Health Care Cost Transparency Board meeting

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board
Agenda

Wednesday, March 5, 2025
2–4 p.m.
Hybrid Zoom and in-person

☐ Mich'l Needham, Interim Chair	☐ Ken Gardner	☐ Ingrid Ulrey
☐ Jane Beyer	☐ Jodi Joyce	☐ Kim Wallace
☐ Eileen Cody	☐ Gregory Marchand	☐ Carol Wilmes
☐ Lois C. Cook	☐ Mark Siegel	☐
☐ Bianca Frogner	☐ Margaret Stanley	

Time	Agenda Items	Tab	Lead
2:00–2:05 (5 min)	Welcome and roll call	1	Mich'l Needham, Chief Policy Officer and Ross Valore, Cost Board Director, Health Care Authority
2:05–2:10 (5 min)	Approval of the January meeting summary	2	Mich'l Needham, Chief Policy Officer Health Care Authority
2:10–2:20 (10 min)	Public comment	3	Ross Valore, Cost Board Director, Health Care Authority
2:20-2:35 (15 min)	Legislative session update	4	Evan Klein, Special Assistant for Policy & Legislative Affairs, Health Care Authority
2:35–3:10 (35 min)	Review OnPoint's Cost Driver Analysis	5	Sheryll Namingit, Health Economics Research Manager and Harrison Fontaine, Senior Policy Analyst, Health Care Authority
3:10–3:40 (30 min)	Analytic Support Initiative (ASI) presentation on cost growth trends	6	Joseph Dieleman, PhD, Institute for Health Metrics and Evaluation
3:40–4:00 (20 min)	Follow-up on National Academy for State Health Policy's Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency	7	Ally Power, Senior Policy Analyst; Jennifer Scott, Senior Policy Analyst; and Ross Valore, Cost Board Director, Health Care Authority
4:00	Wrap up and adjourn Next meeting: April 24, 2–4 p.m.		Mich'l Needham, Chief Policy Officer, Health Care Authority

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board Meeting Minutes

January 30, 2025

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
2:00–4:04 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the Cost Board is available on the **Health Care Cost Transparency Board webpage**.

Members present

Mich'l Needham, Interim Chair
Jane Beyer
Eileen Cody
Lois Cook
Bianca Frogner
Ken Gardner
Jodi Joyce
Margaret Stanley
Ingrid Ulrey
Kim Wallace
Carol Wilmes

Members absent

Greg Marchand
Mark Siegel

Call to order

Mich'l Needham, Interim Chair of the Cost Board and Chief Policy Officer, Health Care Authority, called the meeting of the Health Care Cost Transparency Board to order at 2 p.m.

Agenda items

Welcome and roll call

Mich'l Needham, Interim Chair of the Cost Board and Chief Policy Officer, Health Care Authority

Interim Chair Needham welcomed everyone and walked through the agenda and roll call.

Washington State Health Care Authority

Approval of the November and December 2024 meeting summaries

Mich'l Needham, Interim Chair of the Cost Board and Chief Policy Officer, Health Care Authority

There was a **motion to approve** the November 2024 meeting summary with the following changes:

- In the summary of the presentation on the Best Practices Report, add Rhode Island to the list of 8 states studied.
- Throughout the November summary, health care should be written as two separate words.
- In the summary of the Public Comment, Jeb Shepard's testimony, remove the word "should", from this phrase: "...physician groups **should** reflect contracted hospital rates beyond their control."
- In the summary of Discussion and Recommendations Regarding Business Oversight, in the second recommendation, the word "state" should be changed to "stake."
- In the summary of the Analytic Support Initiative Report, fourth paragraph, "Gerald" should be replaced with "Gerard" and the reference to this article should be included. It is: "It's The Prices, Stupid: Why the United States is So Different from Other Countries" in Health Affairs May/June 2003, Vol. 22, No.3.

There was a **motion to approve** the December meeting summary with the following change:

- Throughout the December summary, health care should be written as two separate words.

Public comment

Mich'l Needham, Interim Chair of the Cost Board and Chief Policy Officer, Health Care Authority

Interim Chair, Mich'l Needham called for comments from the public.

Jeb Shepard, representing the Washington Medical Association, stated that it was a great idea to see the charters for the Health Care Stakeholders Advisory Committee and the Advisory Committee on Data Issues. He suggested adding a description of the feedback loop between the advisory committees and the Cost Board as the charter documents present an opportunity to get the committees on the same page. He also thanked the Cost Board for their willingness to revisit the attribution methodology used to compare cost growth to the benchmark.

Katerina LaMarche, representing the Washington State Hospital Association, thanked the Cost Board for their willingness to review the attribution methodology as a potential advisory committee assignment as improvements will help providers understand their growth and enable them to make actionable changes. She said the Washington State Hospital Association submitted a handful of letters with suggestions to the Cost Board and would be happy to recirculate those for reference if needed.

Rosemary Adamson, a pulmonary and critical care doctor from Seattle and a member of the Washington Community Action Network, spoke next. She encouraged the Cost Board in its mission to increase transparency for patients and taxpayers as, in her experience, navigating the health care systems in the United States is challenging even for a trained doctor. Dr. Adamson told a personal story about medical bills sent to her for services that should have been covered related to the birth of her child and described the time and stress involved in getting the bills corrected. She thinks this likely happens frequently to patients with less English language proficiency, lower level of education, and less confidence and experience with the health care system and that she believes carriers rely on patients not knowing their rights and giving up. She stated that she believes health care should be a right but as that is not the current situation in the U.S., cost control and transparency are crucial in helping to reduce the need for patients to fight for coverage of their care.

Operational updates

Mich'l Needham, Interim Chair of the Cost Board and Chief Policy Officer, Health Care Authority

Interim Chair, Mich'l Needham announced several staffing transitions at the Health Care Authority.

- MaryAnn Lindeblad has been appointed by Governor Ferguson to be the Interim Health Care Authority Director and will be serving until a new permanent director is chosen.
- Ross Valore is the new Director for the Board and Commissions Unit. Ross comes from the Department of Health where he led the Certificate of Need Program for several years. He is excited to think about health care transparency and cost as they relate to long-term planning for WA and future generations.
- Jenn Scott and Harrison Fontaine, both Senior Health Policy Analysts, joined the team in December and will be supporting the Health Care Cost Transparency Board's advisory committees.
- Josefina Magaña, who played a lead role in writing the report on performance against the benchmark, will be leaving in February and we thank her for all of her work and support.
- Kahlie Dufresne was recognized for her amazing work in support of the Health Care Cost Transparency Board which she took over in addition to her other full-time job back in October. She will be helping Ross orient to his role and will be with us for another couple of months.

Interim Chair, Mich'l Needham announced that Ken Gardner was appointed by former Govenor Inslee as a new member of the Health Care Cost Transparency Board and will be joining at the March 5, 2025 meeting. Ken is currently serving as the Director of Growth & Administration for the SEIU 775 benefits group and has also served with the Centers for Medicare and Medicaid Services in a variety of positions.

Interim Chair, Mich'l Needham shared a slide listing the dates of all of the Health Care Cost Transparency Board and advisory committee meetings for 2025. This information is available under Tab 4.

Nominating Committee updates

Carol Wilmes, Nominating Committee Member

Carol Wilmes reported that the Nominating Committee met on January 22, 2025, and will present several recommendations for Board approval.

Committee recommendations

The Nominating Committee presented a recommendation to fill the slot for an Ambulatory Surgery Center representative. The Ambulatory Surgery Center Association submitted three very qualified applicants. The committee is recommending Jamie Fowler, MHA, whose experience and background seem to best align with the work of the Stakeholder Advisory Committee. Jamie is currently the Director of Operations for SCA Health's Washington and Oregon Regions. More information on her background can be found under Tab 5.

The Nominating Committee also brought forward a recommendation for the Advisory Committee on Data Issues. Dr. Nnabuchi Anikpezie, DrPH, MPH, MBBS, is the Senior Director of Health Systems & Workforce Intelligence with the Executive Office of Health care Innovation & Strategy at the Washington State Department of Health. More information on his background can be found under Tab 5.

Vote 1: The Board approved Jamie Fowler as a member of the Health Care Stakeholders Advisory Committee.

Vote 2: The Board approved Dr. Nnabuchi Anikpezie as a member of the Data Issues Advisory Committee.

Updated Advisory Committee Charters

Carol Wilmes presented the Nominating Committee's updates to the Health Care Stakeholders Advisory Committee and Data Issues Advisory Committee charters reflecting that continuity of participation and regular attendance of members are essential to the work of the committees. The charters have been amended to state that if a member misses three meetings (50%) in a calendar year or three consecutive meetings over a 12-month period, they will be removed from the committee due to attendance. Per discussion, Kahlie Dufresne stated that staff will clarify that the intent is to address attendance, whether virtual or in-person. The Board discussed

removing the reference to "50%" as the number of advisory committee meetings varies, and three meetings may not always represent 50% of the meetings for that year.

The Board **moved to adopt the amended charter** language to both committee charters with the stipulation that the reference to "50%" be removed.

Performance Against the Benchmark

Amanda Avalos, Deputy for Enterprise Analytics, Research, and Reporting, Health Care Authority

Kahlie Dufresne, Special Assistant Health Policy Programs, Health Care Authority

Vishal Chaudhry, Chief Data Officer, Health Care Authority

The presenters reviewed the key takeaways from the performance against the benchmark report, expanding on the discussion at the public hearing in December 2024. They also followed up with information to address five questions that were raised during December's public hearing. The slides presented are available in Tab 6.

The key takaways from the performance against the benchmark are summarized as follows: At 3.6%, 2022 statewide per-member cost growth is slightly above the 3.2% growth benchmark and (excluding 2020) is the slowest growth since 2018. Only the Medicare market exceeded the benchmark. Five out of 12 carriers and 5 out of 28 large provider organizations exceeded the benchmark. Per-member spending growth from 2019–2022 was driven by growth in Commercial and Medicare markets, Veterans Affairs spending, and per capita spending growth led by prescription drugs (Medicare, Commercial), non-claims (Medicare, Medicaid), and hospital outpatient (Medicare, Commercial). Per-capita Medicaid spending decreased from 2019–2022 due to a decline in Other Claims that offset an uptick in prescription drug spending.

Kahlie Dufresne stated that the public hearing had included three reflection panels focused on consumer affordability, business and labor, and providers. She presented five questions from the public hearing which required more research and a deep dive from analytics staff.

The discussion of Question 1, "Do other states with Cost Board programs have primary care initiatives that support prevention of other spending?", is summarized as follows: Most other states studied have programs similar to WA's, with initiatives to measure their primary care expenditure as a proportion of total health care spending as well as initiatives with CMS or with multi-payer initiatives focused on transforming the way primary care is delivered in the state. OR and RI participated in the comprehensive Primary Care Plus model with CMS which was a precursor for the Making Care Primary model which WA and MA are using. Many states try to drive primary care spend and focus on getting more practices into alternative payment approaches. A board member asked if CT's primary care expenditure ratio is so different because they have a case management model. Kahlie said this is something staff could look into it further.

The discussion of Question 2, "Can we break out carrier performance by market?", is summarized as follows: Amanda Avalos presented analysis of carrier performance for the Medicaid, Commercial and Medicare Advantage markets. In 2022, none of the 5 carriers exceeded the benchmark for the Medicaid market. Four of 10 carriers exceeded the benchmark in the Commercial market. Nine of 11 carriers exceeded the benchmark for the Medicare Advantage market. It was noted that the Medicare Advantage market excludes Medicare fee-for-service which makes up 46% of all Medicare beneficiaries. A Board member inquired about why we don't have data for the Individual Market. Analytic staff responded that in this analysis, the Individual market is captured as part of the Commercial market. There will be an opportunity to look at the Individual market's performance at the next meeting when data from the cost driver analysis is presented.

The discussion of Question 3, "How does WA's expenditure growth compare to other states?", is summarized as follows: Amanda Avalos stated WA's Commercial market registered the highest growth. WA market spending growth was comparable to the other states with Cost Measurement efforts (CT, DE, MA, OR, RI). There was a question from a Board member about whether there is data comparing the carriers in terms of their total medical expense. Vishal Chaudhry, Chief Data Officer, Health Care Authority, stated that his team will take this

back as a question for follow-up. The top contributors to cost growth in the Commercial market are prescription drugs, hospital outpatient and professional specialty. Top contributors to Medicare growth include non-claims, prescription drugs, and hospital outpatient. Top contributors to Medicaid growth are prescription drugs and non-claims.

The discussion of Question 4, "What are non-claims expenditures? What non-claims expenditures are driving growth in each market?" is summarized as follows: Non-claims are defined as payments that health plans make to provider organizations outside of claims such as incentive payments, risk settlements or recoveries, capitation, direct payments such as salaries, IT infrastructure, and training, and for things such as care coordination fees and population-health payments. In the Commercial market, "other non-claims spending" has been the top non-claims growth contributor. In the Medicare market, non-claims spending had the highest growth among service categories (2019-2022). For Medicare, only Medicare Advantage has reported non-claims spending, but it is expected that FFS has non-claims spending as well. In the Medicaid market, non-claims spending decelerated during the pandemic, driven by slower growth in capitation/ bundled payments. A Board member expressed a desire to better understand the non-claims "other" category and where those dollars are going given that the Commercial market is an outlier compared to the other markets. Vishal Chaudry stated that we may need to work with carriers to understand more about this category. Currently, it is largely a "catch-all".

The discussion of Question 5, "Why do the markets have different inpatient and outpatient hospital spending trends?", is summarized as follows: Overall outpatient spending Per Member Per Month (PMPM) surpassed overall inpatient spending PMPM in 2021. The increase in outpatient spending was driven by growth in outpatient spending in the Commercial and Medicare Advantage markets. The Commercial market changes are due to price intensity and the Medicare Advantage shift is due to a change in utilization. The shift in spending from inpatient to outpatient is most striking. Medicaid inpatient PMPM remained more expensive than outpatient.

Announcing a new dashboard

Vishal Chaudry announced a new Washington All Payers Claim Database (WA-APCD) dashboard. The database was developed in response to a mandated requirement to publish health care cost data and make it transparent and useable for the public. It provides additional data that can help the Cost Board understand the WA's health care delivery system as well as aligning with the Cost Board's focus on transparency. Vishal stated that he would love to get some direction from the Cost Board on how to improve the dashboard to better answer some of the questions the Cost Board will be leaning into in the future. The new dashboard was well received with one suggestion to provide help digesting the information. The link to the database will be available in the meeting summary and slides.

Next steps: The performance against the benchmark analysis helps the Cost Board understand baseline health care expenditures and categories of state spending growth. To identify policies and programs that can help reduce cost growth, we need a complimentary cost driver analysis. The analytic team will return in March to present their analysis of cost drivers and cost experience based on data from the WA-APCD.

Potential Stakeholder Advisory Committee assignment

Kahlie Dufresne introduced a possible assignment for the Stakeholder Advisory Committee for the Cost Board's consideration. The HCA developed the current attribution methodology when first designing the benchmark and the process for how we would measure against it, largely influenced by the methods other states were using. With the benefit of experience, we now have the opportunity to consider whether we want to use the attribution methodology at all. The goal of whatever methodology we use is to provide data that allows the Cost Board to answer questions and develop insights about what is driving cost growth to inform policy recommendations.

The Cost Board has received feedback from stakeholders that the current attribution methodology makes it challenging for providers to use the data to inform interventions to control costs.

The request to the committee is to review the pros and cons of the current attribution methodology which assigns patient spending to a provider entity. The Board asks the committee for a recommendation about whether attribution is the right approach and to determine how the Cost Board can best partner with provider communities and with carriers to make this data as accurate and useful as possible. In response to concerns raised by Board members about not wanting to delay the Cost Board's work as they look into this question, HCA staff explained that the 2026 data call is launching in February 2025 and using the same methodology and approach as in 2024. The assignment to the committee will not change the methodology this year. There has been information on this topic shared with the Cost Board via public comment and those comments will be taken into account as well.

Committee updates

Eileen Cody, Chair, Health care Stakeholders Advisory Committee

Bianca Frogner, Chair, Data Issues Advisory Committee

Harrison Fontaine, Senior Policy Analyst, Health Care Authority

Eileen Cody, the Chair of the Health care Stakeholders Advisory Committee, gave an update on the committee's work at the August and November 2024 meetings. Their assignment was focused on addressing medical debt and work included hearing from a consumer group who spoke about the impacts of medical debt in WA. The committee's recommendation is to focus on prevention of medical debt by ensuring that required charity care efforts are happening and continuing to monitor barriers to access. The committee also talked about relief and transparency issues and the ways that the Cost Board could deal with medical debt in the short term with the long-term goal being to prevent medical debt.

Bianca Frogner, Chair of the Data Issues Advisory Committee, gave an update on the committee's activities at the November 2024 meeting which was a joint meeting with the Health Care Stakeholders Advisory Committee. The committee learned about the Analytic Support Initiative and the disease expenditure report from Joseph Dieleman, PhD, Institute for Health Metrics and Evaluation (IHME). The committee discussed the differences in medical expenses when viewed in aggregate versus a per member per year growth rate as well as defining 'large provider organization' for reporting and reviewing the best practices report. They learned of their assignment from the Cost Board to review business oversight-related data.

Harison Fontaine, Senior Policy Analyst, HCA, provided an update on the status of the request to review the business oversight-related data. Staff are drafting a crosswalk comparing the NASHP Model Act elements and any data being collected by partner agencies. The areas of focus for the crosswalk relate to ownership of health care entities and IDs necessary to understand market consolidation as detailed in Tab 7. The committee will review the crosswalk and recommendations at their next meeting on March 27. The Board recommended keeping the scope narrow so as not to slow progress on a current registry bill under consideration by the legislature that addresses this topic. One Board member stated DOH and OIC are creating their own crosswalks.

