Public comments

From the 2024 Cost Board legislative report

Below are the public comments on the Health Care Cost Transparency Board (Cost Board) 2024 legislative report. The draft report outlined:

- The work of the Cost Board and its advisory committees since 2023
- Recommendations for increasing transparency and reducing health care expenditures
- Health care system spending trends
- Best practices of cost boards in seven other states

Public comment is a crucial part of the Cost Board's work. Feedback received informed the final version of the legislative report and will support future reports and presentations.

During the public comment period, the Cost Board received input from individuals and organizations alike through email and formal letter submission, which are all included in this document. **Please note:** Input shared in this document is exactly how the Cost Board received it, with no changes made to language. However, we changed all underlined words to **semibold** for accessibility purposes.

Email responses

Submitted by Fred Yancy

I have tracked and then read the final report of the Board. I do not claim to understand all the data and presentations that were before the Board. But, I am interested in the topic of both transparency and more importantly, cost.

I am in favor of establishing a universal heath care system for all, and have no problem with paying for such a system both by personal assessments and employer assessments.

What I am concerned about however, is the omission of making recommendations regarding the Medicare population. If I understand correctly, there are federal administrative barriers to incorporating Medicare into a state-wide health care system. It appears to be a hurdle to seek waivers and/or changes in restrictions and the commission apparently has no desire to seek these changes. This is an oversight that weakens the overall report and mission. The Medicare population, many living on fixed and modest incomes need help covering their ever increasing medical costs. I would like to have seen a recommendation to seek changes in Medicare to allow inclusion in a state system. "All" should mean "alll".

These are my thoughts.

—Fred Yancy

Submitted on behalf of Virginia Mason Franciscan Health

Good Afternoon,

I am a Director of Payer Strategy & Relationships at Virginia Mason Franciscan Health (VMFH) and joined the Health Care Cost Transparency Board's (HCCTB) Advisory Committee on Data Issues as a committee member in April, 2023.

Based on the 2024 Cost Board Legislative Report, it is clear that there is a strong bias that all healthcare cost issues can be resolved by focusing on controlling hospital costs. This is an erroneous and unfortunate thesis, particularly given that the consulting firm engaged by the HCCTB provided evidence that **hospital spend was not at all the key driver of healthcare spend increases for the four years studied**. Increases in other factors -- not increases in the amounts negotiated by hospitals -- made up the largest portion of the increase in healthcare costs across all programs. When considering increases in overall commercial hospital healthcare spend over the four-year period that was studied, the average annual cost increases attributed to hospital allowed spend was **1.9%, or less than 8% for all four years**, increases that are well below reasonable Consumer Price Index. Two percent: this is the percentage of hospital spend increase that might be impacted by the topics that this committee is now being asked to focus on. The data presented to our Advisory Committee was based on information presented by Amy Kinner, OnPoint Director of Health Analytics to identify healthcare cost trends and drivers.

The request for initial feedback from the Advisory Committee stated that "there is no easy solution for addressing rising health care costs in Washington State, these strategies were decided through a voting process at the Cost Board Retreat on February 9th as potential policy recommendations that **may lead to the biggest impact at reducing health care cost growth** and addressing price transparency." It would be good to know what evidence was provided to the board prior to the voting process. How can policy recommendations focused on controlling provider costs have the "biggest impact at reducing healthcare cost growth" when, at best, these policy recommendations will only impact the commercial allowed portion of hospital spend (not utilization), which is a relatively small portion of the **total** healthcare spend increases in Washington State? There should be concern that none of the true cost drivers of healthcare spend increases (i.e. increases to health plan premiums, utilization, pharmacy spend, and non-commercial program volume in Medicare and Medicaid) will be addressed.

The HCCTB has provided no response to multiple VMFH communications expressing concerns about the data that was shared with the Cost Driver Committee and the conclusions drawn by that data. Even more concerning is HCCTB's failure to acknowledge the serious flaws in the benchmark data analysis. As a committee member, I question the purpose of the Committees since feedback about the data conclusions are ignored, kept secret, and appear to have no impact to HCCTB's foregone conclusions.

—Christa Able

Submitted by Sarah Huling

Dear Health Care Cost Transparency Board,

I appreciate the opportunity to comment on the Cost Board's draft 2024 report and its ongoing efforts to improve healthcare affordability in Washington. While the Board's recommended measures around facility fees, market consolidation, and primary care are commendable, I urge the integration of payment model adjustments based on research by Harold Miller from the Center for Healthcare Quality and Payment Reform (CHQPR). Miller's analysis provides actionable insights into sustainable funding mechanisms, particularly for small rural hospitals, which could significantly impact Washington's rural healthcare landscape.

1. **Facility Fees and Standby Capacity Payments**

   The Board's focus on limiting and reporting facility fees is an important step toward transparency. However, as Miller's work highlights, rural hospitals incur high fixed costs due to essential 24/7 services such as emergency care. Facility fees alone do not address the structural financial burdens these hospitals face. Miller recommends **Standby Capacity Payments** that would provide consistent support for essential

services, regardless of patient volume, funded by a proportional contribution from all insurance providers. This model would ensure small hospitals can maintain emergency and primary care services, which are critical in communities far from alternative facilities (Miller, April 2023).

2. **Market Oversight and Protection Against Consolidation**

   The Board's recommendation to strengthen oversight on mergers and acquisitions is crucial to mitigate price increases linked to market consolidation. Miller's research shows that increased corporate and private equity involvement often correlates with reduced service availability in rural areas and higher costs for patients. Expanding oversight, as the Board proposes, can protect patient access to local care. I recommend further aligning these efforts with Miller's proposals for **regulatory protections specifically aimed at rural healthcare sustainability**, ensuring rural facilities retain autonomy and not succumb to cost-cutting pressures from larger, consolidated health systems (Health Care Cost Transparency Board, 2024).

3. **Primary Care Expenditure and Value-Based Models**

   Increasing Medicaid reimbursement rates and targeting primary care spending is a valuable approach for long-term savings. However, Miller cautions against models that incentivize service reduction at the cost of access in rural settings. Instead, he proposes **Patient-Centered Payment models** that allow rural hospitals to receive sustainable fees for core services while maintaining service access. This framework is especially relevant for Washington's rural hospitals, which may be unable to absorb cost reductions without risking closure or downgrading service levels. The Board should consider integrating Miller's model as part of its primary care expenditure targets to ensure sustainable support for rural facilities (Miller, April 2023).

In conclusion, while the Board's recommendations are robust, adopting elements of Harold Miller's Patient-Centered Payment model and Standby Capacity Payments would more comprehensively address the unique challenges facing Washington's rural hospitals. These reforms could safeguard essential services while controlling costs, aligning with the Board's commitment to affordability and access for all Washingtonians.

Thank you for considering these perspectives.

Sincerely,

Sarah Huling EdD(c), MBA Rural Healthcare, BS ARRT, ARMS

Note: Sarah included a copy of CHQPR's report, which you can view on CHQPR's website.

Formal letter responses

The remainder of this document contains formal letter submissions.

Washington State Hospital Association

November 18, 2024

Dear Members of the Health Care Cost Transparency Board (Board),

The Washington State Hospital Association (WSHA) offers the following comment in response to the 2024 annual report to the Legislature. Also enclosed are specific responses to the Board's policy recommendations along with a separate analysis of Washington's hospital financial performance and costs.

