Health Care Cost Transparency Board
Board Book

December 15, 2021
2:00 p.m. – 4:00 p.m.
(Zoom Attendance Only)

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Agenda

TAB 1
In accordance with Governor Inslee’s Proclamation 20-28 et seq amending requirements of the Open Public Meeting Act (Chapter 42.30 RCW) during the COVID-19 public health emergency, and out of an abundance of caution for the health and welfare of the Board and the public, this meeting of the Health Care Cost Transparency Board meeting will be conducted virtually.
November meeting minutes

TAB 2
Health Care Cost Transparency Board meeting minutes

November 17, 2021
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 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.

Members present
Sue Birch, chair
Lois Cook
Bianca Frogner
Jodi Joyce
Sonja Kellen
Pam MacEwan
Molly Nollette
Mark Siegel
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent
John Doyle

Call to order
Sue Birch, Board Chair, called the meeting to order at 2:05 p.m.

Agenda items
Welcoming remarks
Ms. Birch welcomed the members.

Adoption of minutes
The minutes were adopted.

Presentation: Recap of last meeting discussions
Michael Bailit of Bailit Health reviewed the discussion and decisions of the September Board meeting. The Board finalized the cost benchmark at 3.2% for 2022-23, 3.0% for 2024-25, and 2.8% for 2026. The Board also discussed strategies to ensure the accuracy and reliability of measurement and endorsed two strategies: the application of confidence intervals, and truncation above a to-be-defined threshold for very high-cost members.
Presentation: Using risk adjustment when determining benchmark performance

Michael Bailit of Bailit Health gave a presentation about the use of risk adjustment to account for changes in population health status that might impact spending growth. Also known as clinical risk adjustment, available models use claim and encounter data such as diagnoses, procedures, and prescription drugs. For purposes of benchmark reporting, risk adjustment is performed at the carrier and provider level, and not the state or market level.

HB 2457 requires Washington's benchmark to consider health status, utilization, intensity of services, and differences in input prices. Mr. Bailit shared that adjusting the benchmark for utilization, intensity of services, and differences in input pricing would not be feasible or desirable, and that no other state adjusts the benchmark for these factors. The Advisory Committee on Data Issues recommended that these factors be addressed in the cost driver analysis rather than benchmark risk adjustment. Ms. Birch asked about the impact of the pandemic on utilization and the benchmark, and Mr. Bailit shared that these years would be recognized as an anomaly in reporting and that states are not changing methodology. One Board member shared her opinion that if all the listed risk adjustments were made to the benchmark there would be nothing of value left.

Mr. Bailit then discussed risk adjustment for health status, reporting that risk scores have been growing every year in a way that does not appear correlated with changes in population health status. He shared the experience of both Massachusetts and Rhode Island that have observed steadily rising risk scores unexplained by demographic trends or changes in disease prevalence. The effect can be to disguise increases in the spending increases in population risk.

Mr. Bailit presented the Board with four options to risk adjust health data: age/sex adjustment performed by the payers, age/sex adjustment performed by the state, clinical risk adjustment normalization performed by payers, and clinical risk adjustment normalization performed by the state. One Board member expressed concern over oversight and consistency if payers submit their own risk adjusted data. Mr. Bailit responded that results were not as “clean” as the state performing one method for all payers and requiring payers to use the same software/method year after year provided a more consistent comparison.

Mr. Bailit also shared feedback from the Advisory Committee on Data issues that the option of age/sex adjustment performed by the state received the most support, but that several Committee members preferred that the state performs clinical adjustment normalization on all payer data. Staff shared that this option was not feasible within current resources.

Design Decision: Accounting for utilization, service intensity and regional pricing

The Board decided not to adjust the benchmark for utilization, intensity of services and difference in input pricing, and expressed an expectation that these factors would be present in the cost driver analysis.

Design Decision: How to risk adjust data

The Board decided to select age/sex adjustment performed by the state. The Board directed that staff explore future adoption of clinical risk adjustment normalization performed by the state, as resources become available.