Adjournment

Mich'l Needham, Interim Chair of the Cost Board and Chief Policy Officer, Health Care Authority

Meeting adjourned at 4:04 p.m. The next meeting is on March 5, 2025.

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

From: Katerina LaMarche
To: HCA HCCT Board
Subject: WSHA comment for 3/5 HCCTB meeting
Date: Sunday, February 23, 2025 4:24:53 PM
Attachments: 2025.3 WSHA letter - HCCTB Cost Driver Analysis II Final.pdf
2025.3 Cost analysis cover sheet.pdf
2025.02.21 Cost and Value of Nursing Care .pdf

External Email

Hello,

Please accept the attached comment letter and supporting analysis with cover sheet for inclusion in the HCCTB's March 5 meeting materials.

If you have any questions, please let me know.

Thank you,

Katerina

Katerina LaMarche, JD
Policy Director, Government Affairs
Washington State Hospital Association
999 Third Avenue, Suite 1400 | Seattle, WA 98104
Mobile: (206) 265-1706
Email: katerinal@wsha.org

Washington State Hospital Association

February 21, 2025

Background for Analysis Group Study on Washington State Hospital Nursing Expenses

In its analysis of health care costs, the Health Care Transparency Board (HCCTB) sponsored a study of Washington hospitals and how Washington hospital costs compare to other states and groups of peer hospitals. This study concluded that a number of Washington hospitals had costs higher than their peers, although the groups of peer hospitals used in the comparisons were not identified. The consultants who did the HCCTB study recognized that Washington hospitals have very low or negative profit margins, and revenues are not high compared to the underlying costs. Yet, based on the peer comparisons, the study concluded that many Washington hospitals are inefficient. This HCCTB study has been used to justify potential cost cuts for hospital payments.

While the HCCTB stated that some Washington hospitals are inefficient, it does not address where savings can be achieved if payments are reduced. It seems that the "solution" is for hospitals to improve their efficiency while maintaining quality and services. To dig deeper into the issue of hospital expenses, WSHA asked Bruce Deal, Managing Principal at Analysis Group, Inc., to look at comparisons between Washington and other states on one major component of hospital expenses – payments for nursing staff. Labor is the major expense for hospitals and nurses' salaries are one of the largest segments.

Analysis Group, a nationally recognized consulting firm, examined a set of data reports hospitals submit periodically to the Centers for Medicare and Medicaid Services on "occupational mix" of labor. The occupational mix report includes detailed data on paid salaries and hours for selected occupational categories (RNs, LPNs, Nursing Aides, and Medical Assistants, and Others). Analysis Group also used annual data from the Medicare Hospital Cost Reports that report these expenditures. The Analysis Group findings show a major reason Washington hospitals have higher expenses is nurses in Washington are paid more than other states and provide more nursing hours than elsewhere.

These findings help illustrate the complexity of health care delivery and raise questions as to whether it is appropriate to simply claim that Washington hospitals are not efficient. The hospitals' higher expenses may be the result of sound judgements on what resources are needed to provide appropriate quality care.
If care is going to be made more affordable in Washington, WSHA requests that the HCCTB do more than simply declare costs are high and instead develop concrete solutions on ways to reduce expenditures while maintaining care for Washington residents.

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Washington State Hospital Association

February 23, 2025

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

We anticipate the upcoming Board meeting will include an update to the Board's earlier analysis on drivers of health care cost increases. The Washington State Hospital Association is submitting these comments to help frame the Board's discussion. These written comments were due prior to the release of the analysis, so we will also provide updated comments during the March 5th meeting.

Analyze not just *where* but *why* health care costs are rising

The initial cost driver analysis done for the Board found that hospital outpatient services are one of the key areas of health care cost growth in our state. We anticipate that finding may be repeated in the new analysis. While this analysis points to *where* health care costs are increasing; it does not analyze *why* they are rising. We hope that a deeper analysis asks the more important question of *why* hospital outpatient payments are rising. Developing effective policy recommendations on how to reduce cost growth necessitates understanding not only where growth is happening, but why it's occurring, whether it's appropriate, and how to actually achieve savings in care delivery.

We anticipate the updated analysis will again disaggregate inpatient and outpatient hospital services and will not consider that hospital care is a combined endeavor. Yet, a combined focus is needed. Growth in outpatient use and costs is due, in part, to the deliberate effort to save on the total cost of care by converting more expensive inpatient care to outpatient.

The previous analysis did not address whether the types of services performed on an outpatient basis have shifted over time and if the services are now more complex and therefore more costly. A shift from inpatient to outpatient raises volumes, intensity, and revenue for outpatient services. For example, many total joint replacement surgeries used to require inpatient treatment. Now, most are performed outpatient. The cost of each total joint replacement procedure is less in an outpatient setting than in the inpatient setting, but the cost of outpatient procedures has also increased over time because of the addition of more complex cases. This shift has occurred throughout the country, but it may be amplified in Washington because of our relative shortage of inpatient beds. According to KFF, our state currently has the fewest number of acute care hospital beds in the country – meaning only the most complex patients are hospitalized. Patients who would be treated as in inpatient in other states are served through outpatient care in Washington State.

Determine where specific cost savings can be achieved without affecting access or quality of care

If hospitals are paid less or payments curtailed for one sector of services, such as outpatient, what will be the overall impact on care? Unlike in some other states where hospitals have positive margins, reductions in payment cannot come out of hospital margins in Washington because our hospitals continue to struggle financially and most still have negative margins. So, where should hospitals reduce their expenditures? How can the hospital absorb significant reductions and still provide inpatient care, outpatient care, and 24-hour emergency care? If the Board wants to constrain hospital costs, we ask that you help hospitals determine where cuts can be made that won't affect patients' access to needed care or the quality of care offered. We ask that the Board dig deeper into the issues that are driving the increases in the costs of hospital services.

Consider the effect of high and rising labor costs

A majority of hospital costs are due to labor and one of the main reasons expenses are increasing is due to

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increases in labor costs. How should hospitals control their costs of labor? One of the most important components of labor is hospital nursing staff. Should these costs be trimmed? It probably can't be accomplished by using fewer nurses, especially with statutory requirements on nurse staffing levels in hospitals. We also don't think it is reasonable to tell our hospitals that they need to limit wage increases for nurses. Hospitals need the salary increases to attract and retain staff and to compete with other states for talent.

Attached is an analysis done for WSHA by Analysis Group Inc. which attempts to dig deeper into hospital nursing expenses. Using CMS Medicare cost reports and survey data, it shows that nursing costs are one of the reasons Washington hospital costs appear higher than those in other states. It also shows that the analysis done previously for the Board by Nash and Bartholomew failed to adjust adequately for the differences in wage rates in our state. Higher nursing costs alone account for one quarter of the difference in operating expenses per case mix adjusted discharge in Washington state. High-cost Washington hospitals pay significantly more to nurses than the national average, even after adjusting for case mix and general wage rate differences.

Offer realistic solutions

We encourage the Board to examine the cost drivers at a deeper level and offer realistic solutions. We believe the way to reduce hospital expenses is by making our population healthier so that fewer people need care, bolstering primary care so health issues are treated before they become acute, developing alternative settings for patients inappropriately stuck in hospitals who need mental health or long-term care, and considering ways to expand the local health care workforce in our state.

Simply saying hospitals cost too much is not a solution if there is no indication of what can be done to lower the expenses. We would be interested in discussing realistic solutions that will help make health care affordable while sustaining access and quality.

Sincerely,

Eric Lewis

Eric Lewis
Chief Financial Officer
Washington State Hospital Association
Member of the HCCTB Stakeholders Advisory Committee

Jonathan Bennett

Jonathan Bennett
Vice President, Data Analytics and IT Services
Washington State Hospital Association
Member of the HCCTB Advisory Committee on Data Issues

ANALYSIS GROUP

A Comparative Study on Cost and Value of Nursing Care in Washington State

Jan 22, 2025

Key Findings

- Washington nursing expenses per adjusted discharge are about 40 percent higher than the national average, even after adjusting for case mix.
  - Higher nursing expenses alone account for approximately one quarter of the observed cost difference in total operating expenses.
- Washington nursing wages per hour are about 20 percent higher than the national average and hours of nursing per discharge are also about 20 percent higher.
- Wage index adjustments used by CMS and the HCCTB Consultants to account for higher labor costs do not fully compensate for higher Washington nursing salaries.
- Variations among hospitals in nursing expenses can explain a lot of the differences observed in overall cost and revenue comparisons among hospitals.

Nursing costs in Washington

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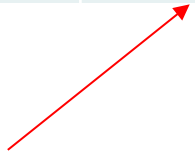
Nursing makes up a large portion of labor expenses, even more so for Washington state

	WA	National	WA Higher than National % Points	State Rank
Nursing Costs as a share of Total Labor Expenses	38.5%	34.9%	+3.6%	14
Nursing Costs as a share of Total Operating Expenses	17.0%	15.1%	+1.9%	5



WA is higher

Source: Occupational Mix Survey, 2022-2025, Centers for Medicare & Medicaid Services

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Overall, Washington State hospitals have relatively high operating cost per adjusted discharge [1] using 2022 Medicare Cost Report Data

Operating Expense per Adjusted Discharge	WA	National	WA Higher than National $	WA Higher than National %	State Rank
Unadjusted	$24,056	$18,420	+$5,636	+31%	5
Adjusted for Case Mix Index	$11,714	$9,257	+$2,457	+27%	7

How much of this difference is directly due to WA nursing costs?

Note:
[1] Adjusted discharges are calculated using total inpatient discharges divided by share of inpatient charges over sum of inpatient and outpatient charges.
Source: Annual Cost Reports, 2022, Centers for Medicare & Medicaid Services

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Washington State hospitals have high nursing expenses per adjusted discharge

Unadjusted for Case Mix

Occupation Group	WA	National	WA Higher than National $	WA Higher than National %	State Rank
Registered Nurses (RNs)	$3,456	$2,353	+$1,103	+47%	3
Licensed Practical Nurses (LPNs)	$129	$124	+$5	+4%	22
Nursing Assistants and Orderlies (NAs)	$354	$256	+$98	+38%	6
Medical Assistants (MAs)	$140	$49	+$91	+186%	4
Total Nursing	**$4,079**	**$2,782**	**+$1,297**	**+47%**	**3**
RNs as a share of Total Nursing	85%	85%			

Source: Occupational Mix Survey, 2022-2025, Centers for Medicare & Medicaid Services

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Even after adjusting for case mix, Washington State hospitals have high nursing expenses per adjusted discharge

Case Mix Index Adjusted

Occupation Group	WA	National	WA Higher than National $	WA Higher than National %	State Rank
Registered Nurses (RNs)	$1,690	$1,194	+$496	+42%	3
Licensed Practical Nurses (LPNs)	$64	$64	0	0%	19
Nursing Assistants and Orderlies (NAs)	$174	$131	+$43	+33%	10
Medical Assistants (MAs)	$65	$24	+$41	+171%	4
Total Nursing	**$1,993**	**$1,414**	**+$579**	**+41%**	**3**
RNs as a share of Total Nursing	85%	84%			

Source: Occupational Mix Survey, 2022-2025, Centers for Medicare & Medicaid Services

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Higher nursing costs alone account for approximately one quarter of the observed cost difference

Operating Expense per Adjusted Discharge	WA	National	WA Higher than National $	WA Higher than National %	State Rank
Unadjusted	$24,056	$18,420	+$5,636	+31%	5
Adjusted for Case Mix Index	$11,714	$9,257	+$2,457	+27%	7

+$579

Higher CMI adjusted WA nursing costs account for 24% of higher CMI adjusted WA total operating expenses

Source: Occupational Mix Survey, 2022-2025, Centers for Medicare & Medicaid Services

ANALYSIS GROUP

Why are nursing costs higher?
Possible reason 1: Higher wages per hour

Occupation Group	WA	National	WA Higher than National $	WA Higher than National %	State Rank
Registered Nurses (RNs)	$73.09	$60.72	+$12.37	+20%	2
Licensed Practical Nurses (LPNs)	$40.91	$35.39	+$5.52	+16%	7
Nursing Assistants and Orderlies (NAs)	$28.93	$23.57	+$5.36	+23%	4
Medical Assistants (MAs)	$31.62	$23.12	+$8.50	+37%	1
Total Nursing	**$60.77**	**$50.37**	**+$10.40**	**+21%**	**2**

Yes, WA is substantially higher

Source: Occupational Mix Survey, 2022-2025, Centers for Medicare & Medicaid Services

ANALYSIS GROUP

Why are nursing costs higher?
Possible reason 2: More intense use of nurses

Unadjusted hours of nursing per adjusted discharge

Occupation Group	WA	National	WA Higher than National	WA Higher than National %	State Rank
Registered Nurses (RNs)	47.3	38.7	8.6	+22%	7
Licensed Practical Nurses (LPNs)	3.1	3.5	-0.4	-11%	29
Nursing Assistants and Orderlies (NAs)	12.3	10.9	1.4	+13%	14
Medical Assistants (MAs)	4.4	2.1	2.3	+110%	12
Total Nursing	**67.1**	**55.2**	**11.9**	**+22%**	**8**
RNs as a share of Total Nursing	70%	70%			

Source: Occupational Mix Survey, 2022-2025, Centers for Medicare & Medicaid Services

ANALYSIS GROUP

Why are nursing costs higher?
Possible reason 2: More intense use of nurses

Case Mix Index Adjusted nursing hours per adjusted discharge

Occupation Group	WA	National	WA Higher than National	WA Higher than National %	State Rank
Registered Nurses (RNs)	23.0	19.7	3.3	17%	8
Licensed Practical Nurses (LPNs)	1.6	1.8	-0.3	-14%	31
Nursing Assistants and Orderlies (NAs)	6.0	5.6	0.4	7%	16
Medical Assistants (MAs)	2.1	1.1	1.1	104%	7
Total Nursing	**32.8**	**28.2**	**4.6**	**16%**	**10**
RNs as a share of Total Nursing	70%	70%			

Yes, WA is substantially higher even adjusting for case mix

Source: Occupational Mix Survey, 2022-2025, Centers for Medicare & Medicaid Services

ANALYSIS GROUP

Why are nursing costs higher?
Possible reason 3: Different mix of nursing levels

Occupation Group	WA	National	WA Higher than National	State Rank
Registered Nurses (RNs)	70.4%	70.2%	+0.2%	19
Licensed Practical Nurses (LPNs)	4.7%	6.4%	-1.7%	36
Nursing Assistants and Orderlies (NAs)	18.3%	19.7	-1.4%	36
Medical Assistants (MAs)	6.6%	3.8%	+2.8%	11
Total	100%	100%	0%	

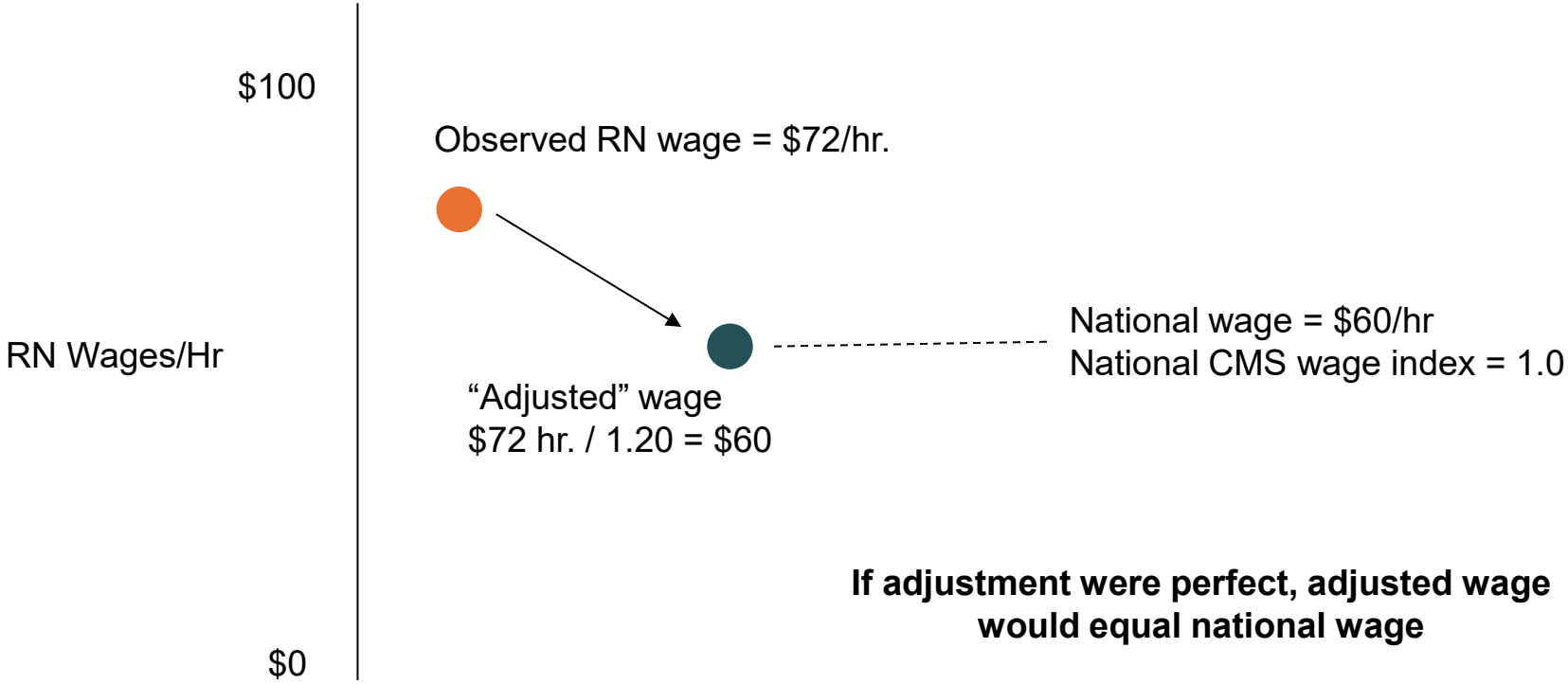
No, WA mix is very similar to National

Source: Occupational Mix Survey, 2022-2025, Centers for Medicare & Medicaid Services

How well does the CMS Wage Index account for nursing wage differences?

