Health Care Cost Transparency Board meeting

July 30th, 2024

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board
Agenda

Tuesday, July 30, 2024
2:00 – 5:00 PM
Hybrid Zoom and in-person

Board Members		
☐ Susan E. Birch, Chair	☐ Jodi Joyce	☐ Kim Wallace
☐ Jane Beyer	☐ Gregory Marchand	☐ Carol Wilmes
☐ Eileen Cody	☐ Mark Siegel	☐ Edwin Wong
☐ Lois C. Cook	☐ Margaret Stanley	
☐ Bianca Frogner	☐ Ingrid Ulrey	

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome and roll call	1	Sue Birch, Chair of the Board and Director, Health Care Authority
2:05-2:10 (5 min)	Approval of the May Meeting Summary	2	Sue Birch, Chair of the Board and Director, Health Care Authority
2:10-2:15 (5 min)	Advisory Committee of Health Care Stakeholders Updates	3	Eileen Cody, Chair of the Advisory Committee of Health Care Stakeholders
2:15-2:25 (20 min)	Facility Fees Introduction Advisory Committee on Data Issues Updates Regarding Facility Fees	4	Jeanene Smith, Health Management Associates (HMA) Bianca Frogner, Chair of the Advisory Committee on Data Issues
2:25-3:35 (70 min)	Facility Fees Panel • Part 1: National Perspective with Q&A (until approximately 3 pm) - Zack Cooper, Associate Professor, Yale - Christine Monahan, Center on Health Insurance Reforms (CHIR) • Part 2: Provider Perspective w/ Q&A - Suzanne Beitel, Senior VP and CFO of Seattle Children's - April E. Lynne, COO, Proliance Surgeons - Darryl Wolfe, CEO, Olympic Medical	5	Panel Facilitated by: - Jeanene Smith and Gary Cohen, HMA
3:35-3:50 (15 min)	Public Comments	6	Sue Birch, Chair of the Board and Director, Health Care Authority
3:50-3:55 (5 min)	Break		
3:55-4:25 (30 min)	Board Discussion on Facility Fees for Potential Recommendations	7	Discussion facilitated by: - Jeanene Smith and Gary Cohen, HMA
4:25-4:30 (10 min)	Nominating Committee	8	Kim Wallace, Member of the Nominating Committee
4:30-5:00 (30 min)	Primary Care Recommendations Vote to adopt recommendations	9	Dr. Judy Zerzan-Thul, Medical Director Health Care Authority
5:00	Wrap Up and Adjourn The Board's next meeting: September 19, 2024, 2-4 PM		Sue Birch, Director Health Care Authority

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board meeting summary

May 15, 2024

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
1 – 4 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

Sue Birch, Chair
Jane Beyer
Eileen Cody
Lois Cook
Bianca Frogner
Jodi Joyce
Greg Marchand
Margaret Stanley
Ingrid Ulrey
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

Mark Siegel

Call to order

Sue Birch, Board Chair, called the meeting to order at 1:05 p.m.

Agenda items

Welcoming remarks

Chair Sue Birch welcomed members of the Health Care Cost Transparency Board (Cost Board) to the meeting and spoke about data review as the focus of the meeting. US News & World Report ranks WA 10th in health care based on access, quality, and public health outcomes. While Washington continues to be ranked in the top tier for health care, more can still be done to improve. Finally, the Cost Board reviewed the agenda.

Meeting summary review of the previous meeting

The Cost Board **voted to adopt** the April 2024 meeting summary.

Washington State Health Care Authority

Financial Analysis of Washington Hospitals

John Bartholomew, Bartholomew-Nash & Associates
Tom Nash, Bartholomew-Nash & Associates

A brief review of the benchmark analysis served as context to the project, allowing for identification of hospitals with highest profits, pricing, and costs. Centers for Medicare & Medicaid Services (CMS) hospital reports are the foundational dataset of the analysis, being measured against the 3.2% cost growth benchmark. A ratio of Medicare payment to cost indicates the level of efficiency of given hospitals. Using findings from a three-prong approach of peer group comparisons, Medicare payment-to-cost ratio analysis, and price and cost trend analysis can help provide insights triangulate price, cost, and profit. Hospitals are categorized by these metrics as high-cost, high-cost, high-profit, etc., allowing for study of outlier institutions that struggle to contain costs. Chair Birch and another board member sought clarity about types of revenue: inpatient, outpatient, professional, emergency department, and other. This analysis also serves as a rough cost driver analysis.

Starting with 104 Washington hospitals, 42 were removed for incomplete data or having fewer than 25 beds, and 17 were removed for being a children's, psychiatric, rehabilitation, and long-term care hospital. In total, 45 hospitals were analyzed for this project. Using 2022 data, these 45 hospitals accounted for 90% of available beds and 85% of hospital patient revenue in Washington. Among peer group comparisons, 27 hospitals which receive about 70% patient revenue statewide have higher prices. 19 hospitals with high-cost account for 39% of patient revenue. 15 hospitals with around 32% patient revenue have both high price and cost. Controlled for wage index and cost of living, and price adjusted by case mix index (CMI) served as data for a peer analysis. Two hospitals met the threshold of being high-cost, -profit, *and* -price.

The second prong, from the standpoint of Medicare reimbursement, a hospital's efficiency can be assessed by payment to cost ratio, with the state median standing at an 83% ratio. 39 of the 45 Washington hospitals showed a cost ratio level below 95% in 2022. According to the Medicare Payment Advisory Commission (MedPAC) March 2024 report, below 97% is considered an inefficient hospital. Chair Birch sought clarity around the MedPAC review process and how often CMS reviews the appropriateness of reimbursement levels. The report is annual with the 2024 report using 2022 data. MedPAC reviews about 15 different provider types, one of them hospitals, to determine if their reimbursements are high enough to meet the Medicare access threshold. Inefficiency of Medicare reimbursement can be an indicator of inefficient Medicaid reimbursement, and therefore require a higher commercial reimbursement amount to break even or generate a margin. A board member asked whether organizations such as the Washington State Hospital Association (WSHA) had a chance to review the analysis and offer feedback or concerns. John mentioned that the assessment that many hospitals are high-price and cost may be controversial, but the metrics used are well documented and broadly used by groups like RAND. Another board member sought clarity on methodology. John and Tom explained adjustments for acuity being key, referencing their prior presentation on April 4, 2023, where they explained the methodology in more detail. Revenues and price metrics are separated from MDCR ratio.

Price and cost trend analysis, the third prong, uses growth rates compared between Washington and national trends across 5- and 10-year intervals. Findings indicated that Washington fared better in some periods and worse in others. Currently, hospitals representing most of the state's hospital industry are experiencing price and/or cost trends that exceed national trends.

A board member asked about how they dealt with the pandemic and if labor cost growth was accounted for in the analysis. Tom noted that labor data can be specifically extracted from the hospital reports. Another board member asked what is causing Washington to be inefficient. Anecdotally, Tom said that if hospitals demand higher prices, they grow into those prices. Market power may contribute to hospital cost levels. A third board member expressed curiosity about what efficient hospitals, low-cost and price, are doing right. The member notes that the report indicates that other reports show the price moving in the same direction, specifically referring to the Washington Health Alliance (WHA) and RAND 5.0 reports. Chair Birch asks what policies could work. John talks about successes in Colorado which performed similar to Washington. Conversations were initiated with each hospital system, including the efficient ones, and costs have since dropped in price and cost.

Starting conversations directly with hospitals and presenting these metrics and from various organizations like WHA are useful to earnestly discuss prices.

Primary Care Committee Policy Option Preview

Dr. Judy Zerzan-Thul, Health Care Authority

Direct investment, capacity growth, patient behavior, and reduced expenditure in other sectors all support the 12% primary care expenditure target. Assessment of policies would consider clearly defined actions and actors, feasibility, and improve access. The following are the seven policies currently under consideration by the Advisory Committee on Primary Care:

1. Increase primary care expenditures as a percentage of total health care spending annually by 1% until expenditure target is met.
2. Increase Medicaid reimbursement for primary care to no less than 100% of Medicare no later than 2028.
3. Multi-payer alignment.
4. Patient engagement efforts, including payer-purchaser education and incentive promoting utilization.
5. Workforce development to prioritize funding for state workforce initiatives in collaboration with the Health Workforce Council.
6. Use value-based purchasing, or alternative payment methodologies.
7. Transition to per capita expenditure measure rather than 12% aggregate.

These options will be discussed, prioritized, and brought to the Cost Board at a later meeting. A board member worries #6 without #3 implemented puts a lot of pressure on providers. Concerns were also expressed that the Center for Medicare and Medicaid Innovation, also known as the CMS Innovation Center (CMMI), might not have a good grasp of whether alternative payment models maintain quality. Judy mentions that care will be taken to not get ahead of the data. Chair Birch asks if the Health Workforce Council recommends requiring graduate medical education. Judy will check back with an answer.

Business Oversight: Mergers & Acquisitions, Private Equity Investments, Provider Ownership & Closures

Dr. Jeanene Smith, Health Management Associates (HMA)

Oversight is important to handle all types of consolidation, be it horizontal or vertical integration, cross-sector mergers, private equity, and closures. The notice and review approach adds transparency to these dynamics in the marketplace. Notice, review, and approval approach adds additional powers to reject mergers deemed harmful to the health care sector based on various criteria. Such powers would reside in the Attorney General's Office. New Merger guidelines from the Federal Trade Commission and the Department of Justice were released in December 2023.

Between 2014 and 2023, 97 acquisitions by private equity occurred in Washington. Corporate buyers have also come into the market, such as Amazon and CVS. In addition to other approaches, requiring a community benefit is another option to ensure transactions are less harmful. A board member notes vertical integration poses the greatest threat to health care. Jeanene notes this can be covered in oversight powers. Consolidation due to need (hospitals in distress) are also considerations.

Data gathering is crucial to the process, building a database to get a snapshot of who owns what in Washington and the number and types of health care professionals they employ. Massachusetts Health Policy Commission had to build this out to investigate and empower oversight. Considerations about data collection could include what is already reported to other agencies such as the Department of Health, Department of Licensing, and other agencies that could partner to share relevant information.

A quick review of various powers built by Milbank that states have enacted shows that Washington has much room to grow. Specific policies enacted include New York considering equity during Certificate of Need discussion and review. Oregon has had good consumer engagement in a public comment process engages the public and ensures access, approving or blocking consolidations with 10 years of follow-up. California analyzes

transactions but does not have the authority to stop them. cannot stop them. However, the Attorney General's Office can be referred for enforcement.

Data from 55 recent reviews indicates that consolidation increases costs but is inconclusive regarding the impact on quality of care. Consumer or patient options can be limited, especially in rural areas, either due to lack of services or care becoming unaffordable.

Potential policy options in Washington could be to enhance business oversight and strengthen enforcement. This may include expanding Attorney General authority, allowing additional oversight entities, and/or comprehensive business ownership and closure reporting. Another option is to increase competition or pre-empt consolidation, including improvement of the reporting processes.

Strategic Lever: Facility Fees

Zach Sherman, HMA

Facility fees are fees assessed for patient visits not directly related to services received by the patient, impacting health care costs for both purhchasers and patients. Current law does not have robust monitoring of these fees, either in terms of detailed data or what health care companies must submit an annual report to the Washington State Department of Health (DOH). In 2022, more than $125 million in these fees were reported, but notably, there are numerous exemptions as to what entities must report, so the figure understates the actual cost of health care. Hospitals argue that these revenues are necessary to remain solvent and cover costs not captured by professional fees.

Other states have stronger reporting requirements, while other states have outright prohibited these fees, mandating *site-neutral payments*. National legislation under consideration would require that services provided to Medicare patients be the same, regardless of care delivery location.

Between 2017 – 2022, reported facility fee revenue ranged from $105 million to $171 million, with the fees being assessed on more than 1.31 million visits in 2022. Health care provider consolidation has driven some of this increase in their frequency. Little transparency is offered by current reporting standards, where provider systems need only report the minimum and maximum fee assessed for the year. Data reported in Massachusetts shows a signifcant impact on consumers, showing that fees for MRIs or colonoscopies can be more than $1000.

