Washington State Health Care Authority

Advisory Committee on Data Issues

September 8, 2022

Washington State Health Care Authority

Advisory Committee on Data Issues
Meeting Materials Book

September 8, 2022
10:00 a.m. – 12:00 p.m.

(Zoom Attendance Only)

Agenda and Presentations

Index

Washington State Health Care Authority

Agenda

TAB 1

Washington State Health Care Authority

September 8, 2022
10:00 a.m. – 12:00 p.m.
Zoom Meeting

Advisory Committee on Data Issues
AGENDA

Committee Members:					
☐	Megan Atkinson	☐	Jerome Dugan	☐	Ana Morales
☐	Amanda Avalos	☐	Chandra Hicks	☐	Hunter Plumer
☐	Allison Bailey	☐	Leah Hole-Marshall	☐	Mark Pregler
☐	Jonathan Bennett	☐	Lichiou Lee	☐	Russ Shust
☐	Bruce Brazier	☐	Josh Liao	☐	Julie Sylvester
☐	Jason Brown	☐	David Mancuso	☐	Mandy Stahre

AnnaLisa Gellermann

Time	Agenda Items	Tab	Lead
10:00 – 10:05 (5 min)	Welcome, call to order, and roll call	1	AnnaLisa Gellermann Health Care Authority
10:05 – 10:10 (5 min)	Approval of May meeting minutes	2	AnnaLisa Gellermann Health Care Authority
10:10 – 10:30 (20 min)	RAND Report 4: the Public Report	3	Ross McCool Health Care Authority
10:30 – 11:00 (30 min)	Washington hospital costs, price, and profit analysis	4	John Bartholomew and Tom Nash Consultants
11:00 – 11:10 (10 min)	Public comment		AnnaLisa Gellermann Health Care Authority
11:10 – 11:40 (30 min)	Washington hospitals: adjustment needed for hospital costs and payment comparison	5	Jonathan Bennett and Albert Froling Washington State Hospital Association
11:40 – 11:55 (15 min)	Introduction to primary care target and measurement	6	AnnaLisa Gellermann Health Care Authority
11:55 – 12:00 (5 min)	Wrap-up and adjournment		AnnaLisa Gellermann Health Care Authority

Subject to Section 5 of the Laws of 2022, Chapter 115, also known as HB 1329, the Committee has agreed this meeting will be held via Zoom without a physical location.

Washington State Health Care Authority

May meeting minutes

TAB 2

Advisory Committee on Data Issues meeting minutes

May 5, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
10:00 a.m. – 12:00 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

Allison Bailey
Amanda Avalos
Bruce Brazier
David Mancuso
Hunter Plumer
Jason Brown
Jonathan Bennett
Josh Liao
Julie Sylvester
Leah Hole-Marshall
Lichiou Lee
Mark Pregler
Megan Atkinson
Scott Juergens

Members absent

Ana Morales
Jerome Dugan

Agenda items

Welcome, Roll Call, Agenda Review

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 10:02 a.m.

Approval of Minutes

AnnaLisa Gellermann provided a recap of the March Committee meeting, and the Committee approved the minutes.

Topics for Today

Topics include truncation reports and recommendations, an update on the benchmark data call technical manual, a presentation on hospital cost in Colorado, and discussion of a potential grant proposal.

Recap of March Discussion

AnnaLisa Gellermann, HCA

Ms. Gellermann presented a recap of the March meeting which included an OnPoint presentation of price and utilization in the commercial market between 2016 and 2019, and a review of data on spending and spending growth in Washington. The committee suggested that future analyses should identify impact of additional mandated services and new drug availability. The committee also reviewed recommendations for benchmark performance assessment including age banding and point in time age progression and had a discussion of truncation pending results of the OnPoint analysis requested by HCA staff.

Truncation report and recommendations

Ross McCool, HCA Staff

Mr. McCool reminded committee members that the Board has determined to truncate high-cost outlier spending when assessing performance against the benchmark for payers and providers. Based upon a recommendation by the Data Committee, staff commissioned Onpoint to conduct a truncation analysis using data from the WA-APCD. Mr. McCool shared the specifications for the analysis, and the approaches used by Onpoint to evaluate truncation points. He then presented the results of the truncation study prepared for the Board upon recommendation by the Data Committee. Mr. McCool then presented the staff recommendation to adopt truncation points removing the top ~5% of spending: Commercial at $200k, Medicaid at $125K, and Medicare at $125K.

One committee member asked why truncation would be used at the payer and provider level but not at the state level. Mr. McCool responded that truncation was used where it would most impact reporting. Michael Bailit of Bailit Health added that it was the practice of other states, largely because change of frequency or incidence of high-cost outliers would be greater at the provider and payer level because populations are smaller and shift from year to year.

One committee member asked a question about the truncation procedure. Mr. McCool responded that in the commercial market, members would be counted but costs truncated at the 250K level.

One committee member asked for clarification about the purpose of truncation. Mr. McCool responded that truncated values would be used to ensure that high-cost outliers would not be unduly shifting the appearance of spending growth to one payer or provider. The goal is to hold them accountable fairly for their spending trends.

One member asked why commercial has a different truncation dollar amount than Medicaid and Medicare. Mr. McCool responded that the percentages of heath care spending removed was similar at around 5%, which resulted in the higher level in the commercial sector.

One committee member asked if Washington's long-term care expenditures were in the WA-APCD. Vishal Chaudry, CDO of HCA, responded that they were not.

One committee member agreed that the recommendation was reasonable, especially considering that it would be combined with other risk adjustment mechanisms such as age banding. Several other members agreed with the staff proposal. When specifically asked for concerns with or opposition to the recommendation, no committee member responded. One committee member asked for additional time to comment, and Ms. Gellermann indicated that was fine, so long as comments were received within two days to allow them to be included in the Board's materials.

Benchmark data call technical manual and updates

January Angeles, Bailit Health

Ms. Angeles updated the committee on the benchmark data call, including identifying submitters, data specifications, the data submission process, and the data submission template. Ms. Angeles discussed how

Washington's data specifications compare to other states. She shared the plan for distributing the initial draft of the manual for feedback, emphasizing the importance of review by the data analysts who would be working on the request. It was suggested that feedback should focus on identifying areas that need further clarification. Ms. Angeles presented a list of the insurers required to submit data, and a draft list of provider entities for which insurers must submit data. She described the support HCA was preparing for data submitters, including a technical webinar, office hours for questions, and additional one-on-one calls as needed.
One committee member asked if the committee could receive a copy of the manual to provide review, and what quality assurance steps were built into the process to ensure accurate and clean information. Ms. Angeles responded that submitters would be educated on the submission, and that HCA would conduct a data validation process including early review of submissions, an initial analysis of trends across service categories and from year to year looking for anomalies, and a series of validation calls with submitters to ensure data was submitted correctly, Ms. Gellermann indicated the manual would be provided to the Data committee prior to release.
One committee member asked where Ms. Angeles had observed in other states were the back and forth with submitters. Ms. Angeles responded it was often the issue of getting membership data submitted correctly, and that partial claims are generally confusing (citing a comment in chat by Sarah Bartelmann, Oregon). She also cited issues particular to Medicaid Managed Care organizations, where some services might need special consideration.
One committee member shared that quality of submitted data was often a concern, taking quite a bit of QA and back-and-forth with submitters. And she stated that the process often needed extensive 1:1 engagement with submitters, and that learning to respond was an iterative process year after year.

Public Comment

There was no public comment.

The Colorado Story: hospital cost analysis

John Bartholomew and Tom Nash, consultants

Mr. Bartholomew and Mr. Nash presented an analysis create by the Colorado Department of Health Care Policy and Financing in response to escalating hospital costs in that state. Per Mr. Bartholomew, Colorado created a hospital provider tax that increased hospital reimbursement for Medicaid services and created a state funding source for the Affordable Care Act Medicaid expansion. The assumption was that higher Medicaid rates and lowered uninsured and bad debt would result in decreased hospital costs. However, analysis showed that Colorado hospital profits grew at 50%+ more than the national average between 2009-2018.

Mr. Bartholomew shared the analysis methodology, based on using Medicare cost report data to observe trends across hospital types and geographic areas. The analysis created metrics based on net patient revenue, hospital-only operating cost, and net income. He shared both visual exhibits including a scatterplot of Colorado hospitals including net income/profit, and trending reports for cost, price, and profit.

Committee members were asked for feedback on the methodology of the analysis, and how it might work in Washington state. It was clarified that a general, statewide analysis of hospital reports is not conducted by HCA.

One committee member reported that based on what they pay for hospital care, there was a big difference between Colorado and Washington rates. She said that it would be interesting to understand the difference in rates between markets.

Grant proposal: review and feedback

AnnaLisa Gellermann, HCA staff

Ms. Gellermann provided the committee a draft copy of a proposed grant in development with the Peter G. Peterson Foundation and Gates Ventures. Per Ms. Gellermann, the grant is being developed with the intention of providing data analytic resources and policy development partnership and could form part of a sustainability plan after the end of the Peterson/Milbank sustainability grant which will sunset at the end of December 2022.

Ms. Gellermann described the grant as providing partnership between HCA staff and external data analysts, in support of the Board's charge to perform analyses of cost drivers and provide insight into potential cost mitigation recommendations.

Committee members were asked for feedback on the potential grant. One committee member shared that use of external partners could cause regulatory barriers, and authority to obtain data would be important to consider.

Wrap Up and Adjournment

Meeting adjourned at 12:00 p.m.

Next meeting

The meeting scheduled for Thursday, July 8, 2022, was cancelled

Washington State Health Care Authority

RAND Report 4: the public report

TAB 3

RAND Report on Hospital Prices: Findings from Round 4

Report can be found here:

Whaley, C. M., Briscombe, B., Kerber, R., O'Neill, B., & Kofner, A. (2022). *Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative*. RAND Corporation. https://www.rand.org/pubs/research_reports/RRA1144-1.html

Washington State Health Care Authority

RAND's Purpose for Study

- RAND is a nonprofit research organization that provides research and analysis for public policy challenges
- Employers have a responsibility for health care costs
- But there is little access to useful hospital pricing data
- Wanted to add in some transparency
- Using data from states' APCDs and voluntary submission from self-insured employers

Washington's Involvement

- In 2021 HBE and HCA jointly contracted to participate in RAND's round 4 analysis
- WA-APCD data was provided to RAND for 2018 through 2020
- Cost Board did not request a "private" report but does have the Washington specific repricing information
- HBE requested a "private" report to isolate the individual market

The Study Sample

- Includes data from all U.S. states except Maryland between 2018 & 2020
- 4,102 hospitals
  - $78.8 billion overall
  - $7.6 billion in professional spending
  - $36.5 billion on inpatient facilities
  - $34.7 billion on outpatient facilities
- 4,091 Ambulatory Surgical Centers (ASC)
  - $2.0 billion