In an earlier study by Nash and Bartholomew, the HCCTB consultants compared hospital expenses after adjusting by the CMS Wage Index. In theory, CMS Wage Index should "normalize" wages to a national level

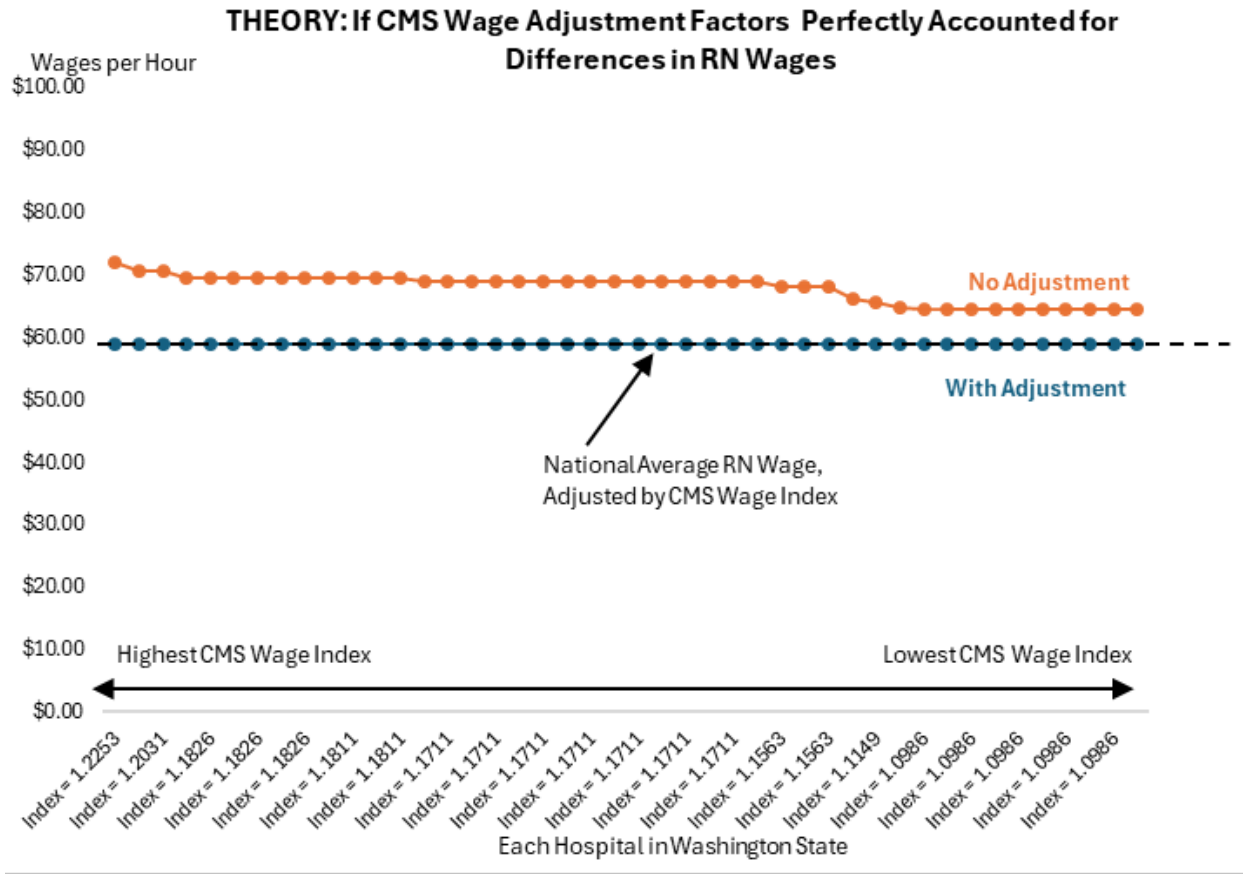
Illustration for Hypothetical "Hospital A", CMS Wage Index = 1.20



If adjustment were perfect, adjusted wage would equal national wage

In theory, CMS Wage Index should "normalize" wages across hospitals

Hypothetical Illustration With Multiple Hospitals



If adjustment were perfect, adjusted wages for all hospitals would equal national wage

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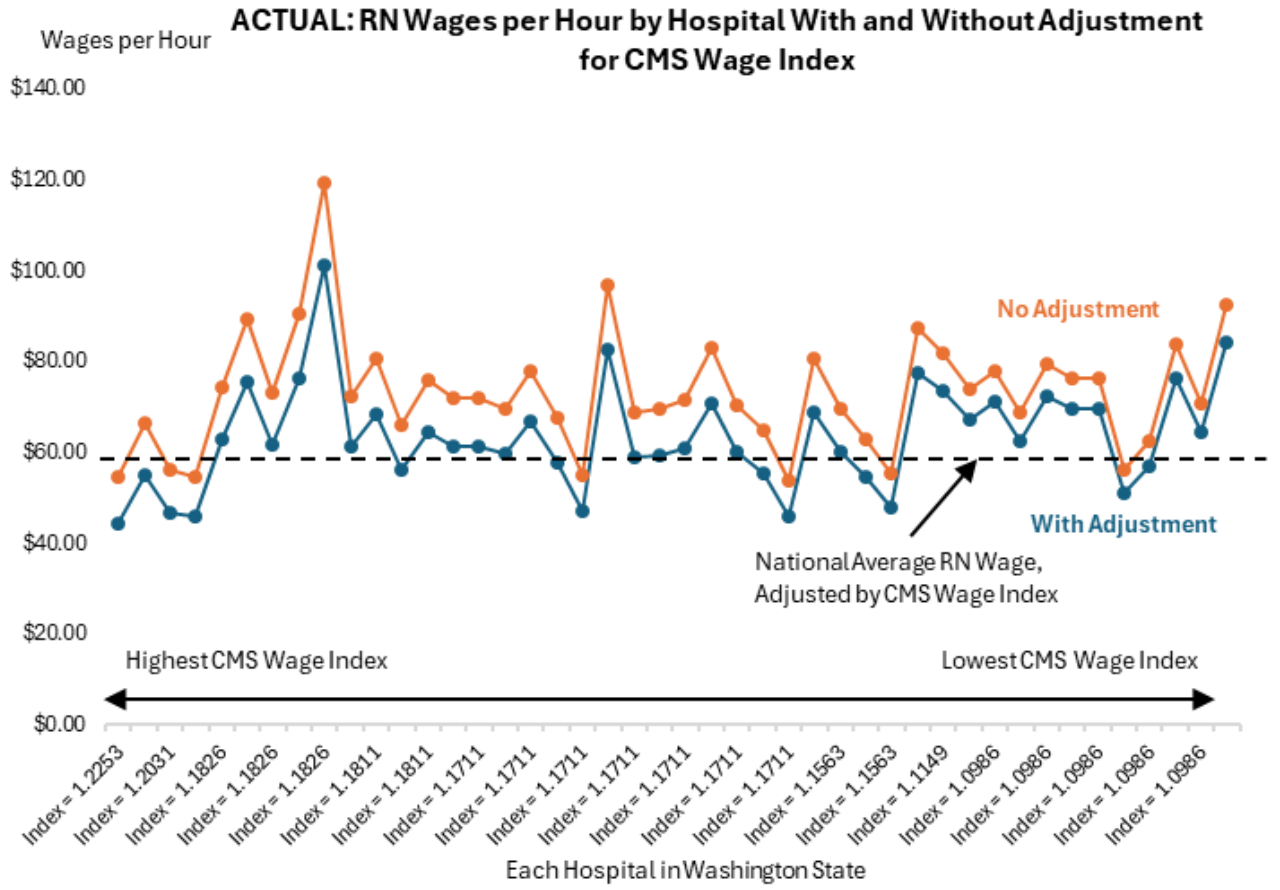
In practice, the CMS Wage Index does not result in all nursing wages being "normalized" in WA state; WA hospitals' wages are not in exact alignment with the national average



27 WA hospitals are still above national level on an adjusted basis

17 WA hospitals are at or below national level on an adjusted basis

Source: Occupational Mix Survey, 2022-2025, Centers for Medicare & Medicaid Services

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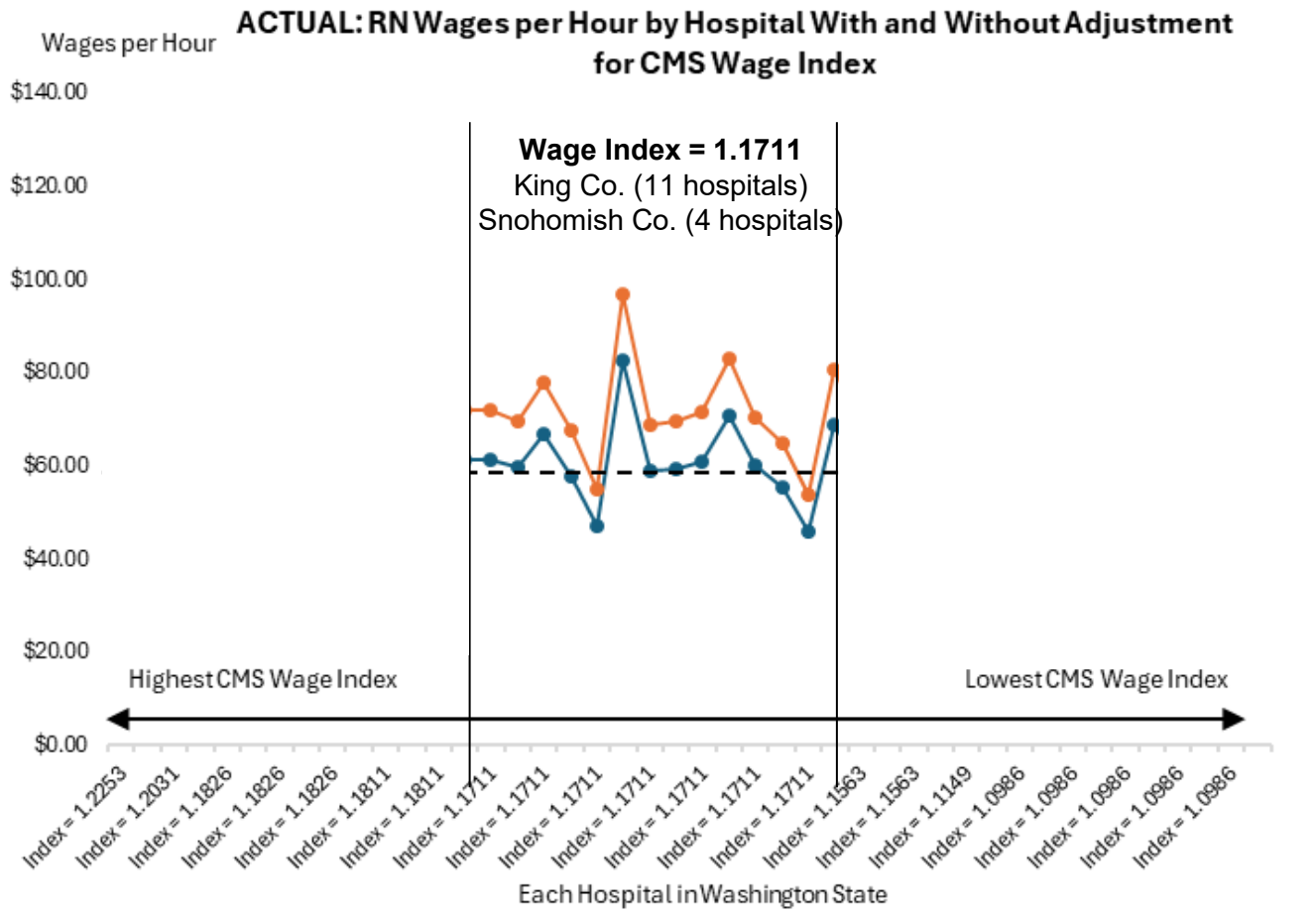
Substantial variation in RN wages exists even for hospitals that get the exact same CMS wage index adjustment



Source: Occupational Mix Survey, 2022-2025, Centers for Medicare & Medicaid Services

Illustration of impact of higher nursing costs

A case study of a King County Hospital (KCH)

ANALYSIS GROUP

KCH was labelled by HCCTB as a "High Cost" Hospital

Total Operating Expense per Adjusted Discharge (Using HCCTB Methodology)	Auburn	National	WA Higher than National ($)	WA Higher than National (%)
Case Mix Index Adjusted	$11,780	$9,257	$2,523	27%
Case Mix Index and CMS Wage Index Adjusted	10,059	9,088	971	11%

HCCTB labeled KCH as "high cost" because it was >10% above its "peers"

Source: Health Care Cost Transparency Board Annual Report (draft), Dec 2024, Washington State Health Care Authority

KCH's nursing wage costs would be substantially lower if it were able to pay national nursing hourly rates even adjusting for the CMS wage index

Occupation Group	Auburn's CMI Adjusted Hours	Auburn's Hourly Wage Unadjusted	Auburn's Adjusted Wages Using CMS Wages Index of 1.1711	National Wage
Registered Nurses (RNs)	31.6	$90.43	$77.22	$60.72
Licensed Practical Nurses (LPNs)	1.6	40.43	34.52	35.59
Nursing Assistants and Orderlies (NAs)	5.2	29.49	25.18	23.57
Medical Assistants (MAs)	0.1	33.10	28.26	23.12
Total Nursing Expenses (sum of products of wages x hours)		**$3,080**	**$2,630**	**$2,102**

Difference not accounted for by CMS wage index adjustment $528

KCH's high nursing wages explain more than half the observed HCCTB cost differences

Total Operating Expense per Adjusted Discharge	Auburn	National	WA Higher than National ($)	WA Higher than National (%)
Case Mix Index Adjusted	$11,780	$9,257	+$2,523	+27%
Case Mix Index and CMS Wage Index Adjusted	$10,059	$9,088	+$971	+11%

Difference due to higher than national wages even with CMS adjustment -$528 -6%

KCH would then be well below the "high cost" threshold → +5%

KCH has almost $7 million in higher nursing costs than national averages, even considering CMS wage adjustments

Total Operating Expense per Adjusted Discharge	Auburn	National	WA Higher than National ($)	WA Higher than National (%)
Case Mix Index Adjusted	$11,780	$9,257	+$2,523	+27%
Case Mix Index and CMS Wage Index Adjusted	$10,059	$9,088	+$971	+11%
Difference due to higher than national wages even with CMS adjustment			-$528	-6%

$528 Additional nursing expenses per discharge **x** **12,966** Total adjusted discharges in 2023 **= $6.9 million**

ANALYSIS GROUP

Washington pays $68 million more a year on nursing salaries than national average even after CMS case mix index and wage index adjustment

Total Operating Expense per Adjusted Discharge	Difference between Adjusted Nursing Expense and National Average per Adjusted Discharge	Total Adjusted Discharges in 2023	Additional Nursing Cost in 2023
27 Hospitals with CMS Wage Index Adjusted Nursing Wage > National Wage	197	648,511	$118 million
17 Hospitals with CMS Wage Index Adjusted Nursing Wage < National Wage	-144	400,701	-$49 million
All 44 Hospitals			**+$68 million**

Observations and Possible Next Steps

- Nursing expenses are a significant driver of high total operating costs of hospitals in Washington state.
- Both high nursing wages per hour and high nursing hours per discharge contribute to high nursing expenses in Washington state.
- Wage index used by CMS and the HCCTB consultants has many limitations. It may be broadly useful for regional adjustments in payments, but it does not accurately adjust for specific variations in nursing expenses among hospitals. These variations may be due to specific needs in these facilities along with state mandates on staffing. They are not necessarily an indication of hospital inefficiency.
- The HCCTB should develop more focused solutions on how hospitals and the state can reduce spending without harming access or quality of care delivery.

Tab 4

Washington State Health Care Authority

Bills of interest for cost transparency

Evan Klein, HCA

March 5, 2025

Washington State Health Care Authority

Bills of interest – agency request legislation

- **Senate Bill (SB) 5083 – Ensuring access to primary care, behavioral health, and affordable hospital services**
  - Aims to redistribute health care costs in Washington by implementing reference pricing, a tool already used in Oregon's public and educator employee programs.
- **House Bill (HB) 1382 – Modernizing the All Payers Claims Database (APCD)**
  - Aligns state law with federal policy regarding health care price transparency by allowing the use of financial data that is already permitted to be used under federal rules.

Other bills of interest

- **SB 5387 – Concerning the corporate practice of health care**
  - Expands practice ownership and control restrictions to ensure corporate entities are not infringing on clinical decision-making.
- **SB 5493 – Concerning hospital price transparency**
  - Requires hospitals to publish all data and comply with all rules related to federal regulations on standard charges and shoppable services by July 1, 2027.
- **HB 1589 – Concerning the relationships between health carriers and contracting providers**
  - Requires OIC to determine whether network providers are actually providing services to enrollees, establishes good faith contract negotiation standards, and studies allowed amounts over time for certain services.