One option to address the rising costs of these fees would be to increase transparency. Modifying exemptions, strengthening reporting requirements, or improved notice to patients could slow the growth of these fees. Such reforms have been implemented in states like Colorado, Florida, and Maine. There are caveats with this approach, however. Advanced notice of fees prior to receiving care is not necessarily reasonable for patients seeking immediate care, who do not have the luxury of shopping for more affordable care. A stronger option would be limiting the charging of facility fees, but there would be no guarantee that a provider would assess additional charges to make up for the lost revenue.

Discussion on the subject ranged widely. One member asked about whether transparency would work or be effective. Chair Birch asked staff to investigate the approach taken by Indiana. Another board member mentioned that Connecticut passed legislation tightening notice requirements before facility fees are levied. Additional comments suggested that futher perspectives could be offered to the Cost Board and voiced skepticism of transparency and notice approaches suggesting that due to geography, shopping for care is often not an option. Placing more responsibility on consumers to shop for more affordable care is an unwanted burden. The consensus of the Cost Board was to have the Advisory Committee on Data Issues review data sources and tranparency, and the Advisory Committee of Health Care Stakeholders seek additional perspective on prohibition strategies, and report back to the Board.

Washington State Health Care Authority

Potential Levers: Consumer Medical Debt

Liz Arjun, HMA

Liz provided a medical debt follow-up to Noam Levey's presentation. There are three opportunities to address medical debt. First, six states require hospitals to provide a minimum amount of charity care. Washington is not one of those states. Oregon does using a formula including revenue and operating margins. Second, Washington requires, but does not prohibit like some states, a waiting period before medical debt is sent to a credit reporting agency. Finally, Washington does not require hospitals offer a payment plan to low-income or uninsured patients like a few other states do.

A board member asked about legislation recently passed expanding charity care beliving it includes the first option. It's clarified that the statute requires charity care be offered, but there's no minimum care expenditure. Chair Birch talked about the importance of enforcement and monitoring from a state agency perspective. Another board member mentions that federal law states medical debt over $500 cannot be shown on a credit report medical debt, but doesn't protect under $500 and could be a policy option. Chair Birch talked about more information around hospitals in other states hiring intermediaries requesting recovery payments, disguising their medical debt collection, which is becoming more of an employer-sponsored issue. More information can help be more aggressive to stop this from happening sooner.

A board member asked if there is correlation between the states that require a minimum amount of charity care and the overall hospital efficiency to see if it helps. Another board member asked how much of the medical debt is due to out-of-network charges. It was also recommended to look more into benefit alignment with the Health Benefit Exchange. A board member mentioned that the Office of the Insurance Commissioner has a report due on July 1 concerning options to reduce or elimate cost sharing for maternity care services that could give insight on per-member per-month impact.

Analytic Support Initiative

Dr. Joseph L Dieleman, Associate Professor for Health Metrics and Evaluation (IHME) | University of Washington

After a brief review of the Analytic Strategy approved by the Cost Board in December 2023, the presentation was grounded in the three analyses and estimates produced by IHME to inform the policy discussions of the Cost Board. The report under review is a Washington-centric summary of health care spending estimates of IHME's Disease Expenditure Project (DEX), covering 2010 – 2019 and constructed from 60 billion insurance claims (550 million from WA). Estimates are divided into four payer categories (Medicare, Medicaid, Commercial, and Out-of-pocket) and 148 disease categories. Of note, the Washington All Payer Claims Database is not part of the dataset.

Total spending broken down by age ranges shows highest levels between 65 – 69, but broken down by capita, spending is highest on Washington residents over the age of 85. Overall, Washington has the 10th lowest spending per person in the US. Cost Board members questioned whether the spending in nursing facilities was underestimated or misallocated to different payers. The estimates will be reviewed, but currently align with State Health Expenditure Account datasets.

In per capita terms, spending increases by roughly 2.9% between 2010 – 2019, the 8th lowest spending growth rate in the US. Reviewing the drivers of this growth, spending can be decomposed by four factors: Service price and Intensity, Service Utilization, Population Age/Sex, and Population Size. Viewed in these terms, Price and Intensity drove much of the spending growth in Ambulatory and Inpatient settings, and Chair Birch reiterated the importance of this point as opposed to Service Utilization.The DEX Report also breaks down spending by disease, with Oral disorders, Joint pain, and Diabetes seeing the highest growth. One member noted that spending on Anxiety disorders likely grew quickly during the pandemic, and building the dataset through 2022 will likely reflect that in the autumn report.

Spending is broken down by county and presented by maps, and can be further broken down by payer. Spending drivers by county can be explored in the dataset as well.

Leading off the discussion of the dataset from the Cost Board, Chair Birch noted that the DEX modeling using survey and claims data, while it shows variation still depicts a high growth of spending, in alignment with other data sources under review by the Cost Board. One clarification made to the Cost Board was that for county spending, data is aggregated based on where a person lives, not where they received care.

Nomination Committee Recommendations and Appointment of Chairs

Liz Arjun, HMA

Liz provided the recommendations from the Nominating Committee based on the changed membership required by HB 1508 that passed this year. For consumers, Adriann Jones with the Washington Community Action Network (WACAN)and Emily Brice with the Northwest Health Law Advocates (NOHLA) were nominated by John Godfrey with WACAN and Janet Varon with NOHLA, respectively. For labor purchasers, Justin Gill with the Washington State Nurses Association and Sulan Mlynarek with the Service Employees International Union Healthcare 1199NW were nominated. And Patrick Connor with the National Federation of Independent Business (NFIB) was nominated for employer purchasers.

A board member requested affiliation be included in addition to the existing information for committee members.

For existing members, Paul Schultz with Kaiser Permanente will replace Justin Evander with Kaiser Permanente. Dr. Nariman Heshmati with the Washington Medical Association will replace Jeb Shepard (interim, non-voting member) with the Washington Medical Association.

New chairs also for Cost Board committees also need confirmation. Bianca Frogner is nominated to chair the Cost Board Committee on Data Issues. Eileen Cody is nominated to chair the Cost Board Advisory Committee on Health Care Stakeholders.

The Advisory Committee Charter has been updated to reflect name and member changes required in HB 1508. A board member pointed out that the updated charter did not include the small business representative. Liz responded the charter will be updated to reflect that change.

A board member asked which business organizations were contacted for employer purchasers in addition to NFIB. Mandy Weeks-Green with HCA responded that legislation requires a small and large business representative be included on the Stakeholder Committee. Still waiting for a recommendation for a large business organization representative as they work their internal processes.

The Cost Board **voted to approve the recommendations** from the Nominating Committee including the charter with suggested updates, new members, and committee chairs.

Public comment

Chair Birch called for comments from the public.

Drew Oliviera, Washington Health Alliance (WHA), talks about providing the Cost Board with WHA's most recent report hospital pricing. The report includes the price paid by two hospitals on the commercial side as compared to Medicare. Next steps of the report include charity care, considering staffing costs, and understanding the breakeven rate for hospitals.

Katarina LaMarche, Washington State Hospital Association, has a preliminary comment about hospital report. Committees were not given a chance to review data. Doesn't disagree that hospital costs are higher in Washington given our health care workforce is highly paid relative to other states. Believes costs drive prices and both should be analyzed together. When that happens certain hospitals actually lost money. Some demographics may have driven some of the price increase.

Emily Brice, NOHLA, expressed support for the Cost Board's review of hospital price cost and profit variations in collaboration with the WHA and RAND 5.0 report. Cautions equating relative overall spending to affordability or

access. If we are spending $51 billion in Washington, more than the gross domestic products in many countries, why is the system experiencing so many affordability and access challenges?

John Godfrey, Washington Community Action Network, expressed excitement around primary care and reinforces urgency. Clients have complaints are around access to quality primary care. The "Get-in, get-out" paradigm leaves clients feeling unsatisfied. Suggests increasing primary care be paired with improved quality that allows more time in the room.

Written public comments can be found in the meeting materials.

Next Meeting

An announcement was made on Rand 4.0. The RAND report mistakenly included some Medicare Advantage claims data. As a result, the pricing for round 4.0 was understated. RAND 5.0 shows the correct data, not including Medicare Advantage claims data.

The next meeting of the Health Care Cost Transparency Board is scheduled for July 30, 2024, from 2 p.m. to 4 p.m.

Adjournment

The meeting was adjourned at 4:29 p.m.

Tab 3

Washington State Health Care Authority

Advisory Committee Update to the Board
Meetings held on: Wednesday, June 12, 2024

- Stakeholders Committee:
  - First meeting as the Advisory Committee of Health Care Stakeholders
  - Reviewed purpose of the committee and the charter
  - Discussed medical debt and potential policy ideas
  - Committee members invited to email ideas for further medical debt discussion
  - Next meeting – Wednesday, August 21, 2024

- Joint Committee:
  - ASI Disease Expenditure Report and discussion
  - Update on provider reporting and methodologies
  - Next meeting – TBD

Tab 4

Washington State Health Care Authority

HMA

Facility Fees: Overview and Information from the Advisory Committee on Data Issues

FACILITY FEES

Why this is important

- Hospitals and some clinics charge fees in addition to and not directly related to the service provided.
- As consolidation has increased, so has the use of facility fees.
- As a result, both purchasers and patients pay more.
- In 2022, hospitals in Washington collected **more than $125** million in revenue from facility fees.
- In both 2021 and 2022, the average facility fee assessed was $100 per patient encounter.

FACILITY FEES: CURRENT WA STATE DATA COLLECTION

Who must provide data and what type?

- **All hospitals with provider-based clinics that bill a separate facility fee** must report as part of year-end financial reporting to DOH:
  a) The number of provider-based clinics owned or operated by the hospital that charge or bill a separate facility fee;
  b) The number of patient visits at each provider-based clinic for which a facility fee was charged or billed for the year;
  c) The revenue received by the hospital for the year by means of facility fees at each provider-based clinic; and
  d) The range of allowable facility fees paid by public or private payers at each provider-based clinic.

No facility fee information collected as part of state licensing requirements of multiple types of facilities overseen by DOH, only ask if bill under a hospital or health system

No facility fee information collected as part of a certificate of need regulation

FACILITY FEES: WHAT IS NOT REPORTED CURRENTLY?

- Not capturing all entities or locations that charge a facility fee in WA State
  - Only hospitals are required to report this data and only for certain types of facilities.
  - Washington does not require notice of facility fees charged by providers not affiliated with a health system or hospital.
  - Likely significant amounts of these fees are not being reported to the state.
  - Unclear which “off campus” entities are charging fees, versus those part of hospital campus
- Not capturing which services have a facility fee charged
  - No detail on what services are associated with a facility fee
  - Could be charging for preventive or telehealth visits in an outpatient setting if a practice is part of a hospital or health system
- Not able to quantify impact on consumers
  - No information on how many times a high or maximum amount was charged in a hospital system, only that it was charged and the range of fees

FACILITY FEES: ADVANCE NOTICE FOR PATIENTS

What is required now?

1. Prior to the delivery of nonemergency services, a provider-based clinic that charges a facility fee shall provide a notice to any patient that the clinic is licensed as part of the hospital and the patient may receive a separate charge or billing for the facility component, which may result in a higher out-of-pocket expense
2. Must post prominently in locations easily accessible and visible to patients, including website

*"**Provider based clinic**"* = site of an off-campus clinic or provider office that is owned by a hospital or health system and licensed as part of the hospital*

*Per WA State RCWs at: RCW: https://app.leg.wa.gov/rcw/default.aspx?cite=70.01.040)

FACILITY FEES: ADVANCE NOTICE FOR PATIENTS WHAT IS NOT REQUIRED?