WSHA appreciates the need to identify ways to make health care more affordable for Washingtonians while ensuring the preservation of access to quality care. At the same time, it is important to recognize that our state is already a leader in many areas. Our health care system, including its hospitals, provides high quality care for its residents with Washington hospital spending per capita well below the US median.[1] In addition, as reported in the annual report, growth in Washington state hospitals on a revenue per discharge basis has been lower than national growth over the last five years.

The annual report does not accurately reflect Washington hospitals' performance.

WSHA disagrees with the report's conclusion that Washington hospitals are high price and high cost. We challenge some of the basis for these findings. A recent separate evaluation by the Analysis Group shows that in a direct comparison among all prospective payment hospitals nationally, Washington hospitals are not high price.

In contrast to the statements in the report, the Analysis Group's findings shows prices in Washington are in the middle range for the nation as a whole. This comparison adjusts for factors that affect the cost of services such as patient mix, teaching intensity, and area wage rates. These adjustment factors are critical to ensure comparisons are controlled for differing factors. The peer group analysis used in the report also incorporates these factors, but the methods for creating the groupings are unclear, the choices of the groups may be arbitrary, and the classification of some of the hospitals as high price is questionable at best.

The annual report's analysis on hospitals does not deal with the complexities of providing care.

While the early explorations of the Board's consultant discussed the low operating margins of Washington hospitals, both the consultant's final report and the Board's annual report ignore this key fact. With margins so low, how can policy solutions propose further reductions without considering their impact on access and quality? Furthermore, in its data explorations, the Board structured its analysis to focus separately on segments of hospital services, inpatient and outpatient, without looking at the entity as a whole. This approach ignores the fact that both inpatient and outpatient care both contribute to the overhead keeping the facility operational.

Despite the claims made in the annual report, Washington hospitals are not inefficient.

The consultant's report claims Washington hospitals are inefficient, but the data in fact shows that Washington hospitals are performing exactly in line with all other hospitals in the nation. All hospitals are struggling with remaining viable at a time when neither Medicare nor Medicaid is covering the costs of care. Washington's low margins are not the result of inefficiency, but more likely the result of historically low Medicaid payment rates. As the consultant's analysis shows, the ratio of hospital payments compared to standardized costs in

[1] Per capita all payer spending for hospitals by state of residence in 2020 was $3784 in Washington State compared to US average of $3855. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence

Washington hospitals is exactly the same as the rest of the country.

The annual report does not explain valid reasons for the growth in hospital outpatient services.

The report finds that hospital outpatient care is one of the largest areas of cost growth but does not consider the underlying factors driving this growth. The Board's earlier analysis showed inpatient care has largely remained flat in terms of revenue changes over time, but outpatient care has increased due to increased volumes of service. The Board's discussions and the report focus on the problem with increases in outpatient care, but the reality is more complicated. Growth in outpatient services is due in part to the deliberate effort to save costs by converting more expensive inpatient care into outpatient care. That raises both volumes and revenue for outpatient services.[2] The report acknowledges this shift has occurred but never examines the overall impact it has had. Expansion in hospital outpatient care is also due to the fact that these services provide access to care in communities where physicians have restricted access for government sponsored patients or discontinued independent practices due to financial and operational hardships of maintaining a practice.

The policy solutions proposed in the annual report do not address cost drivers.

While the Board has identified growth in pharmacy services and hospital outpatient volumes as major cost drivers, the policy options selected by the Board for legislative consideration do not address these drivers. They also fail to consider the impact they will have on hospitals' financial sustainability and patients' access to care. Moreover, the solutions do not address underlying operational cost components for hospitals – primarily wages, supplies, and pharmaceuticals costs.

If the Board and Legislature develop solutions that target hospitals, those solutions need to address how hospitals can achieve sustainable margins and can continue to support the staff needed to provide high-quality care in our communities.

Please see the enclosed for WSHA's detailed comments about the report and the attached findings from the Analysis Group.

Sincerely,

Chelene Whiteaker

Chelene Whiteaker
Senior Vice President, Government Affairs
Washington State Hospital Association

[2] For example a former $10,000 inpatient procedure that becomes a $6,000 outpatient procedure will be cost-effective for the system, but will drive outpatient volumes and revenue per procedure to be higher.

WSHA Detailed Comments on Draft Annual Report

Benchmark report (page 16)

WSHA thinks it is an overstatement to say that large provider groups had an opportunity to validate the benchmark data. While the aggregate data totals were shared with the provider groups, it was not possible for them to validate the information since they were not informed which physicians or patients were included in the analysis or what spending was attributed to their facilities versus other unrelated entities. We ask that future data collection efforts be done in ways that contribute to transparency and meaningful decision making

Facility fees (page 10 to 12)

In line with its emphasis on hospital outpatient care as a cost driver, the Board and this report focus on facility fees. Again, the report ignores the fact that these fees are helping to sustain specialty hospital services at a time when overall margins are poor or negative. If the portion of hospital overhead allocated to outpatient services and paid through facility fees is eliminated, then fees for inpatient services need to increase. The report doesn't explain that facility fees replace office administrative expenses, nor does it address the fact that facility fees often support specialty and other care needed in the area.

WSHA acknowledges that the Board is suggesting more data are needed on facility fees. However, the two graphs and discussion on facility fees are not informative. While the data show a decline in facility fees, the text claims that fees have become more common.

Similarly, the graph included on the range of facility fees by providers is not informative and does not substantiate the text statement that variation shows the unregulated nature of these fees. Larger providers will have more outpatient service fees and revenue than smaller providers. Also, facility fees are a specific part of Medicare and Medicaid payment but not necessarily part of private pay (depending on the negotiated arrangements). The volume of facility fees by provider will vary depending on the size of the facility as well as their mix of payers and negotiating arrangements.

Market oversight (page 13)

The NASHP model legislation presupposes there is a void in underlying law but that isn't the case in Washington. Washington already requires hospitals, hospital systems, and provider organizations to provide pre-transaction notice to the state Attorney General of material change transactions at least 60 days prior to closing. Washington also already has a corporate practice of medicine doctrine through case law and statutorily requires reporting of ownership and control of health care entities. Expanding the scope of entities covered should be considered, because all participants that impact the health care marketplace should be subject to transaction oversight. If there are certain sections of the NASHP model legislation that the Board believes would be useful, the Board should identify these and the rationale for changes in the law.

Primary care expenditures (page 14)

WSHA agrees that there is a case to be made that our system could be improved by spending more on primary care. We suggest it may be informative for legislators to understand that this is a national issue, and not specific to Washington. Washington, as well as the US as a whole, has potentially underspent on primary care. Increasing spending might result in better care and potentially offset other health expenditures. Our state and country also need to focus on the provider shortages in primary care. Even if we increase payments if there are not enough providers, we will still be faced with inadequate access.

Benchmark and performance (page 16)

As we have said previously, WSHA takes issue with the methodology used to calculate the benchmark. The report does not include the fact that the median wage growth was calculated using Washington median wage

from 2000 to 2019, a period of extremely low inflation. How can this be used to measure if the growth rate in health care is sustainable in 2022 and beyond. Our country faced inflation that we haven't seen in 40 years. The report should caveat this data.