Other bills of interest, cont.

- **HB 1686 – Creating a health care entity registry**
  - Requires certain health care entities to submit ownership, affiliation, and health care services information on behalf of the entity and its subsidiaries and affiliates to the Department of Health (DOH) on an annual basis.
- **HB 1881 – Concerning material changes to the operations and governance structure of participants in the health care marketplace**
  - Regulates mergers and acquisitions by requiring filing notice with the Attorney General and HCA.
  - Latest iteration of the Keep Our Care Act (KOCA).
  - Did not pass Policy Committee cutoff (February 21).

Contact

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Washington State Health Care Authority

Tab 5

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Cost Driver Analysis

Review of claims experience

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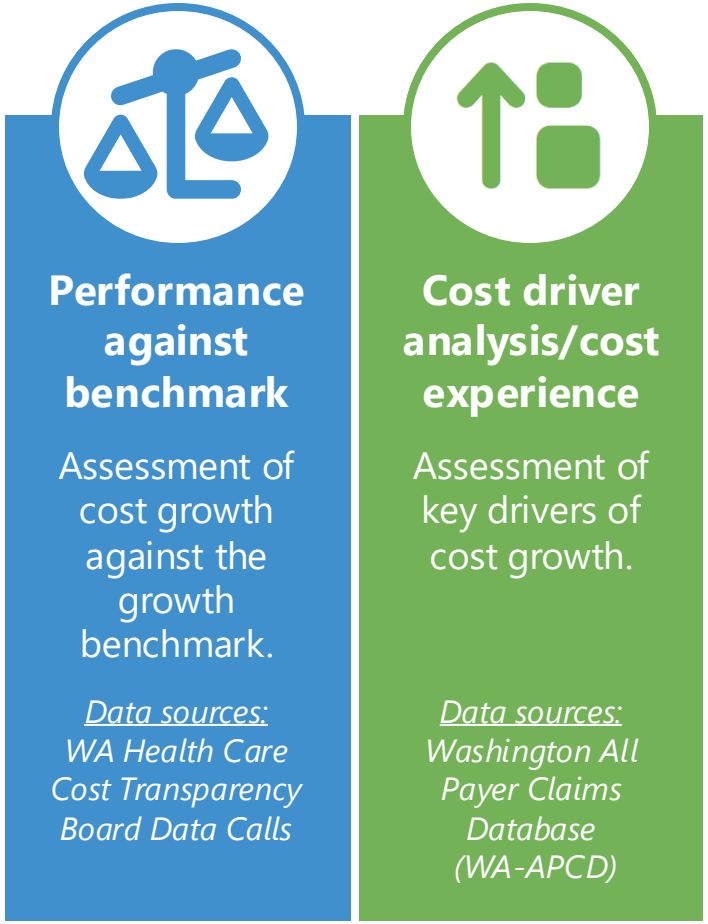
Objectives

- Understand the difference between Data call data vs Cost Driver analysis
- Understand the drivers of cost based on APCD
  - Top growth drivers by service categories + behavioral health
  - Price vs Utilization
    - 2017-2023
    - Analysis on recent developments
- Conduct discussions based on analysis
- Understand deeper and/or broader cost driver analysis need (subject to resource constraints)

Building on data workstreams



- The performance against the benchmark analysis helps us understand baseline health care expenditures and categories of state spending growth.
- To identify policies and programs that can help reduce cost growth, we utilize a **cost driver analysis – looking at claims experience**.
- Examining APCD claims experience provides information on price, utilization, disease burden, demographics, etc.

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Analyzing health care costs - different tools

Components	Performance against benchmark (data call)	Cost Driver Analysis (WA-APCD)
Utilization: Volume of services utilized per capita		X
Service Category: High-level service categories (Inpatient, Outpatient, Rx, etc.)	X	X
Price: Price charged for service (contracted rate or paid amount)		X
Business Practice: Affiliations/Mergers/Acquisitions and other business practices including VBP, pricing strategies, etc.	X	
Disease Burden: Clinical conditions of those who seek care (using Chronic Conditions Warehouse definitions)		X*
Demographics: Core changes in population characteristics (e.g., aging population)		X*
Geographic: Regional or geographic factors		X
Health Equity: Including factors such as Race, Ethnicity, and Rural/Urban		X
Health Policy: Including factors such as supplemental payments, etc.	X	

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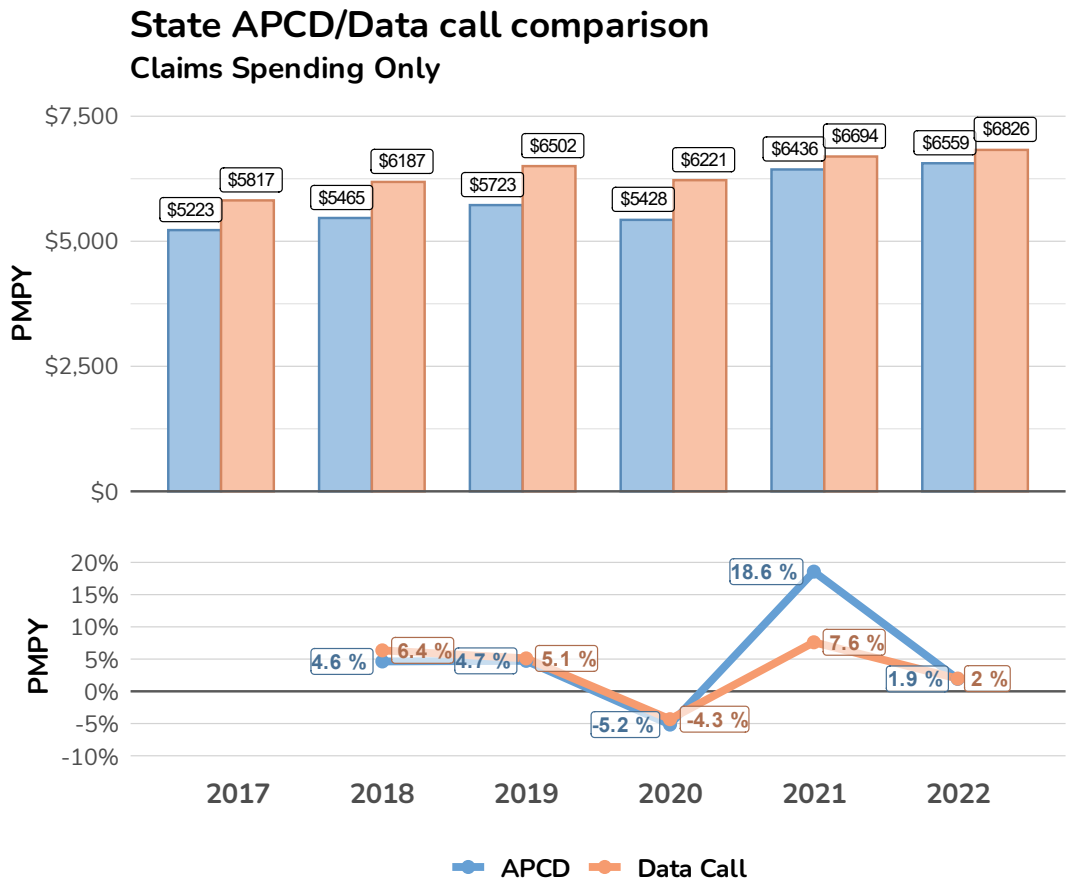
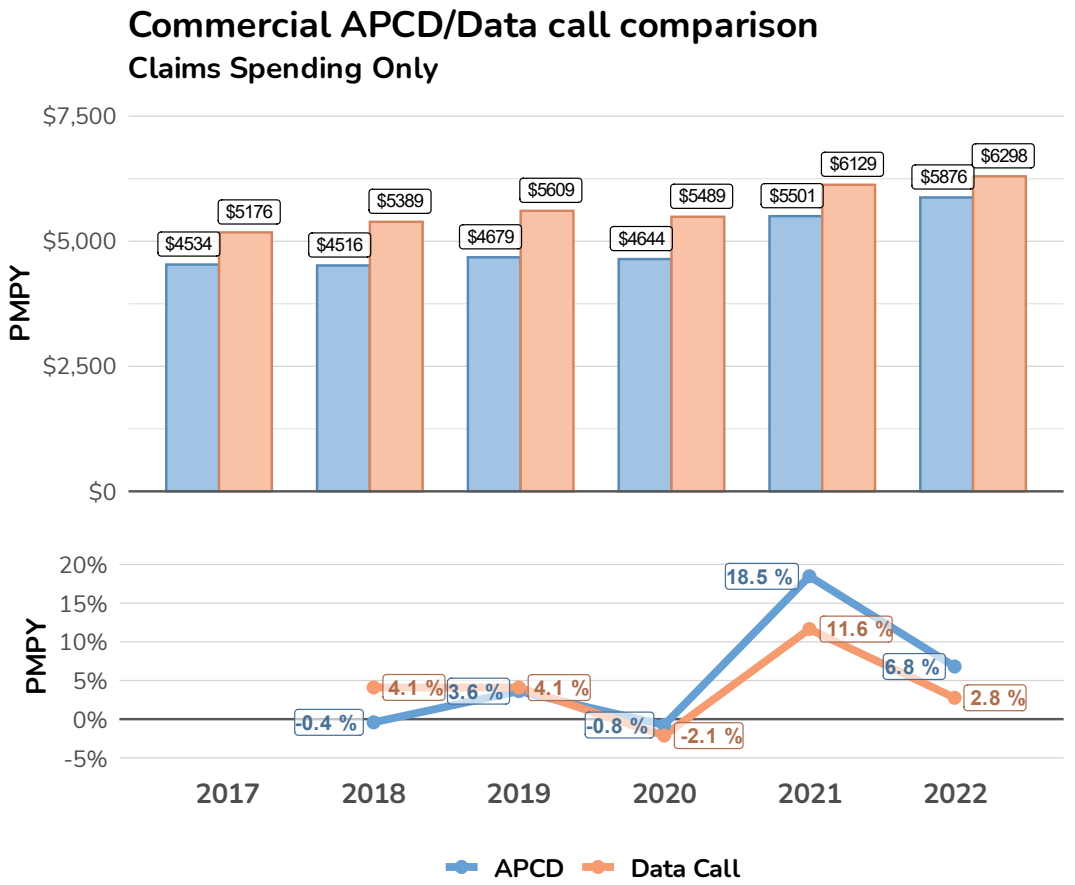
* Data elements available to perform analyses

Data sources – technical notes

Characteristic of data source	Performance against Benchmark (Data Call)	Cost Driver Analysis (WA-APCD)
Data sources: Health care expenditure from all sources	X	
Medicare spending: Medicare spending in data source *Note: APCD Medicare FFS and Part D data was available only through 2022	X	X*
Long term care spending: Long term care spending in data source *Note: some Medicaid long term care spending is not captured	X*	X*
Aggregated: Summarized information in data source	X	
Detailed: Claims-level information detail in data source		X
High Level: Overall indicator of state cost growth performance	X	
Deep-dive: Allows for more specificity and insights		X
Non-Claims: Includes non-claims payments, including incentives, direct payments	X	
Other related costs: Net Cost of Private Health Insurance	X	
Self-insured data: Submission from self-insured health carriers. *Note: self-insured carriers' submissions are voluntary to the APCD.	X	

Monitoring trends across different data streams





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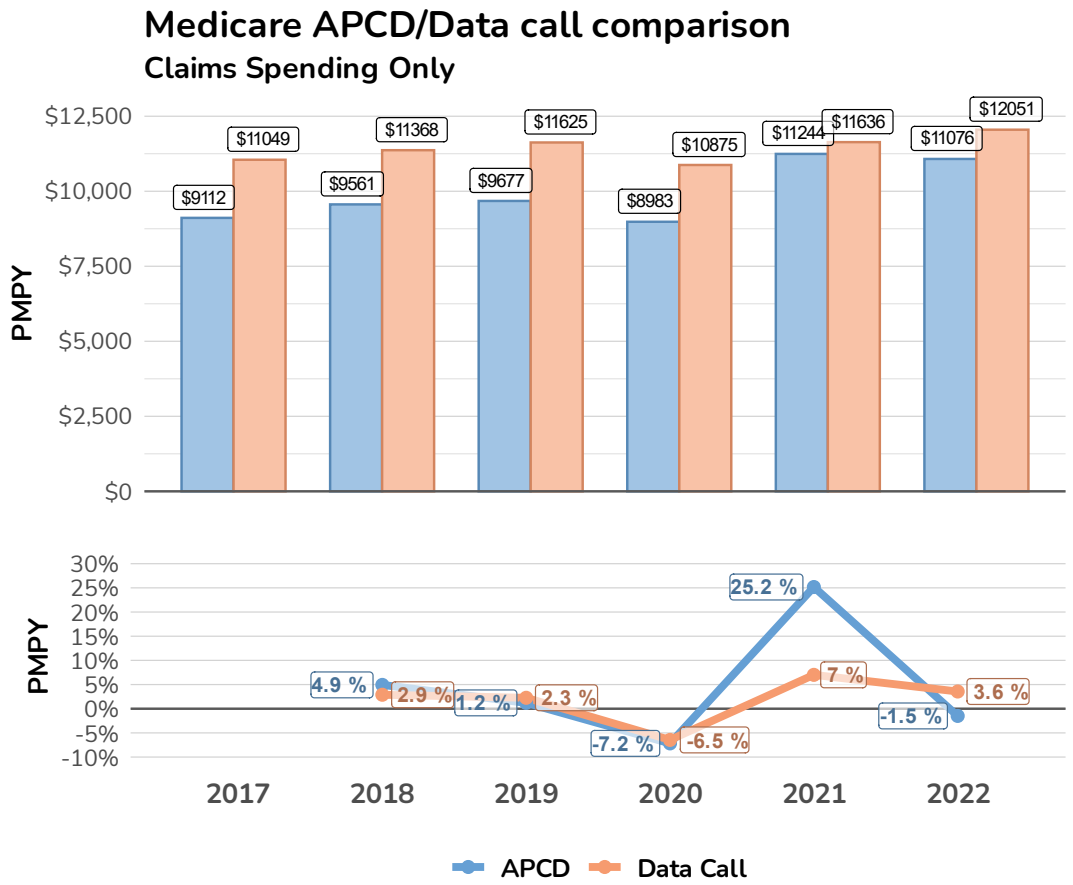
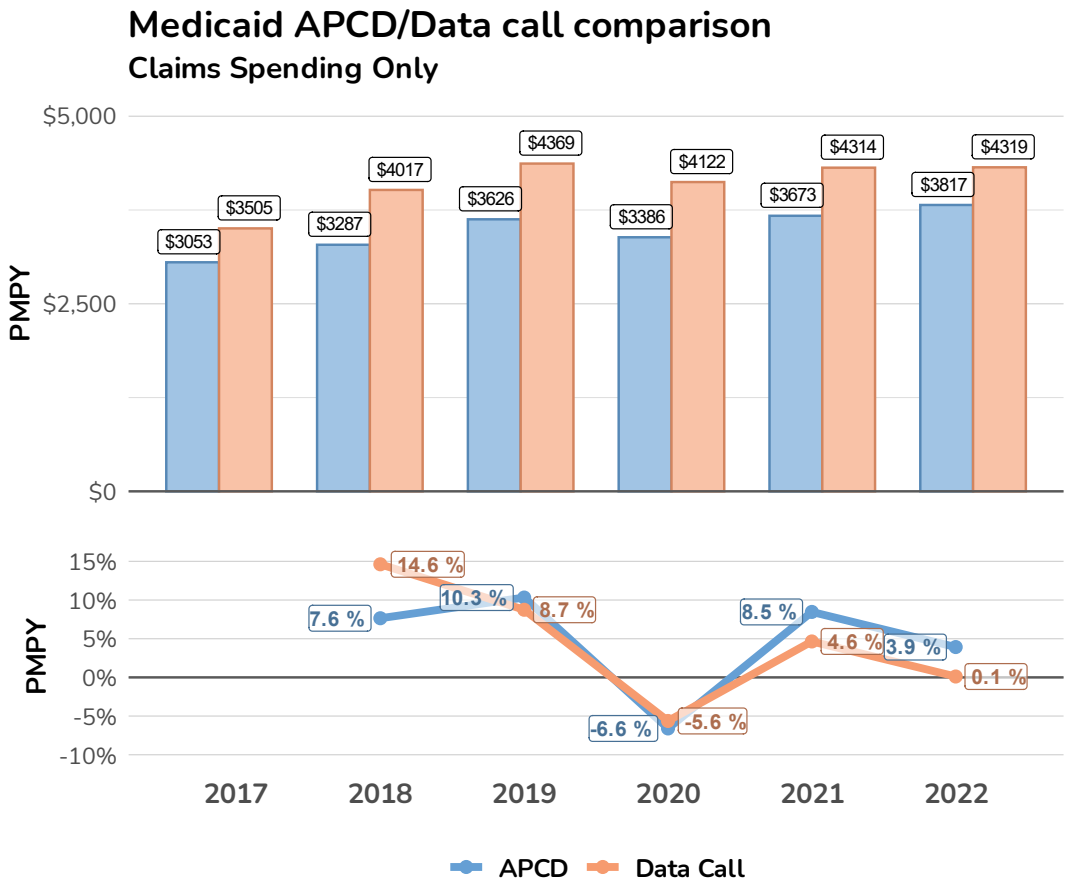
Monitoring trends across different data streams





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APCD cost driver analysis allows us to go deeper