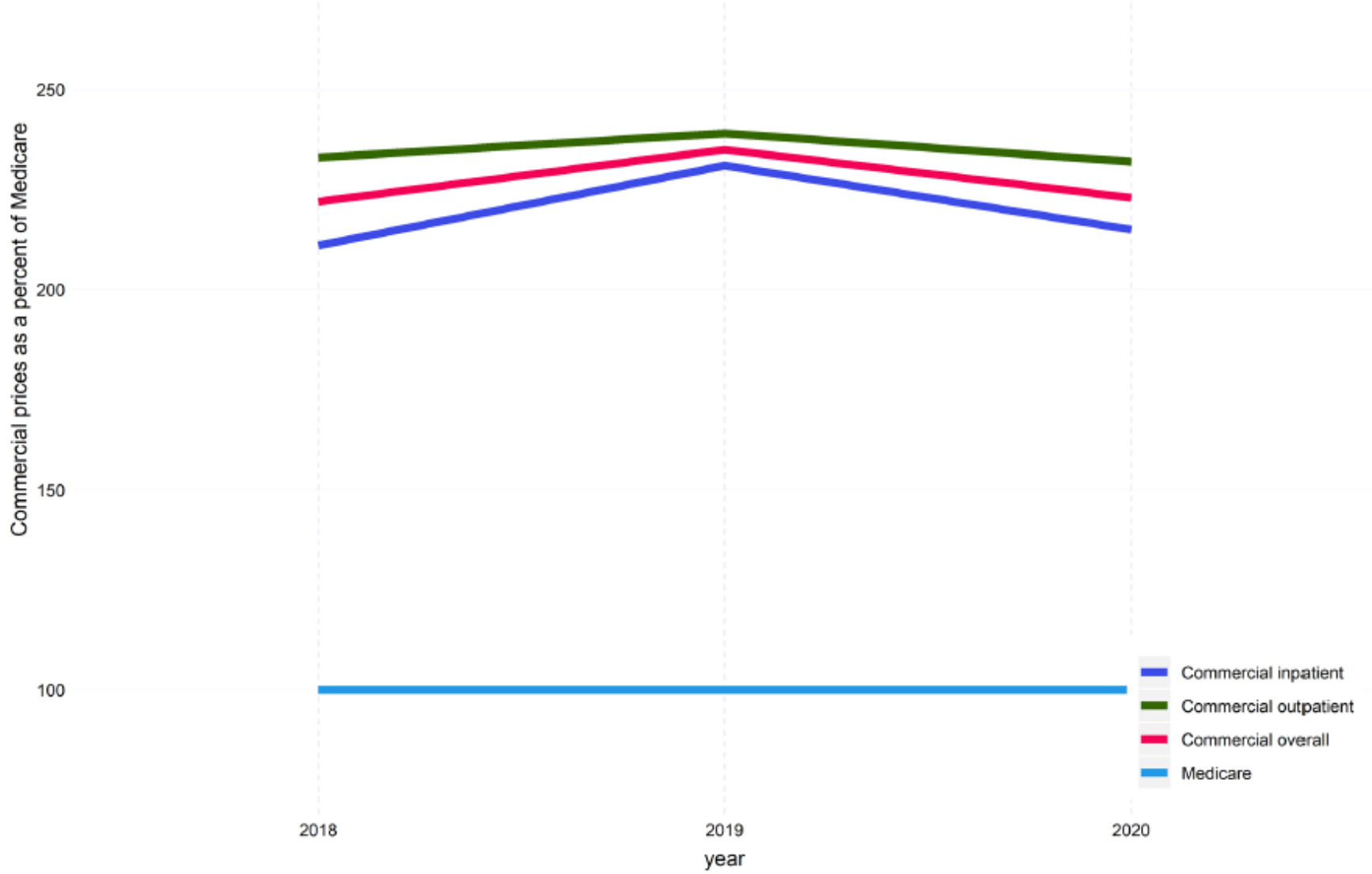
Study Definitions

- Price
  - Allowed amounts which includes payments by health plan and patient (e.g., deductibles, copayments, & coinsurance)
- Standardized Prices
  - Total allowed amount divided by number of standardized units of service based on MS-DRG. A heart transplant with complications has 27.1 standard units of service
- Relative Prices Using Medicare as a Benchmark
  - Ratio of allowed amount from health plan divided by Medicare allowed amount

Some Limitations

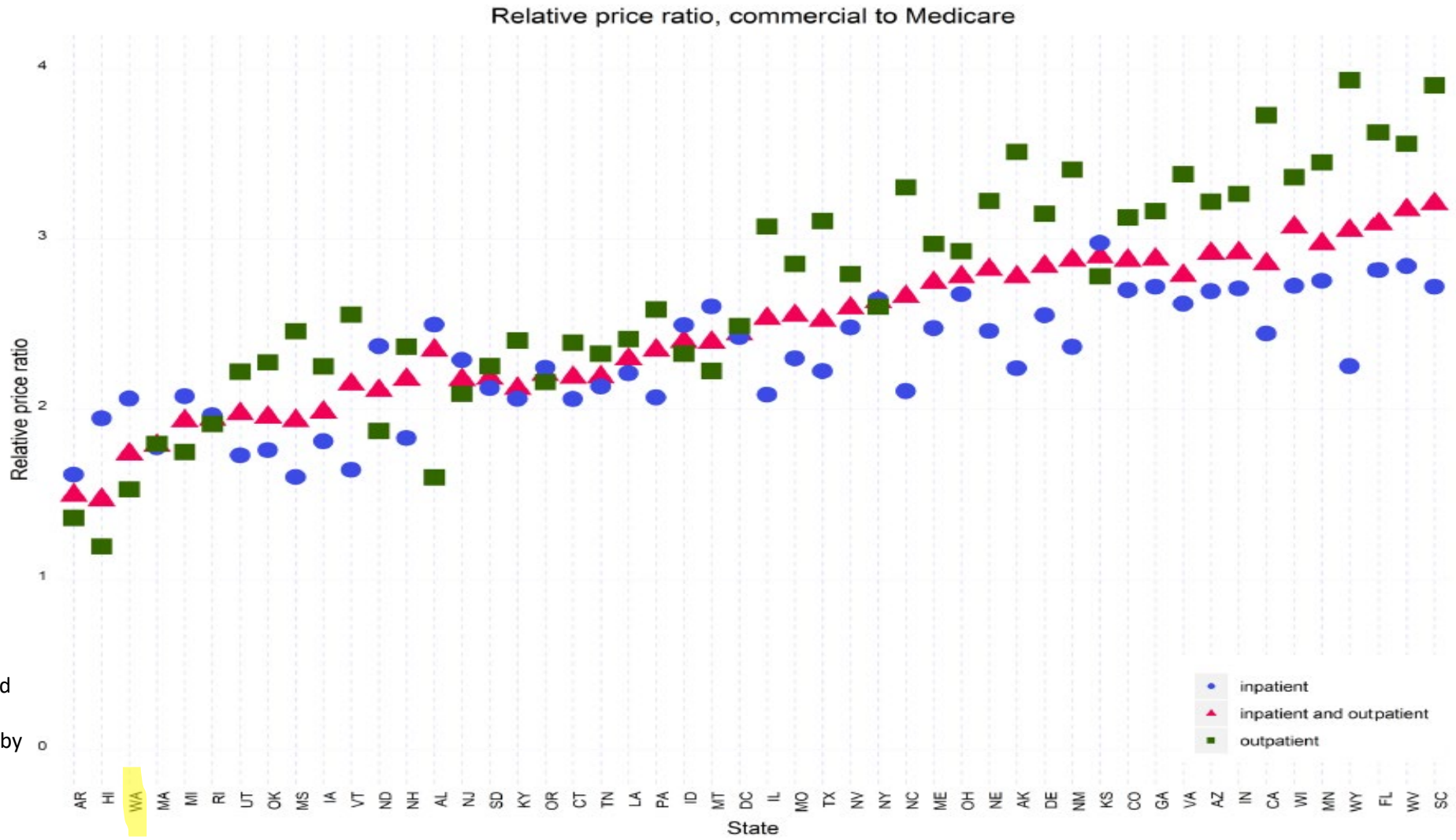
- Data submission was not required
  - Data is only from those who volunteered to be included
- No distinction between in-network and out-of-network prices
- Difficulty in assigning providers to hospitals and hospitals to systems (missing servicing provider, etc.)
- Medicare case mix-adjustment weights may be inappropriate
- No non-claims based payments

RAND Report: All-State Trends in Relative Prices



From "Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative," by C. M. Whaley, et al., 2022, RAND Corporation, p. 12. Copyright 2022 by RAND Corporation.

RAND Report: Relative Prices by State, 2020



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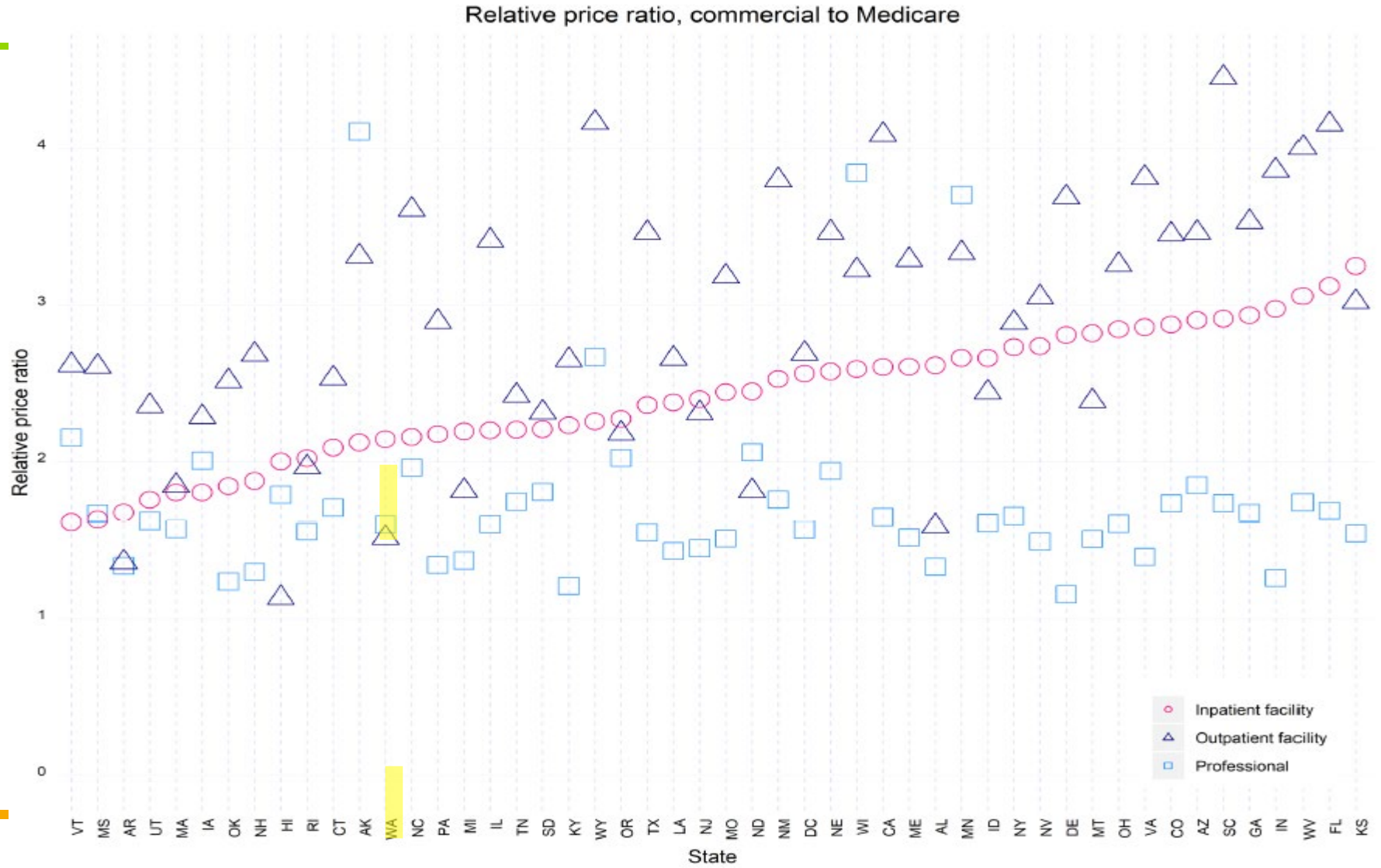
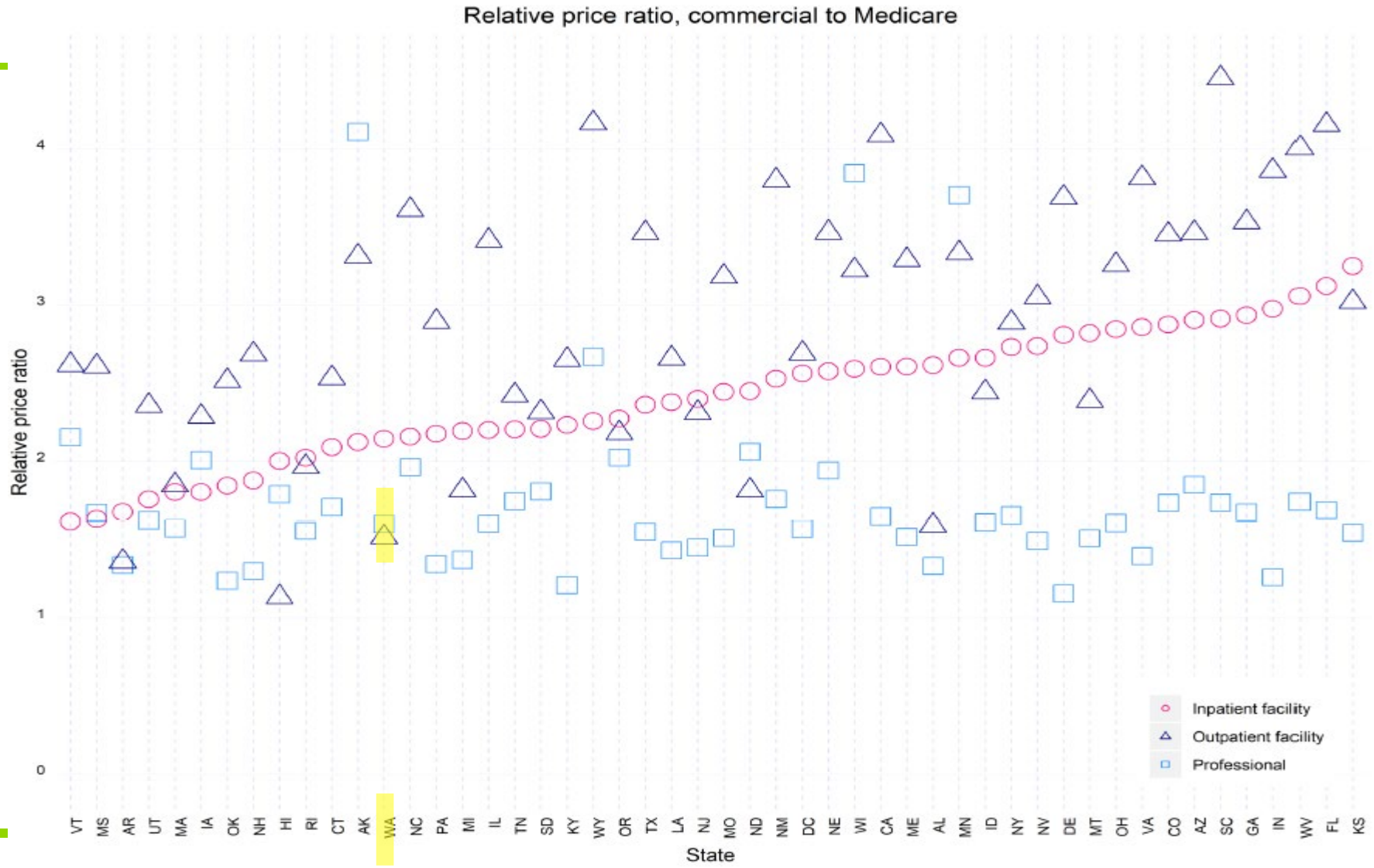
Rand Report: Relative Facility & Prof Prices by State, 2020



