Washington State Health Care Authority

# Washington's Health Care Cost Growth Benchmark Program

## Frequently asked questions (FAQs) on provider reporting

August 2024

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# Version history

| Version number | Release date | Description of changes |
|---|---|---|
| 1.0 | August 02, 2024 | Original publication in Health Care Cost Transparency Board (Cost Board) website |

# About this FAQ

This FAQ is for questions about provider reporting. It contains detailed information about the Health Care Cost Growth Benchmark Program and the Health Care Cost Transparency Board (Cost Board). If you're new to the Cost Board's work or looking for background information, please refer to these resources:

- **Cost Board website section** on **hca.wa.gov**
- **Cost Board resources page**
- **Cost Board general FAQ**

# Frequently asked questions

## Which provider organizations are subject to the cost growth benchmark program and public reporting?

Chapter 70.390 of the Revised Code of Washington (RCW) requires the Cost Board to calculate the total health care expenditures and healthcare cost growth for each health care provider or provider system.

Chapter 70.390 RCW further requires the Cost Board to publicly identify, on an annual basis, any health care providers for which overall health care cost growth and growth by market in the previous performance period exceeded the health care cost growth benchmark.

Provider performance vis-à-vis growth benchmark will be reported at the annual Cost Board public hearing. Public reporting will start in 2024 with 2022 data.

### Defining health care provider

While "health care provider" is defined in Chapter 70.390 RCW as a person or entity that is licensed, certified, registered, or otherwise authorized by the law of this state to provide health care in the ordinary course of business or practice of a profession. However, for performance against the benchmark, the Cost Board only monitors large providers and providers organizations with sufficient patient volume, and not individual clinicians.

### Identifying large provider entities

To determine sufficient patient volume, the Cost Board first developed an initial list of approximately 50 large provider entities for which benchmark performance could potentially be reported. This initial list was created from several sources including:

- Washington Health Alliance's Community Checkup report
- Washington Association for Community Health's list of Community Health Centers
- U.S. Health Resources and Services Administration's Health Center Program Uniform Data System Data
- Washington State Department of Health's 2019 Year End Hospital reports

Next, carriers were surveyed to gather data on each of their providers' total cost of care contracts and the number of covered lives associated with those contracts. Using this survey data, we further modified the initial list to only include provider organizations who could potentially accumulate 10,000 covered lives across all carriers. Provider organizations with at least 120,000 member months (approximately equivalent to 10,000 unique covered lives), based on the submitted data, are considered to have sufficient patient volume for benchmark performance to be accurately and reliably measured.

Based on this data, the following provider organizations were identified to have met the threshold for being classified as a large provider entity:

### Table 1. Large provider entities identified from carrier survey

| Large provider entities |
| --- |
| Community Clinic Contracting Network (includes Yakima Valley, Community Health Center of Snohomish County, Columbia Basin, Columbia Valley, International Community Health, Mariposa, Peninsula Community Health, Unity Care, and Sea Mar) |
| Community Health Association of Spokane |
| Community Health Care |
| Community Health of Central Washington |
| Confluence Health |
| Country Doctor Community Health Centers |
| Cowlitz Family Health Center |
| Evergreen Health |
| Family Care Network |
| Family Health Centers |
| Franciscan Health (includes Virginia Mason Franciscan Health, part of Pacific Northwest Division of Common Spirit) |
| HealthPoint |
| Kaiser Permanente of Washington (medical centers in western Washington and Spokane) |
| Kaiser Permanente NW (medical centers in southwest WA) |
| Legacy Health |
| Lewis County Community Health Services (Valley View Health Center) |
| Moses Lake Community Health Center |
| MultiCare Health (includes Mary Bridge Children’s Hospital; Navos) |
| NeighborCare Health |
| NEW Health Programs Association |
| North Olympic Healthcare Network PC |
| OptumCare (includes Everett Clinic, Polyclinic, and Northwest Physician’s Network) |
| Overlake Medical Center |
| PeaceHealth |
| Providence Health/Swedish Health Services/PacMed/Kadlec |
| Rose Medical |
| Seattle Children's Care Network |
| Seattle-King County Public Health Dept (Health Care for the Homeless Network) |
| The Vancouver Clinic |
| Tri-Cities Community Health |
| UW Medicine (Valley Medical Center, Neighborhood Clinics) |
| Wellfound Behavioral Health Hospitals (partnership with CHI Franciscan and MultiCare) |
| Yakima Neighborhood Health Services |