In discussing the reason for growth in spending (page 19), the report highlights the growth in hospital outpatient care. We understand the cost-driver report is being redone but this report does not mention the initial findings which showed growth in commercial outpatient was due to increased volume of services rather than an increase in price.[3]

Primary care recommendations (page 23)

WSHA does not think increases to primary care spending should be coupled with forced cuts to other health care services. The impacts to patients should be considered. If Medicaid patients cannot see specialists, then they will be forced to wait until their condition is an emergency. This is counter-productive to the goal of reducing expenditure through improved primary care access. If primary care improves health, then the savings should be seen through natural reductions in the spending for other services. WSHA believes savings may be slow to be realized and should not simply be assumed in near future budgets.

Hospital spend (page 25)

WSHA takes issue with the method used to generate these findings and the way that they have been summarized in the annual report. For example, the report says that Washington has higher revenues and higher costs per patient than similar hospitals in the US but we are not sure what evidence is used for this statement.

If it is simply a comparison between Washington and other states on a per discharge basis, it needs to adjust for factors such as wage rates and case mix. Washington state has extremely high relative wages, due to its high cost of living. Washington also treats many patients in an outpatient setting and hospitalizes fewer patients per capita than other states. That makes the inpatient patients sicker and more expensive than in other places. As described in the accompanying report from WSHA's consultants, when adjustments are made to standardize for differences in wages, case mix, and teaching intensity, Washington hospitals are not high price compared to other US hospitals but in the middle of the distribution. And they are *certainly* not high price *and* high profit, the combination that often garners attention and concern.

If the claims in the annual report are derived from the consultant's peer group comparisons between a Washington hospital and its small group of peers, we have concerns as described below with the approach used to generate these findings.

WSHA also takes issue with the discussion on medical debt. The report cites US data on medical debt which may not be relevant to Washington, which has already made major improvements in this area and has one of the best hospital charity care provisions in the nation. WSHA is happy to provide a summary of the charity care law and encourage the consultants to better understand the current Washington requirements.

Peer group comparisons (page 25)

The peer grouping process that the consultants use to compare Washington hospital performance with others is opaque and seems arbitrary. We do not think the set of hospitals named as revenue and cost outliers in this report deserve these labels. Out of thousands of other hospitals in the nation, each hospital was compared with only 5 to 20 "similar" hospitals. WSHA questions the methods used to create these groupings compounded by the incomplete description of the methodology, which states that the selection methods had to be tweaked to arrive at the actual groupings. Furthermore, as discussed in the accompanying report, the report by Analysis

[3] *Health Care Cost Transparency Board Advisory Committee on Data Issues*. 7 Feb. 2023, www.hca.wa.gov/assets/program/hcctb-data-issues-committee-20230207.pdf.

Group using a more transparent methodology fails to replicate the results. Some of the hospitals identified as high price in the consultant's report are actually below the national median in price.

Medicare payment-to-cost ratio (page 26)

WSHA finds the consultant's discussion of efficiency misleading. There are thousands of prospective payment hospitals in the United States, and they have a range of efficiency. In deciding whether the federal government should increase Medicare fee-for-service payments, the federal advisory agency, MedPAC, looked at a variety of factors, including whether Medicare payments were covering marginal hospital costs. MedPAC research shows that some hospitals have been able to move their costs close to a Medicare payment level, but for all hospitals the average is a loss of 17 cents for every dollar received from Medicare. That is the same ratio as the Board's consultants found in Washington. In other words, Washington hospitals, on average, are as "efficient" as the rest of the country's hospitals.

Hospitals already have tremendous economic incentives to be as efficient as possible; the fact that profits are low or negative is the economic reality frequently associated with providing high quality, and often costly, care.

Price- and cost-trend analysis (page 26)

It is relevant to consider overall increases in hospital spending in the state, but again the annual report and the consultants' work on which it is based seem to pick out only a few of the measures.

One would normally expect that total services per hospital in Washington, a state with a high population growth rate over the last decade and last five years, would outpace the national growth in use of services. There simply are more people in Washington getting health care, there hasn't been an expansion of the number of acute care hospitals, and so total spending per hospital in the state should rise more than lower growth areas.

Beyond that, the per-discharge rate of increase comparison for specific hospitals is not informative. A comparison down to the individual level needs to also take into account specific changes in service or other factors which may drive growth, including the initial price of the service.

The bottom line as reported in the consultant's report shows that growth in Washington state hospitals on a revenue per discharge basis has been lower than national growth over the last five years. That indicates hospitals are performing well and controlling their prices.

Analytic support initiative (page 31)

WSHA is pleased the Board has engaged analytic support to look at broad issues in health care spending using large data sets for analyses.

The graphics included in the report are informative, but we think the information on spending could be better understood if there also was a national context on how the spending in our state compares with other areas of the nation. Slides for the analytic support initiative report presented during the Board meeting on November 7, 2024, showed that Washington ranked well when compared to other states. This finding should have been included in the report.

This is consistent with Kaiser Family Foundation findings that ranking Washington has the 15th lowest premium cost in the nation[4], which would indicate that private payer costs are relatively low compared to other areas. National data also show Medicare Part A payments per traditional enrollee are very low in Washington

[4] "Average Annual Single Premium per Enrolled Employee for Employer-Based Health Insurance." *KFF*, 2023, www.kff.org/other/state-indicator/single-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%20Annual%20Premium%22,%22sort%22:%22asc%22%7D. Accessed 13 Nov. 2024.

compared to elsewhere.

We think an important element is to understand not only the variation in Washington but how Washington compares overall to other areas in its health care spending. If spending is already generally low, future improvements may be more difficult, especially given that both salaries and many products are influenced by national markets.

PEBB/SEBB proposal

During the November 7, 2024 Board meeting, the Board voted to add an endorsement of HCA's PEBB/SEBB legislative proposal. WSHA strongly opposes this proposal. Reducing payments in PEBB/SEBB will increase pressure to recoup those losses through other commercial health plan negotiations. This will result in increased costs to employers who purchase those plans and consumers who enroll in them. Additionally, when hospitals cannot recoup losses on other commercial products, they are forced to assess their services and potentially reduce what they provide to their communities. Also, this legislation shifts all power and leverage to the carriers. There is no incentive for a payer to change their rates overtime, and as currently drafted, it is unclear if hospitals could even get inflation increases.

STUDEBAKER | NAULT

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November 18, 2024

Washington State Health Care Authority
Health Care Cost Transparency Board
Cherry Street Plaza
626 8th Avenue S.E.
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VIA E-MAIL: hcahcctboard@hca.wa.gov

Re: Health Care Cost Transparency Board's Draft 2024 Legislative Report

Dear Members of the Health Care Cost Transparency Board:

Our firm represents the Washington Ambulatory Surgery Center Association. We appreciate the opportunity to comment on the draft 2024 Legislative Report (the "2024 Draft Report") of the Health Care Cost Transparency Board (the "Board"). We commend and support the Board's desire to make health care more transparent and affordable for Washingtonians. For your convenience, the recommendations from the 2024 Draft Report on which we are commenting are italicized below.