RAND Report: Relative Facility & Prof Prices by State, 2020



From "Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative," by C. M. Whaley, et al., 2022, RAND Corporation, p. 14. Copyright 2022 by RAND Corporation.

Issue: Does Quality Affect Prices?

- RAND explored correlation between quality of services and price

- RAND's methodology compared hospital quality ratings to low, mid, and high price levels
  - The quality rating used was CMS's star rating (patient experience)
  - The prices were defined as follows:
    - Low: less than 150% of Medicare
    - Mid: between 150% and 250% of Medicare
    - High: greater than 250% of Medicare

Issue: Does Quality Affect Prices?

- RAND conclusion: did not find a clear link between price & quality

- Qualifier: the quality measures used do not capture all the outcomes that health care purchasers value, e.g.,
  - Prevalence
  - Degree of positive health outcomes

Issue: Evidence for Cost-Shift

- Definition: Cost-shift occurs when commercial payers are charged higher prices to offset
  - underpayments by public payers, and
  - losses due to uncompensated care
- RAND's methodology examined prices and the share of discharges attributed to patients without private insurance
- RAND observed that the share of discharges from public payers explains less than 1% of price variation.
- RAND concluded that this did not support the theory of cost-shift

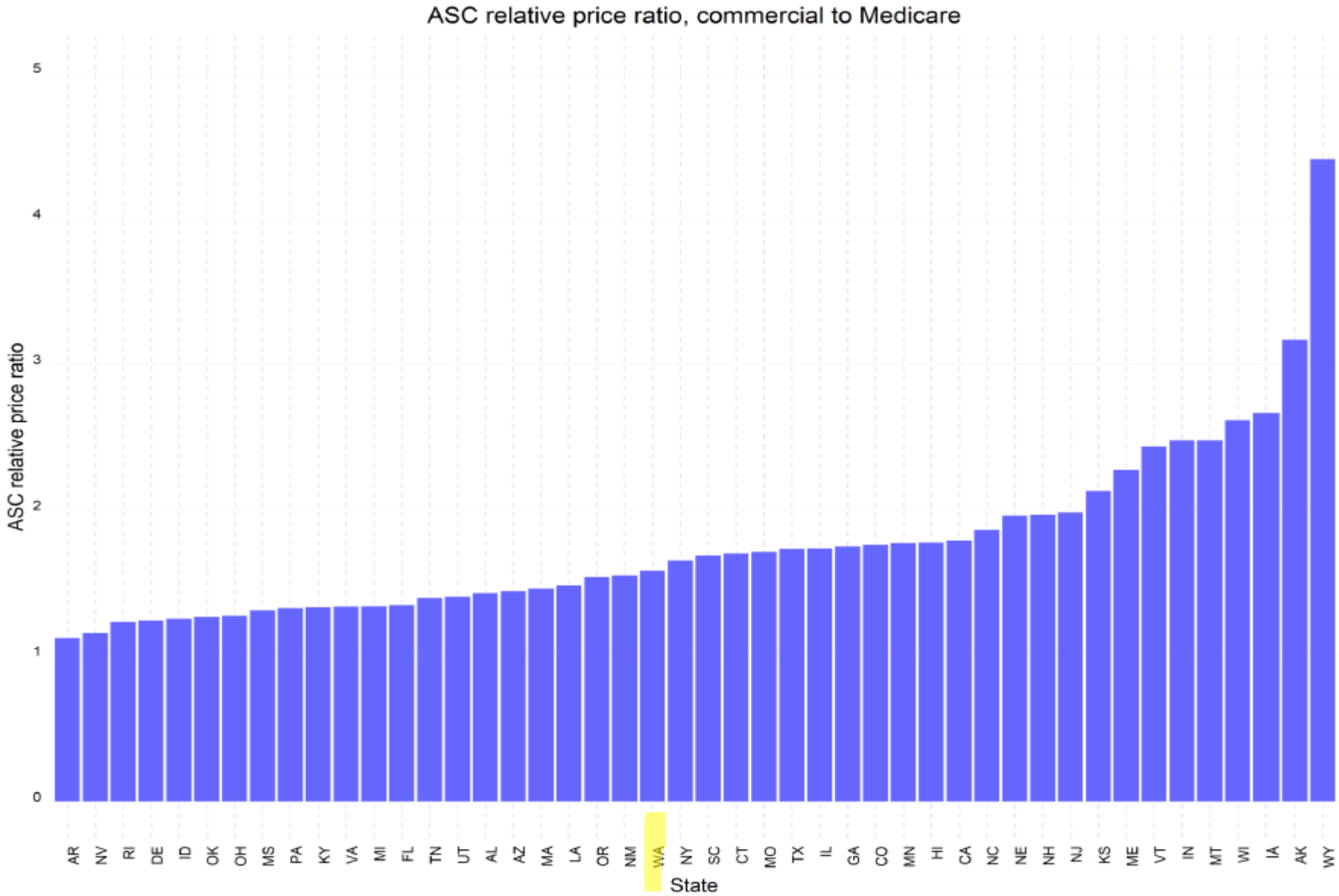
Issue: Impact of Market Share on Price

- RAND explored the correlation between price and hospital market share
- RAND's methodology calculated market share as each hospital's share of hospital beds of the total number of beds in the hospital's metropolitan statistical area
- RAND observed a significant relationship between price & market share
  - A 10% increase in market share is associated with a 0.5% increase in relative price

Issue: Site of Care Differences

- RAND explored whether site of care impacted price
- RAND's methodology compared payments to ambulatory surgery centers (ASCs) vs. hospital outpatient departments (HOPDs) for the same services
- RAND observed that
  - Both Medicare and private insurers pay ASCs at a lower rate.
  - Medicare pays ASCs at 60% of the rate paid to HOPDs
  - Private insurer payments to HOPDs were 2.6 times larger than payments to ASCs
  - Those payments should be ~1.6 to keep in line with Medicare

RAND Report: State-level ASC Relative Prices



From "Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative," by C. M. Whaley, et al., 2022, RAND Corporation, p. 23. Copyright 2022 by RAND Corporation.

Summary of RAND Observations

- Across all hospital services, payments were ~220% of what Medicare would have paid
- Outpatient services usually lead costs (but not in WA)
- ASCs are being paid far less than HOPD for the same services compared to Medicare pricing
- Market share correlated significantly with cost of services
- No support for Cost-Shift Theory
- No support that quality affects price

Questions?

Thank You!

Contact: Ross McCool, Operations Research Specialist
ross.mccool@hca.wa.gov

Board Website:
https://www.hca.wa.gov/about-hca/health-care-cost-transparency-board

Washington State Health Care Authority

Washington hospital costs, price, and profit analysis

TAB 4

Washington Hospital Costs, Price, and Profit Analysis: Review Hospitals by Bed Size Peer Groups

John Bartholomew & Tom Nash
Bartholomew-Nash & Associates

Health Care Cost Transparency Board

September 8, 2022

The Approach to Identify Outliers

- When considering data and findings regarding hospital analytics, you must consider the source.