Public Comment

Ms. Birch called for comments from the public.
Vishal Chaudry, Chief Data Officer, HCA, updated the Board on national developments related to state All Payer Claims Databases (APCD). Specifically, the Federal No Surprises Act creates an advisory committee on the pathway to submit self-insured data to state APCDs. Mr. Chaudry expressed his opinion that the Board creates a shared incentive for all payers to participate in the database.

**Presentation: Key questions to address for provider level reporting**

January Angeles of Bailit Health presented the Board with information related to provider level reporting, including how members should be attributed to clinicians, and how clinicians should be organized into provider entities for reporting. She reminded the Board that all cost benchmark states report on large provider entities. Spending that cannot be attributed to a particular entity will still be captured in the data call and in the statewide and market measures. Members may be attributed through a common methodology, or through each purchaser's own attribution methodology. Ms. Angeles shared that all other states use primary care providers (PCP) attribution, leaving the methodology up to the insurer. Massachusetts and Oregon add specificity of reporting in a hierarchy by member selection, contract arrangement, and utilization.

The Board asked several questions about attributing through PCP, recognizing that many members have no PCP, have no utilization, or do not engage PCPs in seeking care.

Ms. Angeles also summarized the feedback from the Advisory Committee on Data issues that a standard methodology would be difficult for carriers, but that there was value in material consistency in the attribution of methodologies. One Committee member suggested that the state more specifically define and provide a primary care taxonomy or procedure codes. The option that received the most support was to adopt the methodology used in Massachusetts and Oregon of using individual payer methodology with a reporting hierarchy.

Ms. Birch asked what other attribution resources were available in the state, or what else might be considered. The Board discussed attribution related to the Department of Labor and Industries spend, and issues of PCP attribution related to access and accountability. One Board member asked for clarification on the methodologies used by the Washington Health Alliance and One Health Port.

Ms. Angeles shared the two basic methods for organizing clinicians into large provider entities: using a state-wide provider directory (as in Massachusetts) or using a pre-defined list of providers and requesting payers report on them through information in provider contracts. Ms. Angeles shared that Oregon intends to use their data call to assist in building a provider directory and has asked payers to report provider organization by their tax identification numbers (TIN). States without a provider directory, including Rhode Island and Connecticut, perform attribution based on providing payers with a list of identified providers and asking payers to report on them based on existing contracts.

The Advisory Committee on Data Issues felt it was important to identify large provider entities based on a framework of cost accountability.

**Design Decision: How to attribute patients to clinicians**

The Board deferred the decision and requested staff to provide additional information on available attribution methods.
Design Decision: How to organize clinicians into large provider entities
The Board did not consider this issue and deferred the topic to the next meeting.

Adjournment
Meeting adjourned at 4:00 p.m.

Next meeting
Wednesday, December 15, 2021
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.
Topics for today

- Recap of recommendations and discussions from the last meeting.
- Attribution in Washington Health Care Authority programs.
- Finalizing Board recommendations on attribution.
- Cost growth benchmark accountability.
Recap of last meeting discussions

TAB 3
Recap of decisions from the last meeting
Board decisions around risk-adjustment

- The Board decided to address the legislative mandate to account for utilization, service intensity and regional pricing differences in cost growth driver analyses.
- Based on current timing and capacity, the Board determined that HCA should perform age/sex risk adjustment using standard weights developed by the HCA.
- The Board also recommended that for the future, HCA consider performing clinical risk adjustment normalization using data from the All-Payer Claims Database, as resources allow.
Attribution in Health Care Authority programs

TAB 4
Attribution in Health Care Authority programs
Reminder of decision points on attribution

To facilitate the reporting of spending data, payers need instructions on how to do two levels of attribution:

1. Member to clinician
2. Clinician to large provider entity
Board discussion around member attribution (continued)

- Staff presented two options for attributing *members* to *clinicians*:
  1. Require insurers to apply a *standard attribution methodology* that is primary care-based.
  2. Allow insurers to use their *own attribution methodology* (either based on their value-based payment contracts or on internal quality initiatives).