> *Recommendation 1: Outpatient Facility Fee Reporting Requirements*
> *Require hospitals to report on outpatient facility fee billing, including the locations charging facility fees and the revenue from those fees, as well as the volume and amounts of facility fees by service, payer, and location.*

We appreciate the Board's desire to increase transparency related to facility fees. We recommend that the Board clarify this recommendation, however. Under chapter 70.01 RCW, only "hospitals with provider-based clinics that bill a separate facility fee" are required to report on its facility fees.[1] Under RCW 70.01.050(5)(b), a "provider-based clinic" refers to:

> [T]he site of an off-campus clinic or provider office that is owned by a hospital licensed under chapter 70.41 RCW or a health system that operates one or more

[1] RCW 70.01.050(4).

> hospitals licensed under chapter 70.41 RCW, is licensed as part of the hospital, and is primarily engaged in providing diagnostic and therapeutic care including medical history, physical examinations, assessment of health status, and treatment monitoring.

A number of studies have concluded that outpatient procedures performed in hospital provider-based clinics are more expensive than when those same procedures are performed in ambulatory surgery centers ("ASCs").[2] While hospital provider-based clinics may perform certain of the same procedures as ASCs, those procedures, when performed in hospital provider-based clinics, generally cost more. In addition, unlike ASCs (which bill and collect only facility fees and do not bill or collect professional fees), many hospital provider-based clinics bill and collect for both facility fees and professional fees. Therefore, unlike in ASCs, in hospital provider-based clinics, patients can often be left unaware of the true cost of a procedure. This is not the case in ASCs.

We are requesting that the Board clarify its recommendation that the hospital reporting requirement is limited solely to hospitals and their provider-based clinics, not to ASCs.

> *Recommendation 2: Billing and Ownership Transparency*
> *Require hospital-owned and -affiliated providers to acquire and include unique National Provider Identifiers[] (NPIs) specific to the location of care on all claims so that claims and fees can be tracked via the All Payer Claims Database.*

Recommendation 2 is overly broad and ambiguous. Neither chapter 70.01 RCW nor chapter 70.390 RCW define the term "affiliated provider." Affiliations between hospitals and other providers may come in many forms. Many healthcare providers, including ASCs, have agreements with hospitals that have no effect on the fees those providers bill patients or payors, *e.g.*, agreements that allow for transfer of patients to hospitals in the event of an emergency. Absent clarification, those entities may constitute as "affiliated providers" under Recommendation 2, even though they bill separately and are separate legal entities.

As written, this recommendation appears to require hospital-owned and affiliated providers to obtain a new, single NPI. Under the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"), an entity is required to obtain a unique NPI for itself.[3] If a facility is a subpart of a covered entity, it is required to obtain a unique NPI if it would be required to obtain an NPI if it was a separate legal entity.[4]

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[2] *See, e.g., Hospital Outpatient Prices Far Higher, Rising Faster than Physician Sites*, Blue Health Initiative, at 1 (Dec. 2023) ("HOPD common procedure prices were substantially higher — in some cases, five times more expensive — than when performed in an ASC or office setting."); *see also*, Miho J. Tanaka, MD, *Ambulatory Surgery Centers Versus Hospital-based Outpatient Departments: What's the Difference?*, American Academy of Orthopedic Surgeons (Sept. 1, 2019), *available at* https://www.aaos.org/aaosnow/2019/sep/managing/managing02/ ("Payment rates for the same procedures are lower in ASCs than in HOPDs. Procedures performed in ASCs are reported to cost Medicare 53 percent of the amount paid to HOPDs.").

[3] 45 C.F.R. § 162.410(a)(1).

[4] *Id*.

We request that the Board revise this recommendation to comply with 45 C.F.R. § 162.410(a)(1). As such, entities should be permitted to retain their unique NPI if they are required to obtain one under HIPAA.

Additionally, obtaining a new NPI is administratively and, potentially, financially burdensome. Aside from obtaining a new NPI from the National Plan & Provider Enrollment System, an entity will need to update all of its current payor agreements. Not all payors treat a new NPI lightly. Many may require recredentialing or even terminate an agreement, delaying treatment for patients while the entity waits (perhaps for months) for a payor to process the new information.

> *Recommendation 3: Increase Washington State's oversight of mergers and acquisitions Given the evidence that market consolidation increases prices, raises consumer costs, and jeopardizes access, the Cost Board proposes the Legislature use the National Academy for State Health Policy's Model Act for State Oversight of Proposed Health Care Mergers to draft legislation to increase Washington State's oversight of mergers and acquisitions.*
>
> *Recommendation 4: Require ownership structures and legal affiliations reporting The Legislature should require all carriers, health systems, hospitals, and other health care facilities, such as ambulatory surgery and dialysis centers, to report ownership structures and legal affiliations. Reporting should include any acquisition or ownership state by a private equity firm and be designed to provide transparency into any private equity or corporate affiliations with a system, facility or provider.*

Our comments to Recommendation 3 and Recommendation 4 are addressed together. Increasing oversight of mergers and acquisitions of ASCs, as proposed under the National Academy for State Health Policy's Model Act for State Oversight of Proposed Health Care Mergers (the "Model Act"), would lead to additional administrative and financial burdens for ASCs and would be duplicative of processes already in place. Requiring ASCs to further disclose ownership structures, when they are already required to do so in numerous ways. Both of these recommendations are duplicative of existing processes and only add to the burdens imposed on ASCs.

Under Washington law, ASCs are required to undergo a certificate of need review with the Washington State Department of Health prior to the construction, development, or other establishment of their facilities. An ASC seeking a certificate of need or an exemption from the certificate of need review requirement must identify itself and include "[a]ny person or individual with a ten percent or greater financial interest in a partnership or corporation or other comparable legal entity engaging in any undertaking subject to review under chapter 70.38 RCW."[5]

[5] WAC 246-310-010(6).

In determining whether to grant a certificate of need, the Department must assess: (i) whether the population to be served has a need for the service; (ii) whether all residents in the service area will have adequate access to the service, including the extent to which the applicant serves Medicare, Medicaid, and medically indigent patients; (iii) any special needs or circumstances the proposed project is to serve; (iv) the adverse effects the project will have on health professional schools and training programs; and (v) whether the project is needed to meet the special needs and circumstances of enrolled or potential members of a health maintenance organization that are not available from non-health maintenance organization providers or other health maintenance organizations in a reasonable and cost-effective manner.[6] The applications and decisions of the Department are public information.

An ASC that is seeking to obtain an ambulatory surgical facility license pursuant to chapter 70.230 RCW is also required to submit an application to the Department. The ASC must provide the Department with documentation "concerning the ownership and management of the ambulatory surgical facility, including information about the organization and governance of the facility and the identity of the applicant, officers, directors, partners, managing employees, or owners of ten percent or more of the applicant's assets."[7] An ASC must submit an annual license update and also an application for renewal of its license every 3 years thereafter.

Additionally, the 2024 Draft Report notes that a Provider Organization, which includes ASCs with seven or more health care providers, engaging in a "Material Change" is required to provide notice to the Washington Attorney General.[8] "Material Changes" include, but are not limited to, mergers, acquisitions, or contracting affiliations between (i) two or more Provider Organizations, or (ii) a Washington entity and an out-of-state entity where the out-of-state entity generates ten million dollars ($10,000,000) or more in health care services revenue from patients residing in Washington state.

Aside from the Department's certificate of need and licensing reporting requirements, ASCs are also required to disclose the ownership interests, whether direct or indirect, of any person or entity with 5% or more ownership when applying to Medicare or Medicaid[9], including disclosure of entities managing ASCs. Enrollment also requires identifying any managing organizations. ASCs are required to file change of ownership or change of information applications when new owners invest in the ASC. In general, ASCs are also required to revalidate or renew their enrollment every five years.