- This analysis uses self reported Medicare Cost Report data, 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 = **Price per Patient**

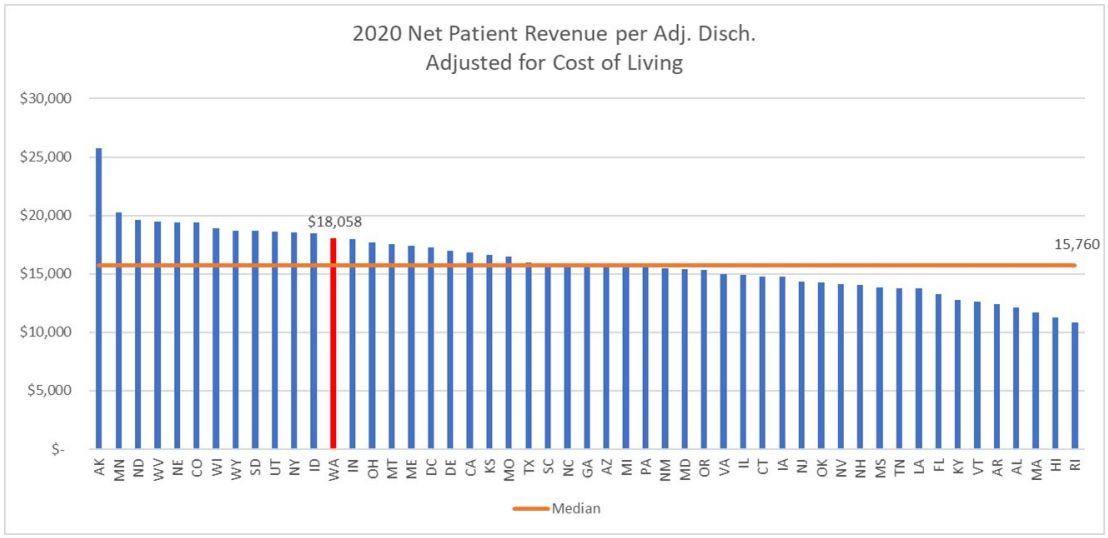
  - Hospital Only Operating Cost divided by Adjusted Discharge = **Cost per Patient**

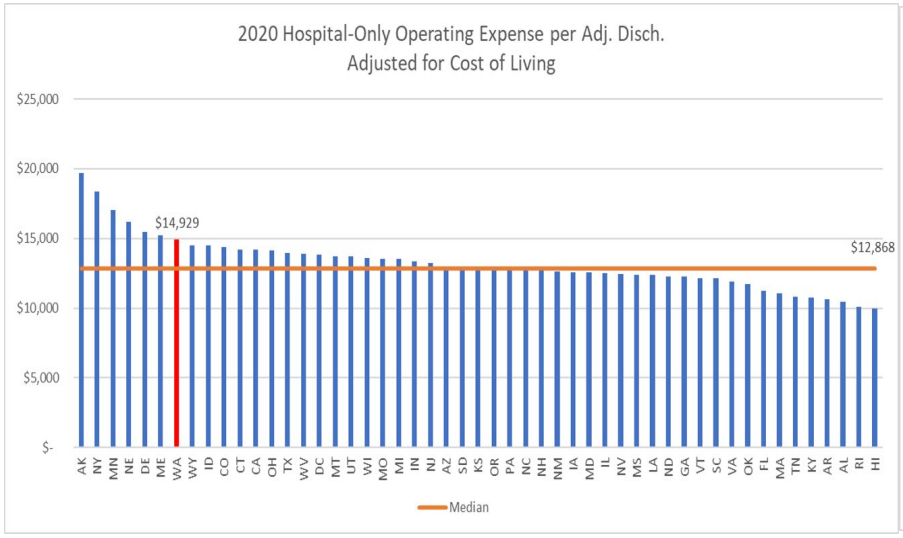
  - Net Income divided by Adjusted Discharges = **Profit per Patient**

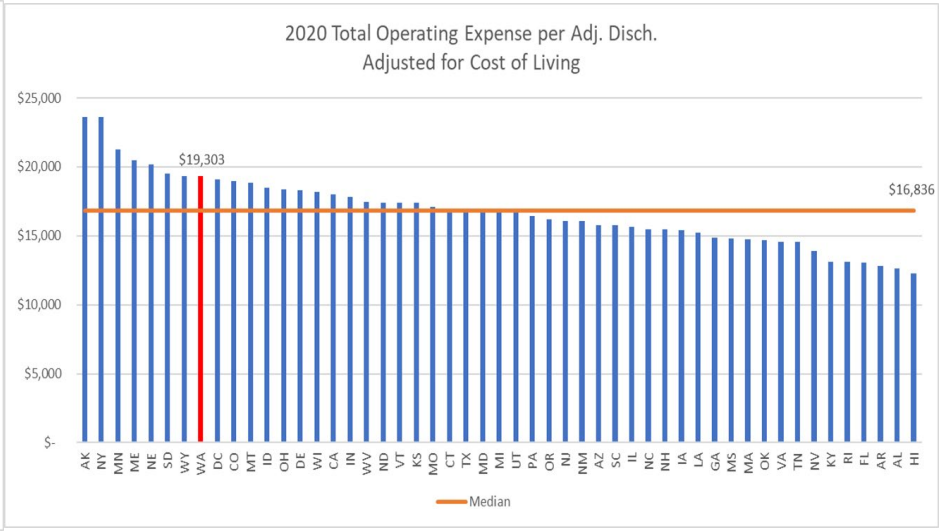
- Observe trends across hospital types and peer groups

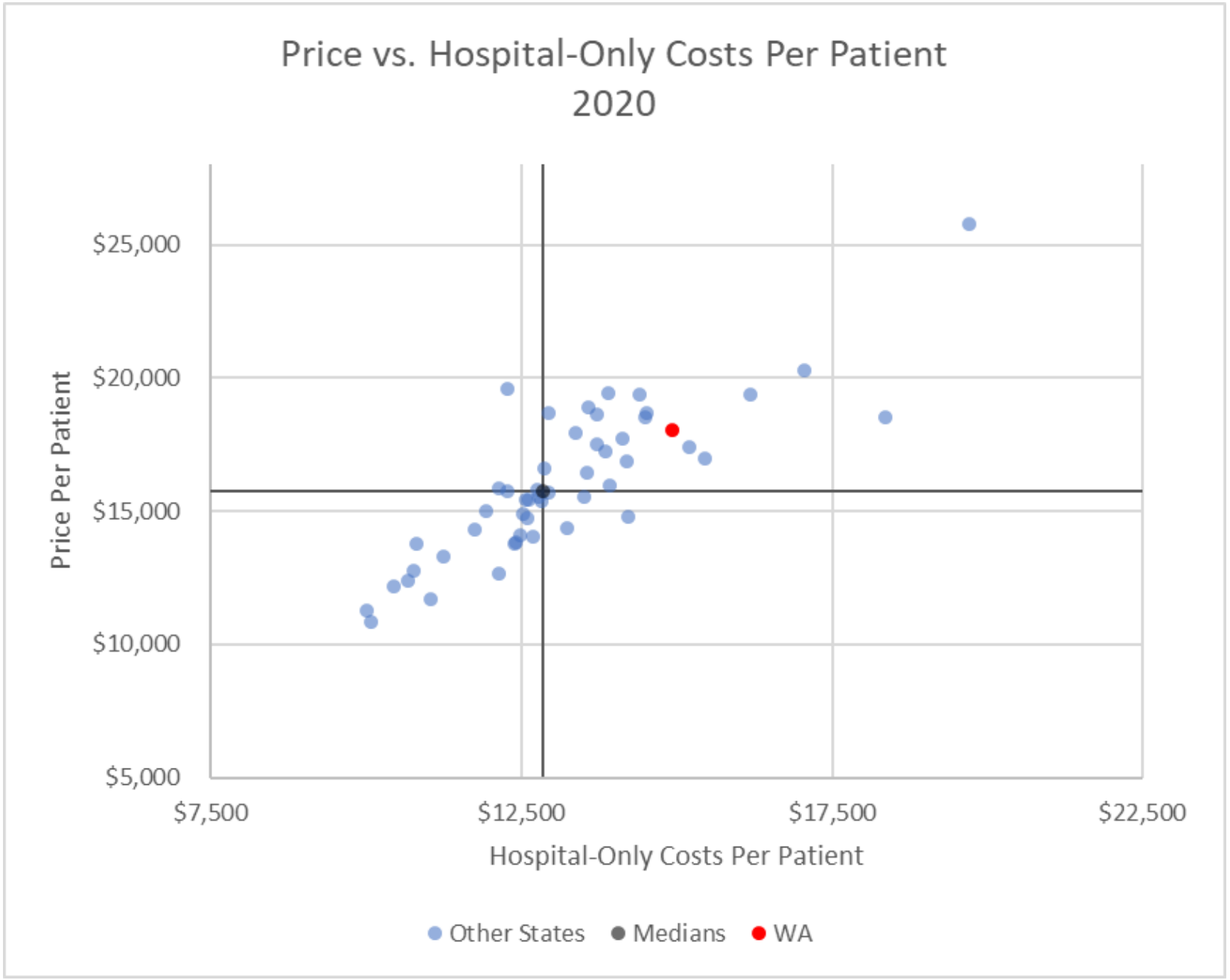
  - Health systems, independents, for-profit, not-for-profit, rural, urban, teaching, and by bed size

2020 COLA Data; WA ranked 13th Highest Price, 7th & 8th Highest Costs








Price vs. Hospital-Only Costs Per Patient
2020
$25,000
$20,000
$15,000
$10,000
$5,000
Price Per Patient
$7,500
$12,500
$17,500
$22,500
Hospital-Only Costs Per Patient
Other States
Medians
WA

Quick Refresh: Overall WA Hospitals in Aggregate have Higher Prices and Costs, COLA, and are lower Using Profit as a Measure*

2020 Statewide Hospital Income Statement All Short-Stay Hospitals		
Description	**Washington**	**National Median**
Net patient revenue	$ 22,031,680,843	
Hospital-only operating expense	18,206,569,189	
Other operating expense	5,370,712,007	
Total operating Expense	23,577,281,196	
Patient services net income	(1,545,600,353)	
Patient services margin	***-7.0%***	***-4.60%***
Other non-patient income	2,377,532,481	
Other non-operating expense	86,166,676	
Net income	$ 745,765,452	
Total margin	***3.1%***	***7.30%***

In aggregate, WA hospitals are lower compared to the national median using two profit measures.

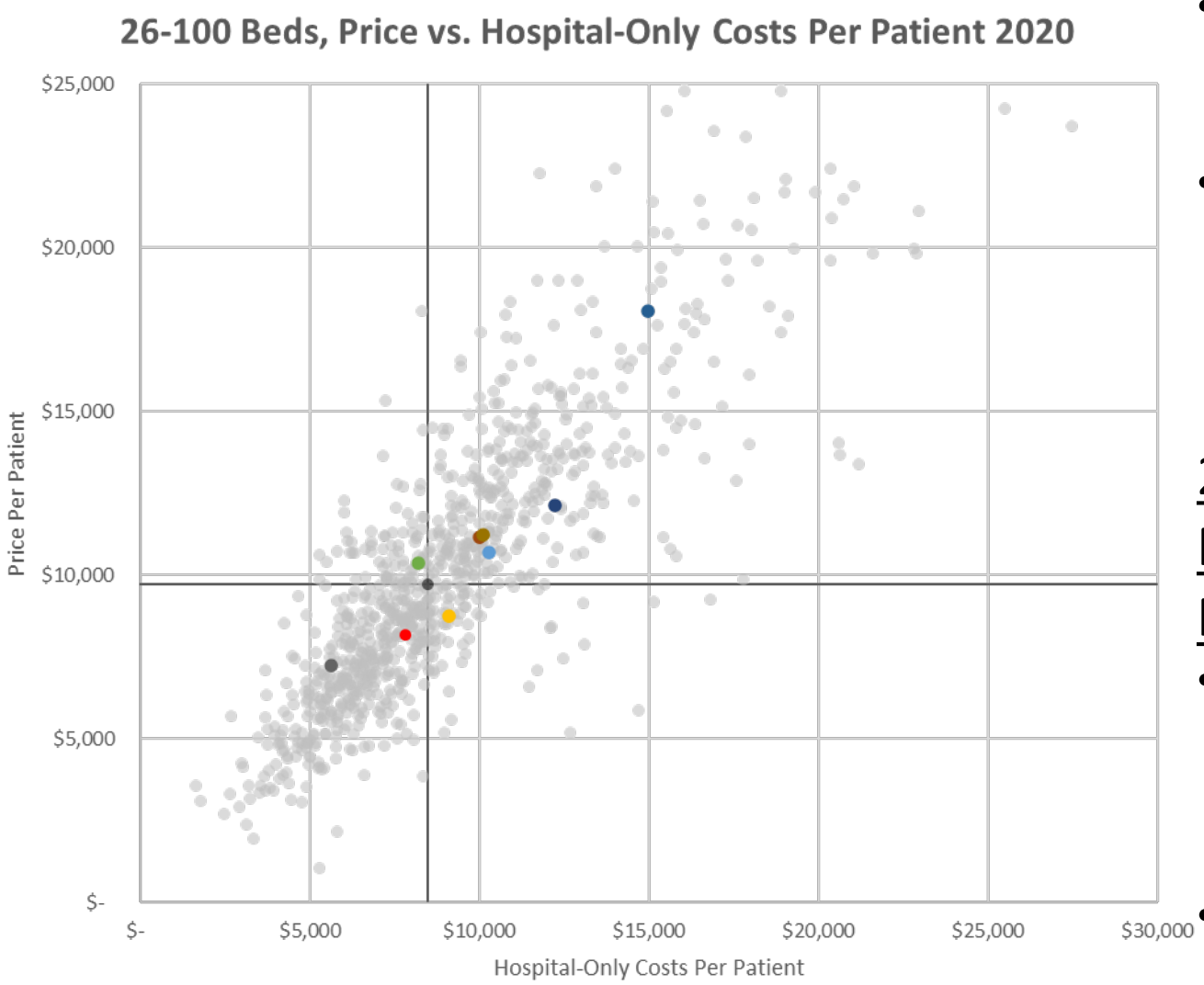
Patient Services Margin is a profit margin based solely on patient services.

