The Health Care Cost Transparency Board's

Advisory Committee on Data Issues

November 20, 2024

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

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Health Care Cost Transparency Board's
Advisory Committee on Data Issues

Wed., November 20, 2024
4:00 – 5:00 PM
Hybrid Zoom and in-person

Agenda

Members of the Advisory Committee on Data Issues		
☐ Christa Able	☐ David DiGiuseppe	☐ Hunter Plumer
☐ Megan Atkinson	☐ Chandra Hicks	☐ Mark Pregler
☐ Amanda Avalos	☐ Leah Hole-Marshall	☐ Russ Shust
☐ Jonathan Bennett	☐ Lichiou Lee	☐ Mandy Stahre
☐ Bruce Brazier	☐ David Mancuso	☐ Julie Sylvester
☐ Jason Brown	☐ Ana Morales	

Chair of the Advisory Committee on Data Issues	Bianca Frogner

Time	Agenda Items	Tab	Lead
4:00-4:03 (3 min)	Welcome, Agenda, Introduction of New Member, and Roll Call	1	Bianca Frogner, Chair
4:03-4:05 (2 min)	Approval of August 2024 Meeting Summary	2	Bianca Frogner, Chair
4:05-4:10 (5 min)	Public Comment	3	Rachelle Bogue, HCA
4:10-4:15 (5 min)	Committee-Cost Board Connection	4	Rachelle Bogue, HCA
4:15 – 4:25 (10 mins)	Performance against the benchmark: update	5	Amanda Avalos, Deputy for Enterprise Analytics, Research, and Reporting, HCA
4:25-4:55 (30 min)	Best practices report (15 min presentation, 15 min discussion)	6	Presentation and discussion facilitated by Gary Cohen and Jeanene Smith, Health Management Associates
4:55	Adjourn	7	Bianca Frogner

David DiGiuseppe

- Vice President of Healthcare Economics at Community Health Plan of Washington (CHPW), a Washington-based not-for-profit managed care organization (MCO) serving 300,000 Washingtonians through Apple Health (Medicaid), Medicare Advantage, and Cascade Select (Washington's public option plan).
- David's expertise includes healthcare financing, behavioral health integration, population health, risk adjustment, and value-based purchasing.
- He appreciates opportunities to collaborate across sectors to improve the quality, efficiency, and accountability of our healthcare system.
- In addition to the Universal Health Care Commission's Finance Technical Advisory Committee, David serves on committees led by the Health Benefit Exchange, Accountable Communities of Health, and Washington Health Alliance.

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board's

Advisory Committee on Data Issues summary

August 21, 2024

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
3:30– 5 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the **Advisory Committee on Data Issues**.

Members present

Bianca Frogner, Chair
Christa Able
Megan Atkinson
Amanda Avalos
Jonathan Bennett
Chandra Hicks
Leah Hole-Marshall
Lichiou Lee
David Mancuso
Mark Pregler
Russ Shust
Mandy Stahre

Members absent

Bruce Brazier
Jason Brown
David DiGiuseppe
Ana Morales
Julie Sylvester
Hunter Plumer

Call to order

Bianca Frogner, committee chair, called the meeting of Advisory Committee on Data Issues (committee) to order at 3:37 p.m.

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Agenda items

Welcome, Agenda, Introduction of New Member, and Roll Call

Bianca Frogner, Chair

Committee chair, Bianca Frogner, welcomed everyone and provided an overview of the agenda, roll was taken.

Approval of Meeting Summary

Bianca Frogner, Chair

The committee **voted to approve** the June 12, 2024 meeting minutes.

Public Comment

Rachelle Bogue, Cost and Transparency Manager, HCA

No comments were received for public comment.

Update of 7/30 Cost Board Meeting

Bianca Frogner, Chair

The Health Care Cost Transparency Board (Cost Board) met on July 30, 2024. The meeting included a facility fees panel and member discission regarding national perspective around facility fees and provider perspective, there was also a discussion about potential policy recommendations around facility fees. There were also new committee member nominations from the nominating committee, from the stakeholder group there is Michele Ritala and from the data issues David DiGiuseppe.

Business Oversight

Jeanene Smith, Health Management Associates (HMA)

Jeanene gave an overview of the business oversight work which includes mergers and acquisitions, private equity, and ownerships and closures. On May 15, 2024, HMA presented a survey of transaction oversight authority across the country to the Cost Board. The Cost Board referred the subject to the committee to help make recommendations about what data is missing and what might be useful for greater business oversight. In the June 2024 meeting there was discussion around data issues such as when data is collected, who is collecting it, and what is captured or not.