In identifying large providers whose cost growth exceeded the benchmark growth, public reporting is limited to large provider entities whose member months met the threshold of 120,000 member months (approximately equivalent to 10,000 covered lives) based on data from the Cost Board’s data call. In addition, public reporting

on market performance by large provider entities is limited to markets where the member months of large provider entities exceeds 60,000 member months (approximately equivalent to 5, 000 covered lives).

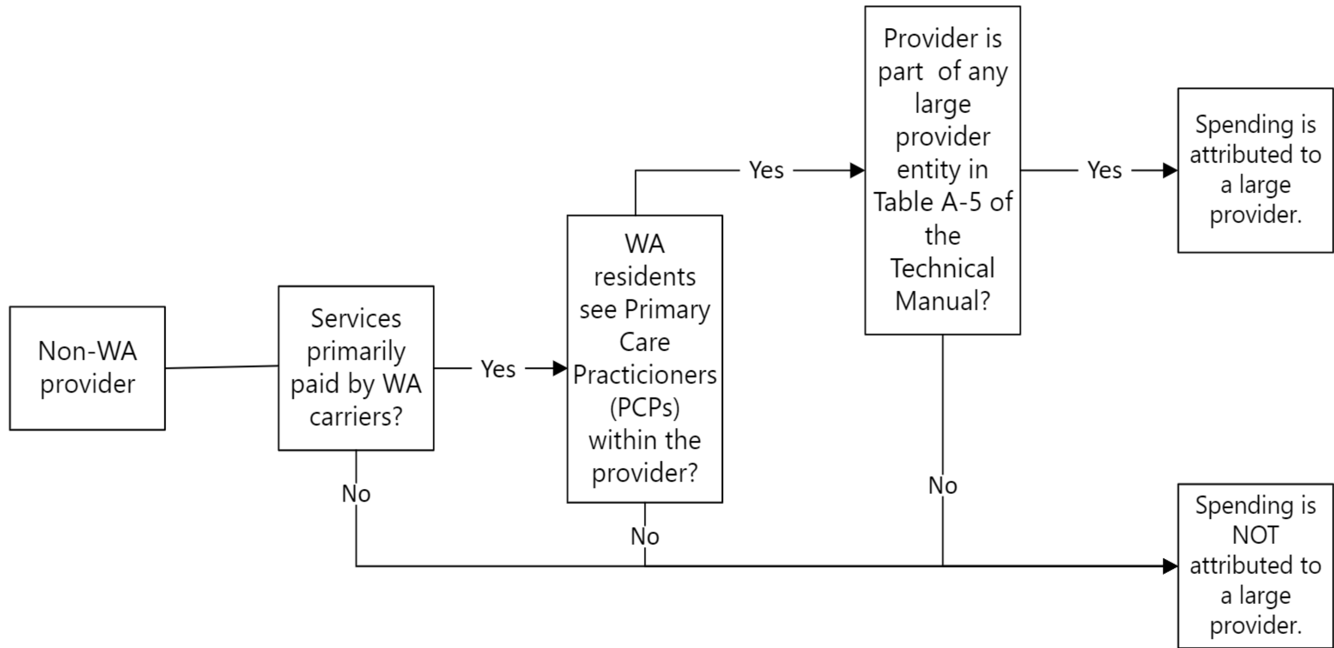
# How are members attributed to provider organizations?