Total Margin is the net of other non-hospital expenses and other non-hospital revenues.

Review of Washington Hospital Outliers

Washington Hospital Groupings
Hospitals with > 25 Beds

Price	High price						Not high price								
	15						32								
Cost	National normal cost			High cost			National normal cost			High cost			Low cost		
	3			**12**			23			6			2		
Profit	High profit	National normal profit	Low profit	High profit	National normal profit	Low profit	High profit	National normal profit	Low profit	High profit	National normal profit	Low profit	High profit	National normal profit	Low profit
	0	2	1	2	6	4	4	11	8	0	2	4	1	1	4

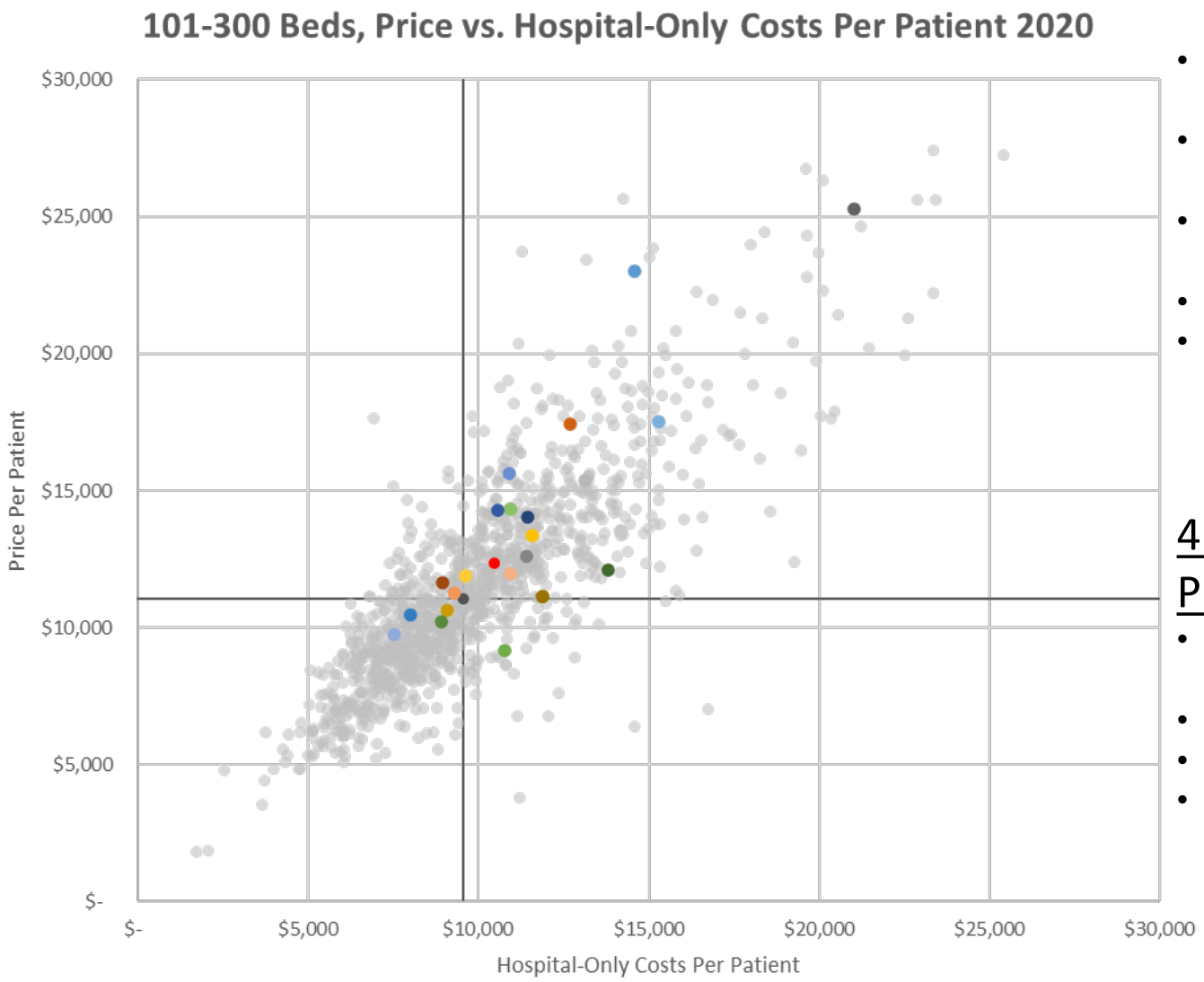


2 Price/Cost Outliers:

- Lourdes Medical Center
- Evergreen Health Monroe

2 Below Median Price/Costs:

- Multicare Covington Medical Center
- Island Hospital

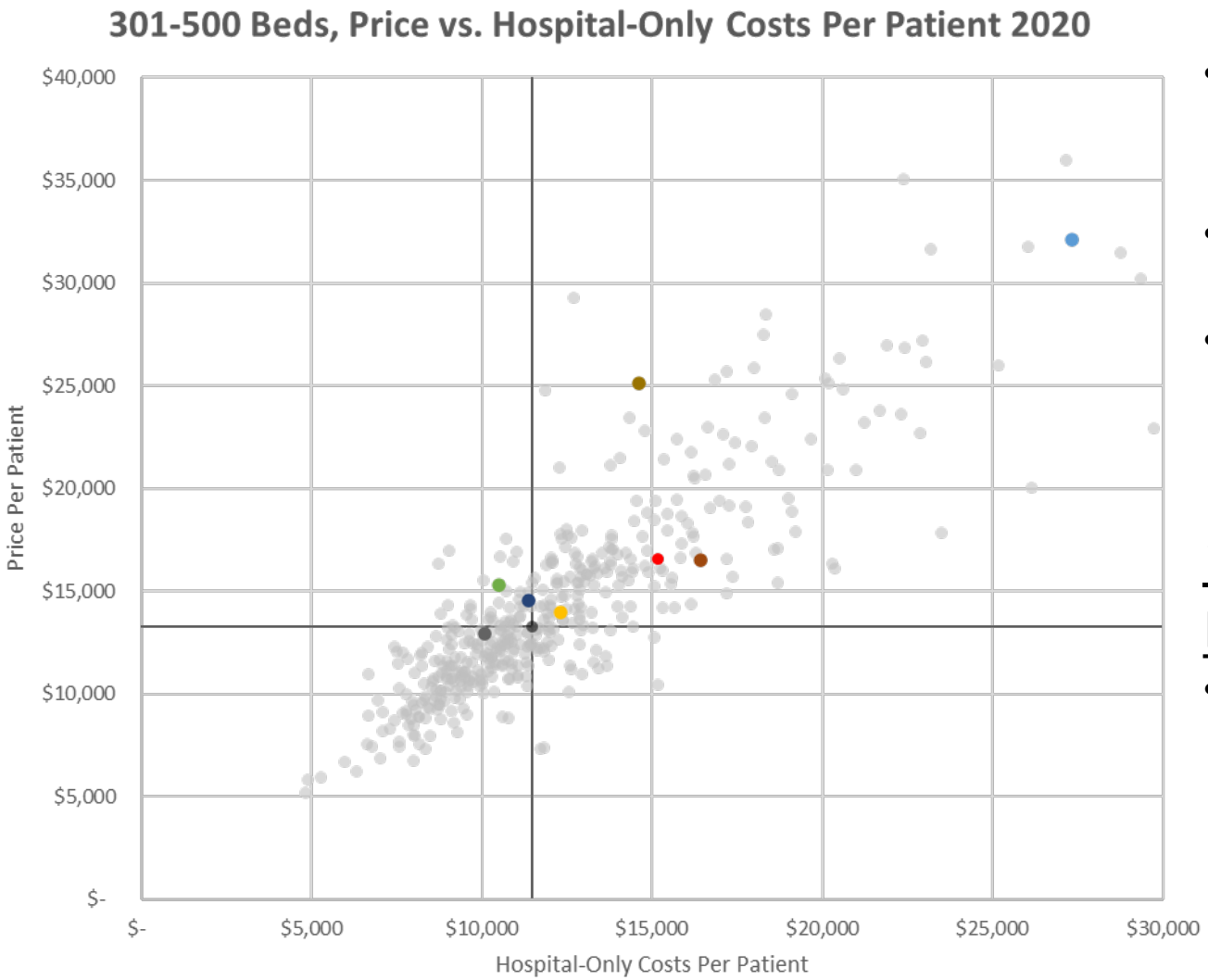


6 Price/Cost Outliers:

- Confluence Health - Central Washington Hospital
- Virginia Mason Med Center
- Deaconess Med Center
- Kadlec Regional Med Center
- Swedish Edmonds
- Peacehealth St. Joseph Med Center - Bellingham

4 Below Median Price/Costs:

- Legacy Salmon Creek Hospital
- Capital Med Center
- St. Francis Hospital
- Multicare Valley Hospital - Spokane