3 examples

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Key Topics

- The Cost Drivers Study used the WA-APCD to study:
  - Drivers of spending by payer type (e.g., Commercial, Medicaid, Medicare Advantage, etc.)
  - Drivers of spending by top 3 service types for expenditures (e.g., inpatient, outpatient, retail pharmacy)
  - Drivers of behavioral health spending

Metrics

- Per-Member-Per Month (PMPM) Spending
- Utilization per 1,000 Members
  - Services are measured by claim headers or inpatient discharges
- Price per Service
- % Change from 2017 Baseline

Drivers of Trend, All Services

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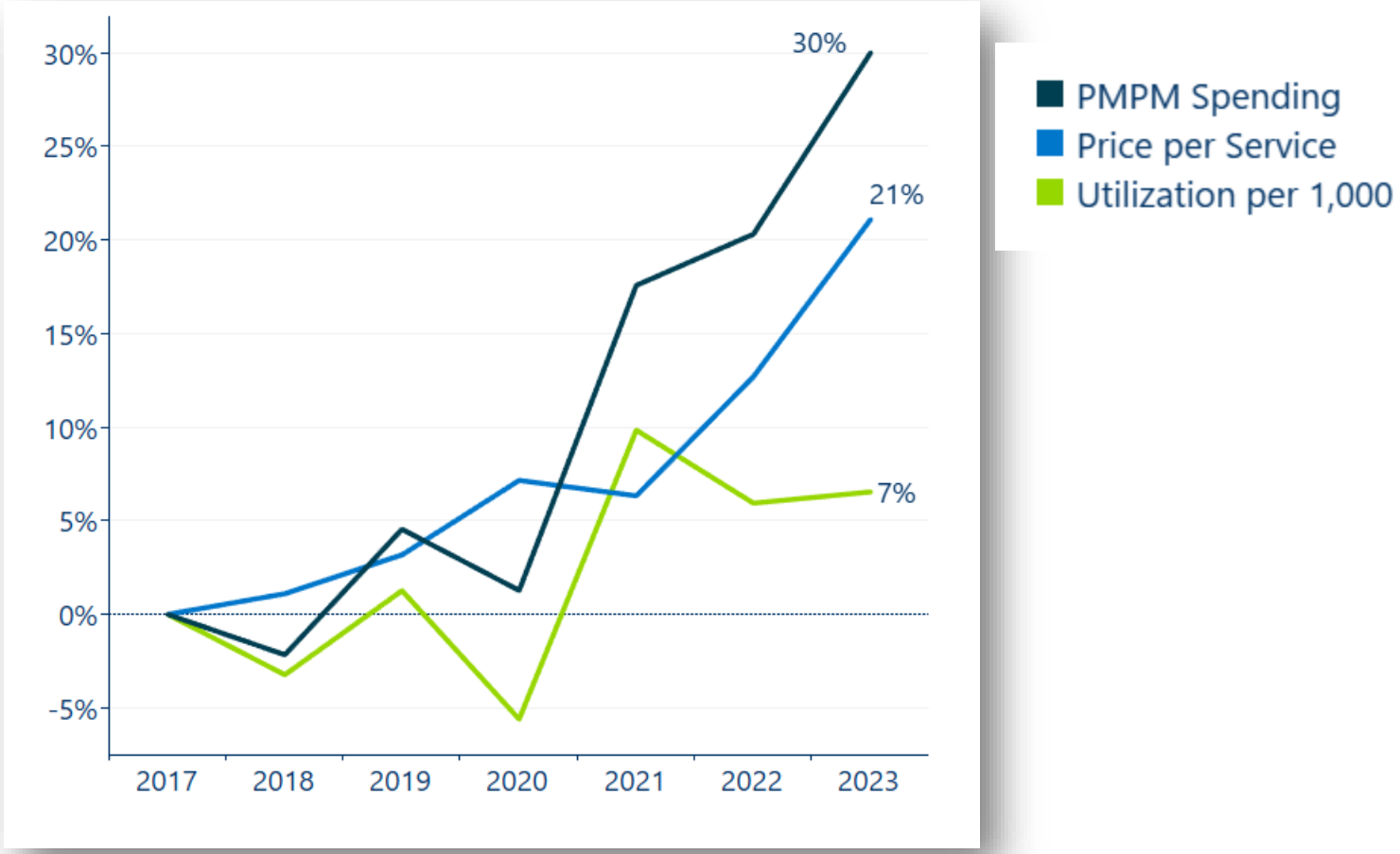
% Change in Spending, Price & Use from 2017 Baseline,

- Statewide, PMPM spending increased 30% between 2017 and 2023
- This was driven by:
  - 21% increase in average price per service and
  - 7% increase in utilization per 1,000 members



Data source: WA APCD; Note: Excludes Medicare FFS

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Drivers by Key Service Categories, All Payers

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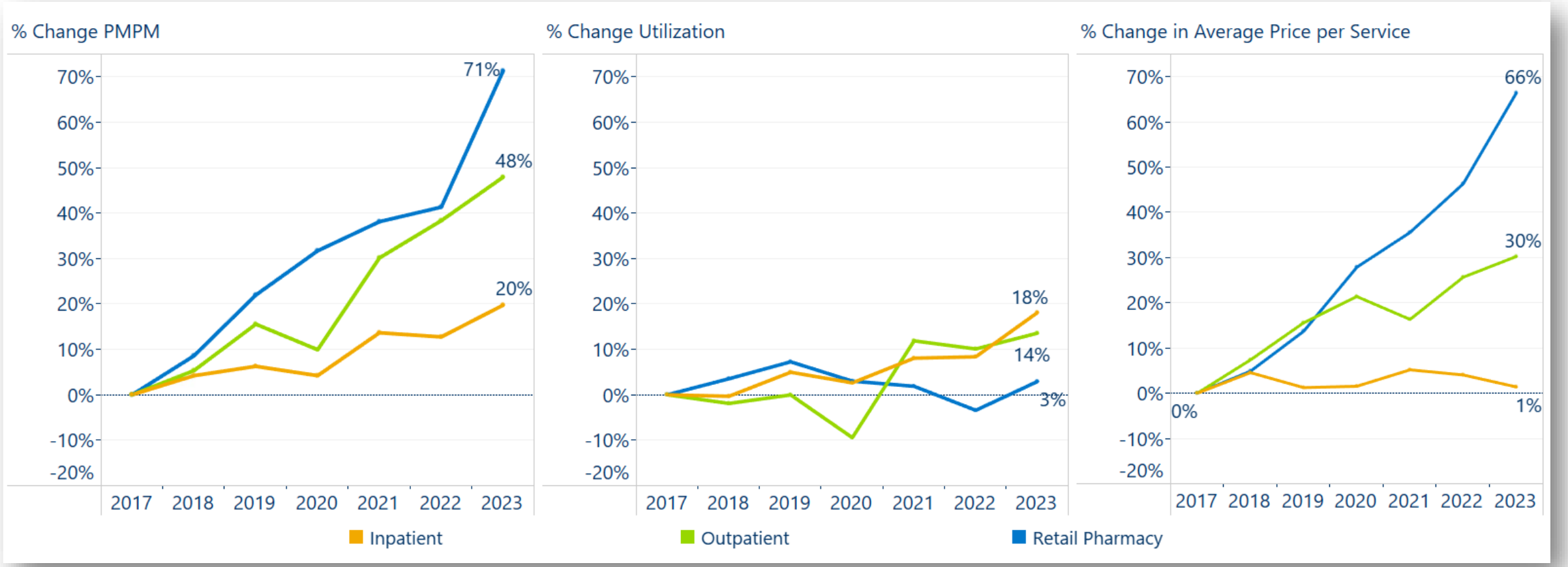
Drivers of Growth, Top Spending Categories (All Payer Types, 2017-2023)



Data source: WA APCD; Excludes Medicare FFS

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Drivers of Growth, Top Spending Categories (All Payer Types, 2017-2023)

- Retail Pharmacy PMPM spending grew 71% across all members in APCD
  - Driven primarily by price growth
- Outpatient PMPM spending grew 48%
  - Driven by both utilization and price growth
- Inpatient PMPM spending grew 20%
  - Driven mainly by utilization
- Note that increased enrollment in Medicare Advantage plans also impacts these data by including more older adults

Drivers of Trend by Payer Type

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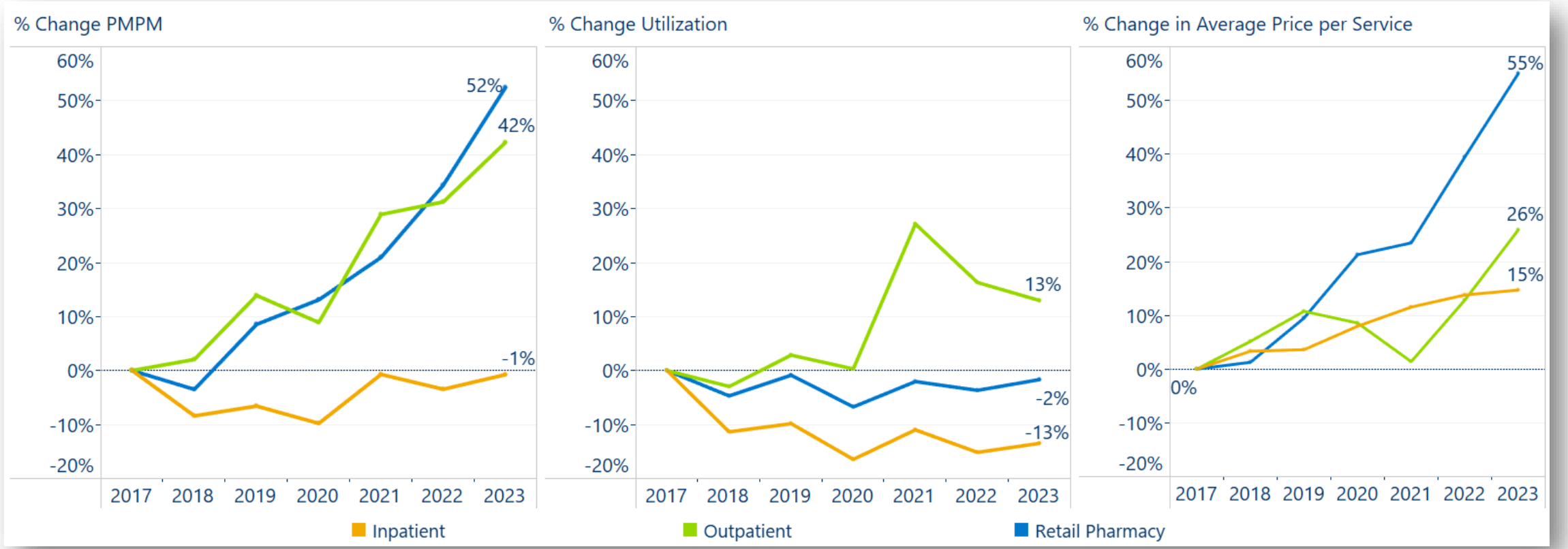
Drivers of Growth, Top Spending Categories (Commercial, 2017-2023)



Data source: WA APCD

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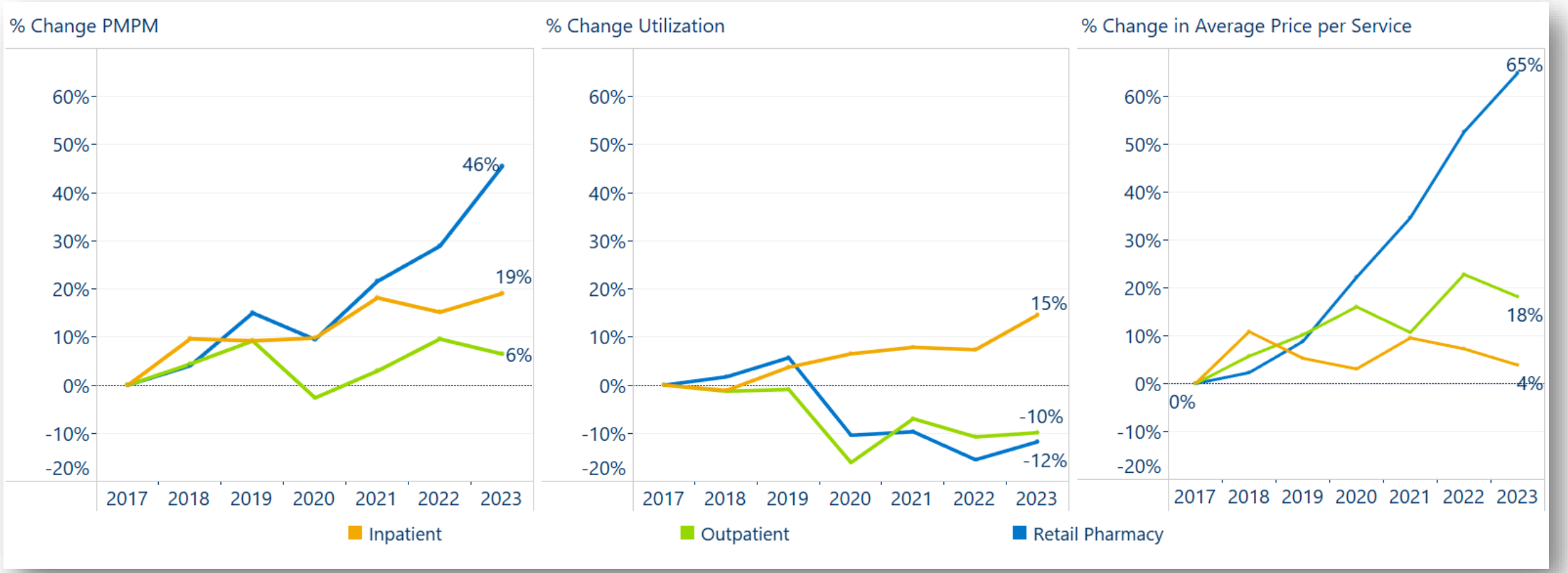
Drivers of Growth, Top Spending Categories (Medicaid, 2017-2023)



Data source: WA APCD

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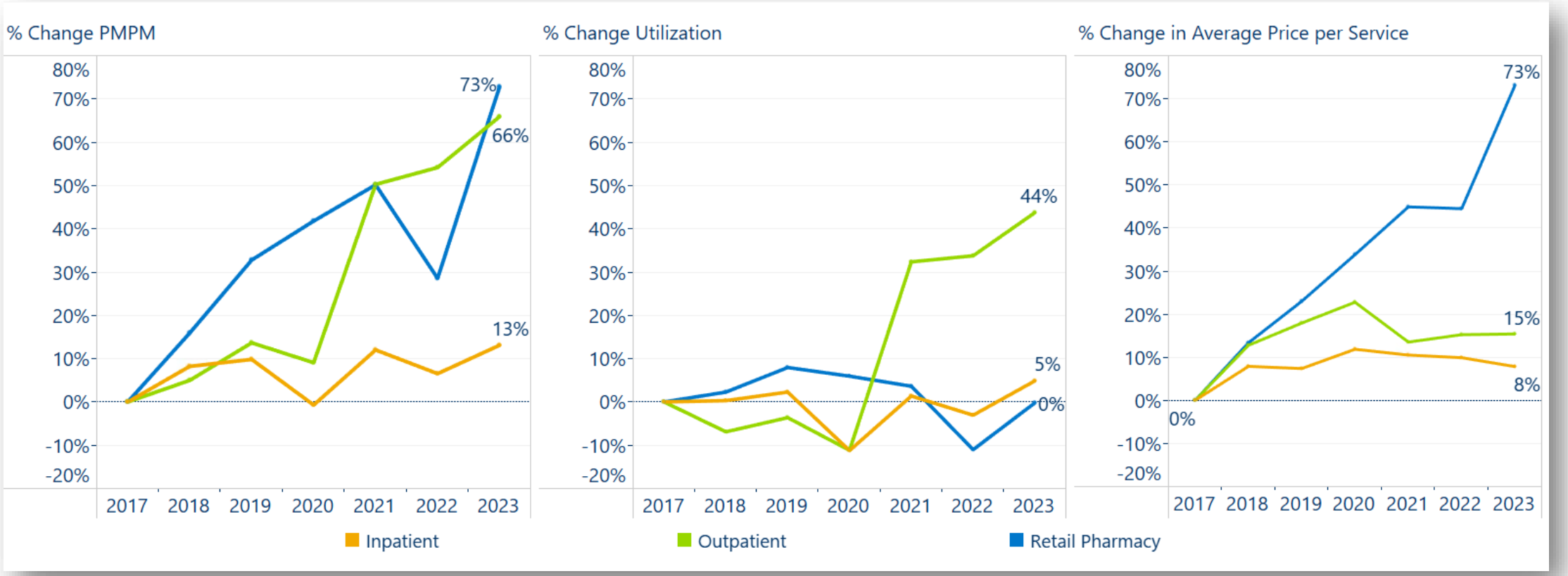
Drivers of Growth, Top Spending Categories (Medicare Advantage)