Business Oversight Data Collection Panel

Jane Beyer, Senior Health Policy Advisor and Cost Board Member, Office of the Insurance Commissioner (OIC)

Mandy Stahre, Senior Forecast and Research Manager and Data Issues Committee Member, Office of Financial Management (OFM)

AAG Travis Kennedy, Assitant Attorney General, Antitrust Division, Attorney General's Office (AGO)

Ian Doyle, Tax Policy Specialist, Legislation and Policy, Department of Revenue (DOR)

Panel presentations emphasized challenges in obtaining comprehensive data on healthcare system ownership, competition, and the role of private equity. For instance, DOR highlighted limitations in tax reporting on ownership changes, while hospital consolidation data from several sources was discussed. Various presenters also discussed data sources and limitations in understanding healthcare affordability and competition in Washington. Other topics were the integration of hospital systems in Washington, with about 80% of licensed hospital beds controlled by multihospital systems. Furthermore, vertical integration of insurers and healthcare providers, which affects competition and pricing, especially with private equity involvement. Limitations of available data, including gaps, in non-claims-based payments and incomplete ownership and affiliation data for hospitals, making it challenging to fully access healthcare competition and costs.

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Discussion

Jeanene Smith, HMA
Gary Cohen, HMA

Facilitators asked committee members how Washington could use the data it already has to understand the impact on consumers and purchasers of consolidation and private equity investment. Also, how could data be gathered and shared more efficiently to reduce administrative burden on data providers, and if the state currently collects data necessary to comprehensively consider business oversight with regards to health care affordability. Several committee members indicated it was essential to have better data collection and analysis tools to understand the impact of consolidations and mergers on healthcare access, quality, and costs. Members proposed exploring ways to centralize this data for more efficient oversight.

Chair Bianca introduced David DiGuiseppe as the newest committee member.

Adjournment

The meeting was adjourned at 4:03 p.m.

Next meeting

Wednesday, November 20, 2024 at 2:00 p.m.
Meeting to be held in-person and on Zoom

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Washington State Health Care Authority

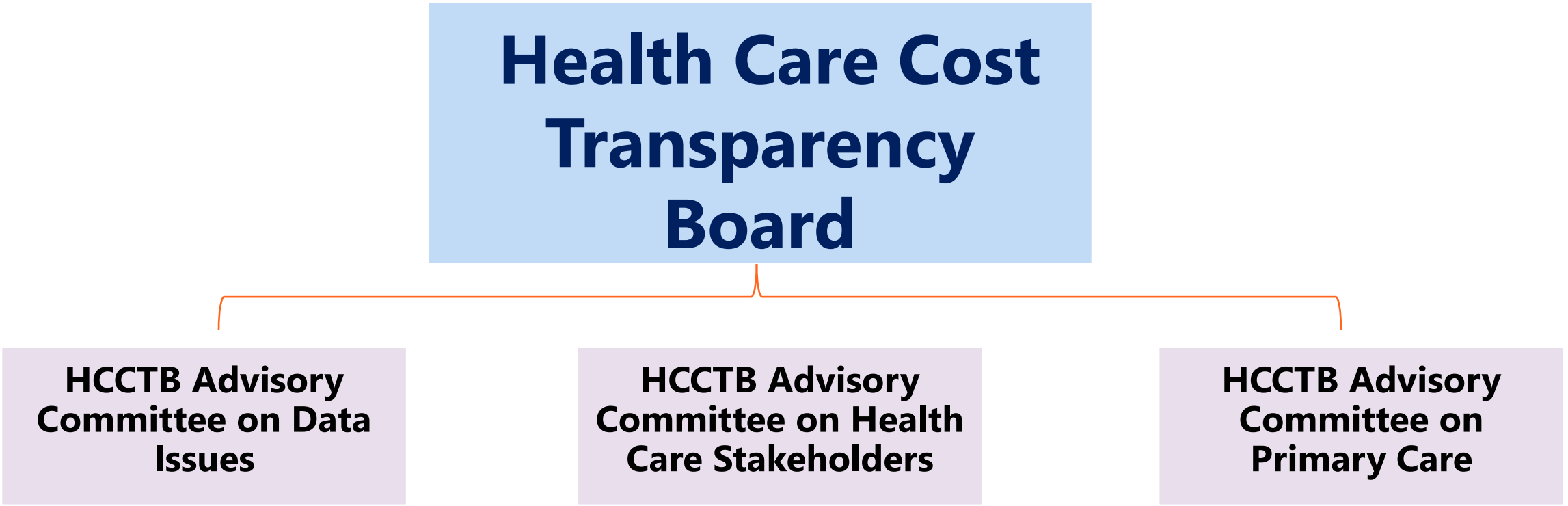
Public Comment

Washington State Health Care Authority

Tab 4

Washington State Health Care Authority

HCCTB & Committees



Data Issues Committee-Cost Board Connection

Current Cost Board priorities

- Lower health care costs for Washingtonians
- Current policies under consideration require focused attention on data issues

Data source support

- Business oversight and facility fees

Data Issues Committee goals

- Provide SME on analysis of existing data sources

Tab 5

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Health Care Cost Transparency Board