Finally, while chapter 19.390 RCW defines "contracting affiliation" and the Model Act defines "Affiliate," Recommendation 4 discusses "legal affiliations" or "corporate affiliations" (apparently interchangeably) without clarifying the scope of those terms. As mentioned above,

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[6] WAC 246-310-210(1)-(5).

[7] RCW 70.230.050(1)(e).

[8] RCW 19.390.030.

[9] *See* 42 C.F.R. § 455.104(b) (requiring the name of any person or corporation with an ownership interest in a Medicaid provider).

"affiliation" is a broad term and can encompass a wide range of activity. We recommend the Board clarify in its recommendations which arrangements or activities constitute "affiliations."

Adding an additional level of reporting, as proposed in the 2024 Draft Report, would merely be duplicative of existing processes and further add to the administrative and financial burdens of ASCs. ASCs are already required to make regular reports of their ownership and business structures to the Department and, in the event of a Material Change, to the Washington Attorney General. Adding this additional approval would likely lead to greater, not lower, costs for Washington residents.

We appreciate the opportunity to comment on the 2024 Draft Report. Should you have any questions regarding the above comments, or if we could provide any additional clarification that will assist the Board, please do not hesitate to contact us directly.

Regards,

STUDEBAKER NAULT, PLLC

Emily R. Studebaker

cc: Board of Directors, Washington Ambulatory Surgery Center Association

ANALYSIS GROUP

Analysis of Washington State Hospital Financial Performance Using 2022 CMS Cost Report Data

Author:

Bruce Deal, Managing Principal

Analysis Group

November 18, 2024

I. About Analysis Group

Analysis Group is an economic, financial, and strategy consulting firm with offices throughout the United States, plus international offices in Canada, France, Belgium, the U.K. and China. Our staff consist of more than 1,500 professionals and support personnel with expertise in statistics, economics, finance, biostatistics, and related disciplines. Our clients include a wide range of organizations, companies, law firms, and governments, and our work covers a variety of issues requiring specialized analysis. Much of the work of Analysis Group involves the evaluation of healthcare data from a wide range of government and private sources, including data on healthcare costs, outcomes, quality measures, utilization of services, and a variety of other types of information.

Bruce Deal, a Managing Principal with Analysis Group, directed this study. Mr. Deal has more than three decades of experience working with a wide range of healthcare information, including data from government and private sources related to hospital prices, costs, and quality. Prior to joining Analysis Group more than 25 years ago, Mr. Deal worked as a consultant and manager with Arthur Andersen in the Seattle, Washington office, where he worked with hospitals throughout Washington State and the western United States.

II. Assignment

Analysis Group received a request from the Washington State Hospital Association (WSHA) to examine the information prepared by Bartholomew-Nash, a consulting firm hired by the Washington State Health Care Cost Transparency Board (HCCTB) and cited in the Board's annual report to the legislature.[1] In particular, Analysis Group was asked to review and comment on the conclusion contained in the Board's report that Washington hospitals generate higher per-patient revenue and per-patient costs than similar hospitals in the United States.[2] This conclusion was based on the work done by Bartholomew-Nash and contained in Appendix A to the annual report.

Bartholomew-Nash did an overall review of the performance of Washington hospitals and attempted to benchmark their performance against similar hospitals in other states. Benchmarking hospitals against one another can be quite challenging, as there are a wide range of circumstances that can affect prices, costs, and other measures. The particular approach taken by Batholomew-Nash was to hand-pick a set of peer hospitals across the nation for each Washington State hospital based on a set of hospitals that met certain characteristics according to categories for four measures, then further broadened or narrowed (a process not described in the report) to achieve between 5 and 20 peers for each hospital.[3] These data were then used to identify whether the hospital had relatively higher or lower prices, costs, and profits than its hand-picked peers. Hospitals that were more than 10 percent higher than the median of their hand-picked peers were identified as being "high" on each dimension. The underlying dataset

[1] https://www.hca.wa.gov/assets/program/cost-board-materials-11072024.pdf

[2] https://www.hca.wa.gov/assets/program/cost-board-materials-11072024.pdf, p. 120 of the pdf, p. 25 of the draft report

[3] https://www.hca.wa.gov/assets/program/cost-board-materials-11072024.pdf, p. 135 of the pdf, p. 40 of the draft report

used for this analysis was based on Medicare cost reports, but the specific data set, including the specific hospitals selected to compare to each Washington State hospital, are not publicly available.

Analysis Group was not asked to replicate the exact method used by Bartholomew-Nash, but was instead asked to use standard data sources, techniques, and adjustments to answer a fairly simple question: *do Washington State hospitals appear to be outliers in terms of price relative to the rest of the country?*

III. Methodology

Bartholomew-Nash used an approach to look at financial performance and compare hospitals to peer institutions. While comparisons to peers is a standard practice in many industries, the specific results of any such exercise depend on factors such as: 1) the variables selected for the comparisons, 2) adjustment made to those variables, 2) the data ranges or categories selected for each of the characteristics, and 4) the number of peers in the groupings.

Rather than develop our own set of specific peer hospital benchmarks for comparison, we used a simpler, more straightforward approach. We compared the performance of Washington prospective payment hospitals to all other such hospitals in the United States by standardizing the performance of each hospital to account directly for certain factors that influence its cost and therefore its price. These are: 1) its mix of inpatients and outpatients, 2) its case mix (severity of patients served), 3) its regional wage factor, and 4) its teaching status. Case mix, regional wage factors and teaching status are the three variables CMS uses to standardize its inpatient payments across all prospective payment system hospitals.

Like Bartholomew-Nash, Analysis Group used hospital Medicare Cost Report information reported annually to the Centers for Medicare and Medicaid Services (CMS). To measure prices, we used the same measure as used in the report, net revenue per adjusted discharge. Conceptually this is a measure of the revenue generated across various payors (Medicare, Medicaid, and Private Payors among others) from providing care for a typical inpatient.

There are number of challenges associated with doing cross-hospital comparisons using any measure, including a measure of price expressed as net revenue per adjusted discharge. Several of the key challenges associated with this measure are discussed below, along with a description of the techniques used to make appropriate adjustments.

- **Volume Adjustments for Outpatient Care** - Revenue[4] is received from both inpatient and outpatient services by most hospitals. In order to calculate a standardized amount per unit of service, a common practice is to take the number of inpatient discharges (as provided in the Medicare Cost Report) and increase it by the ratio of outpatient charges to inpatient billed charges. Thus, if outpatient billed charges were 50 percent of the total amount of inpatient billed charges, the number of inpatient discharges would be increased by 50 percent. This results in a measure of adjusted discharges. It should be noted that this

[4] In the remainder of this report, revenue is used to refer to net patient revenue, which is the amount of payment received by hospitals for the services provided. Net patient revenue is also sometimes expressed as gross revenue (billed charges) less discounts from charges provided to various payors.

conceptually assumes that $1 of billed charges for outpatient services is equivalent in costs and service intensity to $1 in inpatient services.