Data source: WA APCD; Excludes Medicare FFS

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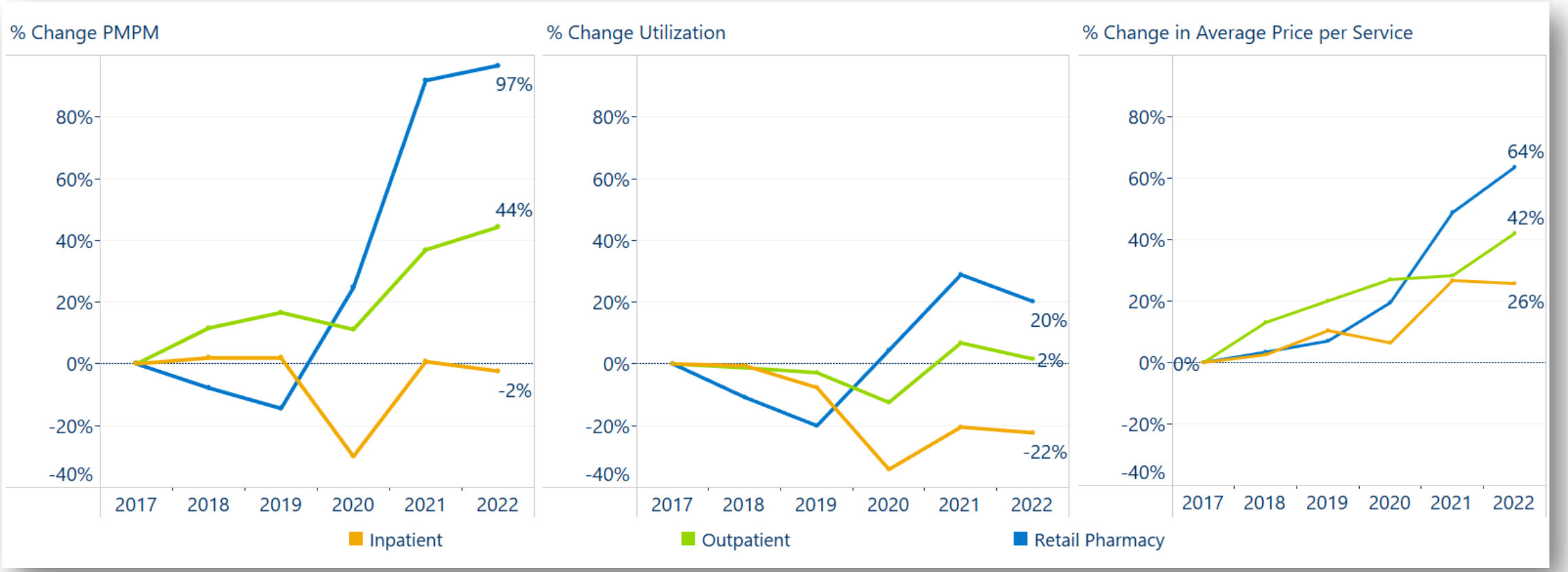
Drivers of Growth, Top Spending Categories (Medicare FFS)



Data source: WA APCD

Note: Medicare FFS data only available through 2022

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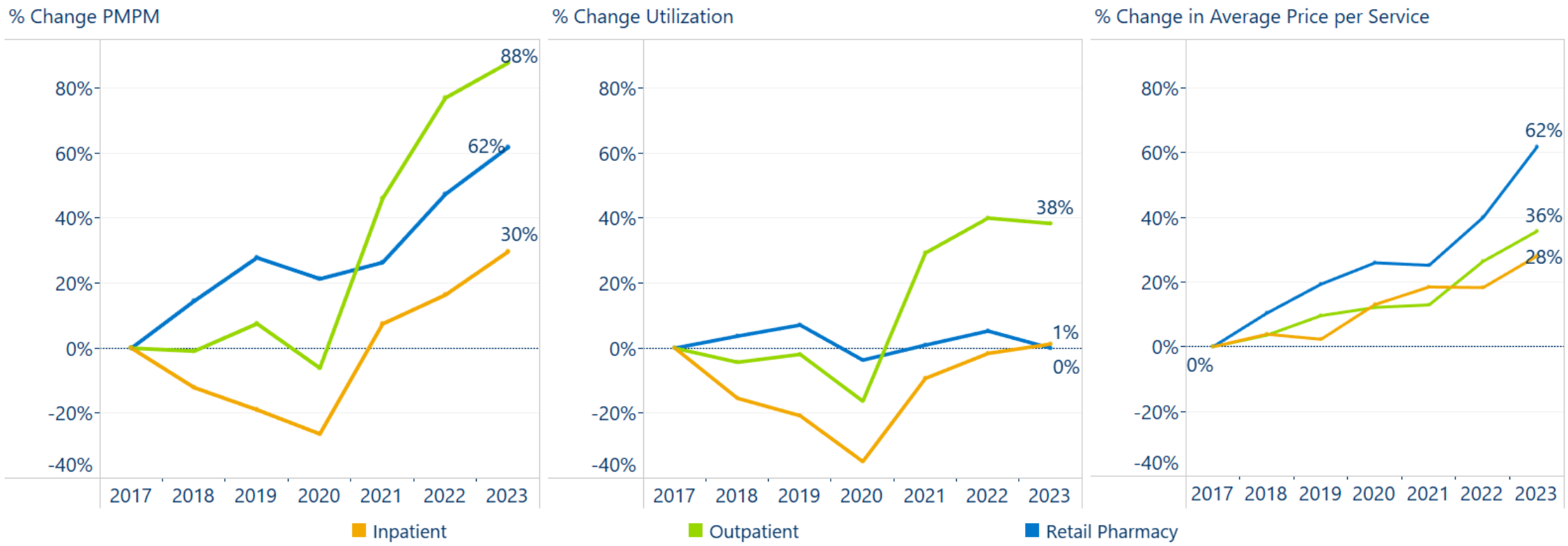
Drivers of Growth, Top Spending Categories (Exchange Plans)



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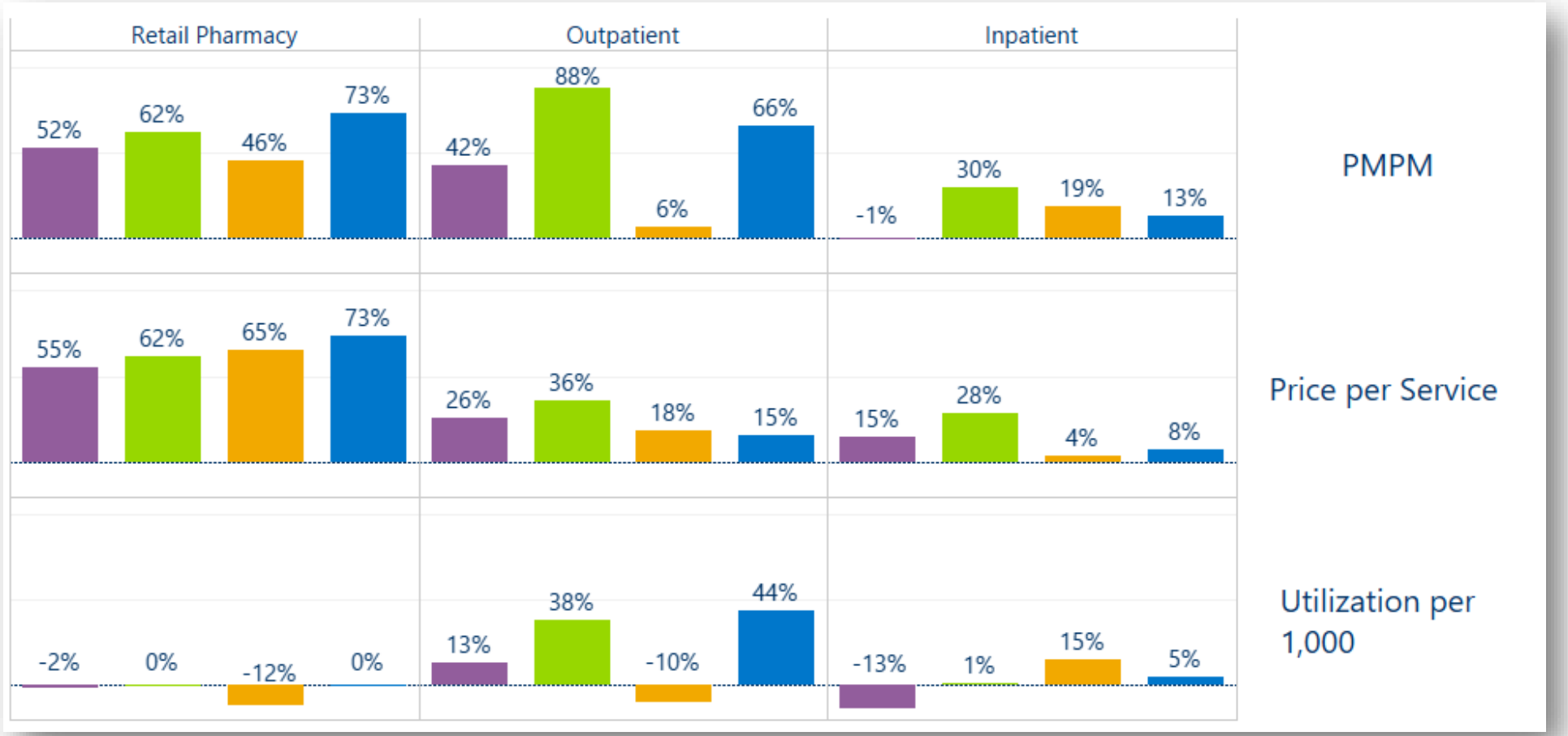
Change between 2017 and 2023 by Payer Type and Category



Data source: WA APCD; Excludes Medicare FFS

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Summary: Change Between 2017 and 2023 by Payer Type & Category

- Retail pharmacy
  - PMPM spending grew rapidly across all markets
  - Driven by increased prices (ranging from 55% Medicaid to 73% Medicare Adv)
- Outpatient
  - High PMPM spending growth among all except Medicaid
  - Driven by combination of price and utilization
- Inpatient
  - Slower PMPM spending growth than other service types
  - Less inpatient utilization among Commercial members over time

Behavioral Health Spending

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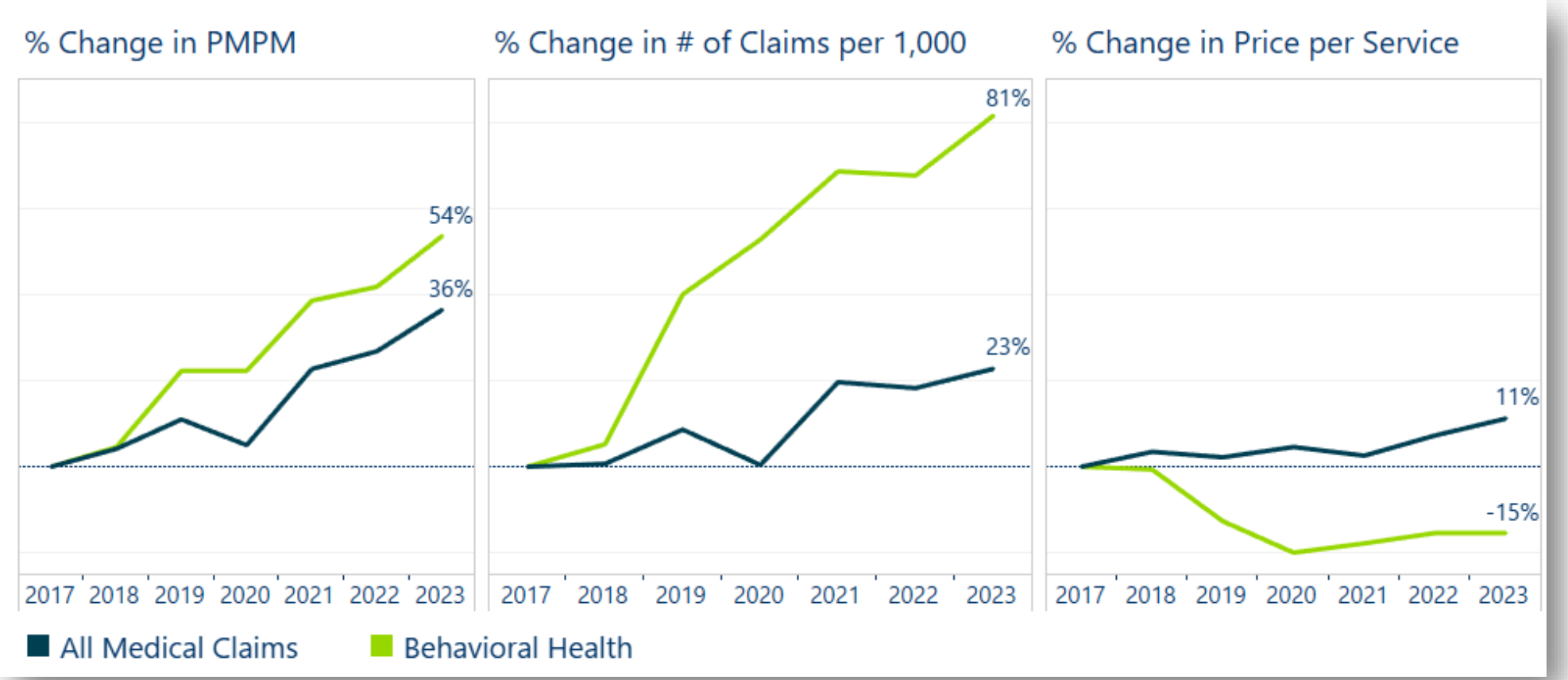
Behavioral Health Claims Spending Compared to All Medical Claims Spending



Note: Medicare FFS data not included.

Behavioral health analyses include only claims-based payments submitted to WA-APCD

Pharmacy is not broken out separately for behavioral health.

Data source: WA APCD; Excludes Medicare FFS

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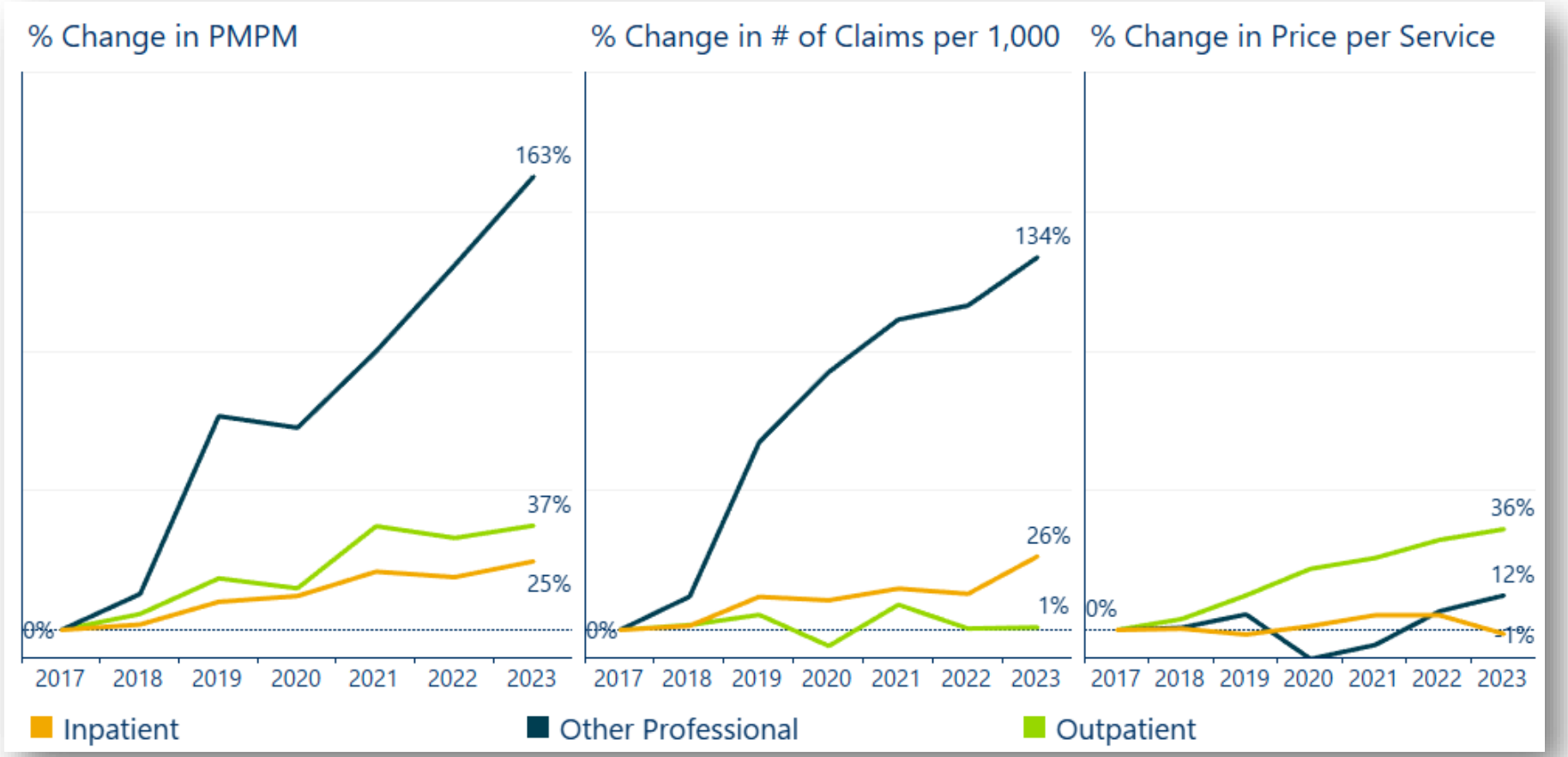
Drivers of Behavioral Health Claims Spending Growth



Other professional includes licensed practitioners that are not primary care or specialists. Includes counselors and social workers and BH care provided in community health centers.

Data source: WA APCD; Excludes Medicare FFS

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Summary of Behavioral Health Claims Spending Growth (2017-2023)

- BH spending has grown more quickly than total medical spending due to substantial increases in BH services reflected in claims
- BH spending for Other Professional services (including counseling and social work and community health centers) increased substantially
  - Driven by 134% increase in # of claims per 1,000

Note: The WA-APCD contains incomplete SUD claims as not all claims are being submitted due to 42 CFR Part 2. There is no prohibition to submitting SUD data but also not regulatory compulsion to submit these data.