- Does not include notices to be provided to consumers by all clinics
  - Exempt: If provide labs, X-rays, testing, therapy, pharmacy or educational services or if is designated as rural health clinics
- Also not included are ambulatory surgical centers or other providers unaffiliated with hospitals/health systems
- Does not require notice before appointments which may add additional complications when providers charge cancellation fees.
- Some states require at time of scheduling or that consumers must receive an estimate in advance of the scheduled visit

REFERENCES ON FACILITY FEES

- RCW 70.01.040 Re: Facility Fees https://app.leg.wa.gov/rcw/default.aspx?cite=70.01.040
- Maine Recommendations: https://www.pressherald.com/2024/04/19/maine-lawmakers-approve-slimmed-down-version-of-hospital-facility-fee-bill/
- Massachusetts Recommendations: https://www.mass.gov/news/new-hpc-report-identifies-key-health-care-cost-drivers-and-calls-for-immediate-action-to-confront-pressing-affordability-challenges-facing-the-commonwealth
- NASHP: https://nashp.org/combat-rising-health-care-costs-by-limiting-facility-fees-with-new-nashp-model-law/
- https://unitedstatesofcare.org/wp-content/uploads/2023/06/State-Successes-Passing-Laws-to-Promote-Fair-Billing_Facility-Fees.pdf
- https://www.pressherald.com/2022/08/21/hidden-charges-denied-claims-medical-bills-leave-patients-confused-frustrated-helpless/

Tab 5

Washington State Health Care Authority

Outpatient Facility Fee Billing Reforms: Options for States

- July 2024-

Christine H. Monahan

Assistant Research Professor

GEORGETOWN UNIVERSITY
McCourt School of Public Policy

CENTER ON HEALTH INSURANCE REFORMS

@GtownCHIR

Georgetown University Center on Health Insurance Reforms (CHIR)

Nationally recognized team of private insurance experts

- Part of McCourt School of Public Policy
- Legal & policy analysis
  - Federal and state regulation
  - Market trends
- Published reports, studies, blog posts
- Technical assistance

Facility Fee Reform Options

Issues to tackle:

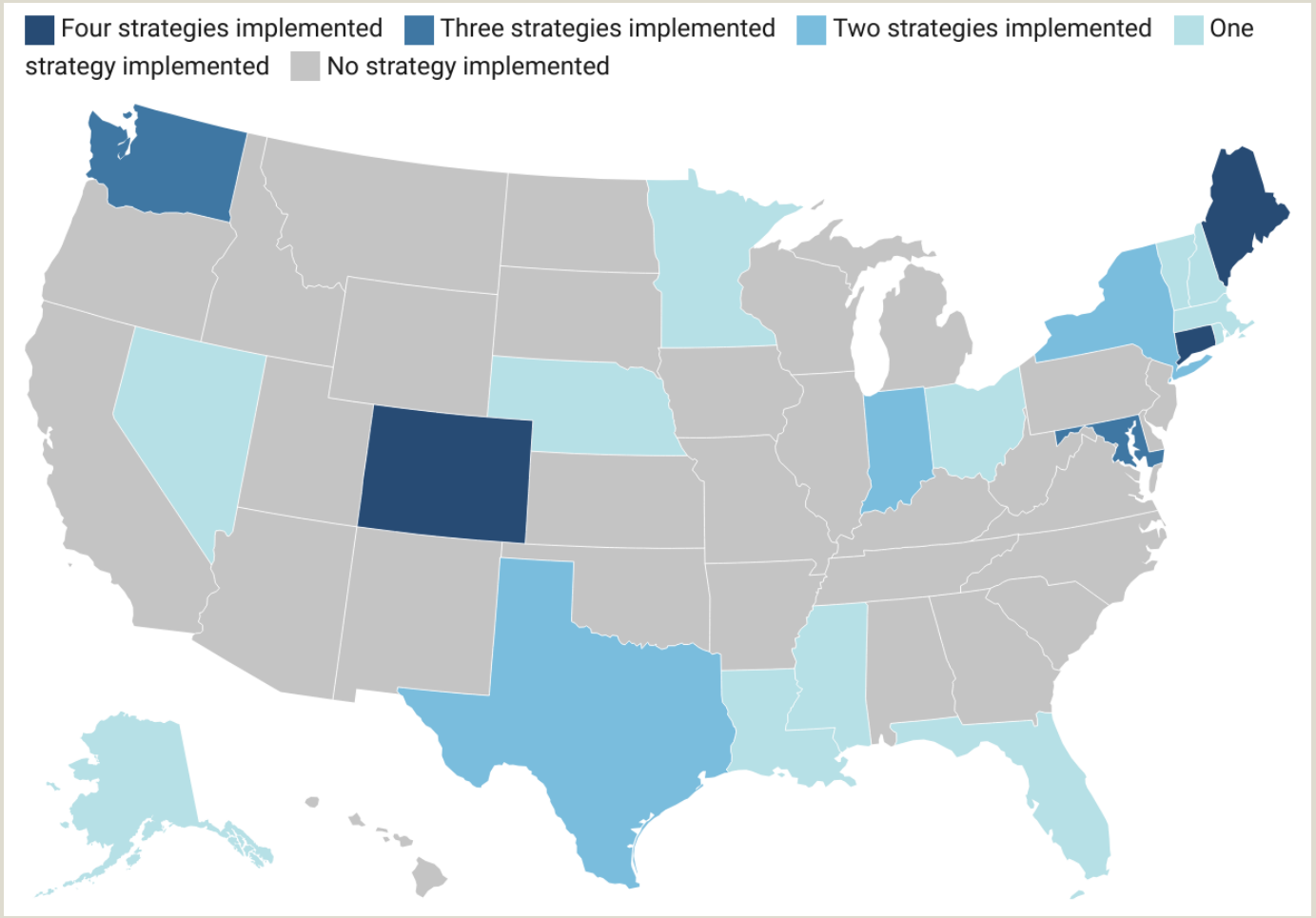
- Consumer out-of-pocket cost exposure
- Rising spending
- Lack of transparency in billing and ownership

Potential solutions

- Site-neutral payment
- Facility fee billing ban
- Billing transparency
- Public reporting
- Cost-sharing protections
- Consumer notification requirements

See how different policies measure up on our [Cheat Sheet for Policymakers]

Overall Picture of State Reforms



State Uptake By Reform

Reform	State Uptake
Site-Neutral Payment	0: (Proposals in development)
Facility Fee Billing Ban	9: CT, IN, MD, ME, MS, NY, OH, TX, WA
Billing Transparency	4: CO, ME, NE, NV
Public Reporting	9: AK, CO, CT, IN, MD, ME, NH, VT, WA
Cost-Sharing Protections	2: CO, CT
Consumer Notification Requirements	12: CO, CT, FL, LA, MA, MD, ME, MN, NY, RI, TX, WA

Questions?

More on Outpatient Facility Fees:

https://facilityfeereform.chir.georgetown.edu/

Other CHIR Publications:

www.chir.georgetown.edu

CHIRblog:

www.chirblog.org

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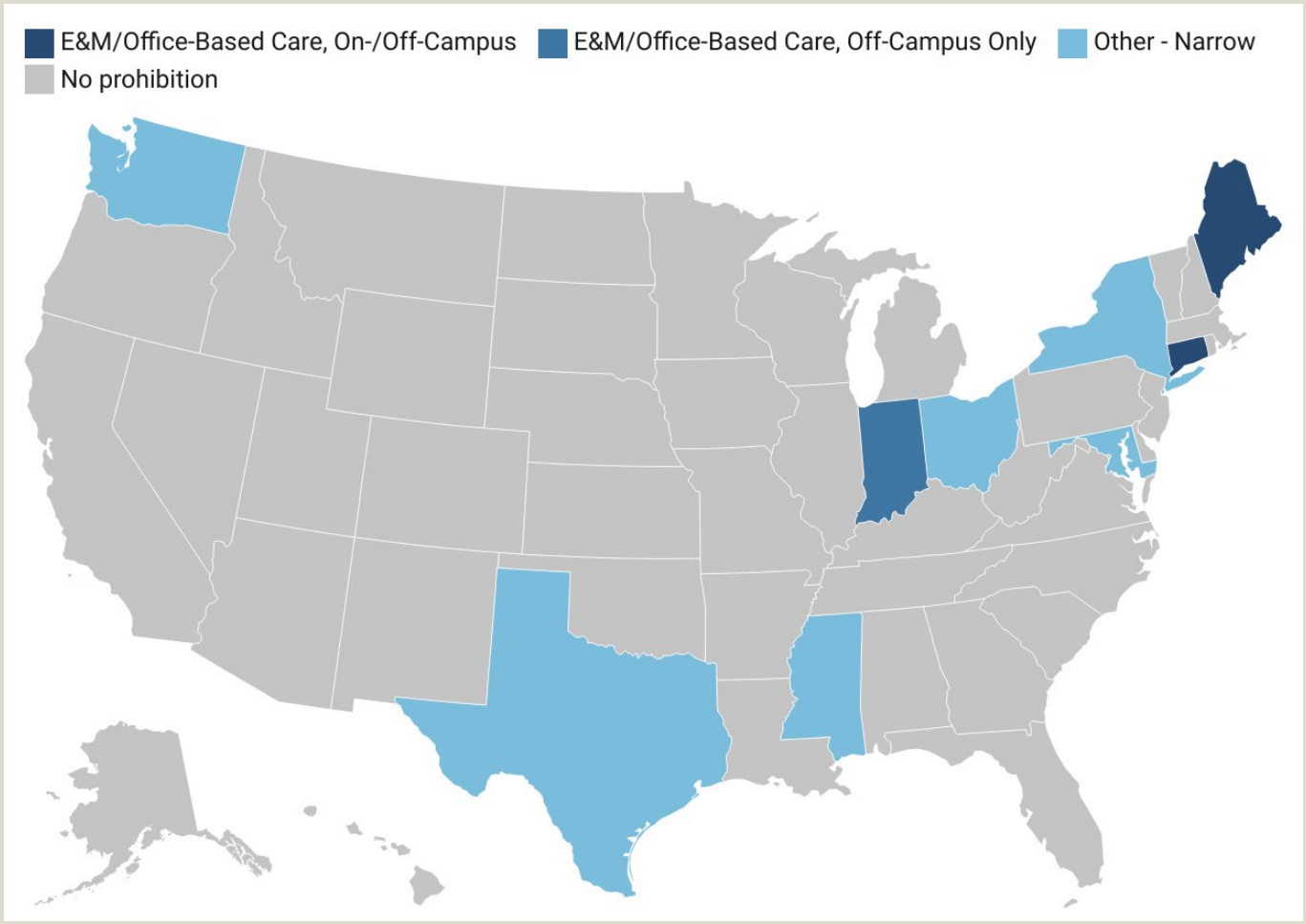
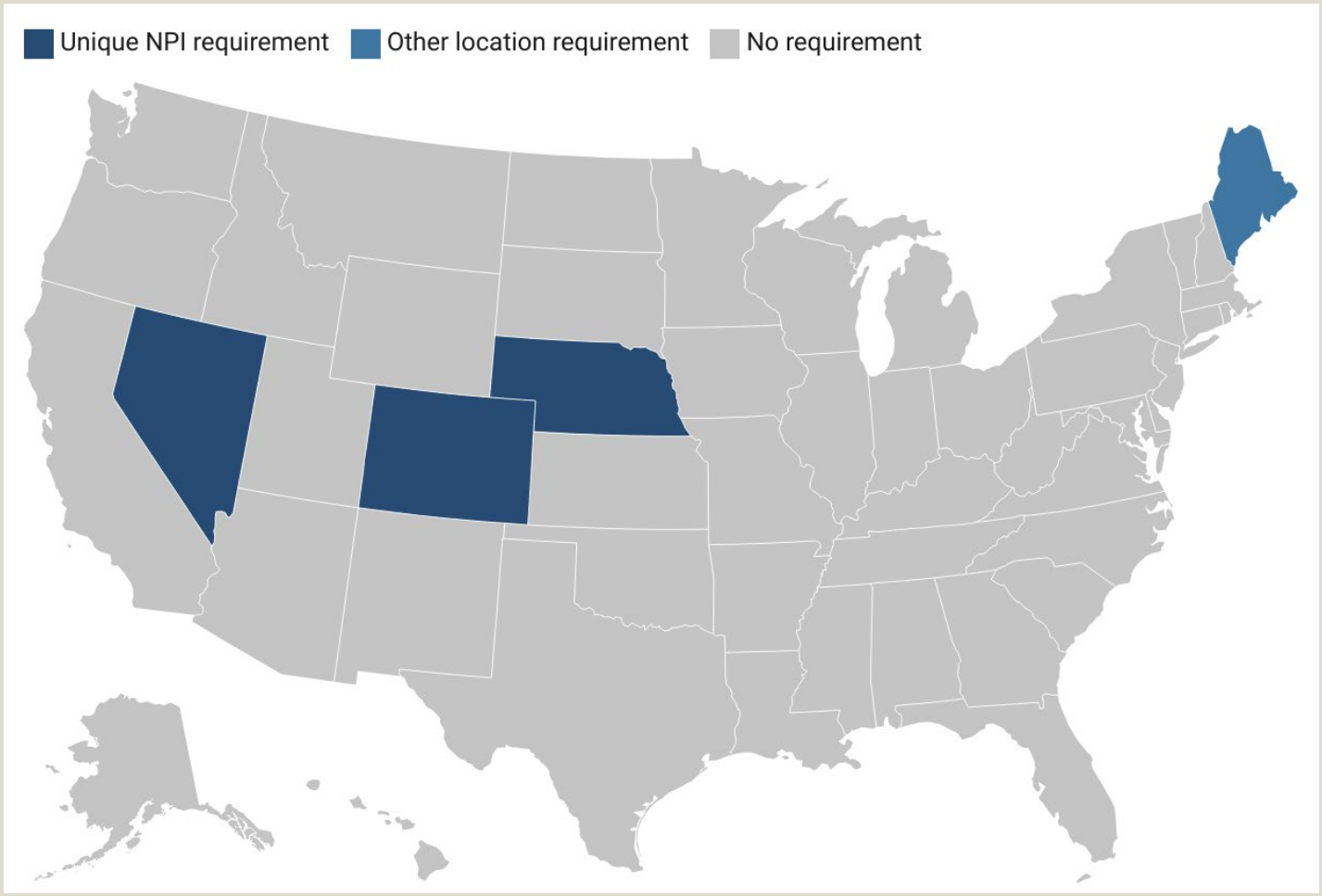
APPENDIX