- **Case Mix** – Some hospitals may care for more seriously ill patients than other hospitals, typically resulting in additional costs and additional revenue. A common technique to adjust for this is to "normalize" the costs or revenues using a case mix index to adjust the data. Thus, if a hospital's revenue was $10,000 per adjusted discharge and the case mix index was 2.0, the revenue would be divided by the case mix index to calculate a $5,000 per adjusted discharge revenue for a "normalized" case mix of 1.0. The hospital's actual revenue is double the resulting amount, but that is conceptually due to the fact that its patients are twice as costly compared to a hospital with "average" patients. While this is a critical factor that impacts hospital costs and revenues, there is no case-mix number easily available for all the patients the hospital treats. While imperfect, we use the Medicare inpatient case mix as a proxy for all the cases (as did the Bartholomew-Nash analysis.) This approach is based on an assumption that hospitals which treat more acute Medicare patients also likely treat more acute Medicaid and private pay as well.

- **Regional Wage and Input Cost Variation** - Certain parts of the country are known to have higher labor and other input prices than other parts of the country. CMS recognizes this and adjusts its payments accordingly. We use the Wage Index Table developed by CMS based on area-wide wage differences for hospital employees to adjust the operating costs for each hospital to account for these variations.[5]

- **Teaching Status** – An important function of many hospitals is to serve as a setting to teach future doctors and other professionals. These functions can raise costs for hospitals, which is often recognized by CMS and other payors via higher payments. We use the Indirect Medical Education (IME) factor used by CMS in setting payments to adjust for differences in payment across hospitals due to teaching intensity.[6]

- **Data Source and Aggregation -** For all of our calculations, we use the Medicare Cost Report data available for calendar year 2022 for the prospective payment system (PPS) hospitals. There are 45 hospitals in Washington State and 3,039 hospitals nationwide that had reported data sufficient for this analysis. We make the adjustments to the data as discussed above. We then aggregate the data across each state to determine and overall state revenue per adjusted discharge.

There are necessarily judgments and assumptions that are implicit in any data comparisons, particular those involving organizations offering the range of complex services provided by modern acute care hospitals. One needs to be aware of the limitations inherent in such an analysis, the underlying assumptions, and the inherent variability that will result from any such exercise.

[5] Our analysis adjusted operating expenses by the wage index. Bartholomew-Nash used a more complex approach to adjust a portion of the operating expense by the wage index and adjust the remaining portion of operating expense using a different index. (see p. 41 of the report cited above)

[6] IME = c x $[(1 + r)^{.405} - 1]$ where c is a payment multiplier currently set to 1.35 and r is the hospital's resident-to-bed ratio. Thus if a hospital's resident-to-bed ratio was 0.5, the implied IME would be 0.24, meaning a hospital would receive 24% more payment per discharge. As a result, we divide revenue by 1.24 to standardize the payments.

IV. Findings

Our findings show that Washington State is not a "high price" state for hospital care. We find that Washington State is very much "in the middle" of the 50 states with regards to revenue per adjusted discharge.

At the state level, revenue per adjusted discharge using the methodology described above results in a range from over $12,000 to $5,600. Washington State, at $8,515 is within 4 percent of the median value of $8,220. Seventeen states have higher prices than Washington.

Prices generally track with costs, but prices in Washington are even lower compared to costs than other states. As the Bartholomew-Nash report itself found, Washington State hospitals are generally *not* high profit hospitals. In fact, Washington State hospitals typically spend more in providing the care they provide than they generate in revenue, resulting in operating losses. Of the 45 hospitals in Washington State in our analysis, 91 percent reported operating losses in 2022, and the aggregate *loss* of more than 11 percent of net revenues puts Washington State in the lowest-profit 20 percent of all states.

Of course, within any state there will be a range of individual hospital outcomes when comparing prices or costs per discharge. Bartholomew-Nash use their methodology to identify hospitals that they categorize as high price and/or high cost hospitals (those hospitals with prices or costs more than 10 percent above the hand-selected peer group median value on each dimension). While the findings are described in the report without any specific consequences or recommendations for these hospitals, the implication of the identification of outliers is that there is problem with their operations, especially for those identified as high price, high cost and high profit.

In our experience, one must be very careful when using necessarily imperfect comparison data for an "outlier identification" exercise that names specific hospitals and implies substantial operating inefficiencies or excessive prices. Data reporting issues, normal variation year-to-year, and important differences among hospitals make such identification problematic. The idiosyncratic practice used by Bartholomew-Nash of hand-picking a set of 5 to 20 hospitals across the country as comparisons for each Washington State hospital can also lead to widely varying results, depending upon which hospitals are included.

As an example of these challenges, we examined those hospitals identified by Bartholomew-Nash as being in the "high price" outlier category. Our results, based on the standardized methodology described above, do not align with the Bartholomew-Nash findings. For example:

- Highline Medical Center, a 132 bed hospital located in Burien, Washington, was labeled as a "high price" hospital (and a "high cost" hospital) by Bartholomew-Nash. Our methodology found just the opposite; Highline Medical Center was 31 percent *below* the national median price using our methodology.
- Trios Health, a 111 bed hospital located in Kennewick, Washington, was also labeled as a "high price" (and "high cost") hospital by Bartholomew-Nash. Our methodology again found just the opposite; it was 17 percent *below* the national median price using our methodology.
- At least 7 other Washington State Hospitals (including Skagit Valley Hospital and Olympic Medical Center), which were also labeled as "high price" by Bartholomew-Nash, would not have been labeled as high price using our data, since their revenue was within 4 percent of the national median.

V. Conclusion

Our analysis takes a different, simpler, and more transparent approach than the one used by Bartholomew-Nash and our findings differ from some of the findings in the Bartholomew-Nash work. These differences illustrate the inherent challenges of doing cross-institution comparison where substantial variation exists across a variety of dimensions. As discussed and illustrated, the results can vary even at the aggregate level, and certainly at the individual institution level, depending upon to specific approaches used, time periods studied, and adjustments made to "normalize" data. Interpreting the findings of such analysis, and more particularly using findings to imply specific problems or inefficiencies without a more complete understanding of all the factors that affect financial performance of an institution, must be approached with caution.

Bruce Deal, Managing Principal, Analysis Group

November 18, 2024

Washington State Medical Association
Physician Driven, Patient Focused

November 18, 2024

Health Care Cost Transparency Board
Washington State Health Care Authority
Cherry Street Plaza
626 8th Avenue SE
Olympia, WA 98501

Delivered electronically

Dear Members of the Health Care Cost Transparency Board,

On behalf of the Washington State Medical Association (WSMA) representing nearly 13,000 members, I am writing to provide comments on the Health Care Cost Transparency Board's (Board) draft 2024 report to the Legislature. We are grateful to the Health Care Authority's (HCA) staff for allowing us the opportunity to comment and we are optimistic that the Board will include this, and other feedback received from the public, when submitting this year's report to the Legislature.

The WSMA acknowledges the vital importance of fully understanding health care cost drivers and implementing strategies for making healthcare more affordable and accessible for patients; we have offered constructive feedback, through letters and public comment, since the Board's inception. We do, however, have concerns that this critical feedback and context is not being effectively considered and incorporated into the work of the Board. The timing of the current report is a good illustration of our concerns. The Board released a draft of the report on Monday November 4 and then voted to approve the report at its November 7 meeting – despite the public comment period not closing until November 18. Additionally, the draft was not shared with the Stakeholder Advisory Committee – a formal component of the Board's work - for review and feedback in advance of a Board vote. This pattern leads us to believe that our perspectives are not being seriously considered and incorporated. Regardless, we believe it is important for the physician community to be on the record and have once again outlined our input below.