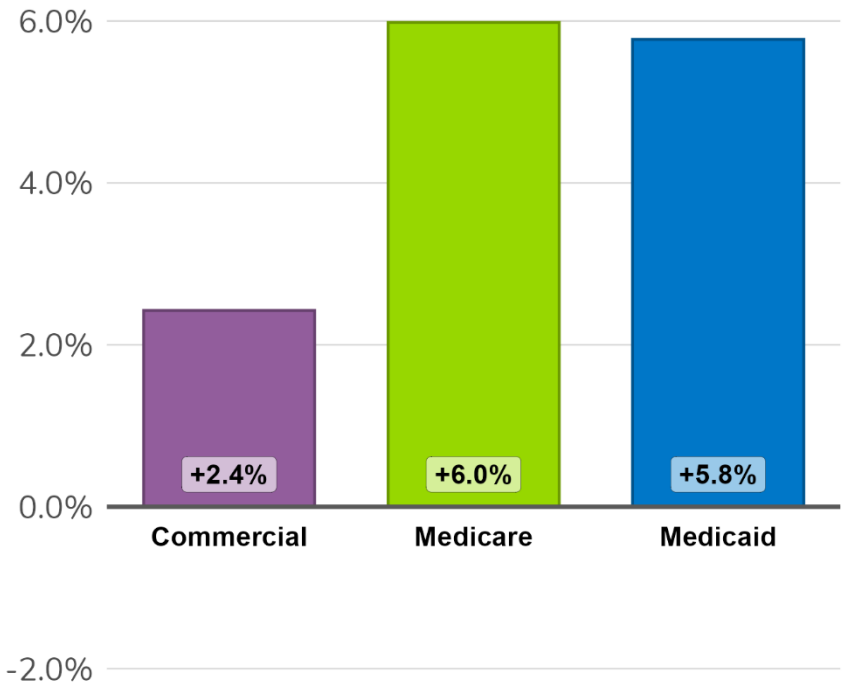
Updates from 2024 Data Call

November 20, 2024

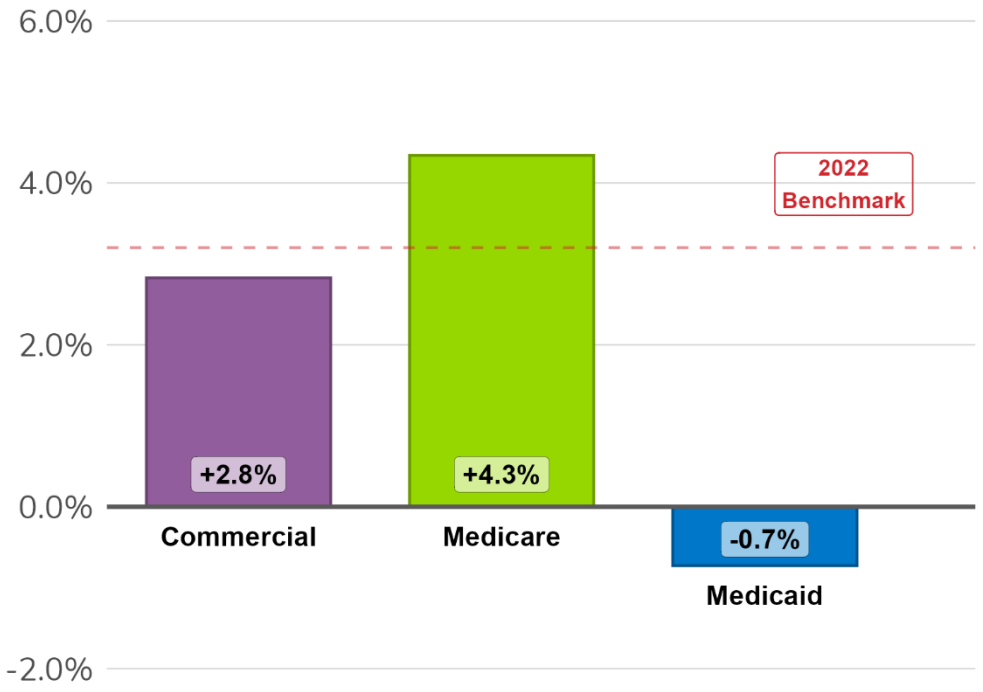
Washington State Health Care Authority

Benchmark – at the PMPY level

Total medical expense growth 2021-2022



Total medical expense growth per member 2021-2022



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Contracting entities*

Contracting entity:

Community Clinic Contracting Network (CCCN)

Attributed member-months (2022): 4.77 Million

Provider organizations:

- Yakima Valley
- CHC Snohomish
- Columbia Basin
- Columbia Valley
- International Community Health
- Mariposa
- Peninsula Community Health
- Unity Care
- Sea Mar

* CCCN not included in 2024 large provider organization reporting. Cost Board staff will revisit and reassess as part of next year's analyses.