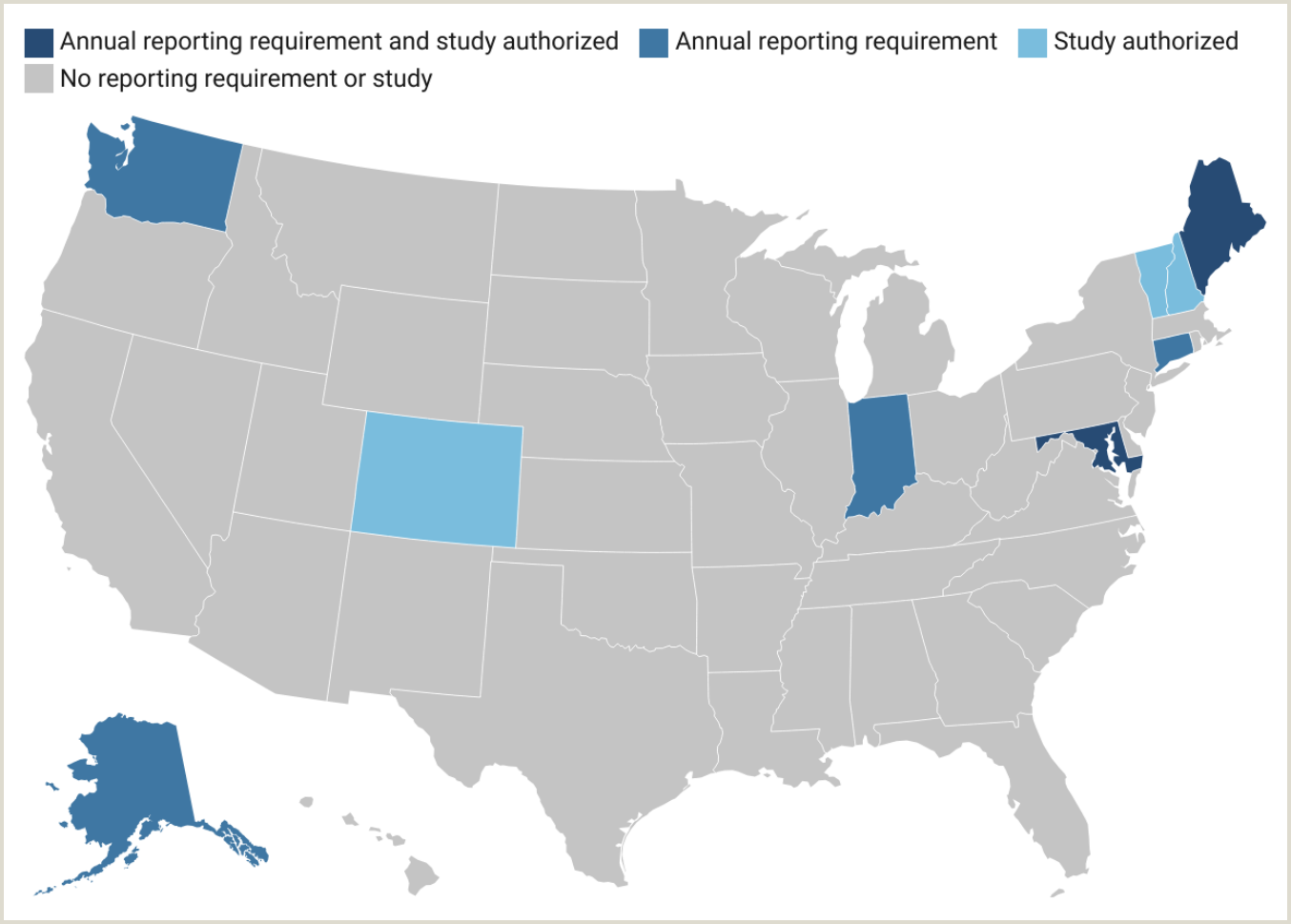
Facility Fee Prohibitions



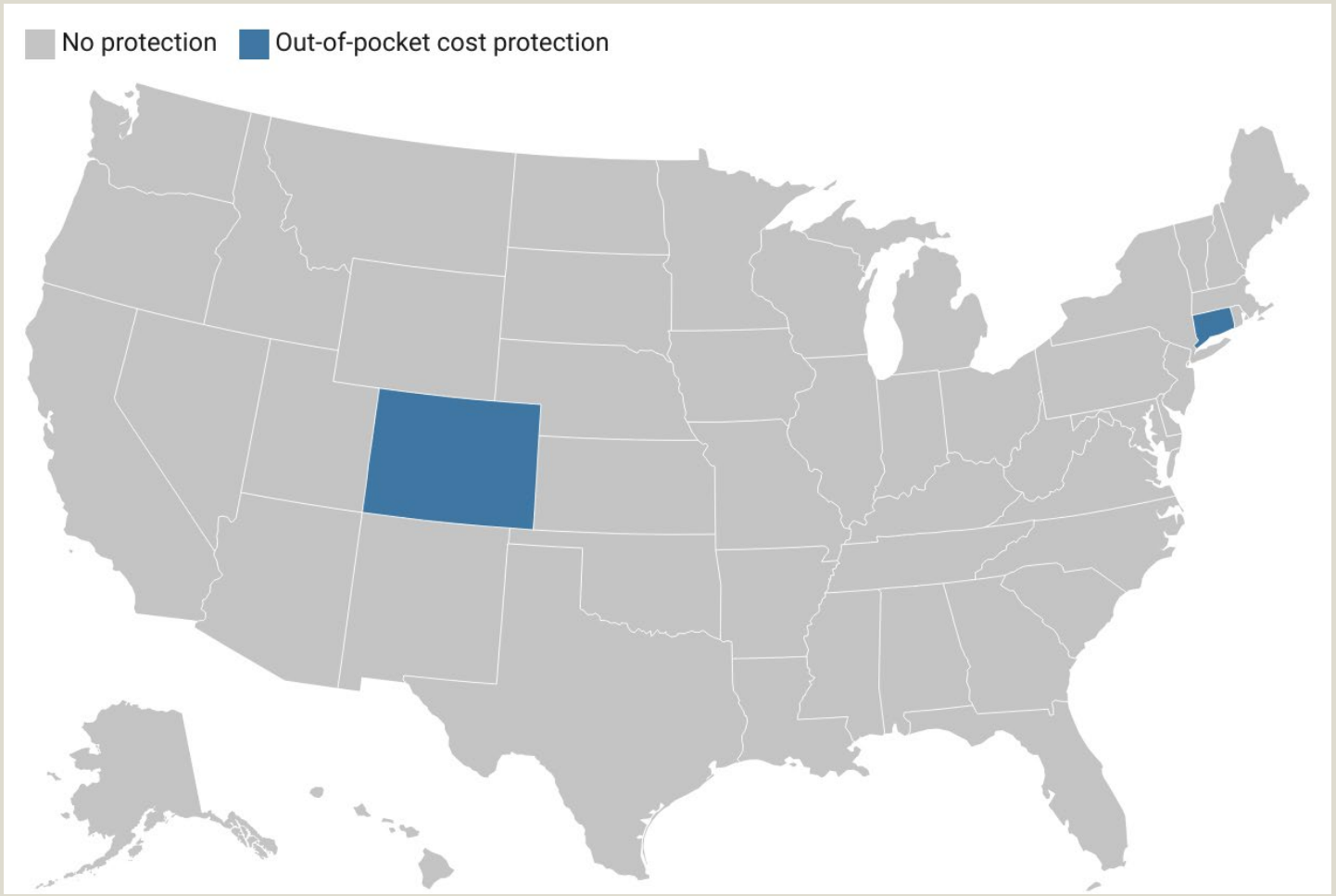
Billing Transparency



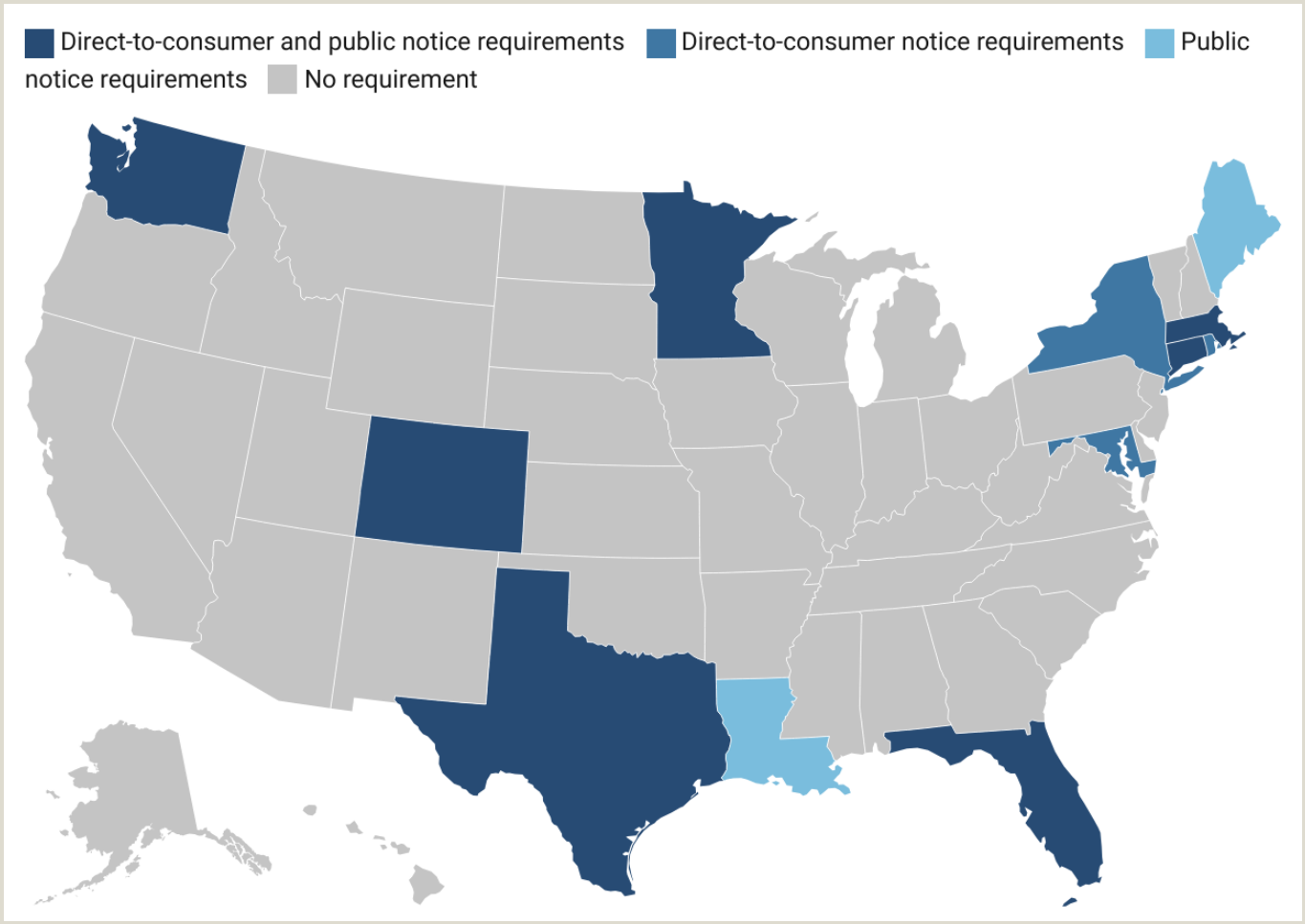
Public Oversight



Cost-Sharing Protections



Consumer Notification Requirements



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westhealth

Regulating Outpatient Facility Fees:

States Are Leading the Way to Protect Consumers

BY CHRISTINE H. MONAHAN, KAREN DAVENPORT, RACHEL SWINDLE, AND CAROLINE PICHER

July 2023

In recent years, health care consumers, payers, and policymakers have brought attention to the growing prevalence of hospital outpatient facility fees in the United States. As hospitals and health systems expand their ownership and control of ambulatory care practices, they are typically charging new facility fees for services delivered in these outpatient settings. Consumers, too, are facing greater financial exposure to these charges as insurance deductibles increase and payers develop new benefit designs that increase patients' exposure to cost-sharing, particularly in hospital outpatient settings.

Consequently, state policymakers, spurred on by consumer advocacy groups and a budding contingent of employers and business groups, are pursuing reforms that would limit hospitals' ability to charge outpatient facility fees and/or better protect consumers from such bills.

This issue brief explores why and how many states are taking on the regulation of outpatient facility fees. Its findings are informed by an analysis of current laws and regulations across 11 study states—**Colorado, Connecticut, Florida, Indiana, Maine, Maryland, Massachusetts, New York, Ohio, Texas,** and **Washington**—and more than 40 qualitative interviews with key stakeholders and experts between November 2022 and April 2023. For a more in-depth examination of this issue, a companion report is available here.

Key Findings:

- Concern is growing that hospital outpatient facility fees are adding to consumers' and employers' health care costs—both through higher out-of-pocket charges and rising insurance premiums.

- States have been at the forefront of protecting consumers from unwarranted outpatient facility fees in the commercial market. The five reforms most commonly adopted by states are described in Table 1. These include:
  1. Prohibitions on facility fees;
  2. Out-of-pocket cost protections for consumers;
  3. Consumer disclosure requirements;
  4. Hospital reporting requirements; and
  5. Provider transparency requirements.

- Despite strong opposition from hospitals, state action to constrain outpatient facility fees is clearly gaining momentum.

Why Action on Facility Fees Is Needed

Facility fees are the charges institutional health care providers, such as hospitals, bill ostensibly to cover their operational expenses for providing health care services. Hospitals submit these charges separately from the professional fees physicians and certain other health care practitioners, such as nurse practitioners, physician assistants, and physical therapists, charge to cover their time and expenses. Traditionally, public and private payers pay more in total for the same services provided in a hospital—including, importantly, hospital-owned outpatient departments—than care provided in an independent physician's office or clinic.

This payment differential both encourages and exacerbates the effects of vertical integration in the U.S. health care system, as hospitals and health systems increasingly acquire physician practices and other outpatient health care providers. When a hospital acquires or otherwise affiliates with a practice, ambulatory services provided at the practice often newly generate a second bill, the facility fee, on top of the professional fees the practitioners charge. As hospitals expand their control over more physician and other outpatient practices, they can also exert greater power in their negotiations with commercial health insurers and extract even higher charges.

> We are very worried about the prices that facility fees impose on the consumer, the carrier, and ultimately the premium."
>
> **— STATE HEALTH INSURANCE REGULATOR**

The growth in outpatient facility charges increases overall health care spending, resulting in higher premiums. Our research also suggests that insurance benefit designs are increasing consumers' direct exposure to these charges. Rising deductibles, which can subject consumers to several hundred dollars or more in facility fee charges for a single outpatient service, appear to be one factor. Even when a consumer has met their insurance deductible, a separate facility fee from the hospital, on top of a professional bill, may trigger additional cost-sharing obligations for the consumer, such as a separate co-insurance charge on the hospital bill. Commercial insurers also may impose higher cost-sharing on patients for receiving hospital-based care.

Consumers are often caught off guard by outpatient facility fee charges and may question why they are getting billed by a hospital for a run-of-the-mill visit to the doctor. Hospitals maintain that they need to impose these charges because of the extra costs they incur and services they provide—such as round-the-clock staffing, nursing and other personnel costs, and security—even though individual patients may not pose any additional costs or use the hospital's services. In contrast, payers and a range of policy experts view facility fee billing as a way hospitals leverage their market power and take advantage of the United States' complex and opaque payment and billing systems to increase revenue.

> You pay for the courtesy of going to the building owned by the hospital."
>
> **— FORMER STATE OFFICIAL**

Table 1. Outpatient Facility Fee Requirements in 11 Study States

	Regulatory Reform				
STUDY STATE	**1. Prohibition on Facility Fees** State prohibits providers from charging facility fees for specified procedures and/or care settings	**2. Out-of-Pocket Cost Protections** State limits consumers' financial exposure to outpatient facility fees in specified circumstances	**3. Consumer Disclosure Requirements** State requires specified providers and/or insurers to disclose that outpatient facility fees may be charged and/or the expected amount of outpatient facility fee charges or cost-sharing obligations, as applicable	**4. Hospital Reporting Requirements** State requires that hospitals make annual or one-time disclosures to the state on outpatient facility fee-related data	**5. Provider Transparency Requirements** State requires that health care providers register with national or state databases to better monitor where care is provided and/or who is providing care
COLORADO		No balance billing for facility fees for preventive services*	Hospitals and hospital-owned facilities,* freestanding emergency departments (EDs)	One-time study	Unique national provider identifier for off-campus locations
CONNECTICUT	Evaluation and management services on-* and off-campus, telehealth	No separate copayment on off-campus outpatient facility fees	Hospitals and hospital-owned facilities, insurers	Annual reporting	
FLORIDA			Hospitals and hospital-owned facilities, freestanding EDs		
INDIANA	Off-campus office settings owned by non-profit hospitals*			Annual reporting	
MAINE**	On- and off-campus office settings				
MARYLAND	Telehealth, COVID-19 testing and monoclonal antibodies		Hospitals and hospital-owned facilities	Annual reporting	
MASSACHUSETTS			Hospitals and hospital-owned facilities, insurers		Provider registry on ownership and affiliation
NEW YORK	Preventive services		Hospitals and hospital-owned facilities		
OHIO	Telehealth				
TEXAS	Drive-thru services at freestanding EDs		Freestanding EDs, insurers		
WASHINGTON	Telehealth (audio-only)		Hospitals and hospital-owned facilities	Annual reporting	

* Legislation has been enacted but requirement has not yet gone into effect. ** Maine recently enacted a bill to establish a task force to study facility fee billing and make a report to the legislature with recommendations. It also requires the state's all payer claims database to annually report on facility fee payments based on otherwise available data beginning in January 2024.

State Strategies to Regulate Outpatient Facility Fee Billing

While federal lawmakers and regulators have begun reining in payment discrepancies based on the site of care under Medicare, states are at the forefront of tackling outpatient facility fee billing in the commercial sector. Our analysis of the laws and regulations currently on the books in 11 study states demonstrates the range of reforms available (Table 1). Specifically, we identify five types of reforms states are beginning to adopt: (1) prohibitions on facility fees; (2) out-of-pocket cost protections; (3) consumer disclosure requirements; (4) hospital reporting requirements; and (5) provider transparency requirements. At the same time, our research shows how much more states can still do, both with respect to strengthening existing reforms to be more protective of consumers and adopting additional types of reforms.

1. Prohibitions on Outpatient Facility Fees: Stopping Charges Before They Happen

Several study states have prohibited facility fee charges in some circumstances, although the scope of these laws varies significantly. **Connecticut, Indiana,** and **Maine** have gone the furthest, prohibiting facility fees for selected outpatient services typically provided in an office setting. Some states have targeted more specific services, including telehealth services **(Connecticut, Maryland, Ohio,** and **Washington)**, preventive services **(New York)**, and Covid-19 related services **(Maryland, Texas,** and, during the public health emergency period, **Massachusetts).**

Maine's law is the oldest facility fee prohibition among the study states. It specifies that all services provided by a health care practitioner in an office setting—"a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility"—must be billed on the individual provider form. A Maine health care provider confirmed that this law means hospitals cannot charge facility fees for office-based care, even when provided in a hospital-owned practice. This provider has narrowly interpreted the scope of services to which the law applies, however. As such, they do not charge facility fees for Evaluation and Management (E&M) services,[1] but do charge facility fees for more complex procedures or services where a physician is not directly involved at the point of care, like infusion therapy to treat cancer and other illnesses. **Indiana** uses the same office-setting framework in its recently enacted law, which will go into effect July 1, 2025, and more narrowly prohibits facility fee billing for off-campus facilities owned by non-profit hospitals. **Connecticut** currently bars hospital-owned or -operated facilities from charging facility fees for outpatient E&M and assessment and management (A&M) services at off-campus locations. Beginning July 1, 2024, this prohibition will extend to on-campus locations as well, excluding emergency departments and certain types of observation stays.

In interviews, stakeholders emphasized that prohibitions on outpatient facility fees can provide significant financial protection to consumers, who otherwise may need to pay a significant portion, if not all, of a facility fee charge, depending on their insurance coverage. The impact on insurance premiums may be more muted, however, as hospitals with market power may make

[1] Evaluation and Management (E&M) services are non-procedural services where health care practitioners diagnose and treat illnesses, injuries and other conditions. Examples of E&M services include diagnosing a sinus infection and prescribing antibiotics, or an office visit focused on managing an ongoing and complex condition such as diabetes.

up for the lost revenue by securing higher rates for other services in their negotiations with commercial payers. (This is different from Medicare, where the government sets payment rates for health care providers.)

2. Out-of-Pocket Cost Protections: Limiting Consumer Charges for Facility Fees

Two study states have adopted relatively narrow restrictions that limit consumers' exposure to out-of-pocket costs while continuing to allow hospitals to charge facility fees in at least some circumstances. **Connecticut** prohibits insurers from imposing a separate copayment for outpatient facility fees provided at off-campus hospital facilities (for services and procedures for which these fees are still allowed to be charged) and bars health care providers from collecting more than the insurer-contracted facility fee rate when consumers have not met their deductible. More narrowly, health care providers in **Colorado** will not be allowed to balance bill consumers for facility fee charges for preventive services provided in an outpatient setting beginning July 1, 2024.

It is unclear to what extent coverage requirements such as state benefit mandates and the essential health benefit package require coverage of facility fees when the underlying service is covered. Multiple state insurance regulators suggested in interviews they had not previously considered this question. While coverage requirements would protect consumers from balance billing of facility fees when they receive care at an in-network facility, some interviewees cautioned that such rules could encourage health care providers to increase the frequency and amount of facility fee charges where they apply.

