered meal programs, home health services, adult daycare, self-directed personal assistance services, and programs designed to assist individuals with long-term care needs who receive care in their home and community, such as PACE or Roads to Community Living. Does not include payments made for professional services rendered during a facility stay that have been billed directly by a physician group practice or an individual practitioner.

Data Submission Template – TME Claims Based Spending Fields

Retail Pharmacy

- Sum of the allowed amount from the claims paid to retail pharmacies for prescription drugs, biological products or vaccines as defined by the carrier's prescription drug benefit. This category should not include claims paid for pharmaceuticals under the carrier's medical benefit. Pharmacy payments made under the medical benefit should be attributed to the setting in which it was delivered (e.g., drugs delivered in a hospital inpatient setting should be attributed to the "Claims: Hospital Inpatient" category). Medicare Advantage carriers that offer stand-alone prescription drug plans (PDPs) should exclude stand-along PDP spending from their reporting. Pharmacy data should be reported **gross of applicable rebates.**

Other

- Sum of the allowed amount from the claims paid to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services. Payments made to members for direct reimbursement of health care benefits/services may be reported in "Claims: Other" if the carrier is unable to classify the service.

Data Submission Template – TME Non-claims Based Spending Fields

Capitation or Bundled Payments

- All non-claims based payments made to cover health care services. Examples include capitation, global budget, case rate, and episode-based payments.

Performance Incentive Payments

- All payments made to providers for achievement of specific pre-defined goals for quality, cost reduction, or infrastructure development (e.g., pay-for-reporting and pay-for-performance payments). This includes shared savings distributions and shared risk recoupments.

Population Health and Practice Infrastructure Payments

- All payments made to providers to develop capacity and practice infrastructure to help coordinate care, improve quality, and control costs. This can include EHR/HIT infrastructure payments, patient-centered medical home (PCMH) recognition payments, and primary care and behavioral health integration payments that are not reimbursable through claims.

Data Submission Template – TME Non-claims Based Spending Fields

Provider Salaries

- All payments for salaries of providers who provide health care services not otherwise included in claims and non-claims categories.

Recovery

- All payments recouped during the measurement year as the result of a prior review, audit, or investigation, regardless of the time period of the initial payment. This field should be reported as a negative number. Only report data in this column that is not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recovery amount in this column).

Other

- All other payments made pursuant to the carrier's contract with a provider that were not made based on a claim for health care benefits/services and that cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants, or other surplus payments. It may also include Medicaid Transformation Project (MTP) payments made directly by Carriers to providers. Only payments made to providers are to be reported; carrier administrative expenditures (including corporate allocations) are not included in TME.

Data Submission Template – TME Truncated Spending Fields

- The last two columns include the total truncated claims spending and the count of members with truncated claims.
- Each market has a separate truncation point

Insurance Category	Amount to Truncate on a Per Member Basis
Medicare Expenses for Non- Dual Eligible Members	$125,000
Medicaid Expenses for Non-Dual Eligible Members	$125,000
Commercial — Full Claims	$200,000
Commercial — Partial Claims, Adjusted	$200,000
Medicare Expenses for Medicare/Medicaid Dual Eligible	$125,000
Medicaid Expenses for Medicare/Medicaid Dual Eligible	$125,000

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Data Submission Template – TME Truncated Spending Fields

- All payments spent on members after truncation has been applied on a per member basis. This is the only column that will have truncated spending values made on a per member basis.
- Truncation should be applied to individuals' total spending, inclusive of all medical and pharmacy spending. For carriers reporting Insurance Category Code 4 (Commercial: Partial Claims), the member level truncation should be applied after estimates of carve-out spending have been made, so that truncation is being applied to an estimate of individual members' total claims spending

Data Submission Template – SD

SD01 code Carrier Code	SD02 year Reporting Year	SD03 code Market Code	SD04 code Large Provider Entity Code	SD05 non-negative integer Member Months	SD06 Non-negative integer Total Claims Truncated Spending	SD07 Non-negative number Standard Deviation PMPM

- A row for each large provider and a row for the carrier overall (code = 100)

Data Submission Template – SD
Calculating Standard Deviation

- Calculate average monthly spending amount of each member using claims based allowed amounts
  - Calculate after partial claims adjustments and truncation of member level spending
  - Non-claims based spending should be excluded
- Using the per-month average, multiple by the number of enrolled member months for that member
- Sum the values for all the members of the group you are calculating and divide by the total member months

Data Submission Template – SD
Calculating Standard Deviation

- Using the per member per month dollar amount to calculate the SD
- Use population SD (divide by N) for this calculation
  - Not sample SD (divide by N-1)

$$SD = \sqrt{\frac{\sum_i (X_i - \bar{X})^2}{N}}$$

Data Submission Template – LOB Enroll

LOB01 code Carrier Code	LOB02 Line of Business Category	LOB03 non-negative integer Year 2017 Member Months	LOB04 non-negative integer Year 2018 Member Months	LOB05 non-negative integer Year 2019 Member Months

- LOB02 is prefilled in for each line of business

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Data Submission Template – Rx Rebates

RXR01 code Carrier Code	RXR02 year Reporting Year	RXR03 code Insurance Category Code	RXR04 negative integer Medical Pharmacy Rebate Amount	RXR05 negative number Retail Pharmacy Rebate Amount	RXR06 negative number Total Pharmacy Rebate Amount (Optional)

- Rx Rebates should be reported as a negative
- RXR06 is there if medical and retail Rx cannot be separated out

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Data Submission Template – Reference Tables

- Insurance Category Codes
- Market Codes
- Line of Business Codes
- Age Band Codes
- Sex Codes
- Large Provider Entity Codes
- Carrier Codes
- Valid Years

Validation in Template

Unexpected Values

- If an unexpected code or value is put into a cell, the cell will turn red
  - For example, if a provider entity is spelled out instead of the code for that provider entity, the cell will turn red

Q&A and Insights

Thank you!

- More information can be found at the board website – https://www.hca.wa.gov/about-hca/health-care-cost-transparency-board
- Future office hours are scheduled for:
  - Tuesday, August 9 from 10:00am – 12:00pm.
  - Wednesday, August 24 from 9:00am – 11:00am.
  - Please reserve your time and submit all questions in advance at hcahcctboard@hca.wa.gov.