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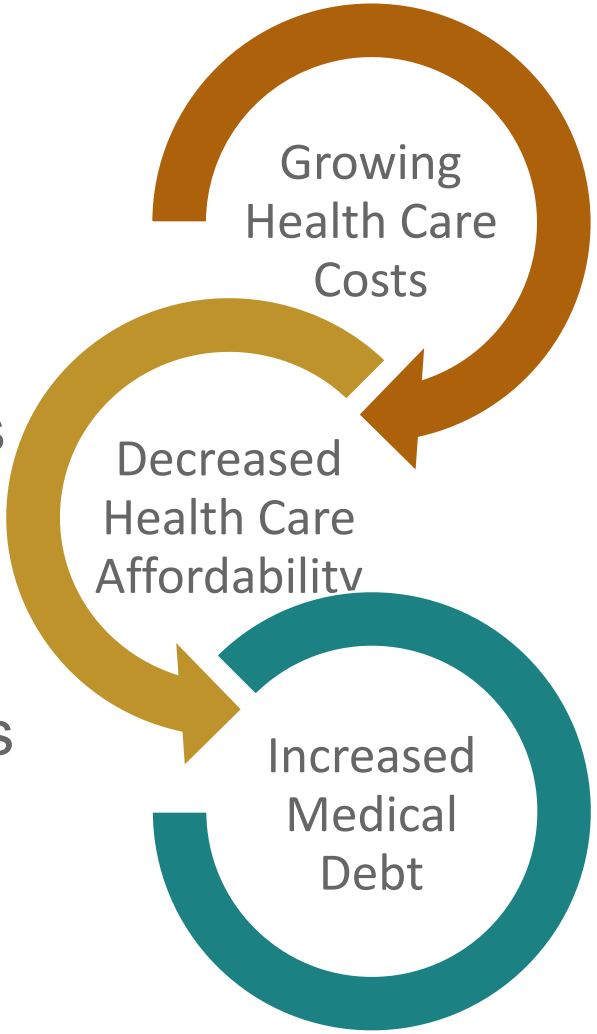
REFRESHER - COST BOARD CHARGE

- Cost Board is tasked with developing benchmarks and understanding the underlying drivers of growing health care costs in response to the growing impact on health care consumers, employers and the state budget
- Interventions to address drivers of growing health care costs are longer-term strategies
- Consumers continue to face growing out-of-pocket expenses through premiums, co-pays, facility fees, which lead to medical debt
- Important to protect consumers from this debt while Cost Board deliberates and recommends policies to address costs



Reducing Health Care Costs, Increasing Health Care Affordability and Lowering Consumer Medical Debt: Policy Levers

Health Care Costs (Long term)

- Reference based pricing
- Provider rate setting
- Price growth caps/ Price caps
- Hospital global budgets
- Consolidated state purchasing
- Business oversight of mergers and acquisitions
- Restricting anti-competitive practices
- Increased rate review

Consumer Health Care Affordability (Medium Term)

- Increase transparency of facility fees
- Ban or limit facility fees
- Standardize health plans
- Increase medical loss ratio
- Implement reinsurance
- Increase subsidies for premiums and cost-sharing

Consumer Medical Debt (Short Term)

- Reduce barriers to applying for financial assistance (e.g., presumptive eligibility)
- Expand entities required to provide financial assistance
- Set minimum spending floors for financial assistance
- Require income-based repayment plans
- Further cap interest rates
- Limit credit reporting
- Prohibit wage garnishment
- Restrict liens and foreclosures
- Buy existing medical debt
- Require reporting of collections actions
- Break down financial assistance data by patient demographics

TODAY'S FOCUS AREA: BUSINESS OVERSIGHT AND MERGERS

- Cost Board voted to recommend the NASHP model legislation on business oversight and mergers – recognizing there are outstanding questions about data.
- Cost Board requesting support from the Data Issues Committee to crosswalk what data is necessary and what we are currently doing in Washington.
- Best practices report lays out how other states doing addressing business oversight and mergers including approach data collection, reporting and analytics.

VOTE SPECIFICS

Recommendation 3:

- 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

Recommendation 4:

- 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.

HMA

Overview of State Health Care Cost Growth Programs' Infrastructure:

From Cost Board's Study of Best Practices

DRAFT November 2024

STUDY OF BEST PRACTICES

- The Legislature directed the Cost Board to study best practices from other states regarding the infrastructure of state health care cost growth programs
- An environmental scan was conducted looking across states that had active health care cost growth programs
- Four states identified for more detailed survey and interviews to further understand their Cost Growth programs, structure, scope, financing and staffing
- Information also requested regarding the infrastructure of those focus states that also have business oversight programs to oversee mergers/acquisitions etc.
- Comparisons with Washington's current efforts and recommendations are provided in the report

EIGHT STATES HAVE COST GROWTH BENCHMARKING PROGRAMS: DEEPER FOCUS ON FOUR

2012: Massachusetts

2018: Delaware

2019: Rhode Island, Oregon

2020: Connecticut, Washington

2021: New Jersey

2022: California

The benchmark programs have had variable results over the years with the Covid pandemic impacts due to changes in healthcare utilization and inflation, and some programs are very new and just beginning their program

Common Features

- **Authority to collect and use data to monitor health system spending trends**
- Growth target against which to measure spending trends
- Spending measurement to collect and track healthcare expenditures
- **Data and analytic capacity to support data analysis, reporting and use cases**
- **Data use strategy to advance state strategies**
- Public reporting with steering committees' oversight
- Some states also have market oversight programs

Note: A ninth state, Nevada, initiated efforts by Executive order in 2021 but not supported by current governor, so efforts were not continued as of 2023

DATA APPROACH: BEST PRACTICES

Comprehensive data collection allowing analysis and reporting providing insight into the entire health care system is key to the success of the programs.