- All states use the second approach but ask insurers to use a primary care-based attribution model.
  - Oregon and Massachusetts, allow insurers to use their own primary care-based attribution methodology, and suggest following a hierarchy that prioritizes primary care provider selection, followed by contracting arrangements, and then primary care utilization.
Some Board members expressed concerns about using a primary care-based attribution methodology, noting that:

- It could penalize primary care providers (PCPs) who may not play a role in the individual’s care.
- There is no accountability for non-PCPs that may be contributing to high and rising costs.
Considerations for defining the attribution methodology

It is standard for attribution in total cost of care (TCOC) contracts to be primarily, if not exclusively, PCP-based.
The Washington Health Alliance attribution methodology

- The WHA applies a PCP-based attribution “based on the concept that the PCP is the clinician who is primarily responsible for a patient’s preventive care management.”

- Each patient is assigned to a single PCP based on the following hierarchy:
  1. Greatest number of Evaluation and Management (E&M) visits.
  2. Highest sum of relative value units associated with the services based on the E&M visits in #1 above.
  3. Most recent service date.
Staff Assessment of Feasibility of Using the Washington Health Alliance Methodology

- The attribution methodology has been vetted with clinical leaders and payers across the state.
  - To the extent that the Board wishes to require payers to use a standard methodology, this methodology has the greatest likelihood of gaining acceptance.
- However, some payers would likely have difficulty implementing the second level of the attribution methodology which relies on proprietary software.
Staff recommendations on member attribution

- Staff recommend allowing insurers to use their own primary care-based attribution methodology that, if possible, prioritizes:
  1. Member selection
  2. Contract arrangement
  3. Utilization

- This is in line with recommendations made by the Advisory Committee on Data Issues.

- It is also based on staff assessment that this would strike the best balance between having some level of standardization and operational feasibility for insurers.
Design decision: Member attribution methodology

Does the Board wish to require that payers attribute members to clinicians based on:

- Payers’ own methodologies?
- Payers’ own methodologies, that, if possible, prioritizes member selection, contract arrangements, and then utilization?
- A common methodology, specifically the Alliance methodology?
Public comment
Provider entities accountable for total medical expenditures

TAB 5
Provider entities accountable for total medical expenditures
Provider entities accountable for total medical expenditures

While patients are attributed to a specific provider, the accountability for total medical expenditures (TME) falls to the large provider entity, not to the individual clinician.

TME-accountable provider entities typically include those that could (in theory) take on total cost of care contracts because they:
- Include PCPs who direct a patient’s care.
- Can exert influence over where a patient receives care.

Provider entities do not have to be in actual TCOC contracts to be TME-accountable.
### Health Systems
- With contracted and/or employed PCPs
- May include combination of hospitals, medical groups, and ancillary providers

### Hospitals
- Not part of health systems
  - with PCPs
  - w/o PCPs

### Medical Groups
- Not part of health systems
  - with PCPs
  - w/o PCPs

### Independent Physician Associations (IPAs)
- Network of independent physician practices, including PCPs

### Free-Standing Ancillary Providers
- Not accountable for TME

### Solo / Small Providers (not PCP)
- Not accountable for TME

### Post-Acute Providers
- Not accountable for TME

### Pharmacy
- Not accountable for TME

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**Accountable for TME**

**Not accountable for TME**

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[Washington State Health Care Authority]
Board discussion around clinician attribution

Staff presented two options for attributing clinicians to large provider entities:

1. Attribution based on a statewide provider directory (Massachusetts and Oregon approach).
2. Attribution based on contracting arrangements (Connecticut and Rhode Island approach).

Board members discussed available options for developing a provider directory including:

- The Health Insurance Exchange’s provider directory.
- A database maintained by the Office of the Insurance Commissioner that includes all contracted providers and their NPI numbers.
- Directories maintained by OneHealthPort and the WHA.
The Washington Health Alliance provider directory

- The WHA maintains a roster of providers that are assigned to clinics, some of which are assigned to larger medical groups or health systems.