3. Consumer Disclosure Requirements: Notifying Consumers About Outpatient Facility Fee Charges

All but two study states require health care providers—typically hospitals and hospital-owned facilities and sometimes freestanding emergency departments—and/or health insurers to notify consumers that they may be charged a facility fee in certain circumstances. For example, **Connecticut** and, as of July 1, 2024, **Colorado** require providers to disclose certain information about their facility fee billing practices upon scheduling care, in writing before care, via signs at the point of care, and in billing statements. Upon acquiring a new practice, hospitals in these states also must notify patients that they may be charged new facility fees. Other study states have adopted a subset of these requirements, such as requiring disclosures before care is provided and/or in signage at the facility. Some states require consumers to be more proactive, requiring only that information about facility fee charges be available online or provided upon request by hospitals and/or health insurers.

Interviewees generally did not believe that these disclosures would drive many consumers to seek care in settings that do not impose facility fees, observing that consumers tend to prioritize their existing provider relationships and seek care where their providers refer them. They did think disclosures can reduce consumer confusion when they receive a facility fee bill, however. Some interviewees also suggested that consumer disclosure requirements could generate broader support for reforms by increasing awareness of the extent of facility fee billing.

4. Hospital Reporting Requirements: Disclosing How Much Hospitals Charge and Receive in Outpatient Facility Fees

Five study states have adopted public reporting requirements to better understand how much hospitals charge and receive for outpatient care. Four of these states—**Connecticut, Indiana, Maryland,** and **Washington**—have enacted annual reporting requirements, while **Colorado** recently required a study that includes collecting facility fee data from hospitals (among other sources) with a report due in the fall of 2024.[2]

The value of public reporting requirements depends on what information the state collects. More detailed information, broken down by facility, payer, and service, will offer policymakers a deeper and more nuanced understanding of the scope of facility fee billing and trends over time. Agencies charged with collecting this data also must have the authority, capacity, and will to ensure hospitals comply and to effectively analyze the data.

> Connecticut's law has been good from the exposure standpoint, on what the real problems are, specifically the opacity of facility fees and the lack of a rational basis for what the charges are."
>
> **— FORMER STATE OFFICIAL**

5. Provider Transparency Requirements: Who Is Providing Care Where?

Colorado and **Massachusetts** have taken steps to bring more transparency to the questions of where care is being provided and by whom. Unfortunately, existing claims data often conceal the specific location where care was provided and the extent to which hospitals and health systems own and control different health care practices across a state. This makes it challenging for payers, policymakers, and researchers to effectively monitor and respond to outpatient facility fee charges.

In an effort to understand where care is provided, **Colorado** requires every off-campus location of a hospital to obtain a unique identifier number (referred to as a national provider identifier or NPI) and include that identifier on all claims for care provided at the applicable location. Federal lawmakers and other states are considering similar proposals. One challenge **Colorado** has faced, however, is tracking the affiliations between different locations, all now represented by unique NPIs. A recently enacted law requires **Colorado** hospitals to report annually on their affiliations and acquisitions, which may help address this gap. **Massachusetts** does not have a unique NPI requirement but maintains a provider registry that includes information on provider ownership and affiliations among other data, enabling the state to better monitor trends in consolidation and integration.

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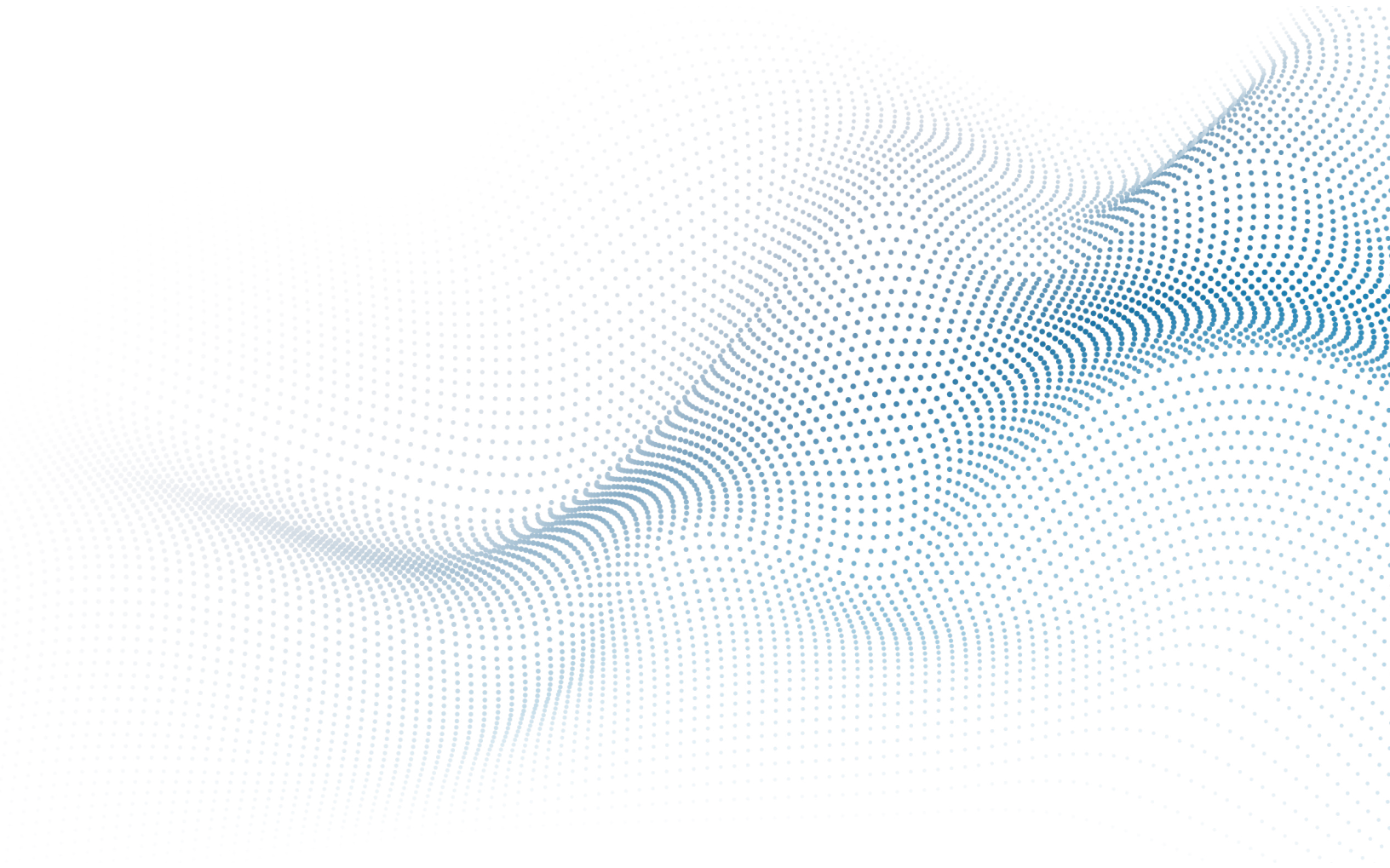
[2] Similar to Colorado, Maine recently enacted a bill to establish a task force to study facility fee billing and make a report to the legislature with recommendations. Unlike Colorado's law or other laws discussed in this section, however, Maine's law does not require any new reporting by hospitals, although it also requires the state's all payer claims database to annually report on facility fee payments based on otherwise available data beginning in January 2024.

Looking Ahead: Growing Momentum Despite Hospital Pressure

The hospital industry remains a powerful force, leveraging significant influence over policymakers, regulators, and other stakeholders to stifle reforms that would reduce their revenue or restrict their operations. Yet interviews revealed that cracks are forming in hospitals' defenses as momentum grows for reform. Hospitals are facing public criticism on a range of issues, from their facility fee charges, to debt collection practices, and for exploiting their non-profit tax status. The growing prevalence of facility fees specifically, and the financial toll they can take on unsuspecting consumers, is catching the eye of journalists, regulators, and policymakers. As more information on hospital prices and costs come to light through public and private transparency initiatives, the employer community also is increasingly engaging on the issue of outpatient facility fees and other issues affecting the cost of health care for their businesses and their employees. And states are building their internal capacity to tackle these topics, including establishing new offices and expanding the authority of existing departments to look at health care costs and affordability.

These forces are generating broad interest in tackling hospital pricing generally, and outpatient facility fee charges in particular. While addressing these issues is no small challenge, it is a challenge more and more policymakers and stakeholders are willing to tackle.



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For additional sources relied on for this issue brief, please see our companion report.

About

GEORGETOWN UNIVERSITY McCourt School of Public Policy **CENTER ON HEALTH INSURANCE REFORMS**

ABOUT GEORGETOWN CENTER ON HEALTH INSURANCE REFORMS

The Center on Health Insurance Reforms (CHIR) is a research center within Georgetown University's McCourt School of Public Policy, composed of a team of nationally recognized experts on private health insurance and health reform.

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GEORGETOWN UNIVERSITY McCourt School of Public Policy
CENTER ON HEALTH INSURANCE REFORMS

November 2023

Outpatient Facility Fee Reform Strategies

A Cheat Sheet on Key Goals and Strategies for Policymakers

Policymakers have several options for reforming hospital outpatient billing practices to better protect consumers, reduce health care costs, and increase transparency. These goals and the strategies outlined below are not mutually exclusive and may be pursued as a complementary package.

Policies to protect patients are emerging incrementally.

As hospitals acquire or otherwise affiliate with physician practices, they can charge facility fees—**a second fee in addition to a health care professional's bill**—for outpatient care. This practice results in higher spending, which increases premiums and out-of-pocket costs for consumers without improving quality.

Policymakers are responding with a variety reforms, with states leading the way.

- States are **prohibiting hospitals from charging fees for certain outpatient services**, such as evaluation and management services or preventive care, **or care provided in certain outpatient settings**, such as off-campus office practices, on the basis that these services and settings do not draw on significant facility resources.
- States are seeking to **shield consumers from out-of-pocket costs** by requiring health plans to treat facility fees as covered benefits, limiting consumer cost-sharing for these charges, and requiring providers and insurers to **disclose facility fee to consumers**.
- States are **improving their data on facility fee payments and practice ownership** to better understand facility billing. These efforts can facilitate policy change, bolster effective implementation and oversight of reforms, and support private payer actions to respond to facility fee billing.
- Federal policymakers have initiated similar payment reforms by requiring Medicare to make "site neutral" payments—the same price for the same service, regardless of setting—for outpatient services in some circumstances and introduced proposals to **set site-neutral payment caps for certain outpatient services in the commercial market**.

STATES LEADING THE WAY

Colorado

Colorado requires hospital outpatient departments and other hospital-owned or affiliated locations to acquire and use unique National Provider Identifiers (NPI) and expanded its law in 2023 to address ownership transparency and establish a steering committee to study additional reforms.

Connecticut

Connecticut leads the country in the scope and comprehensiveness of its facility fee reforms, including laws that prohibit facility fees for certain services, require public reporting on facility fee charges, protect consumers from out-of-pocket costs, and require facilities to disclose fees to consumer in advance of medical appointments and at the point of service.

Indiana

In 2023, Indiana enacted a law prohibiting large non-profit hospitals from charging facility fees for certain services and requiring hospitals to report on facility fee charges.

What about ERISA?

ERISA limits states' authority to regulate employer-sponsored health plans, but states retain broad authority to regulate health care providers, including what hospitals and other providers may charge for services, what they must report to states, and what they must tell consumers about health care charges.

Facility Fee Reform Strategies: A Closer Look

STRATEGY 1: Site-Neutral Payment Caps

Prohibit hospital-owned and -affiliated facilities from charging facility fees for specified outpatient services **AND** cap provider reimbursement for these services (e.g., at a percentage of Medicare rates or the median price insurers pay independent physician offices in the same area).

STRATEGY 2: Facility Fee Billing Prohibitions

Prohibit hospital-owned and -affiliated facilities from charging facility fees for specified outpatient services, such as those that can be safely and effectively provided outside of a hospital-setting.

STRATEGY 3: Billing & Ownership Transparency

Require hospital-owned and -affiliated providers to acquire and include unique National Provider Identifiers specific to the location of care on all claims. Monitor health care provider affiliations and acquisitions.