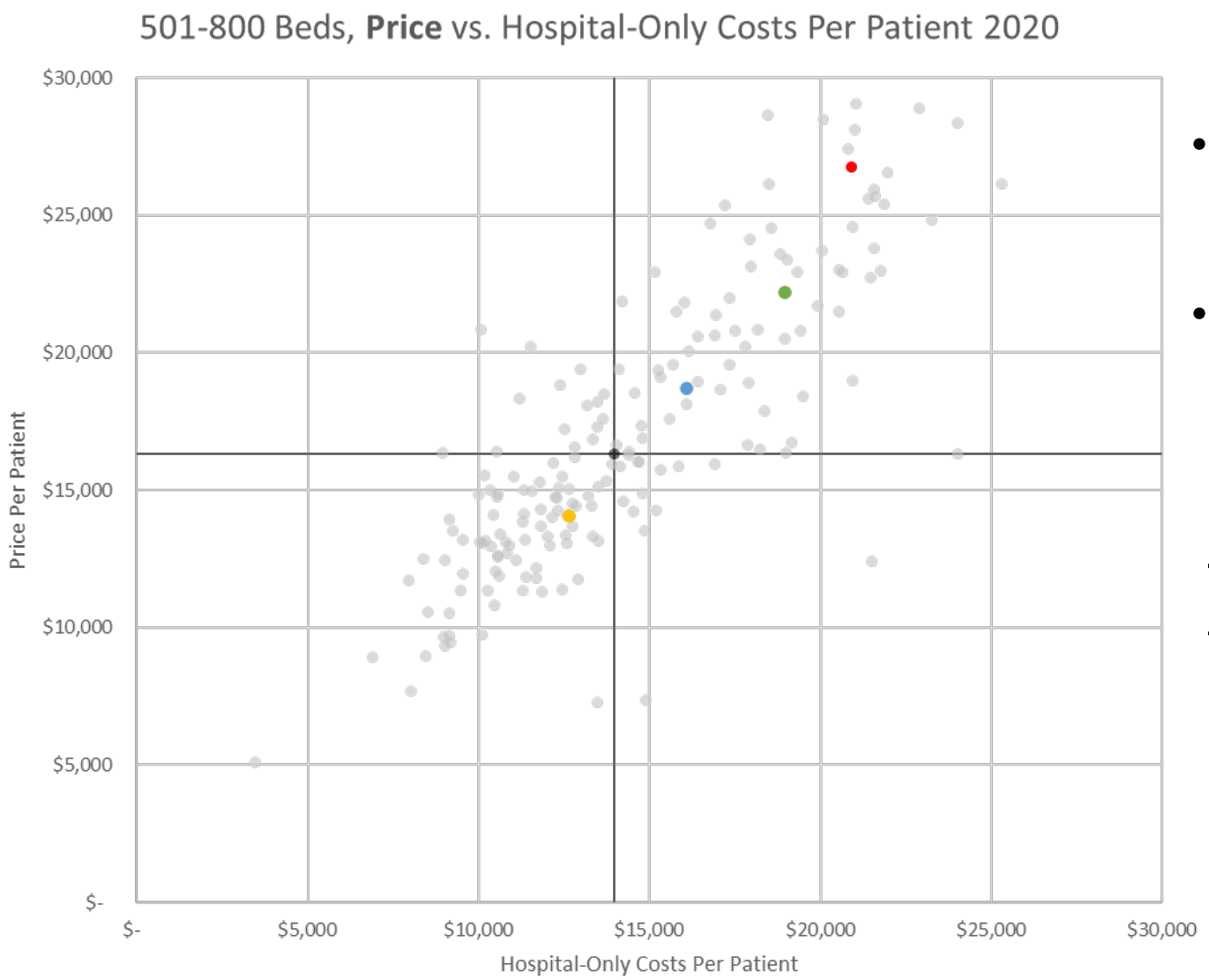


4 Price/Cost Outliers:

- Harborview Med Center
- Tacoma General Allenmore Hospital
- St. Joseph Med Center
- Providence St. Peter Hospital

1 Below Median Price/Costs:

- Evergreen Healthcare Kirkland



3 Price/Cost Outliers:

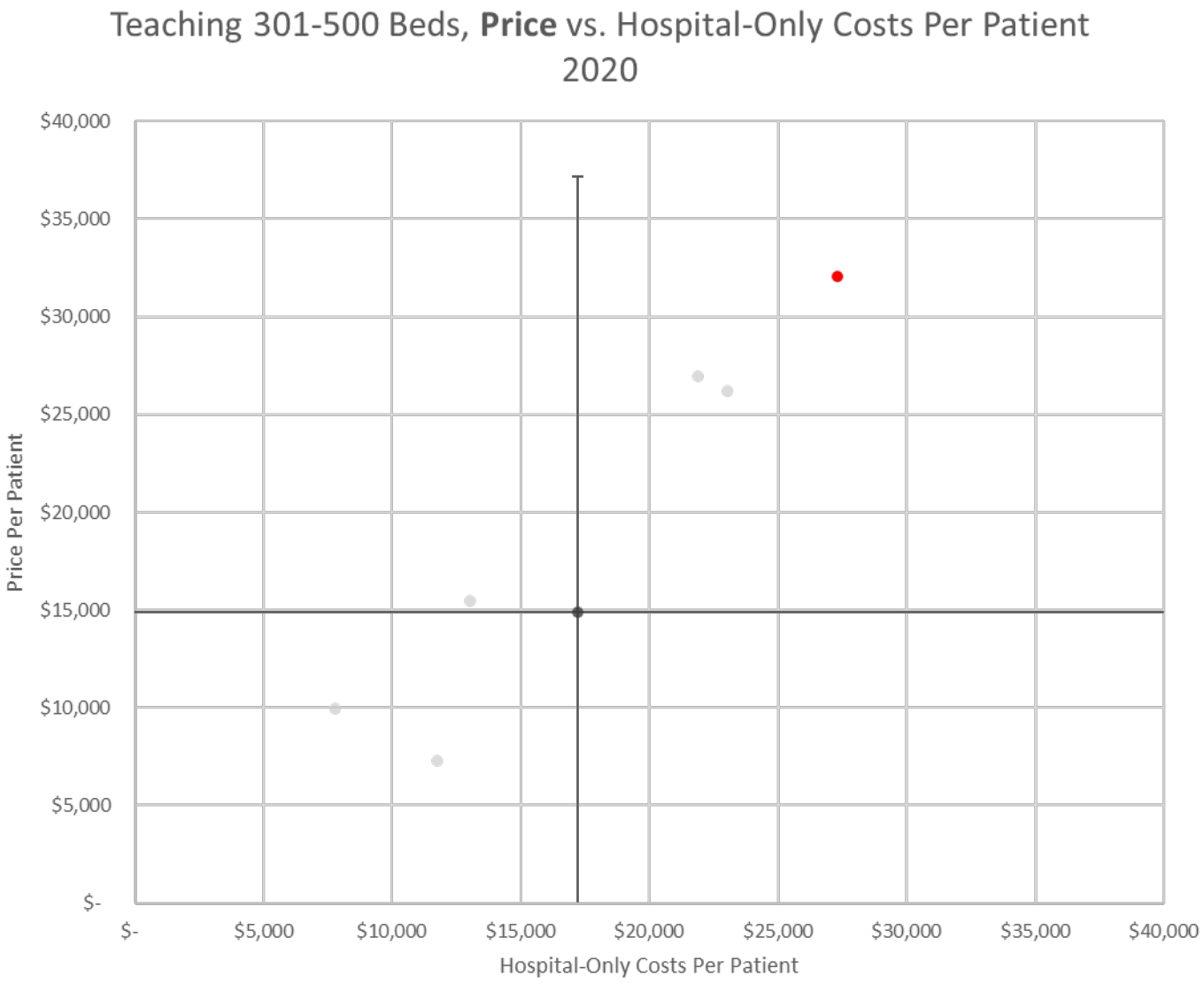
- University of Washington Med Center
- Providence Sacred Heart Med Center
- Swedish Med Center - Seattle

1 Below Median Price/Costs:

- Providence Regional Med Center Everett

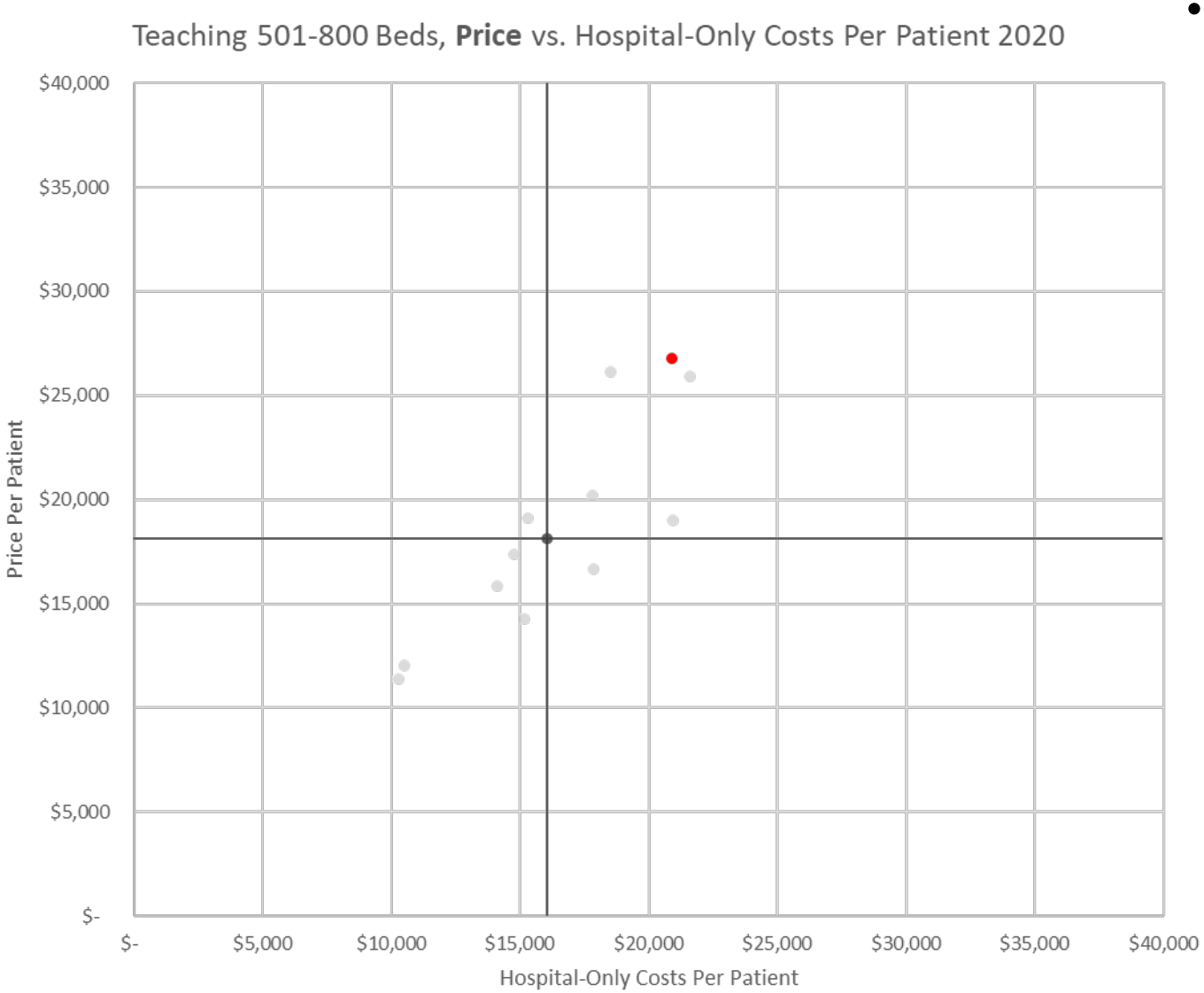
1 Price/Cost Outlier:

- Harborview Med Center



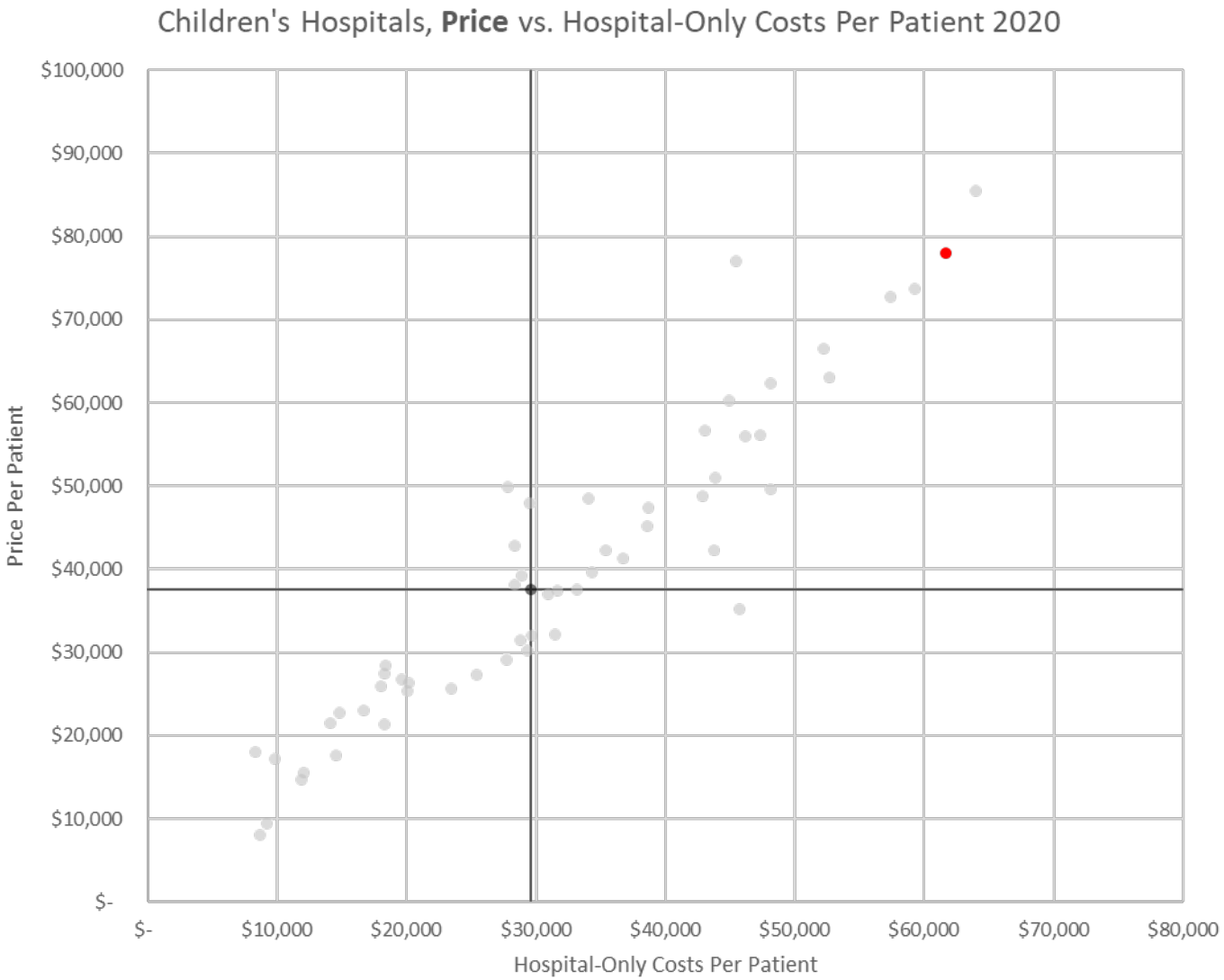
1 Price/Cost Outlier:

- University of Washington Med Center



1 Price/Cost Outlier:

- Seattle Children's Hospital



Conclusion:

- **There is more work that needs to be done.**
- **A deeper dive would be important to further understand Price, Cost, and Profit variations from the National Median over time.**
- **But also, for a fair and accurate comparison, we need to look at other measures, such as, case mix, service intensity measures, operating environment, payer mix, and other financial measures to enable better comparisons between hospitals.**
- **The goal is to adjust for service intensity, acuity, location, and other differences so the variation in price and cost is isolated to business decisions or price discrimination.**

Additional Questions/Comments?

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Washington hospitals: adjustment needed for hospital costs and payment comparison

TAB 5

Adjustments Needed for Hospital Cost & Payment Comparisons

WSHA Presentation to the HCCTB Data Committee

WA Law on HCCTB (HB 2547)

Washington State Hospital Association

HCCTB shall:

"Annually calculate total health care expenditures and health care cost growth:…. For each health care provider or provider system and each payer**, taking into account** the health status of the patients of the health care provider or the enrollees of the payer, utilization by the patients of the health care provider or the enrollees of the payer**, intensity of services provided to the patients of the health care provider or the enrollees of the payer, and regional differences in input prices."**

Importance of Case Mix (Intensity of Service)

Washington State Hospital Association

Case Mix Adjustments

Hospital costs and prices differ based on types of patients served

HCCTB Consultant to date hasn't incorporated any adjustment in comparisons among states; adjusts WA comparisons by grouping hospitals by bed size

- Bed size group is related to case mix, but not an accurate adjuster for all differences

WSHA recommends adjusting using a DRG based Case Mix Index

- A hospital's Medicare CMI could be a proxy used for all cases
- Alternatively, the consultant could calculate CMI using all inpatient data based on CHARS

Hospitals Serve Different Types of Patients

Name	Bed Size	Medicare CMI
Swedish Cherry Hill	227	3.08
Swedish First Hill	659	1.94

Importance of Adjustments for Input Price Differences

Washington State Hospital Association

Wages and salaries account for 68 percent of hospital costs

HCCTB Consultant analysis shows statewide comparisons using Cost of Living Adjustments

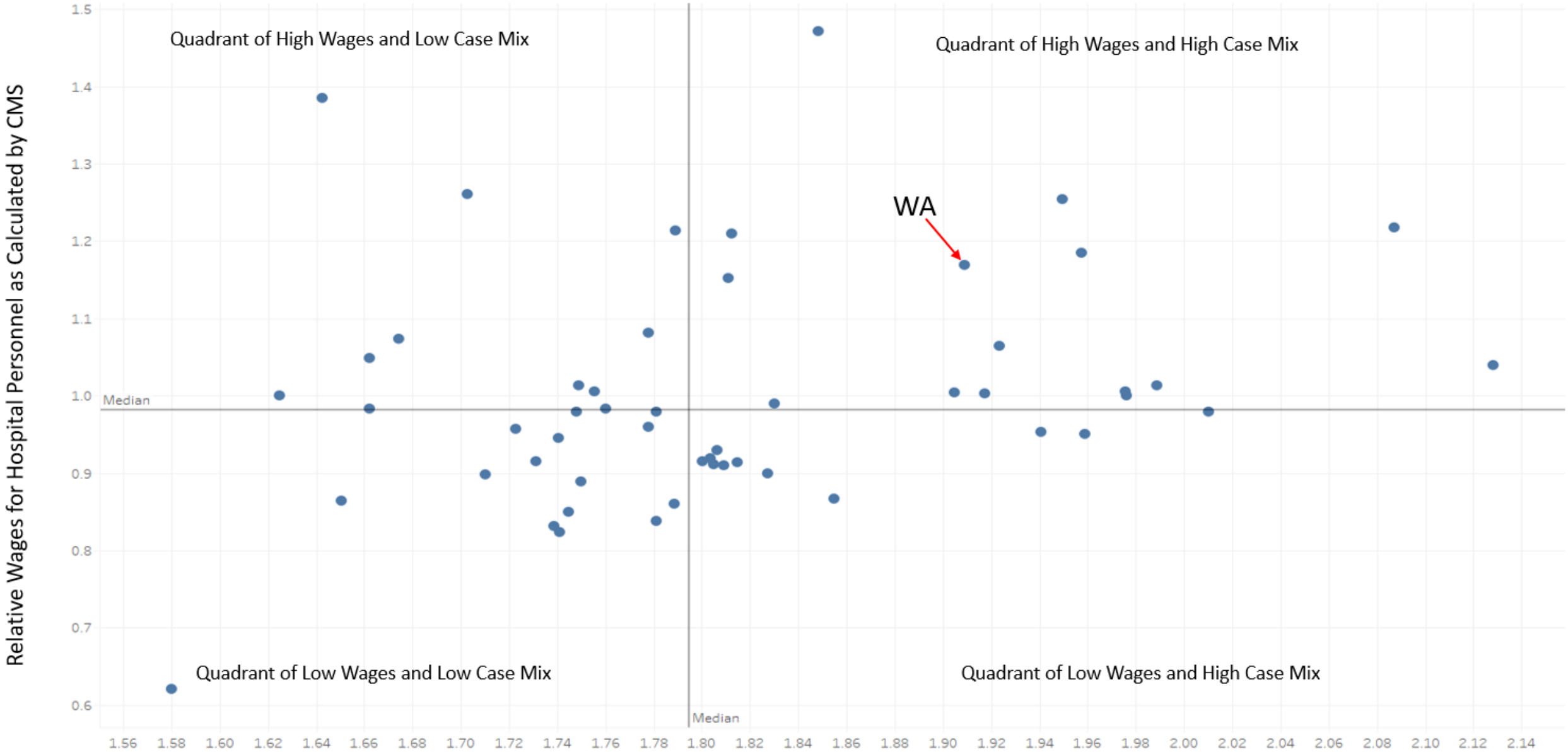
- These account for regional differences in food, rent, etc.
- Available only on a statewide basis or for large amalgamated urban areas
- Consultant has not yet accounted for differences in input prices among WA hospitals

WSHA recommends adjusting using CMS Area Wage Index

- Available for all hospitals
- Based on area equivalent wages for hospital type personnel

EXAMPLES OF IMPORTANCE OF ADJUSTMENTS

US State Scatterplot Showing Relative Hospital Wage Index and Case Mix Rankings*



Froling, WSHA,
August 2022

EXAMPLE OF IMPACT ON A SPECIFIC HOSPITAL

Hospital	Cost Per Discharge (taking account of outpatient use)
Swedish Cherry Hill with No CMI or Wage Adjusters	$ 40,851 per discharge
Swedish Cherry Hill with Adjusters for CMI and Wage Adjusters*	$ 20,588 per discharge

* CMI and Area Wage Index applied to 68 percent of costs, representing operating portion

Washington State Health Care Authority

Introduction to primary care target and measurement

TAB 6

Overview of Primary Care Measurement

Health Care Authority

September 8, 2022

Washington State Health Care Authority

Recommendations: Overview

- Definition of Primary Care
- Claims-Based Measurement
- Non-Claims-Based Measurement
- Reporting Requirements; barriers and how to overcome them

Definition of Primary Care

- Primary Care Transformation Model (PCTM)
  - Defining payer/provider Accountabilities and an Alternative Payment Model (APM) to transform primary care
  - Collaborative model development, including:
    - Multi-payer workgroup (commercial and Medicaid plans)
    - Provider workgroup
    - Purchaser workgroup (employers, HBE)
  - PCTM defines primary care consistent with CMS guidelines, OFM, the Bree Collaborative
- Primary Care Practitioners (PCPs)
  - The defined type of practitioners that can be a PCP are fairly consistent
    - Physician (family medicine, internal medicine, geriatric medicine, pediatric medicine), Nurse Practitioner, or Physicians Assistant
    - Some minimum percentage of billed services are “primary care”
    - Messy: practitioners who practice in primary and specialty settings (behavioral health, pediatrics, mid-levels, other)
- Primary Care Services—variation amongst stakeholders and APMs. Typically defined by claims-based, and non-claims-based measurement.

Claims-Based Measurement

- Who, What and Where
- Typically defined by CPT code
- Includes office visits, preventive/wellness visits, developmental/behavioral health screenings
- May include vaccine administration, OB care, basic laboratory services
- Generally excludes procedure codes and physician-administered drugs—though common office procedures (without anesthesia) may be included
- Pharmacy claims? Physician-administered drugs? Medical devices?