- The rosters are updated by providers themselves, some of whom provide more frequent updates than others.

- Staff are reviewing the WHA’s guidelines for external use of Alliance intellectual property to determine the feasibility of using the WHA’s provider directory.
Options for attributing clinicians to a large provider entity

1. Provide insurers with a provider directory that details organizational affiliations so they can perform the attribution.

2. Instruct insurers to attribute clinicians based on their contracting arrangements with large provider entities.
   - Insurer contracts should specify which clinicians are part of the contract with the large provider entity.
## Pros and cons of approaches to clinician attribution

<table>
<thead>
<tr>
<th>Option</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Option 1:</strong> Insurers do attribution based on the Alliance provider directory</td>
<td>Clear delineation of entities to which clinicians “belong”</td>
<td>Feasibility depends on terms of licensing agreement for provider directory</td>
</tr>
<tr>
<td><strong>Option 2:</strong> Insurers do attribution based on contracting arrangement</td>
<td>More closely aligned with payer and provider arrangements around accountability</td>
<td>Definition of which clinicians belong to which provider entity may vary from payer to payer or by product line</td>
</tr>
</tbody>
</table>
Design decision:
Clinician attribution

- Staff recommend Option 1 if determined to be feasible, with Option 2 as the fallback should terms for using the Alliance’s provider directory not allow for Option 1.

- Does the Board support moving forward with the above recommendation?
Cost growth benchmark accountability

TAB 6
Cost growth benchmark accountability
Legislative language on benchmark accountability

“The board shall provide analysis of the factors impacting these trends in health care cost growth and, after review and consultation with identified entities, shall identify those health care providers and payers that are exceeding the health care cost growth benchmark.”
Questions for the Board to consider

What process(es) should be in place for reporting cost growth benchmark performance?

How should performance be reported?
  ▶ Report only whether the entity met or exceeded the benchmark?
  ▶ Report entity’s cost growth?

How much and what types of communication should accompany the cost trends report?

What other activities, if any, should accompany the release of the cost trends report?
Massachusetts’ accountability process

**Step 1: Benchmark**
Each year, the process starts by setting the annual health care cost growth benchmark.

**Step 2: Data Collection**
CHIA then collects data from payers on unadjusted and health status adjusted total medical expense (HSA TME) for their members, both network-wide and by primary care group.

**Step 3: CHIA Referral**
CHIA analyzes those data and confidentially refers to the HPC payers and primary care providers whose increase in HSA TME is above “bright line” thresholds (e.g., greater than the benchmark).

**Step 4: HPC Analysis**
HPC conducts a confidential review of each referred provider and payer’s performance across multiple factors.

**Step 5: Decision to Require a PIP**
After reviewing all available information, including confidential information from payers and providers under review, the HPC Board votes to require a PIP if it identifies significant concerns and finds that a PIP could result in meaningful, cost-saving reforms. The entity's identity is public once a PIP is required.

**Step 6: PIP Implementation**
The payer or provider must propose the PIP and is subject to ongoing monitoring by the HPC during the 18-month implementation. A fine of up to than $500,000 can be assessed as a last resort in certain circumstances.

Topical material

TAB 7
## List of Potential Carriers for Benchmark Performance Data Collection
### DRAFT as of 10/26/21