- Factors that influence each state's ability to obtain a comprehensive view of the drivers of cost growth:
  - Existing data infrastructure
  - Authority to collect data (whether authority given to the cost growth program or to other state agencies)
  - Staff and funding available to do data analysis
- **Massachusetts** stands out as the best example with comprehensive data collection via their CHIA;
- **Oregon** has consolidated its data and analytics into one office inside the Oregon Health Authority

WASHINGTON'S DATA APPROACH

- Data that supports the **Cost Board (within HCA)**:
  - Use of the Washington's voluntary All-Payer Claims Database (APCD)
  - A call to carriers and providers for information about health care expenditures
  - Analysis by a small staff within the HCA and through a partnership with the Institute for Health Metrics and Evaluation at the University of Washington

OTHER SOURCES OF DATA IN WASHINGTON

Department of Health

- Collects information about ownership and licensure of certain health care facilities and health professional licensure,
- Collects information through the Comprehensive Hospital Abstract Reporting System (CHARS)
- Collects Data from hospitals and Emergency Medical Services (EMS) on hospital discharges, financial reports, charity care, and adverse events.

Office of the Insurance Commissioner

- Collects financial reporting and ownership from health insurance plans

Office of the Attorney General

- If part of a merger, collects ownership information - primarily larger merger/acquisition transactions as reviews and/or pursues action

Office of Financial Management

- Collects and analyzes data about the health care system including workforce, utilization and coverage to inform health policy development.

Department of Social and Health Services Research and Data Analysis

- Provides data, analytics, and decision support tools (includes behavioral health, long term care and other health related social needs)

DISCUSSION – FOCUS ON DATA COLLECTION FOR ANALYSIS & REPORTING

- Considering other state's approaches and what is currently done here in Washington, in what ways could Washington improve its data collection and analysis efforts?
- In what ways can Washington improve its collection and analysis efforts to **support the current** Cost Board charge?
- If additional authorities related to business oversight were added, how do these efforts need to change?
- How should we accomplish the task the Board has given us given next meeting isn't until March 27?

Additional Materials

BEST PRACTICES HIGHLIGHTS

Governance Structure: Each structure has trade-offs; some structures may enable the program to be more efficient in carrying out the functions they have been assigned, have credibility and "buy-in" from stakeholders.

Authority to Enforce Compliance: Some states have the authority through the use of performance improvement plans (PIPs) and/or civil penalties.

- MA, CA, and OR all have enforcement authority with MA required one for Mass General Brigham Health System that has directed $176.3 million in savings that the system is on track to achieve.

Market oversight authority augments the cost growth programs in MA, OR and CA

- Oregon's Market Oversight program can review transactions involving health care entities, such as mergers and acquisitions and private equity investment, with the authority to deny or approve with conditions.
- Massachusetts' Health Policy Commission just completed a report focused on private equity's impact on the health care market and see it as an area of increased interest for their state.

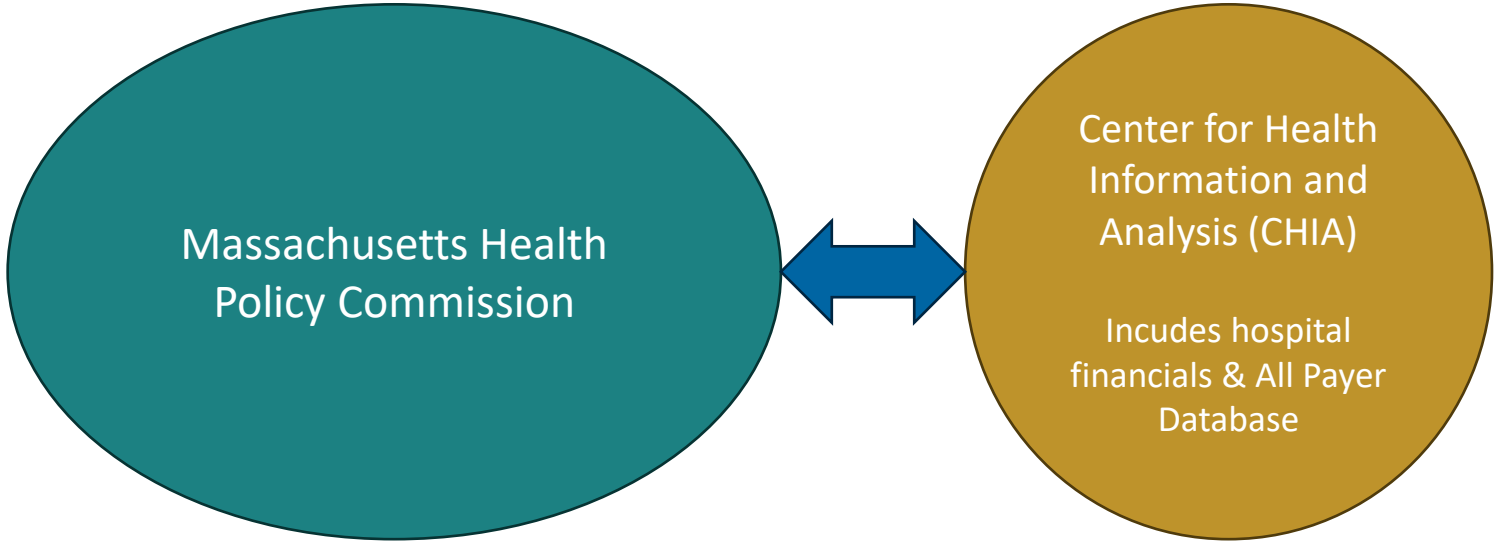
Funding scaled to scope and expectations