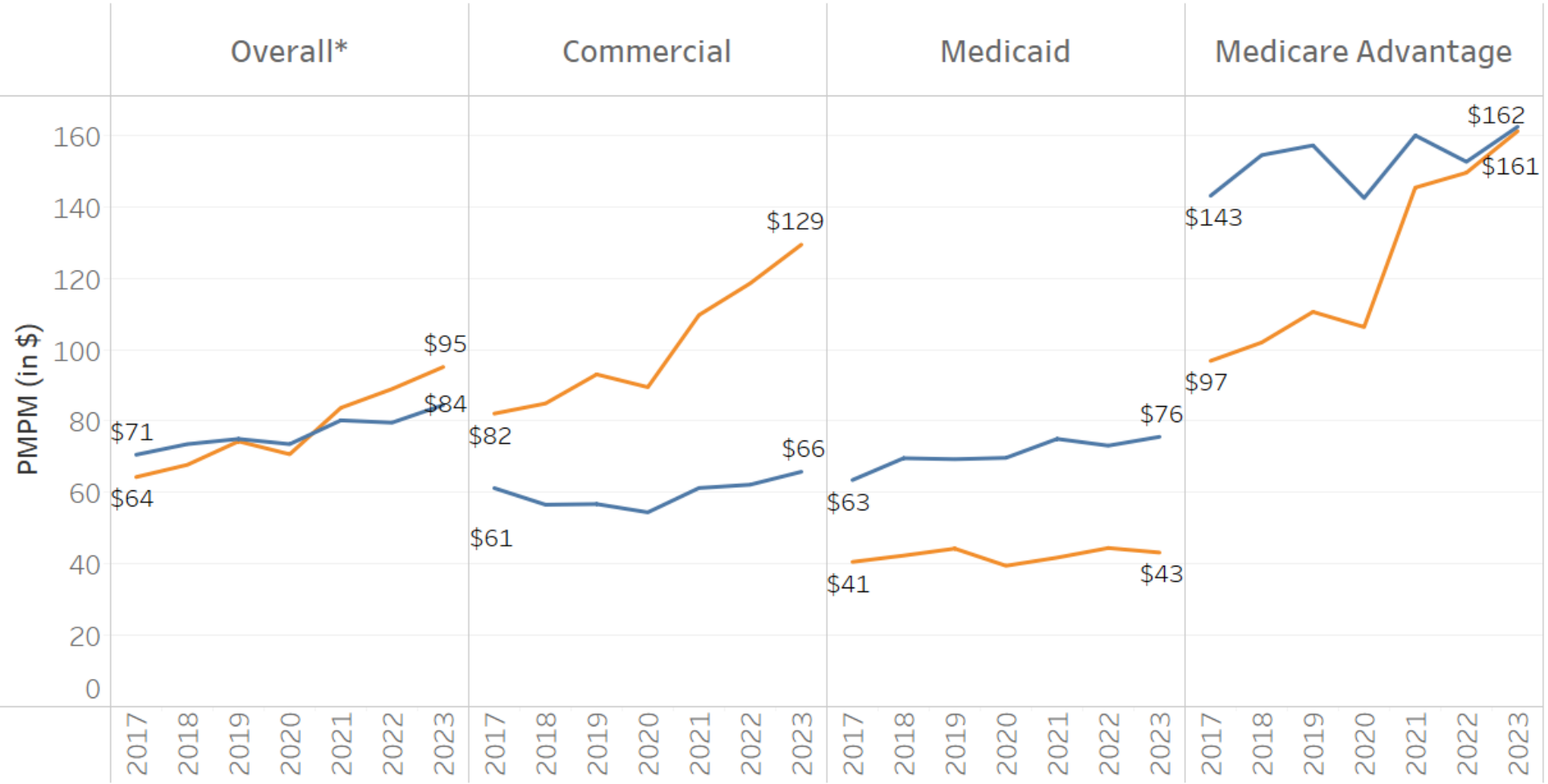
Key Takeaways

Key Takeaways: Cost Drivers Analysis (2017-2023)

- Retail pharmacy PMPM spending had highest rate of growth, followed by hospital outpatient PMPM spending
  - Pharmacy price increases drove spending across all payer types
  - hospital Outpatient marked by increases in price and utilization
- Hospital outpatient PMPM spending grew steadily over time
  - Driven by price and utilization increases in Commercial, Exchange & Medicare Advantage payer types
- BH claims per 1,000, particularly in the Other Professional category, have risen substantially

Inpatient vs. outpatient hospital spending PMPM by market

Modified



- Overall outpatient spending PMPM has surpassed overall inpatient spending PMPM in 2021.
- Increase in outpatient spending is driven by growth in outpatient spending in Commercial and Medicare Advantage markets.

*Excluding Medicare FFS

Inpatient
Outpatient

Source: APCD, OnPoint 2024 Cost Driver Analysis

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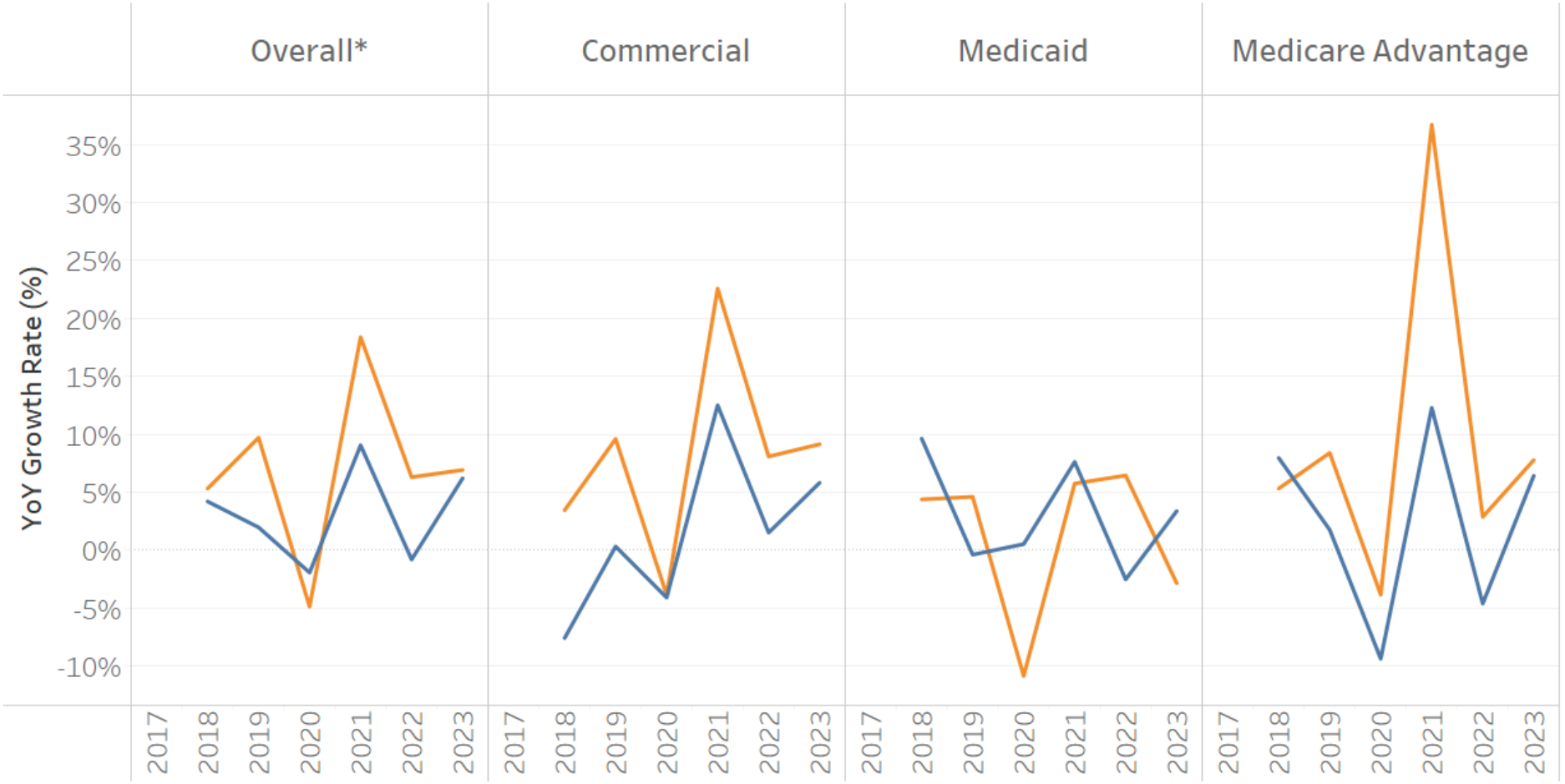
Inpatient vs. outpatient hospital spending growth by market

NEW



- Except for 2020, overall outpatient cost growth has consistently exceeded inpatient cost growth.

*Excluding Medicare FFS

Inpatient
Outpatient

Source: APCD, OnPoint 2024 Cost Driver Analysis

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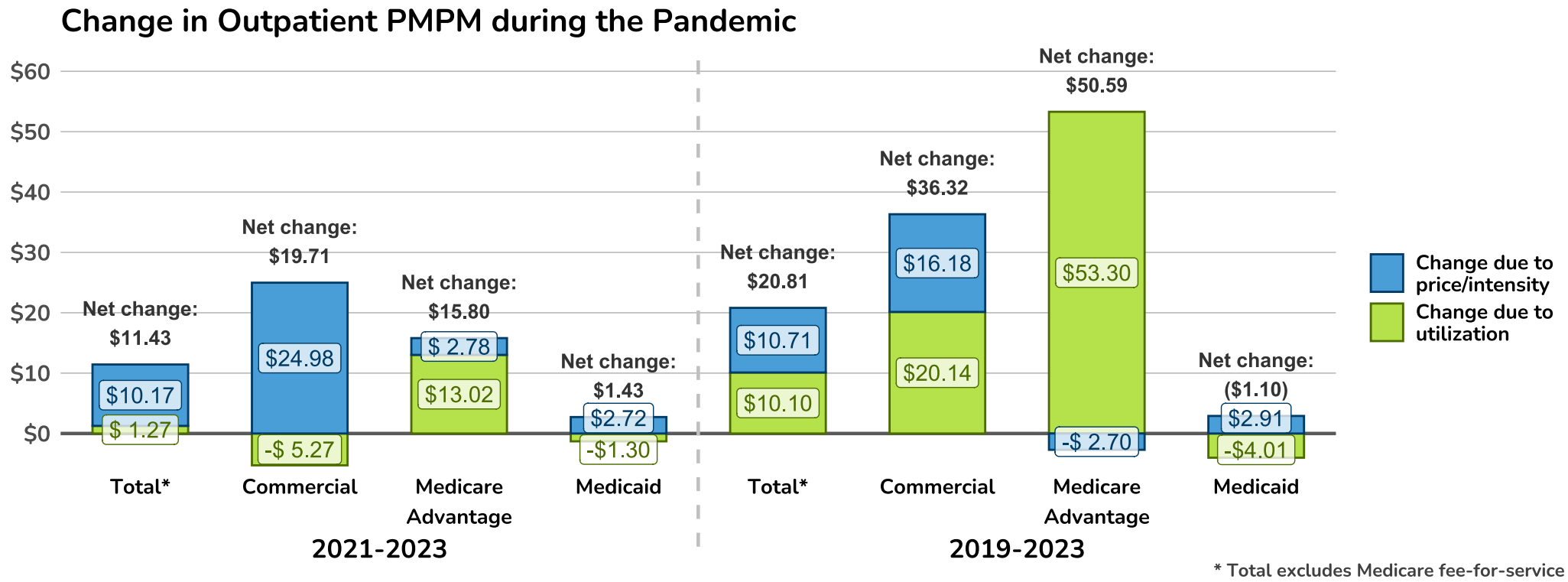
Hospital Outpatient PMPM growth drivers: utilization or price/intensity?

Modified



Source: HCA staff calculations; APCD, Onpoint 2024 Cost Driver Analysis
Breakdown methodology: The amount attributed to utilization was calculated by looking at what the change in PMPM would have been if the average allowed amount per service had stayed the same and only utilization changed. The remainder of the change in PMPM is assumed to be due to changes in price and/or intensity of services. Since the data source only provides an average allowed amount per service aggregated at service category level, HCA staff are unable to disentangle changes in price (costs increased for the same service) from intensity (members received more intense, and therefore more costly, services).

Important caveat: This assumes that the only factors that impact PMPM are utilization and price/intensity.

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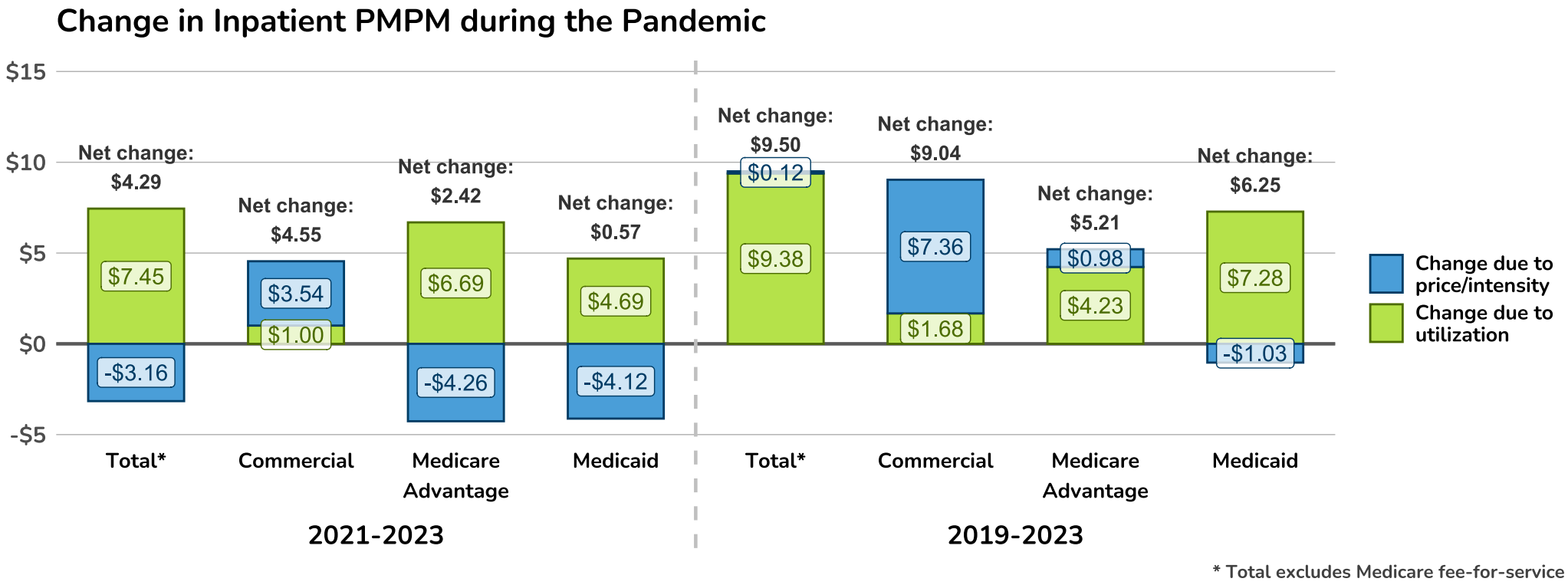
Hospital inpatient PMPM growth drivers: utilization or price/intensity?

New



* Total excludes Medicare fee-for-service

Source: HCA staff calculations; APCD, Onpoint 2024 Cost Driver Analysis
Breakdown methodology: The amount attributed to utilization was calculated by looking at what the change in PMPM would have been if the average allowed amount per service had stayed the same and only utilization changed. The remainder of the change in PMPM is assumed to be due to changes in price and/or intensity of services. Since the data source only provides an average allowed amount per service aggregated at service category level, HCA staff are unable to disentangle changes in price (costs increased for the same service) from intensity (members received more intense, and therefore more costly, services).

Important caveat: This assumes that the only factors that impact PMPM are utilization and price/intensity.

Washington State Health Care Authority

Is there a shift from inpatient to outpatient spending? NEW

Growth rate in utilization, overall and by market*

	(A) 2017-2023		(B) 2017-2019		(C) 2019-2021		(D) 2021-2023	
	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
Overall*	18.1%	13.6%	5.0%	0.0%	3.0%	11.9%	9.3%	1.5%
Commercial	-7.5%	26.3%	-10.2%	3.8%	1.3%	27.8%	1.6%	-4.8%
Medicaid	14.6%	-9.9%	3.7%	-0.9%	4.0%	-6.1%	6.3%	-3.1%
Medicare Advantage	5.0%	43.2%	2.2%	-3.4%	-1.4%	36.0%	4.2%	9.0%

Source: HCA staff calculations; APCD, Onpoint 2024 Cost Driver Analysis
*Notes: *Excludes Medicare FFS*
Important caveat: This assumes that the only factors that impact PMPM are utilization and price/intensity.

- Overall changes in utilization do not suggest large-scale shifts in procedures and costs from inpatient to outpatient settings
- But there may be some shifting occurring in the commercial and Medicare Advantage markets.

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What policy interventions do these analyses suggest we should investigate further?

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Context

- PMPM is driven by price per service and less so by utilization.
- Rising price per service is coming from:
  - Retail pharmacy
  - Hospital outpatient
- Post-pandemic (2021-2023) analysis shows that outpatient PMPM is largely driven by increase in price and/or intensity, largely coming from commercial.
- There may be some shifting in procedures and costs from inpatient to outpatient settings occurring in the commercial and Medicare Advantage markets.