STRATEGY 4: Outpatient Facility Fee Reporting Requirements

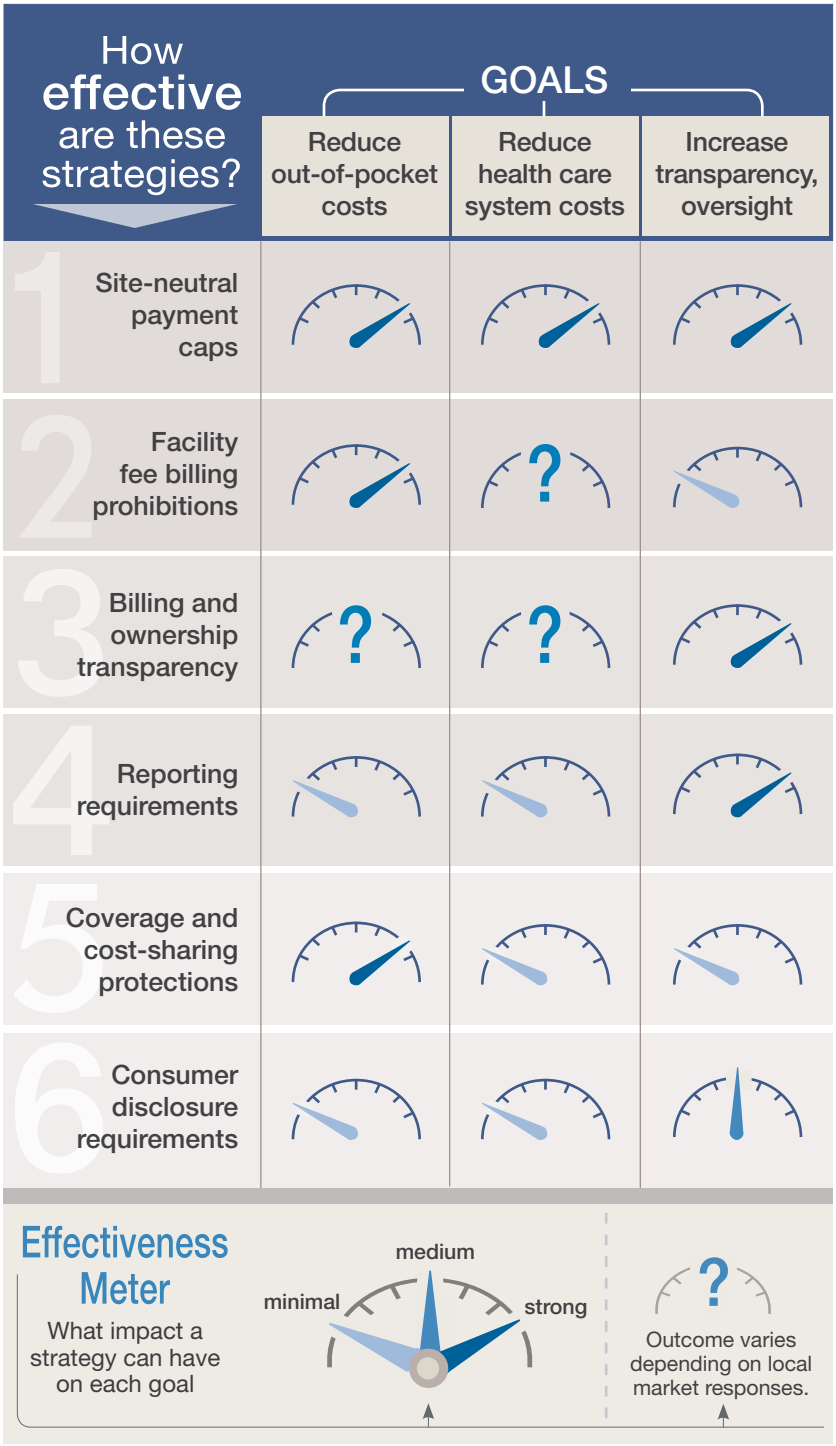
Require hospitals to report on outpatient facility fee billing, including the locations charging facility fees and the revenue from those fees, as well as the volume and amounts of facility fees by service, payer, and location.

STRATEGY 5: Coverage and Cost-Sharing Protections

Require state-regulated insurance policies to cover and limit consumer cost-sharing for outpatient facility fees.

STRATEGY 6: Consumer Disclosure Requirements

Require health care providers and state-regulated insurers to notify consumers before charging outpatient facility fees, including through physical signs and written and oral communications.



Want to learn more?

For more detailed information on state actions to regulate outpatient facility fee billing, see the recent report and issue brief from the Center on Health Insurance Reforms (CHIR) and West Health.

Policymakers and advocates considering facility fee reforms are encouraged to contact CHIR experts for technical assistance at FacilityFeeTA@georgetown.edu.

Tab 6

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board

Public Comment Materials & Written Comments

Public Comment Materials and Written Comments Submitted by Email

1. Washington State Hospital Association
2. Washington State Hospital Association and Washington State Medical Association

Comments Received at the May Meeting

The Zoom video recording is available for viewing here:
https://www.youtube.com/watch?v=vrhFVvsrqMQ

Washington State
Hospital Association

July 12, 2024

Marty Ross

Delivered via email: HCAHCCTBDataAdvisoryCommittee@hca.wa.gov

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

Thank you for the opportunity to provide feedback on the questions related to facility fees. WSHA understands that there are questions about why, how and when facility fees are charged. We believe the Board is primarily interested in the billing and payment of outpatient, off-campus hospital departments, but wanted to provide background before answering the questions posed by Board staff.

Background on Facility Fees

On the inpatient side, all hospitals bill for the facility components, which include nurses, technologist and other non-physician caregivers, building costs, equipment, drugs, supplies, and all of the overhead to ensure a hospital can provide patient care. Provider services such as physician services, anesthesia and radiology readings are billed separately by the relevant provider.

On the outpatient side, a hospital-based outpatient department or clinic bills for the facility components (called facility fee) related to the service, which cover the staff, building cost, supplies and other overhead. There is also a separate professional billing for the professional service.

On these professional claims associated with services at an outpatient department/clinic that charges a facility fee, the payment is reduced compared to when a service is provided in a freestanding clinic. This is because the professional payment does not include payment for the facility overhead expenses when performed at a hospital-based site. There is no double billing or double payment, though the combined payment (professional plus facility fee) may be greater when performed in a hospital-based clinic setting than a freestanding clinic. For many of the services provided at hospital-based clinics, there are no freestanding clinic alternatives.

How are Hospital Outpatient Clinics/Departments Different than Freestanding Clinics

Hospital outpatient departments, on-campus and off, are different than traditional physician offices. For example, these sites are regulated and must meet all Centers for Medicare and Medicaid Services (CMS) and state requirements to qualify as a department of the hospital. This includes: complying with hospital building codes; staffing in a way that is integrated with the hospital (including complying with Washington hospital staffing laws); and providing charity care (reduced and free care) to low and medium-income patients who apply.

Many of the services provided at these clinics are of a type and complexity that are not available at freestanding sites. Compliance with hospital standards creates additional costs that may not always be visible to patients but are real if the patient needs specialized care or has financial needs. Hospital outpatient departments also serve more patients in government programs such as Medicare and Medicaid than private clinics, particularly in regions where there is limited primary and specialty care.

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Unfortunately, Medicare and Medicaid do not cover the cost of providing outpatient care. Most specialty providers in Washington State haven't seen a significant Medicaid rate increase for more than 15 years, while inflation has skyrocketed. In fact, many of these off-campus sites exist as hospital-based sites to ensure access to care is provided to all in their community, such as Yakima and Sequim. These off-campus sites have been integral to ensuring that services like cancer treatment, pediatrics, and primary care can exist in diverse communities with greater health needs and lower health outcomes.

WSHA is gathering more information this summer about off-campus hospital clinics. According to our review of the Department of Health filings, there are about 16 hospitals with 112 off-campus clinic sites that bill facility charges. We expect to have more information about these patient services in late Fall.

See below for our responses to questions posed to members of the Advisory Committee on Data Issues.

Responses to questions posed to the Advisory Committee on Data Issues

Should advance notice requirements for patients be adjusted?

- **Should there be greater transparency as to the amount of the charge in providing advance notice (i.e., provide the specific amount of the charge to be included in the advanced notice to patients)?**

  Hospital-based clinics are already required to provide signage and notification that the site is a hospital department and that the facility component will be billed as a separate billing rather than added into the professional billing. Providers are also required to provide a good faith estimate of charges upon request. We observe that the legislature has required hospitals to post numerous signage requirements and that patients are overwhelmed by the information. We recognize that this information is not sufficient for some patients.

  Unfortunately, the charge for services cannot always be determined in advance of the services, particularly in the case of evaluation and management services where the codes and charges vary based on the complexity of the patient and time involved. A procedure that is seen as routine may become much more complicated when actually performed. We are interested in a discussion regarding the best way to provide advance indication of the potential magnitude of charge without delaying care, perhaps a statement including charges for the 10 most common services provided at the site. Some hospital clinics already provide this information on their websites.

- **Should there be adjustments as to who must provide advance notice to include other services such as diagnostic testing or other routine services?**

  We have attempted to answer this question but would need more detail to understand the intent and more adequately answer the question. Off campus hospital outpatient sites that provide the facility equipment and overhead and bill a facility fee are already subject to the requirements described above. While hospitals provide signage to patients and report information according to state law, there are other types of facilities that charge for equipment and overhead for radiology or diagnostic services, similar to hospital-based sites. We are unclear if this is what the question aims at answering.

- **Should there be adjustments to who can charge a hospital facility fee? (i.e., to not allow for routine services delivered off the hospital's campus)**

All hospital-based sites that charge a hospital facility fee meet CMS' requirements as a hospital department including clinical, staffing, and financial integration with the hospital, and are subject to hospital building codes and charity care requirements. Most are specialty oriented and are generally services not available at freestanding sites. The sites that provide primary care generally exist to sustainably meet access to care needs that are not met by other providers in the community. As such, there is a mix of highly specialized and "routine" services provided at off-campus sites. We are concerned about any determination along these lines without a comprehensive review of the impact on access to these services. Many of these off-campus sites were created with the understanding that they would be able to bill a facility fee and therefore cover the costs of operations and losses from government programs.

As discussed in the background section, these off-campus sites provide charity care and provide services to patients in Medicare and Medicaid. Without facility fees, these sites may not be viable. This is the effect we have seen throughout the state with physicians closing practices or reducing Medicare and Medicaid patients because the payments allow for the clinics to stay open.

Should facility fee reporting requirements be adjusted?

- **Should additional facilities/services be included in the hospital/health system reporting requirements? (i.e., labs, imaging, other service facilities)?**

  We would need more detail regarding this question. We believe the current reporting requirements and format can be improved and would like to be included in that discussion.

- **Should non-hospital affiliated facilities be required to report their fees?**

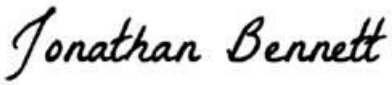
  We believe much of the attention regarding hospital facility charges is due to a false perception that freestanding entities do not charge for their facility overhead, equipment costs and staffing. We also know there are non-hospital facilities that bill similar to hospital outpatient departments with an equipment/overhead bill and the professional services billed separately by providers. Such a requirement would help show that they also bill and are paid for these costs, but we do not know that that is the most efficient way of making the comparison. We would welcome being part of that discussion. We also think the landscape could be researched without imposing new requirements.

- **Should greater detail be provided about the amount of the fees, frequency of charging higher fees, etc.**

  We think there is opportunity to improve reporting to give a clearer understanding of these charges. We are concerned that there is a false assumption that any facility billing is an "extra" charge, rather than the only means to pay for the building, staffing, and other costs. As described in the background section of our response, the facility fee component or bill is common and required for many hospital settings. There are overhead costs, such as the building, supplies and drugs, and staff that must be paid for in order for direct care to be possible, and that should be considered. As mentioned above, when a hospital bills an outpatient facility fee, professional services at hospital facilities are paid less than at freestanding sites in recognition that the professional billing also include a facility component, it is just not separately billed.

Thank you for the opportunity to comment. We welcome further discussion of these issues with experts in hospital operations and health care finance.