Challenges facing the physician community

To illustrate context to the draft report and your work more generally, I am sharing a local article that serves as a reminder of challenges facing the independent physician community – paradoxically, a lower cost setting where many healthcare services are delivered, including primary care, chronic disease management, outpatient surgery, mental and behavioral health and many more services that keep people healthier and out of higher cost settings:

Closure of Seattle clinic after 73 years adds to health care pain

This Seattle Times piece, submitted by Dr. Judy

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Kimelman, highlights many of the difficulties independent physician practices have faced for well over a decade; existential challenges such as reimbursement rates that do not cover the ever-rising cost of delivering care, practice expenses exacerbated by insurance carrier and state regulatory administrative burden, staff salaries responsive to general inflation, and many, many other issues which are out of a practice's control. The author points out that Washington's Medicaid reimbursement rates are some of the lowest in the country and warns readers that our medical system is "ailing," noting the issues that caused Seattle Obstetrics & Gynecology Group to close are "impacting physician practices across our state and country."

To add some specifics – The Affordable Care Act, which we supported – provided regulatory and financial incentives that favor consolidation across the continuum of care and added significant economic burden to physician practice. These burdens were further exacerbated by the pandemic's inflationary pressures: the increasing cost of medical supplies, malpractice premiums, staff salary and benefits, pharmaceuticals, office rent, utilities, unequally applied state B&O taxes. These changes, coupled with high licensure fees and the high costs of complying with ever-growing state/federal/insurance carrier administrative requirements are, as you can see, putting independent practices in a perilous position, increasing the risk of practice closure or driving merger with larger health systems in a desperate attempt to maintain access to care in our vulnerable communities.

Making care more affordable to deliver – address underlying cost drivers

Since the Board's inception, the WSMA has urged identification and consideration of strategies to mitigate these underlying drivers that lead to inexorable increases in the cost of delivering care – costs that are proving impossible for medical practices simply to absorb. We are disappointed the report does not seem to prioritize solutions to help mitigate many of these underlying cost drivers, necessarily impacting health care affordability.

We urge the Board to acknowledge that attempting to reduce the cost of healthcare without addressing the input prices that are raising these costs will have a devastating effect on physicians, patients, and practices. We continue to implore the Board to account for this cost burden when making recommendations around reducing the cost of care.

Benchmarking reports

Physician groups subject to the benchmark received their first reports earlier this autumn. We were able to discuss reports with them and we offer constructive feedback around how to ensure the reports are actionable and assist practices in meaningfully and responsibly understanding their costs; comments we received:

1. The Medicare data seems incomplete. As an example, the benchmark report does not include data from Humana - a large Medicare Advantage partner. For one group in our membership, the Medicare data seems only to reflect about 30-35% of its total Medicare population.

2. To drive meaningful change, there should be a process whereby physician groups can verify accuracy of their reports. The current direction given to groups for verifying data is burdensome. Groups are told to reach out to carriers to understand the data without contact information and only a short timeframe in which to do so. We would urge a more robust and collaborative verification process that includes physicians.

3. Our members are concerned about aggregation of data at the provider entity level because it poses significant challenges to validation and does not allow for understanding variable costs and potential outliers. To address this issue we recommend sharing data provided by carriers unbundled at the TIN level.

4. At times, patient attribution methodology is non-standard and carrier specific (*vide* the hierarchy on page A-4 of the carrier data submitter technical manual). When attributions are based on utilization, carriers should define patient attribution in a standard, uniform fashion or, at a minimum, the idiosyncratic carrier attribution methodology should be included in the reports.

5. Finally, there are subtleties that the Board would be well advised to acknowledge. For example, if a patient is assigned to a specific physician group, and that patient is then hospitalized, hospital costs are attributed to the physician practice. Physician practices have no control over those contracted hospital rates. We acknowledge that the method used by the Board is generally aligned with how the industry attributes patients for value-based payment initiatives, but we would urge context be provided when using the methodology to publicly report benchmark data. We also believe utilization data should always be included with cost data in order to make the reports more meaningful to physician practices.

Recommendations

Recommendation 3 (pg. 13): *Increase Washington State's oversight of mergers and acquisitions*

The physician community supports ensuring access to a full suite of health care services in communities across our state. While well intended, the NASHP model bill may have the unintended consequence of reducing avenues for care in a community by precluding the ability of physician groups to enter into necessary partnerships.

Consolidation of health care providers and facilities happens for several reasons. Among physician groups, contributing factors include low Medicaid reimbursement rates, declining Medicare reimbursement rates, increasing costs of operating a practice, administrative burden, and a state tax code that imposes a higher B&O tax rate on physician groups than other care settings. The model bill does nothing to address the upstream causes of consolidation, and could prevent, or severely delay groups from entering partnerships that may be necessary to ensure viability and continued delivery of care in a community. We urge the State to utilize the already significant oversight tools at its disposal when reviewing these transactions.

Recommendation 4 (pg. 13): *Require ownership structures and legal affiliations reporting*

We appreciate the Board's desire to understand ownership structures and legal affiliations and would urge consideration of this recommendation in lieu of the previous recommendation regarding increased oversight. We believe it's prudent to understand the specific landscape in Washington before recommending wholesale adoption of a model bill drafted by a national organization that would significantly add to state regulations. We would urge adoption of language recommending that the process for data collection be as free from increased cost and burden as possible for physician practices. We understand there are good models in other states and would welcome dialogue.

Recommendation 5 (pg. 14): *Setting a target rate of primary care expenditure increases*

The National Academy of Science, Engineering, and Medicine (NASEM) identifies that high quality primary care is the foundation of a high-functioning health care system and is essential for achieving health care's Quadruple Aim of enhancing patient experience, improving population health, reducing costs, and improving the health care team experience. To that end, the WSMA supports increasing primary care expenditures:

The WSMA advocates expediently for measures intended to increase investment in primary care towards 12% of total medical expenditures in Washington. (Res C-16, A-23)

Recommendation 6 (pg. 15): *Increasing Medicaid reimbursement for primary care services*

Washington state's Medicaid reimbursement rates are some of the worst in the nation, falling far short of the cost of providing care resulting in difficulty getting appointments, delays in care, and worsening health conditions for 2.5 million Washingtonians.

While acknowledging the importance of primary care, Medicaid patients often have complex care needs that span the care continuum. There are many specialties that are essential to the provision of primary care (radiology, pathology) and many others that are critical in addressing patient needs when primary care physicians believe their patients need more specialized care (cardiology, rheumatology, endocrinology etc.) which if not accessible or delayed, often leads to worse outcomes and need for higher cost care downstream.

WSMA's preferred approach is to promote access to all care in the Medicaid Access Program (MAP), which leverages federal matching funds to increase Medicaid rates across the board for *all* physicians in *all* settings to at least the equivalents paid by Medicare. We urge the Board to look carefully at the logic and detail of our proposal and include support of MAP in its report to the legislature as a strategy to ensure access to the full continuum of care and minimize need for routing to higher-cost care in higher-cost settings.