Questions

Washington State Health Care Authority

Tab 6

Washington State Health Care Authority

Analytic Support Initiative

WA Health Care Cost Transparency Board

March 5, 2025

HCA & Institute for Health Metrics and Evaluation

ASI

Analytical Support Initiative Overview

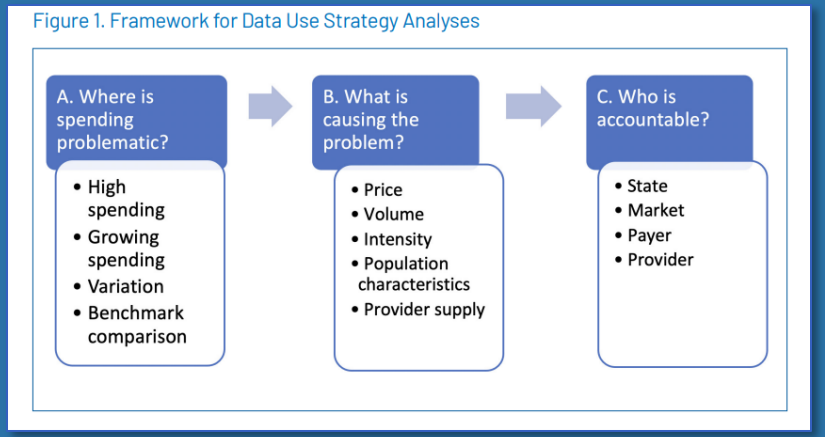
Condensed objective:

- **develop WA specific analyses of cost growth trends** to identify specific areas of focus for discussion, additional analysis, and support of cost mitigation strategies
- **provide information** that will result in actionable recommendations on reducing health care cost growth in WA

Philanthropic funding for July 2023-July 2025

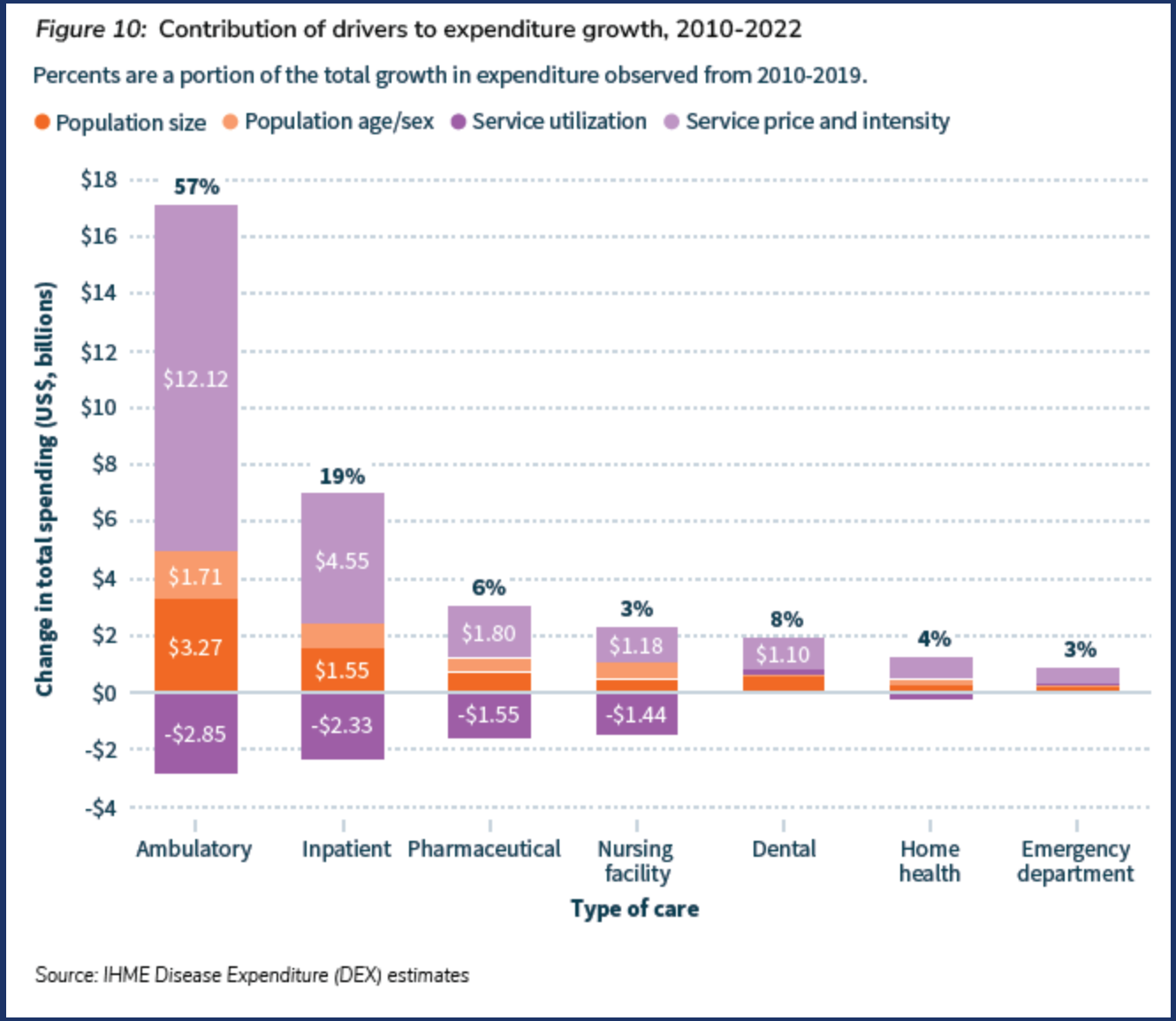
Timeline:

- 1st six months → building foundation
- 2nd and 3rd six-month periods → doing the work collaboratively
- 4th six months → formalizing recommendations



Spending estimates and decomposition analysis provided in report provided in end of 2024 and included in the 2024 legislative report

Interactive visualization to go live in early 2025



Next steps

Key questions:

1) How does the relationship between missing supply and preventable admissions interact with rurality and payer type?
2) Who is most impacted by preventable admissions and what is the associated spending burden?

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1) How does the relationship between missing supply and preventable admissions interact with rurality and payer type?
2) Who is most impacted by preventable admissions and what is the associated spending burden?

Analytic strategy:

a. Quantify **outpatient visits and/or prescriptions per prevalent case** for key diseases for each county. Build composite index of access to care for each county.

b. Quantify **inpatient admissions or ED visits for preventable diseases** for each county. Build a composite index of preventable admissions for each county.

c. Assess relationship between (a), (b), rurality and payer.

d. Quantify spending on preventable admissions and ED visits by payer and county.

Next steps

Key questions:

1) How does the relationship between missing supply and preventable admissions interact with rurality and payer type?
2) Who is most impacted by preventable admissions and what is the associated spending burden?

Deliverables

a. Short report in the form of a PowerPoint deck providing key results and findings, and overview of methods and information about how to interpret results and findings.

b. Goal is to have this to present to the Cost Board on XXX.

Next steps

Key questions:

1) How does the relationship between missing supply and preventable admissions interact with rurality and payer type?
2) Who is most impacted by preventable admissions and what is the associated spending burden?

Challenges/limitations

a. Visits per prevalent case is limited to 78 health conditions for which we have prevalence estimates.

b. Analysis will use estimates from 2022.

c. “Who is impacted” will be reported at the county-payer level.

Thank you

ASI

Tab 7

Washington State Health Care Authority

	Facility types that are subject to bill	Who currently regulates these facility types	Facility types not currently regulated
NASHP Model	• Hospitals and other licensed inpatient facilities, • Health systems consisting of one or more health care entities that are jointly owned or managed, • Ambulatory surgical or treatment centers, • Skilled nursing facilities, • Residential treatment centers, • Diagnostic, laboratory and imaging centers, • Free-standing emergency facilities, • Outpatient clinics, and • Rehabilitation and other therapeutic health settings.	**DOH** • Hospitals • ASCs • RTFs • Medical Test Sites **DSHS** • Nursing homes	• Diagnostic and imaging centers • Free-standing emergency facilities • Outpatient clinics • Rehabilitation and other therapeutic health settings
SB 5704 (HB 1881) – Adding Access to Protected Health Services to Material Change Transaction Review	• Hospitals • Hospital systems • Provider organizations	**DOH** • Hospitals • Hospital systems	• Provider organizations
SSB 5387 (HB 1675) – Amending Corporate Practice of Medicine	• Hospitals • Private establishment • Ambulatory Surgical Center • Nursing Home • Birthing center • In-home care agency • Telemedicine-exclusive medical practice	**DOH** • Hospitals • Private establishment • Ambulatory Surgical Center • Nursing Home • Birthing center	• Telemedicine-exclusive medical practice

		• In-home care agency	
SB 5122 – Enacting Uniform Antitrust Premerger Notification Act	• Individual • Estate • Business or nonprofit entity • Government, agency or instrumentality • Other legal entity	**<u>DOH</u>** • Hospitals • ASCs • RTFs • Medical Test Sites **<u>DSHS</u>** • Nursing homes	• Diagnostic and imaging centers • Free-standing emergency facilities • Outpatient clinics • Rehabilitation and other therapeutic health settings
SHB 1686 (SB 5561) – Health Care Entity Registry	• Health care facility licensed by DOH or DSHS • Pharmacies licensed by DOH • Provider organization • Physician organizations • Health care benefit manager • Health Carrier	**<u>DOH</u>** • Hospitals • ASCs • RTFs • Medical Test Sites **<u>DSHS</u>** • Nursing homes	• Diagnostic and imaging centers • Free-standing emergency facilities • Outpatient clinics • Rehabilitation and other therapeutic health settings • Urgent Cares • Provider clinics

Business/Market Oversight Follow-up Status Report

Ally Power, Jenn Scott, Ross Valore

Washington State Health Care Authority

Background: market consolidation

- WA has seen a significant degree of consolidation and integration — likely to continue without intervention
- Private equity purchasing and corporate buyers are increasing and changing the landscape of health care
  - Higher costs for patients and insurers
  - Lower patient satisfaction
  - Jeopardized access
- The Office of the Attorney General reviews some transactions but smaller transactions may go unreported and unreviewed
- To help fill gaps, the Cost Board approved two recommendations at the November 2024 meeting and formalized the recommendations in the 2024 Cost Board's annual legislative report

Source: Cost Board Report to the Legislature, Dec. 2024

Market oversight: Cost Board's recent work

Cost Board Meeting Nov 2024	Cost Board's 2024 Legislative Report Dec 2024	Committee & HCA Staff Activity Dec 2024–Jan 2025	Cost Board Meeting Jan 2025	Cost Board Meeting March 2025

RECOMMENDATIONS
• Require ownership structures & legal affiliations reporting.
• Use the NASHP Model Act to draft legislation increasing WA State's oversight of mergers & acquisitions
• Align recommendations w/legislative priorities & upcoming legislative session to maximize impact
• Coordinate data collection & analysis across agencies
• Ask Data Issues Advisory Committee to analyze existing data sources, review reporting gaps and cross-reference with NASHP model recommendations
	RECOMMENDATIONS
	• Require ownership structures and legal affiliations reporting (Recommendation 3)
	• Increase WA State's oversight of mergers & acquisitions (Recommendation 4)
	  • Propose the Legislature use the NASHP Model Act for State Oversight of Proposed Health Care Mergers to draft legislation to increase WA State's oversight of mergers & acquisitions
		RECOMMENDATIONS
		• At Nov 24 meeting, Data Issues Advisory Committee enlisted HCA staff assistance in cross referencing existing WA State data sources w/NASHP Model Act
		• HCA staff began crosswalk finding:
		  • Significant gaps in existing State data sources
		  • Need for greater coordination w/other agencies to do a thorough crosswalk
			DISCUSSION
			• Bills related to market oversight and NASHP Model Act are currently under consideration by the legislature
			• DOH and OIC are already creating crosswalks (SB 5561)
			• Keep the scope of HCA staff's work on NASHP crosswalk narrow to not slow progress on current bills
				AGENDA
				• Review & discuss current bills relevant to Cost Board's legislative recommendations
				• Staff recommendations re: NASHP crosswalk
				  • Cost Board's goals are being accomplished via legislation
				• Next steps: Cost Board's recommendations
				  • Support for provider registry bill?
				  • Types of facilities that should be included

About NASHP model legislation

- Model legislation for states to address the issues of corporate and private equity entry into health care markets, health care consolidation, and closures of key service lines or facilities.
- Includes measures that:
  1. Update definitions that reflect current market conditions.
  2. Extend health care market and transaction oversight to corporate changes of control of health care provider groups (including management services organizations), real estate sale-leasebacks involving health care entities, and planned closures of facility or service lines.
  3. Strengthen laws regulating the corporate practice of medicine and physician non-competes.
  4. Require transparency of health care ownership and control structures.

NASHP definitions to note

- “Health care entity”: a health care provider, health care facility, provider organization, pharmacy benefit manager, or carrier that offers a health benefit plan in the state
- “Health care facility”: a licensed institution providing health care services or a health care setting, including, but not limited to:
  - Hospitals and other licensed inpatient facilities
  - Health systems consisting of one or more health care entities that are jointly owned or managed
  - Ambulatory surgical or treatment centers
  - Skilled nursing facilities
  - Residential treatment centers
  - Diagnostic, laboratory and imaging centers
  - Free-standing emergency facilities, outpatient clinics, and rehabilitation and other therapeutic health settings

Crosswalk of Facility Oversight Legislation

	NASHP Model	SB 5704 (HB 1881) – Adding Access to Protected Health Services to Material Change Transaction Review	SSB 5387 (HB 1675) – Amending Corporate Practice of Medicine	SB 5122 – Enacting Uniform Antitrust Premerger Notification Act
Facility types that are subject to bill	• Hospitals • Health systems • Ambulatory surgical centers, • Skilled nursing facilities, • Residential treatment centers, • Diagnostic, laboratory and imaging centers, • Free-standing emergency facilities, • Outpatient clinics, and • Rehabilitation and therapeutic health settings.	• Hospitals • Hospital systems • Provider organizations	• Hospitals • Private establishment • Ambulatory Surgical Center • Nursing Home • Birthing center • In-home care agency • Telemedicine-exclusive medical practice	• Individual • Estate • Business or nonprofit entity • Government, agency or instrumentality • Other legal entity

Crosswalk of Facility Oversight Legislation cont'd

	NASHP Model	SB 5704 (HB 1881) – Adding Access to Protected Health Services to Material Change Transaction Review	SSB 5387 (HB 1675) – Amending Corporate Practice of Medicine	SB 5122 – Enacting Uniform Antitrust Premerger Notification Act
Who regulates these facility types	**DOH** • Hospitals • ASCs • RTFs • Medical Test Sites • Hospice accepting Medicare/Medicaid **DSHS** • Nursing homes	**DOH** • Hospitals • Hospital systems	**DOH** • Hospitals • Private establishment • Ambulatory Surgical Center • Nursing Home • Birthing center • In-home care agency • Hospice accepting Medicare/Medicaid	**DOH** • Hospitals • ASCs • RTFs • Medical Test Sites **DSHS** • Nursing homes

Crosswalk of Facility Oversight Legislation cont'd

	NASHP Model	SB 5704 (HB 1881) – Adding Access to Protected Health Services to Material Change Transaction Review	SSB 5387 (HB 1675) – Amending Corporate Practice of Medicine	SB 5122 – Enacting Uniform Antitrust Premerger Notification Act
Facility types not currently regulated	• Diagnostic and imaging centers • Free-standing emergency facilities • Outpatient clinics • Rehabilitation and other therapeutic health settings • Dialysis facilities • Hospice (non-Medicare/Medicaid)	• Provider organizations	• Telemedicine-exclusive medical practice	• Diagnostic and imaging centers • Free-standing emergency facilities • Outpatient clinics • Rehabilitation and other therapeutic health settings

Summary of Health Care Entity Registry SB 5561/HB 1686

- Health care entities must annually report prescribed business identification, financial, and ownership information to DOH (2027)
- DOH will create a public, searchable interactive tool (2028)
- DOH may audit for failure to submit information or if there is reason to question the accuracy or completeness of information submitted
- Civil penalties will be charged for failure to provide a complete report or for submitting false information
- DOH may refer entities to the Attorney General for noncompliance

Crosswalk of Provider Registry
SHB 1686/SB 5561

	Facility types that are subject to bill	Who currently regulates these facility types	Facility types not currently regulated
SHB 1686 (SB 5561) – Health Care Entity Registry	• Health care facility licensed by DOH or DSHS • Pharmacies licensed by DOH • Provider organization • Physician organizations • Health care benefit manager • Health Carrier	**DOH** • Hospitals • ASCs • RTFs • Medical Test Sites **DSHS** • Nursing homes	• Diagnostic and imaging centers • Free-standing emergency facilities • Outpatient clinics • Rehabilitation and other therapeutic health settings • Urgent Cares • Provider clinics

Issue Provider Registry Addresses & Benefits of Provider Registry

Issue: Washington does not currently regulate some of the facility types identified in transaction/transparency legislation and would not have information necessary to identify who should be reporting or how they should be reporting information.

Benefits of Provider Registry

- Provider registry provides demographic information for specified facility types available to both state and public.
- Provider registry allows state to determine what facility types should be subject to reporting to provider registry.
- Provider registry allows state to consider duplicative reporting and identify solutions to ease burden on facilities.

Closing statements and adjournment

Washington State Health Care Authority