What We Already Know

- OFM primary care spend using WA APCD for 2018
- Bree work on primary care
- Other states to follow

Washington State Health Care Authority

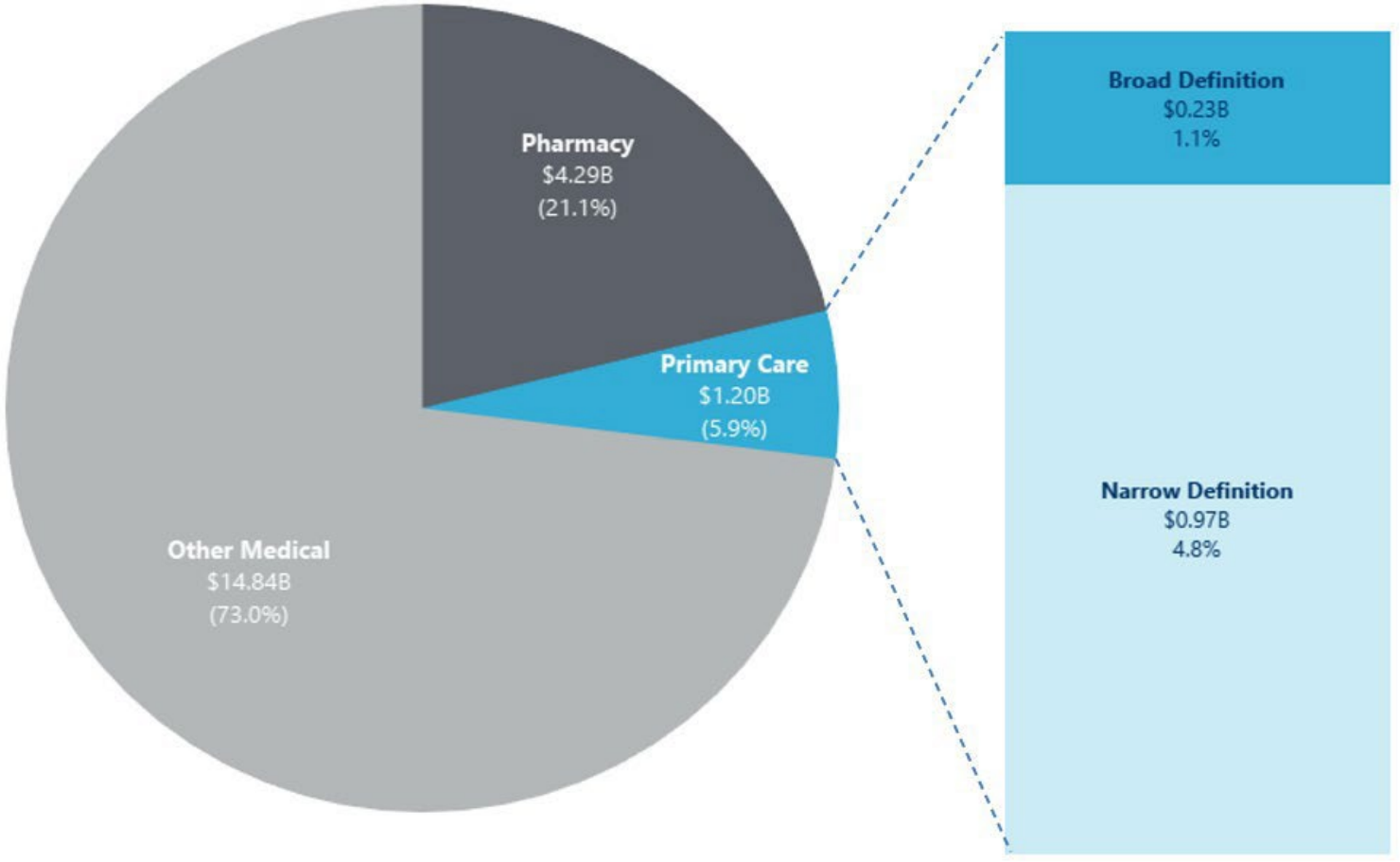
APCD Methods – Study Population

- Calendar years included
  - 2018, 2019, 2020
  - 2018 was refreshed to be consistent with changes to the WA-APCD extract and to ensure compatibility for trending
- Payer types
  - Plans included: Commercial, Medicare Advantage, Medicaid managed care, PEBB
  - Plans excluded: Medicare FFS, Medicaid FFS
- Claims limited to first service date between Jan. 1 and Dec. 31 of each year
- Pharmacy claims included
- Dental claims excluded

Methods – Identification of Primary Care

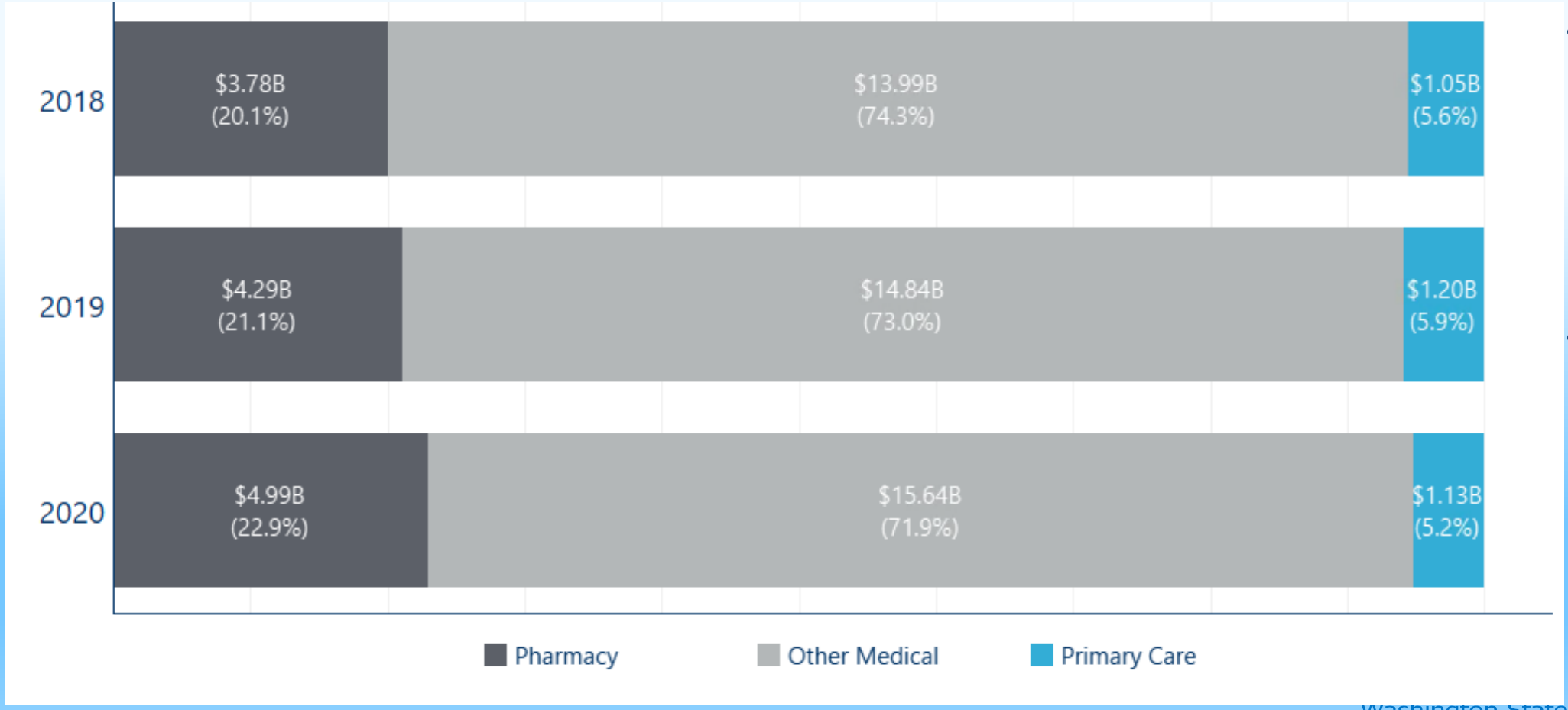
- Analysis replicated methods from 2019 OFM study (e.g., same taxonomy, CPT/HCPCS codes)
- Primary care providers
  - Identified by a set of taxonomy codes
  - Narrow and broad definition
- Primary care services
  - Identified by CPT and HCPCS procedure codes
  - Narrow and broad definition

Primary Care Spending Comprised 5.9% of Total in 2019



* Does not include Medicare FFS or Medicaid FFS plans

The % Primary Care Spending Ranged from 5.2% to 5.9% between 2018 & 2020



- Uptick between 2018 (5.6%) and 2019 (5.9%)
- Decline in 2020 (5.2%), likely due to COVID impacts

* Does not include Medicare FFS or Medicaid FFS plans

Summary of Claims-based Spend Findings

- Primary care spending was a small percentage of total medical and pharmacy spending (5.9%) in 2019
  - – Results were consistent with OFM's findings in their report on 2018 data
    - – Age variations were consistent with OFM report (e.g., higher percentage in pediatric population)
  - – Payer variations also consistent with OFM report
- It appears there was a small uptick in primary care spending as a percent of all spending between 2018 and 2019
  - – Driven by increases in the older adult population (65+) and Medicare Advantage
- Decrease in primary care as a percent of total in 2020
  - – Office and preventive visits decreased

Non-Claims-Based Measurement

- Billable Services and other primary care-related costs that may not appear on claims
  - Services may be paid as part of alternative payment mechanism (capitation, bundles, etc.)
  - Encounter-eligible services
  - Services that providers choose not to bill due to administrative burden (Collaborative Care codes, other)
  - Patient cost sharing
- Non-billable Services and other costs that may not appear on claims
  - Care coordination
  - Community Health Workers
  - Data management like patient registries
  - Quality incentives

Next Steps

- Select and contact Primary Care Committee members
- Present committee to the Board
- Develop meeting schedule
- Prepare agenda and materials for first meeting (Recommendation 1)

Washington State Health Care Authority

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TAB 7

Washington State Health Care Authority

2022 Health Care Cost Transparency Board benchmark data call

Frequently asked questions (FAQ)

This FAQ shares responses to questions from health insurance carriers and state agencies that are submitting data for the 2022 benchmark data call. Most of the questions are technical and ask the Health Care Cost Transparency Board to define or clarify how to submit data.

We will continue to update this FAQ as we receive additional questions.

1. **Please clarify the file submission schedule for this year's data. Should I submit by September 1 or October 1, 2022?**

   Please submit all data **by October 1**.

   Note: for this initial year, the board is providing a longer data submission period. We want to give you time to understand the submission process and submit your data. Please do not delay your data submission, and file as soon as possible.

2. **Can you confirm that I will report spending aggregated at the parent company level?**

   Yes, please report at the parent company level.

3. **What level of leadership should provide the data submission's attestation signature?**

   A chief financial officer, chief data officer, or other executive should sign the attestation.

4. **How will the board consider risk adjustments for the cost growth benchmark?**

   As part of the data submission, the board requires submitters to provide data stratified by age and sex. The board will calculate an adjustment factor, based on the submitted age and sex spending.

5. **Will the board calculate the net cost of private health insurance (NCPHI)? And will this be at the state level?**

   Yes, you are only required to report total medical expense. The board will calculate NCPHI at the state-level only.

6. **When will the board ask for calendar year 2020 or 2021 data?**

   In future data calls, the board will ask for two years of data to account for potential methodology changes and ensure accuracy. We have not yet determined the years that will be requested in the 2023 benchmark data call.

7. **In the Large Provider Entity Code list, what does code 100 "Over All Provider Entities" mean?**

   This code is used when you are reporting data that includes **all spending**. For example, you would use this code in the standard deviation tab where you provide all the standard deviation of all of the parent company's spending.

8. **In the Large Provider Entity Code list, what does code 999 "Unattributed to a Large Provider Entity" mean?**

   Please mark spending by assigning a member to a primary care provider, and then to a provider entity. If the assigned provider entity is not in the Large Provider Entity Code List, code the provider as "999" (meaning that associated spending is unattributed to a Large Provider Entity).

9. **Can the board provide a list of Taxpayer Identification Numbers (TINs) associated with the Large Provider Entity Codes?**

   No. The board does not have a list of provider TINs that we can share publicly.

10. **How do I associate spending for capitated payments if the member went to multiple provider entities, resulting in capitated payments to multiple provider entities?**

    Please assign a member to a primary care provider, and then that primary care provider to a sole provider entity. All spending for that member (and their member months) should be assigned to the sole provider entity.

11. **Should I report prescription drug (Rx) spending gross of rebates, even if another entity administered the benefit? Or if the submitter was not at risk for the benefit?**

    Please report Rx spending gross of rebate in the Total Medical Expense tab and use the Rx Rebate tab to report the rebate amounts. The board will calculate the net Rx spending.

12. **I consider some forms of payment to be incentive payments; however, they may also be associated with payments to enhance infrastructure. Should I report these in the Performance Incentive Payments category or the Health and Practice Infrastructure Payments category?**

    If the payment is contingent on the receiver of the payment to meet a certain metric (e.g., pay for performance, pay for value), then include the payment in the Performance Incentive Payments category.

    If the payment is not contingent on a certain metric being achieved, include the payment in the Health and Practice Infrastructure Payments category.