- Massachusetts and California are examples of programs with dedicated funding source that includes an assessment on health care entities.
- Oregon and California can assess entities for the cost of the full reviews for their Market Oversight programs

MASSACHUSETTS: HEALTH POLICY COMMISSION

- Established in 2012 by Legislation
- 3 key functions of the Health Policy Commission:
  - Care Delivery Transformation
  - Health Care Cost Containment
  - Market Oversight and Monitoring

- Structure in Government: Independent state agency



Infrastructure

Funding

- *$12 million for HPC*
- *CHIA has separate budget of ~$30 million*

Staffing

- *Averages 60-65 positions overall for the Cost Growth program, Market Oversight, operations and a grant program*

Ability to Engage Consulting & Other Resources

- *Works closely with MA's CHIA which houses the All-Payer Database, hospital financial data*

Key Features

- *Funding is via an annual assessment of hospitals/delivery systems, payers and ambulatory surgical centers.*
- *Close relationship with CHIA for data*

Infrastructure

Funding

- *Biannual budget of $2 million for CGT*
- *Biannual budget of $1 million for HCMO*

Staffing

- *Authority for 8 positions for CGT*
- *Authority for 4 positions for HCMO*
- *Integrated within Office of Health Analytics*

Ability to Engage Consulting Services & Other Resources

- *Housed in OHA's Health Analytics office w APCD & actuaries, work closely together*
- *Funding through Peterson Foundation's grants to states for additional consultants*

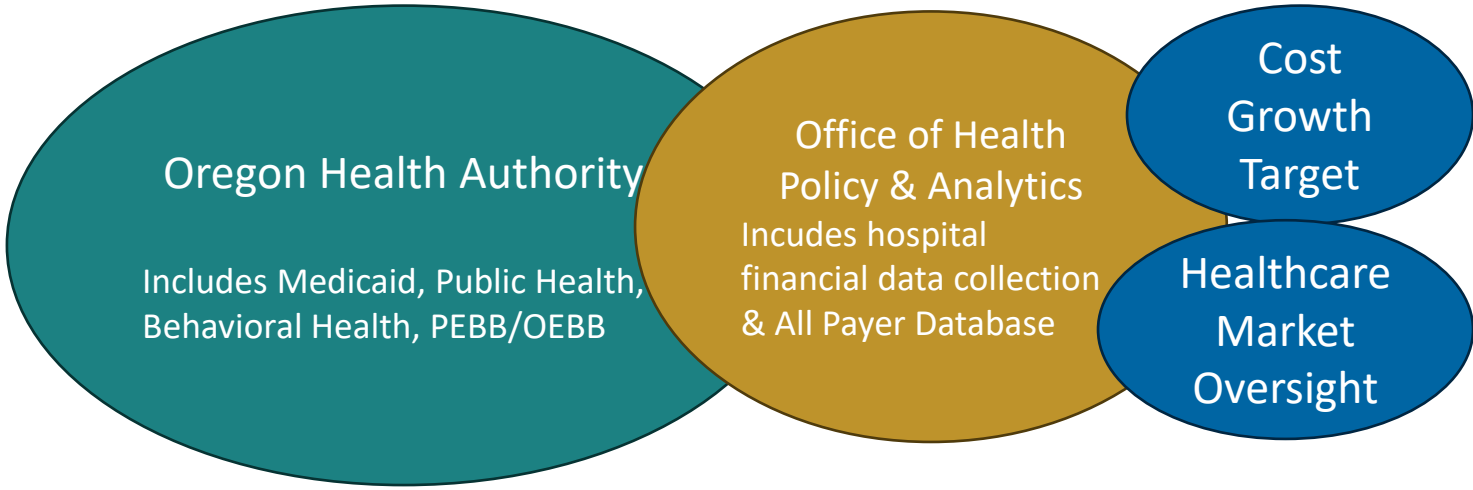
Key Needs/Wishes

More dedicated funding for:

- *Staffing for data analysis and policy development*
- *Legal expertise particularly for accountability*

OREGON: COST GROWTH TARGET (CGT) & HEALTHCARE MARKET OVERSIGHT PROGRAMS (HCMO)

- Both programs established by Legislation
  - **Cost Growth Target Program Goals**
    - Set and update the Cost Growth target
    - Ensure that health care costs don't outpace wages or the state's economy
    - Identify opportunities to reduce waste and inefficiency, resulting in better care at a lower cost.
  - **Market Oversight Program Goals:**
    - Promote transparency
    - Support statewide priorities
    - Monitor impacts
- Structure in Government:



RHODE ISLAND: HEALTH SPENDING ACCOUNTABILITY & TRANSPARENCY PROGRAM

Infrastructure

Funding

- *~$1.5 million*

Staffing

- *No dedicated staff, work done by Consultants*

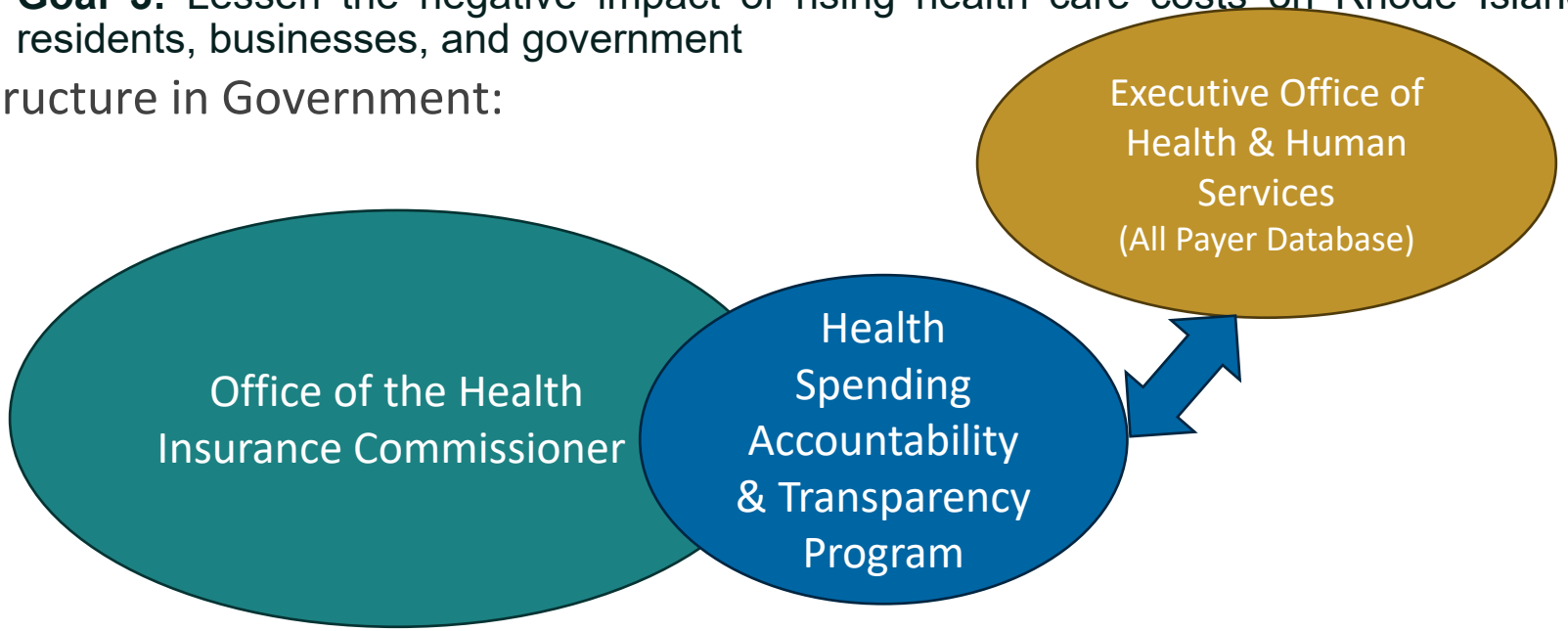
Ability to Engage Consulting & Other Resources

- *Work closely with the state's APCD consultants that include claims and data scientists*
- *Not used actuaries or economists to date*
- *Not used legal expertise to date as no enforcement authority*

Key Distinctions

- *Voluntary compact between Insurance Commissioner and stakeholders*
- *Commissioner Uses rate review authority to cap reimbursement rates paid to hospitals*

- Established by Exec Order; Overseen by a Steering Committee and the Office of the Health Insurance Commissioner
- 3 Key Goals:
  - **Goal 1:** Understand and create transparency around health care costs and the drivers of cost growth
  - **Goal 2:** Create shared accountability for health care costs and cost growth among insurers, providers, and government by measuring performance against a cost growth target tied to economic indicators
  - **Goal 3:** Lessen the negative impact of rising health care costs on Rhode Island residents, businesses, and government
- Structure in Government:



Infrastructure

Funding

- *Annual continuing appropriation of $22 million overall for OHCA*
- *More dollars going toward market consolidation work, smaller portions to cost growth and high value areas*

Staffing

- *Authority for 80 positions- still working on hiring staff*
- *Mix of data analysts, policy analysts and stakeholder engagement/Board support*