Members are attributed to provider organizations per the instructions in Appendix A of the **Technical Manual**. Carriers first attribute individual members to a primary care provider (PCP), then attribute the PCPs (and attributed members) to a large provider entity. To attribute members to a PCP, carriers are required to follow the hierarchy outlined below:

1. **Member Selection**: Members who were required to select a PCP by plan design should be assigned to that PCP.
2. **Contract Arrangement**: Members not included in step 1 and who were attributed to a PCP during the performance period pursuant to contract between the carrier and the provider, should be attributed to that PCP.
3. **Utilization**: Members not included in step 1 or step 2, and who can be attributed to a PCP based on the member's utilization history should be attributed to that PCP. Carriers may apply their own primary care-based methodology when attributing a member to a PCP based on utilization.

Attribution of PCPs to a large provider entity is performed consistent with carriers' contracts for financial and quality performance assessment purposes that were in place with the large provider entity during the reporting periods. To calculate the total health care expenditures and healthcare cost growth of providers, the Cost Board collects data from carriers via the **Cost Board's call for data** (data call). Carriers are required to attribute member months to these large provider entities, then aggregate claims and non-claims spending by attributed large provider entities as listed in Table 1. Spending from members who are not attributed to any of the large providers in Table 1 are categorized as "Unattributed to large providers."

The data reported for each provider entity include all total medical expense (TME) for all attributed members for each month a member was attributed, so long as the member was a Washington resident at the time of attribution, even when care was rendered by providers outside of or not affiliated with the respective provider entity. Carriers may choose whether residency is established as of the first of the month, last of the month, or another day of the month, consistent with their monthly attribution methodology. Box 1 shows how healthcare spending on out-of-state services received by Washington residents is treated in the data call.




## How is the Cost Board working to improve the attribution method?

We recognize that every attribution method has its limitations. To address attribution issues, the Cost Board is continuously looking for ways to improve attribution accuracy. For example, in August 2024, the Cost Board has started collecting providers' Tax Identification Numbers (TINs). This list will be provided in future data calls to help carriers correctly classify and identify claims by large provider entities. We welcome suggestions by carriers and providers on how we can improve attribution practices.

## Will the Cost Board provide the list of attributed members and corresponding PCP in provider reporting?

No, the Cost Board does not collect this information from carriers and will not provide this to large provider entities. However, provider organizations may request this information from specific carriers. We understand that knowing the PCPs, hospitals in the system, and/or patients who are driving cost growth is important to identify areas that need improvement.

## What should we do if we have questions on attributed member months?

Any feedback on the provider report should be sent by the due date specified in the cover page of the Provider Report (see Questions section). For specific question on attribution, providers need to identify which carriers have questionable data and email the specific carrier, copying **hcacostboarddata@hca.wa.gov**.

To facilitate a quicker resolution, provider organizations should be ready to share the following information:

- Your TIN numbers
- List of your primary care providers with their National Provider Identifiers (NPIs) and/or location
- Other helpful information that carriers may use to improve accuracy of attribution

## How are high-cost outliers accounted for?

To account for high-cost patients that may be unfairly driving cost growth for provider organizations, cost growth is based on adjusted TME per member per month (PMPM). Adjustment is done in two ways:

- Truncated claims spending
- Age and sex risk adjustment

### Truncating claims spending

Instead of using the overall claims spending when calculating the TME PMPM cost growth, the Cost Board staff uses truncated claims spending. Truncated claims spending refers to all claims payment spent on members after spending above the truncation threshold has been deducted on a per member basis. The truncation thresholds are set per market such that total amount of per member spending above threshold is ~95% of overall market (per 2019 data from Washington State's All Payers Claims Database (APCD)).

For more details, see page A11-A16 of the **Technical manual**.

### Age and sex risk adjustment

In addition to using truncated claims spending when calculating the TME PMPM cost growth for each large provider entity, the Cost Board staff uses age-sex risk adjusted TME PMPM. For providers that are treating relatively more patients in expensive age and sex brackets (e.g., the elderly population), the TME PMPM is adjusted downwards (and vice versa). Because carriers are required to submit spending stratified by age and sex, the Cost Board can calculate TME PMPM by age-sex brackets and identify which brackets are more expensive. Bracket rate relative to general rates as well as changes in member distribution across age-sex brackets are used to calculate risk scores. These risk scores are then used to adjust the TME PMPM.