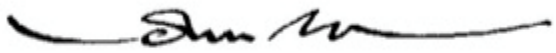
Recommendation added at November 7, 2024 meeting*: Support HCA's referenced based pricing for PEBB/SEBB*

Referenced based pricing assumes that healthcare providers operate on fixed costs, when we know the cost of delivering care can vary between patient populations and geographic location. We are opposed to unsustainable strategies that would result in reimbursement that does not cover the cost of providing care and, inevitably, harm access to that care.

Finally, we understand that this 2024 report represents a good faith outreach by the Board memorializing its ongoing investigations and attempts to understand the negative drivers of health care affordability in Washington state. The WSMA, specifically, and the larger physician community will welcome any and every opportunity to add vital context and information to aid the Board in its important work.

Thanks again for the opportunity to submit our thoughts on the draft 2024 report to the Legislature. Please consider WSMA a resource, and with any questions about our comments or approach to your work in general, please contact WSMA Director of Policy Jeb Shepard at jeb@wsma.org.

Sincerely,



John Bramhall, MD, PhD
President
Washington State Medical Association

FAIR HEALTH PRICES
WASHINGTON

December 4, 2024

To: Health Care Cost Transparency Board
(Submitted via email to: hcahcctboard@hca.wa.gov)

Thank you for the opportunity to offer comments on the Health Care Cost Transparency Board's Annual Report to the Legislature. We recognize that the deadline for formal comments has passed, but we would like to go on the record with our recommendations.

We believe that the Health Care Cost Transparency Board (HCCTB) has the potential to be an effective force in addressing the affordability crisis facing patients, consumers, and purchasers in Washington state. We appreciate the HCCTB's work in recent years to shed light on cost trends, and we applaud the Board's efforts to advance public policies that would help to make health care more affordable. We recognize some of these recommendations may need further development, but we appreciate and support the direction of the Board's recommendations.

Comments on Recommendations to the Legislature

Recommendation 1: Outpatient Facility Fee Reporting Requirements
Require hospitals to report on outpatient facility fee billing, including the locations charging facility fees and the revenue from those fees, as well as the volume and amounts of facility fees by service, payer, and location.

> Comment: We support this recommendation; the current reporting requirements are insufficient to identify the scope and scale of facility fees for hospital outpatient services. We strongly encourage the HCCTB, however, to recommend that unjustified facility fees be eliminated. There should be no additional fees for services that are identical to those provided in independent physician offices, i.e., "same service, same price".

Recommendation 2: Billing and Ownership Transparency
Require hospital-owned and -affiliated providers to acquire and include unique National

Provider Identifiers (NPIs) specific to the location of care on all claims so that claims and fees can be tracked via the All Payer Claims Database.

> Comment: We support this recommendation to improve transparency and the usefulness of claims data for public reporting and analysis.

Recommendation 3: Increase Washington State's oversight of mergers and acquisitions
Given the evidence that market consolidation increases prices, raises consumer costs, and jeopardizes access, the Cost Board proposes the Legislature use the National Academy for State Health Policy's Model Act for State Oversight of Proposed Health Care Mergers to draft legislation to increase Washington State's oversight of mergers and acquisitions.

> Comment: We strongly support this recommendation. Consolidation has led to greater market power by health systems and provider groups, which has led to higher prices and premiums charged to consumers and purchasers. While some elements of the NASHP model act are already in place in Washington, other elements are missing or incomplete.

Recommendation 4: Require ownership structures and legal affiliations reporting
The Legislature should require all carriers, health systems, hospitals, and other health care facilities, such as ambulatory surgery and dialysis centers, to report ownership structures and legal affiliations. Reporting should include any acquisition or ownership state by a private equity firm and be designed to provide transparency into any private equity or corporate affiliations with a system, facility or provider.

> Comment: We strongly support this recommendation. The lack of ownership transparency has been a barrier to understanding the degree and nature of consolidation in the health care industry. We encourage the HCCTB to amend the recommendation to reflect the broader range of entities for which the state lacks data, such as provider group organizations and other kinds of outpatient facilities such as urgent care centers. It is our understanding that the state lacks a census of these kinds of entities, which impedes the state's ability to monitor ownership and acquisition.

Recommendation 5: Setting a target rate of expenditure increases
Increase primary care expenditures one percentage point annually until Washington achieves a primary care expenditure ratio of 12 percent.

> Comment: We support the goal of increasing primary care expenditures to 12 percent of total medical expenses. We encourage the Board to consider a more aggressive schedule, however, to achieve this goal.

This recommendation requires legislative action to amend budgetary allocations and health care spending guidelines. It may involve changes to funding formulas or budget priorities within the state's health care system.

Comment: We encourage the Board to be more specific regarding the legislative action and budgetary allocations that are needed to achieve the goal of 12 percent. In particular, the recommendations should include tangible incentives and accountability for achieving the target, including where offsetting savings may be possible to ensure that overall expenditures remain aligned with the cost growth benchmark.

Recommendation 6: Increasing Medicaid reimbursement for primary care services
The Legislature should increase Medicaid reimbursement for primary care to no less than 100 percent of Medicare by 2028.

Comment: We conditionally support this recommendation, since it is consistent with the goal of increasing spending on primary care and addressing the inequities in access to primary care. We encourage the Board, however, to develop recommendations to ensure that savings accrue in non-primary care services. If primary care payment rates are increased, it is important to make sure the onus to fund the increase does not fall disproportionately on vulnerable parts of the health care market and does not get passed onto patients and consumers. Furthermore, we encourage realistic awareness of the state's budget situation, given that HCA has proposed extensive cuts to Medicaid services in response to OFM budget savings directives. Maintaining services must be the first priority.

<u>Comments on Best Practices for State Health Care Cost Benchmark Programs</u>

The report states that "*... any recommendations for changes to the Cost Board arising from the study [of regulatory approaches and best practices], must be submitted by the board as part of the annual legislative report no later than December 1, 2024."*

The report also states that "*The best practices that were identified [in the study] as providing the greatest opportunities for Washington to consider are the following:*

- *Comprehensive data collection allowing analysis and reporting providing insight into the entire health care system, ideally provided to a single entity (California, Massachusetts).*
- *Responsibility for examining and addressing a broad range of factors impacting health care cost growth, including the prices charged for health care services, adoption of alternative payment models and less reliance on fee-for-service reimbursement, encouraging investment in services that currently are under-resourced, such as*

primary care and behavioral health, consolidation, and health equity (California, Rhode Island).
- *Authority to enforce compliance with cost growth targets (California, Massachusetts)*
- *Authority to regulate health care prices (Oregon, Rhode Island).*
- *Budget authority adequate to perform the functions of the program (California, Massachusetts).”*

Comment: We strongly support the serious consideration of all of these best practices from other states. In particular, the authority to enforce compliance with cost growth targets and the budget authority to perform the functions of the program are essential elements to maximizing the likelihood that the cost growth targets will be met.

In summary, we believe that the HCCTB’s policy recommendations – especially if they are strengthened per our comments above – would enable the state to make significant progress in improving affordability for patients, consumers, and purchasers. We appreciate the opportunity to offer these comments, and we would be happy to discuss them further if that would be helpful to you.

Sincerely,

William E. Kramer
Senior Advisor for Health Policy
Purchaser Business Group on Health

Emily Brice
Co-Executive Director (Advocacy)
Northwest Health Law Advocates

Sam Hatzenbeler
Senior Policy Associate
Economic Opportunity Institute

Jim Freeburg
Executive Director
Patient Coalition of Washington