Ability to Engage Consulting & Other Resources

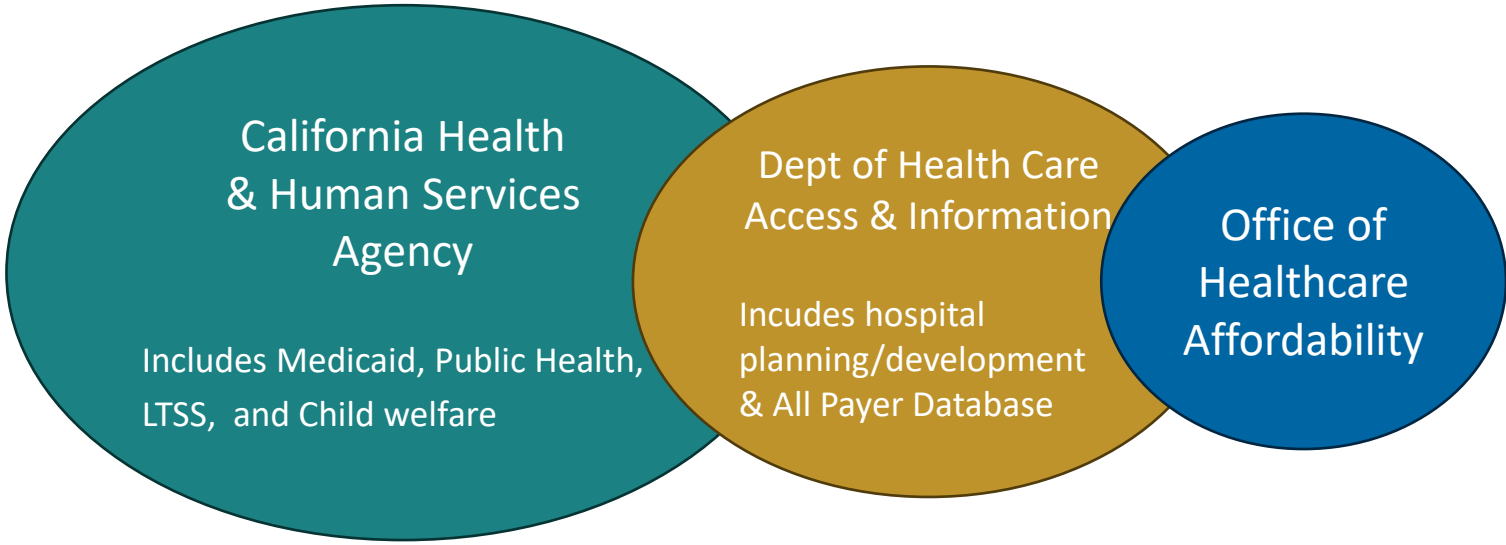
- *Have resources if dollars not otherwise spent on internal staff*
- *Have engaged with higher priced services like actuaries that are hard to entice into state salaries*
- *Have flexibilities from contracting rules and ability to hire quickly for rapid access to services needed*

Note: *OHCA is just starting up its programs*

CALIFORNIA: OFFICE OF HEALTHCARE AFFORDABILITY (OHCA)

- Three Areas of Focus:
  - Slow spending growth with target and monitoring of expenditures
  - Assess market consolidation with cost and market impact reviews
  - Promote high value with focus on primary care, behavioral health, workforce, APMs, equity and quality

- Structure in Government: Established by Legislation



BEST PRACTICES HIGHLIGHTS (CONTINUED)

Other States with Authority to Go Beyond Cost Growth Programs

- Oregon passed a law in 2017 that requires health insurers and third-party administrators that contract with the state employee plan to cap payments for hospital facility services at 200% of Medicare rates for in-network and 185% of Medicare rates for out-of-network services.
  - Outpatient rates declined by 25% in the first 2 years. Smaller price reductions in inpatient but reductions resulted in $107.5 million in savings for the state in the first 27 months of the policy
- Rhode Island has used rate review authority to limit increases in hospital prices, using affordability standards
  - Net reduction in enrollee spending by a mean of $55 in 2016; utilization didn't change with an increase in primary care spending by $21 per enrollee
- Washington has proposed legislation for requiring reference-based pricing for health care services for public employees (PEBB) and school employees (SEBB) plans

MEDICAL DEBT: CURRENT WA STATE CHARITY CARE REQUIREMENTS

- **RCW 70.170** and **WAC 246-453** require hospitals to develop charity care policies and procedures to ensure that:
  - All patients with family incomes below 200 percent of the federal poverty guidelines are able to obtain medically necessary hospital health care free of charge, and
  - Patients with family incomes up to 400 percent of the federal poverty guidelines are able to obtain that care at a discount.
- At larger hospitals (having 80% of beds in the state),
  - Those with income up to 300% Federal Poverty Level (FPL) are entitled to receive treatment with no out-of-pocket costs, regardless of insurance or immigration status.
  - Those at 300-350% are entitled to 75% discount; 350-400% FPL are entitled a 50% discount
- In February, AG reached settlement with Providence over failure to offer charity care to those entitled to it, requiring $158 million in refunds and debt forgiveness
- Six states require hospitals to provide minimum amount of charity care; Washington does not. Oregon uses formula considering revenue and operating margin.

MEDICAL DEBT: CURRENT WA STATE BILLING & COLLECTIONS PRACTICES

- Federal law requires waiting periods and notification before hospitals implement certain extraordinary collections practices (ECPs) such as garnishing wages or selling the debt to a debt collection agency
- The Biden Administration has proposed prohibiting medical debt from affecting credit scores; regulations have not yet been issued
- Washington requires a waiting period and a screen for eligibility for financial assistance before a hospital can send a bill to collections
- Washington requires a waiting period before medical debt can be sent to a credit reporting agency, but ***does not prohibit it***, as some states do
- A few states require hospitals to offer a payment plan to low-income and uninsured patients; ***Washington does not***