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Covered Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kaiser Foundation Grp</strong></td>
<td></td>
</tr>
<tr>
<td>Kaiser Found Hlth Plan of the NW</td>
<td>93,720</td>
</tr>
<tr>
<td>Kaiser Found Hlth Plan of WA Options</td>
<td>153,315</td>
</tr>
<tr>
<td>Kaiser Foundation Hlth Plan of WA</td>
<td>430,146</td>
</tr>
<tr>
<td><strong>UnitedHealth Grp</strong></td>
<td></td>
</tr>
<tr>
<td>All Savers Ins Co</td>
<td>6,261</td>
</tr>
<tr>
<td>Pacificare Life &amp; Hlth Ins Co</td>
<td>603</td>
</tr>
<tr>
<td>Sierra Hlth &amp; Life Ins Co Inc</td>
<td>2,599</td>
</tr>
<tr>
<td>UnitedHealthcare Ins Co Inc</td>
<td>Not available</td>
</tr>
<tr>
<td>UnitedHealthcare of OR Inc</td>
<td>117,916</td>
</tr>
<tr>
<td>UnitedHealthCare of WA Inc</td>
<td>273,312</td>
</tr>
<tr>
<td><strong>Premera Blue Cross Grp</strong></td>
<td></td>
</tr>
<tr>
<td>Lifewise Assur Co</td>
<td>259,939</td>
</tr>
<tr>
<td>LifeWise Hlth Plan of WA</td>
<td>38,580</td>
</tr>
<tr>
<td>Premera Blue Cross</td>
<td>614,625</td>
</tr>
<tr>
<td><strong>Molina Healthcare Inc Grp</strong></td>
<td></td>
</tr>
<tr>
<td>Molina Healthcare of WA Inc</td>
<td>977,248</td>
</tr>
<tr>
<td><strong>Cambia Health Solutions Inc</strong></td>
<td></td>
</tr>
<tr>
<td>Asuris NW Hlth</td>
<td>38,840</td>
</tr>
<tr>
<td>BridgeSpan Hlth Co</td>
<td>2,169</td>
</tr>
<tr>
<td>Regence BCBS of OR</td>
<td>62,511</td>
</tr>
<tr>
<td>Regence Blue Shield</td>
<td>439,995</td>
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<tr>
<td>Regence Blue Shield of ID Inc</td>
<td>1,282</td>
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<tr>
<td><strong>Centene Corp Grp</strong></td>
<td></td>
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<tr>
<td>Coordinated Care Corp</td>
<td>37,036</td>
</tr>
<tr>
<td>Coordinated Care of WA Inc</td>
<td>204,061</td>
</tr>
<tr>
<td>Health Net Hlth Plan of OR Inc</td>
<td>902</td>
</tr>
<tr>
<td>WellCare Hlth Ins Co of WA Inc</td>
<td>80</td>
</tr>
<tr>
<td>WellCare of WA Inc</td>
<td>1,442</td>
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<tr>
<td><strong>Community Hlth Network Grp</strong></td>
<td></td>
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<tr>
<td>Community Health Plan of Washington</td>
<td>253,014</td>
</tr>
<tr>
<td><strong>Anthem Inc Grp</strong></td>
<td></td>
</tr>
<tr>
<td>Amerigroup Washington Inc</td>
<td>208,826</td>
</tr>
<tr>
<td>Unicare Life &amp; Hlth Ins Co</td>
<td>Not available</td>
</tr>
<tr>
<td><strong>Humana Grp</strong></td>
<td></td>
</tr>
<tr>
<td>Arcadian Hlth Plan Inc</td>
<td>54,728</td>
</tr>
<tr>
<td>Humana Ins Co</td>
<td>103,917</td>
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<tr>
<td><strong>CVS Grp</strong></td>
<td></td>
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<tr>
<td>Aetna Better Hlth of WA Inc.</td>
<td>22,235</td>
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<tr>
<td>Aetna Hlth &amp; Lif Ins Co</td>
<td>Not available</td>
</tr>
<tr>
<td>Aetna Hlth Inc PA Corp</td>
<td>3,121</td>
</tr>
<tr>
<td>Carrier</td>
<td>Covered Lives</td>
</tr>
<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>Health Alliance NW Hlth Plan</td>
<td>11,872</td>
</tr>
<tr>
<td>Cigna Hlth &amp; Life Ins Co</td>
<td>Not available</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4,414,295</td>
</tr>
</tbody>
</table>

NOTES:

- List includes group and individual markets for Accident and Health LOB as Reported by OIC.
- Membership across all listed insurers with enrollment data comprise 66% of total membership if including limited benefit plans (e.g., prescription, dental, vision), and 96% of membership if excluding limited benefit plans.
- Medicaid managed care plans include:
  - Amerigroup – 211,402
  - Community Health Plan of Washington – 221,798
  - Coordinated Care of Washington – 187,972
  - Molina Healthcare of Washington – 915,234
  - UnitedHealthcare Community Plan – 224,943

## List of Potential Providers for Health Care Cost Growth Benchmark Measurement

**DRAFT as of 10/26/21**

<table>
<thead>
<tr>
<th>Community Health Centers</th>
<th>Medical Groups and IPAs</th>
<th>Health Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Columbia Basin Health Association</td>
<td>1. Allegro Pediatrics</td>
<td>1. Astria Regional Medical Center</td>
</tr>
<tr>
<td>2. Columbia Valley Community Health</td>
<td>2. The Vancouver Clinic</td>
<td>2. Confluence Health</td>
</tr>
<tr>
<td>4. Community Health Association of Spokane</td>
<td></td>
<td>4. Harbor Regional Health</td>
</tr>
<tr>
<td>5. Community Health Center of Snohomish County</td>
<td></td>
<td>5. Inland Northwest Health Services</td>
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<tr>
<td>6. Community Health of Central Washington</td>
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<tr>
<td>7. Country Doctor Community Health Centers</td>
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<tr>
<td>8. Cowlitz Family Health Center</td>
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<tr>
<td>9. Family Health Centers</td>
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<tr>
<td>10. HealthPoint</td>
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<tr>
<td>11. International Community Health Services</td>
<td></td>
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<tr>
<td>12. Lewis County Community Health Services (Valley View Health Center)</td>
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<td></td>
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<tr>
<td>13. Moses Lake Community Health Center</td>
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<td></td>
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<tr>
<td>14. Neighborcare Health</td>
<td></td>
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<tr>
<td>15. NEW Health Programs Association</td>
<td></td>
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<tr>
<td>17. Peninsula Community Health Services</td>
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<tr>
<td>18. Sea Mar Community Health Centers</td>
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<tr>
<td>19. Seattle-King County Public Health Dept (Health Care for the Homeless Network)</td>
<td></td>
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<tr>
<td>20. Tri-Cities Community Health</td>
<td></td>
<td></td>
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<tr>
<td>21. Unity Care Northwest</td>
<td></td>
<td></td>
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<tr>
<td>22. Yakima Neighborhood Health Services</td>
<td></td>
<td></td>
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<tr>
<td>23. Yakima Valley Farm Workers Clinic</td>
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<td></td>
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<td>7. Kaiser</td>
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<td></td>
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<td>8. Kittitas Valley Healthcare</td>
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<td></td>
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<td>9. Legacy Health</td>
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<td></td>
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<td>10. LifePoint Health</td>
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<tr>
<td></td>
<td></td>
<td>11. Mason General Hospital and Family of Clinics</td>
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<td></td>
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<td>12. MultiCare Health</td>
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<td></td>
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<td>13. Olympic Medical Center</td>
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<td></td>
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<td>14. OptumCare</td>
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<td></td>
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<td>15. Overlake Medical Center &amp; Clinics</td>
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<tr>
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<td>16. Pacific Medical Centers</td>
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<td></td>
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<td>17. PeaceHealth</td>
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<td>18. Providence Health</td>
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<td>19. Skagit Regional Health</td>
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<td>20. Swedish Health Services</td>
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<tr>
<td></td>
<td></td>
<td>21. UW Medicine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>22. Virginia Mason Franciscan Health</td>
</tr>
</tbody>
</table>
NOTES:
- Focuses on large provider entities that provide primary care and could enter into total cost of care contracts.
- The list of Community Health Centers does not include four that have less than 5,000 covered lives: (1) Seattle Indian Health Board Inc; (2) Mattawa Community Medical Clinic; (3) The NATIVE Project; and (4) Colville Confederated Tribes.
- Some health systems include several medical centers that may be worth reporting on separately.