For more details on age and sex risk adjustment as well as a sample calculation, please refer to section A of the "**Age-sex risk adjustment, pooled variance, and confidence interval of cost-growth calculation for provider reporting"** document and **sample calculation**.

## How is cost growth or provider performance calculated for provider organizations?

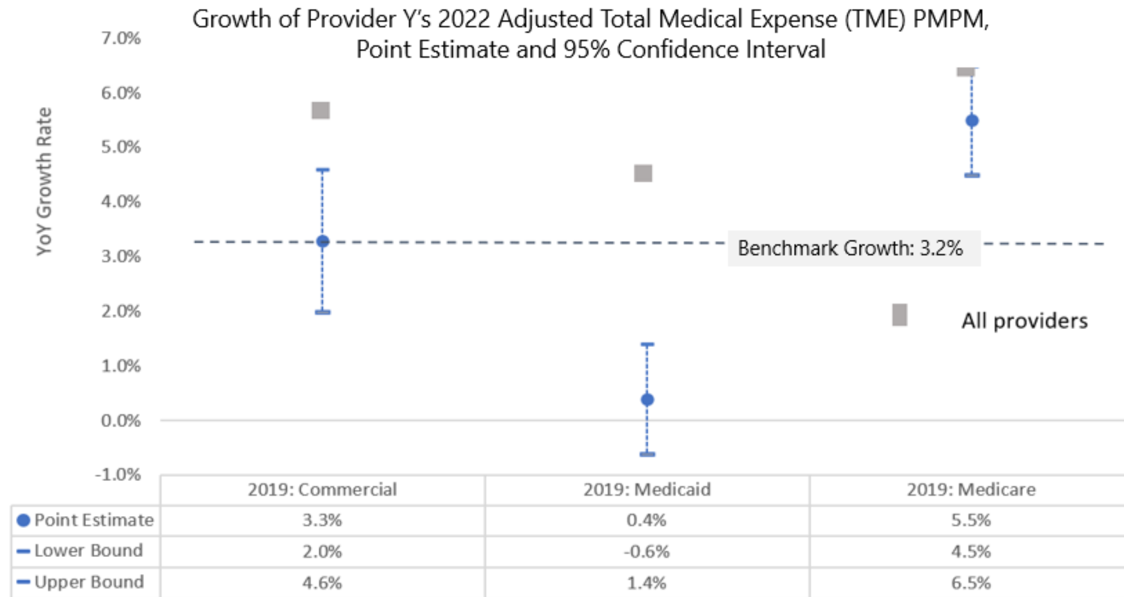
Provider performance or cost growth is measured by the 95% confidence interval of the growth rate of adjusted TME PMPM (i.e., truncated, age/sex risk-adjusted claims spending PMPM + unadjusted non-claims spending PMPM). The 95% confidence interval is calculated based on variance of the truncated claims PMPM pooled across carriers.

For more details on pooling variances and calculating the 95% confidence interval, please see section B of "**Age-sex risk adjustment, pooled variance, and confidence interval of cost-growth calculation for provider reporting**" document and **sample calculation**.

## How will the Cost Board identify which providers' cost growth performance exceeds the growth benchmark?

A provider's performance exceeds the benchmark if the lower bound of the provider's cost growth rate exceeds the benchmark. Performance is said to be indeterminant if the confidence interval contains the growth benchmark. Providers did not exceed the growth benchmark if the upper bound of the provider's growth rate is lower than the benchmark. Cost growth will be evaluated by overall performance (all markets) and by market. See Box 2 for sample performance comparison by market.

## Box 2. Sample Provider Performance Comparison to the Benchmark




| | 2019: Commercial | 2019: Medicaid | 2019: Medicare |
|---|---|---|---|
| Point Estimate | 3.3% | 0.4% | 5.5% |
| Lower Bound | 2.0% | -0.6% | 4.5% |
| Upper Bound | 4.6% | 1.4% | 6.5% |

- Commercial market: Provider Y's performance is indeterminate relative to the cost growth benchmark.
- Medicaid market: Provider Y's performance is lower than the cost growth benchmark.
- Medicare market: Provider Y's performance exceeds than the cost growth benchmark.