Sincerely,



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

Washington State Hospital Association

Washington State Medical Association
Physician Driven, Patient Focused

July 19, 2024

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

The Washington State Hospital Association (WSHA) and Washington State Medical Association (WSMA) offer the following comment on the importance of ensuring the benchmark data collected and analyzed by the Board is transparent and helps drive change in the health care delivery system. We are concerned that as presently designed, and absent an ability for providers to verify accuracy, the data on provider-specific annual increases will not be held in high confidence and, more importantly, will not be actionable for providers striving to make changes to meet the benchmark in the future. We have previously commented on this issue when addressing other topics but feel it's important to address this issue independently given its impact.

We appreciate the Board's staff hosting a webinar for providers on June 6 to explain the health care cost growth benchmark, provider attribution methodology, and the provider report template. The information was helpful but did not address provider concerns about the level of data specificity and the ability to verify the data. We encourage the Board to convene another meeting with providers to address additional issues.

Our understanding is that providers will receive the year-on-year growth rate of their adjusted total medical expense per member per month in each market and reporting year relative to the set benchmark. It will be difficult, however, to verify that the data are valid without knowing the following:

1. Which primary care providers are attributed to large provider entities and which covered lives are attributed to each primary care provider;
2. What portion of total spend was by the attributed primary care providers and what portion was by outside providers; and
3. Transparency of yearly age and sex variation adjustments, so providers can understand whether their mix of patients grew or decreased in complexity.

In addition, it would be helpful to know the spending for each attributable provider rather than simply an aggregate number. Even more useful would be to have the spending for each attributable provider separated by service category. This will help large provider entities understand the data and consider practice changes to promote cost-savings.

We think it would be worthwhile for the Board to convene one or more follow-up meetings with the targeted providers where they are asked specifically to provide additional comments on the template reports and possible modifications.

We hope the transparency in attribution can be done when the first results are released (with a document that shows which providers are assigned to which systems and which patients are assigned to each provider). We understand some of the additional requests on specificity would need to wait until the next cycle since the plan submissions themselves would need to be revised. We have heard additional requests from some of our members such as breakouts by geography, inclusion of the

number of visits, and ways to understand the severity of patients. We think this merits additional discussion for what is collected in future years.

We hope Washington can be a leader in its approach to benchmark reporting and that the Board will work to construct reports that can be both validated by the provider entity and used by the provider to engage in changing the health care system. Thank you for your consideration. We would be pleased to discuss any of the issues raised here.

Sincerely,

Katerina LaMarche, JD
Policy Director, Government Affairs
Washington State Hospital Association
katerinal@wsha.org

Jeb Shepard
Director of Policy
Washington State Medical Association
jeb@wsma.org

Tab 7

Washington State Health Care Authority

NOMINATING COMMITTEE & ADVISORY COMMITTEE UPDATES

OVERVIEW:

- **Nominating Committee**
  - *Meeting held on Wednesday, July 17*
  - *Confirmation votes on Advisory Committee Members:*
    - 1 new Health Care Stakeholder Committee member nominated (based on 1508 updates / committee expansion)
    - 1 new Data Issues Committee member nominated
- **Advisory Committee Application form** (review—are updates needed?)
- **Vote to adopt Nominating Committee recommendations**

HEALTH CARE STAKEHOLDER ADVISORY COMMITTEE NOMINEES (1508 UPDATE):

Number of members	Representing the interests of…	Selected from a list of nominees submitted by…
At least 2, including at least 1 small business representative	Employer purchasers: ➢ ***Michele Ritala*** represents businesses organizations, nominated by PBGH ➢ 20 years experience managing employee health benefits for up to 340,000 lives ➢ Currently works for King County Department of Human Resources	Business organizations

DATA ISSUES ADVISORY COMMITTEE NOMINEE:

➢ **David DiGiuseppe**

➢ Vice President of Health Care Economics at Community Health Plan of Washington (CHPW) a Washington-based not-for-profit managed care organization serving 300,000 Washingtonians through Apple Health (Medicaid), Medicare Advantage, and Cascade Select (WA's public option plan.)

➢ Also serves on the Universal Health Care Commission's Finance Technical Advisory Committee.

Michele Ritala, MPA

Experience Summary

- 20 years employee health benefits management for up to 340,000 lives
- Strengths: strategic planning, implementation, program management

Education

- Master of Public Administration, University of Washington Evans School, 2007
- Bachelor of Arts, Journalism, cum laude, University of South Carolina, 1985

Work History & Selected Accomplishments

King County Department of Human Resources: May 2019 - Present

Health Benefits Strategic Planner. Strategic planning, benefits bargaining, procurement, contracting, and evaluation of medical, pharmacy, dental, well-being, childcare, voluntary benefits for 34,000 lives.

Puget Sound Energy, Inc.: Aug. 2014 –2019

Health & Welfare Program Manager. Health benefits program management including medical, dental, wellness program and voluntary benefits.

- Replaced benefits consultant, wellness vendor, ACA reporting vendor, outsourced benefits enrollment processes, and transitioned retiree population to a private exchange—all within 5 years.

Washington State Health Care Authority, PEBB Program: 2004 – 2014

Manager, Strategy & Benefit Design (November 2012 - August 2014).

- Managed strategic planning process for PEBB's health benefits program offered to 340,000 public employees, retirees and dependents.
- Wrote strategic plan for PEBB's SmartHealth wellness program, resulting in Governor Inslee's Executive Order 13-06 establishing the first statewide wellness program offered to state employees.

Health Benefits Program Manager for PEBB (2009 - 2012).

- Managed multiple programs and projects for PEBB program including implementing three Consumer-Directed Health Plans in 2011. Managed UMP's Health Counts Wellness Program.

Communications & Appeals Manager, Uniform Medical Plan (UMP) 2004-2008

- UMP's CAHPS scores for member communications steadily improved from below the 50th percentile in 2004 to the 99th percentile in 2009.
- Received a "Plain Talk" award for the UMP Benefits Book from Governor Christine Gregoire for "making it easier for the public to do business with the State" in 2007.
- Improved 30-day decision response time on appeals from 64% to 95% in one year.

Health Policy Analysis Program (HPAP), University of Washington: 2000 – 2004

Communications/Events Manager for School of Public Health policy center. Disseminated health policy research findings via website, media relations, and public forums. Managed budget and logistics for the "Washington Health Legislative Conference" which attracted 700 attendees and featured up to 45 speakers annually. This conference was resumed by "State of Reform" after HPAP dissolved in 2004.

DAVID DIGIUSEPPE

HEALTHCARE FINANCE | ORGANIZATIONAL LEADERSHIP

Results-driven healthcare executive with 20+ years of experience leading strategic and operational initiatives across Medicaid, Medicare Advantage, and commercial insurance product lines. Proven track record in leveraging data analysis to improve operational performance and drive innovation.

LEADERSHIP & EXPERTISE SUMMARY

- Healthcare Economics: cost & utilization analysis, performance reporting, ROI
- Risk adjustment: chronic condition management and documentation, provider network partnerships
- Star ratings: data source enhancement, program management
- Product strategy and innovation
- Value-based care
- Organization-level strategic planning and execution

PROFESSIONAL EXPERIENCE & CONTRIBUTIONS

Community Health Plan of Washington & Community Health Network of Washington

Feb 2004-Present

CHPW is a not-for-profit health plan serving approximately 300,000 Medicaid beneficiaries, 15,000 Medicare Advantage members, and 25,000 public option/commercial members. CHNW is statewide network of 21 Federally Qualified Health Centers.

Vice President, Healthcare Economics (reporting to CFO) **May 2017-Present**

- Built team of 47 highly skilled and motivated FTEs across actuarial services, population analytics, risk adjustment, quality measurement and MA product strategy.
- Led initiatives improving MA performance in partnership with major clinic partners through intensive focus on chronic condition management and documentation, and star rating performance improvement.
- Implemented risk-adjustment performance components of, and supported clinic partners' performance in, multimillion-dollar value-based care arrangements.
- Designed processes to monitor and assess all components of the medical expense ratio - enrollment, revenue, and expense - including benchmark comparisons and deep dives into drivers of performance.
- Drove strategic vision for developing innovative third-party partnerships, setting business intelligence vision, conducting program evaluations, and implementing predictive modeling techniques.

Vice President, Population Health Management (reporting to CMO) **Nov 2015-Apr 2017**

- Promoted to lead QI and care management initiatives.
- Led successful NCQA re-accreditation effort.
- Restructured care management leadership to improve operational performance.
- Spearheaded integration of behavioral health into Medicaid managed care, opening company's first satellite office.

Director, Medical Management Program Development **Apr 2015-Oct 2015**

- Designed company's first risk stratification model and established population health management approach.
- Implemented innovative Model of Care pilot projects with clinic partners to close gaps in care.

SEATTLE, WA | (206) 550-7532 | LINKEDIN | DAVEDIGIUSEPPE@GMAIL.COM

DAVID DIGIUSEPPE

HEALTHCARE FINANCE | ORGANIZATIONAL LEADERSHIP

Director, Medicare Strategy **Mar 2013-Mar 2015**

- Led process to stabilize Medicare Advantage product line via improvements in product strategy.
- Designed an innovative in-clinic care gap closure program and forged new third-party vendor partnerships.

Director, Healthcare Economics **Aug 2012-Feb 2013**

- Chaired multi-department Healthcare Economics Workgroup, securing significant cost savings.
- Managed risk adjustment programs, commercial exchange product pricing, and MA bid submission.

Director, Strategy & Analytics **Jan 2010-Jul 2012**

- Prepared and delivered detailed cost & utilization opportunity analyses for each of 20 primary care network partners.
- Established corporate strategic planning and execution process.

Product Development Director **Nov 2007-Dec 2009**

- Evaluated and implemented new business opportunities.
- Directed implementation of integrated mental health pilot with government and academic partners.

Product Development Manager **Feb 2004-Oct 2007**

- Designed corporate product development process.
- Played key role in launching new Medicare Advantage product line.

EXTERNAL COMMITTEE PARTICIPATION (CURRENT)

- **Washington State Health Care Authority**
  - Universal Health Care Commission, Finance and Technical Advisory Committee
  - Healthcare Cost Transparency Board, Primary Care Advisory Committee
  - Multi-Payer Collaborative
- **Washington Health Benefits Exchange**, Technical Advisory Committee
- **Washington Health Alliance**, Health Economics Committee
- **HealthierHere (King County Accountable Community of Health)**, Finance and Audit Committee

EDUCATION & PUBLICATIONS

- **Master of Science in Health Services Research,** Case Western Reserve University
- **Bachelor of Arts in Economics,** University of Michigan
- Published 15 times in peer-reviewed journals including JAMA, Pediatrics and Health Services Research

SEATTLE, WA | (206) 550-7532 | LINKEDIN | DAVEDIGIUSEPPE@GMAIL.COM

Washington State Health Care Authority

Advisory Committee of Health Care Stakeholders

Members

Member	Title	Agency/Organization	Nominating Entity	Committee Member Position
Emily Brice	Deputy Director, NoHLA	Northwest Health Law Advocates (NoHLA)	Janet Varon, CEO of NOHLA	Consumer Organization
Patrick Connor	Washington State Director	NFIB	NFIB	Business organizations, least 1 small business representative
Bob Crittenden	Physician and Consultant	Empire Health Foundation	WA Academy of Family Physicians	One primary care physician, selected from a list of three nominees
Paul Fishman	Professor, Dept. of Health Services	University of Washington	Self-nominated	At least two members representing the interests of consumers
Justin Gill	President, Washington State Nurses Association	Washington State Nurses Association	Washington State Nurses Association	Washington State Labor Council
Adriann Jones	Graduate Student	Washington Community Action Network (WACAN)	John Godfrey, Community Organizing Manager WACAN	Consumer Organization
Jodi Joyce	Chief Executive Officer	Unity Care NW	Washington Association for Community Health	One member representing federally qualified health centers
Louise Kaplan	Associate Professor, Vancouver	WSU College of Nursing	ARNPs United of Washington State	One member representing advanced registered nurse practitioners
Stacy Kessel	Chief Finance and Strategy Officer	Community Health Plan of Washington	Association of Washington Health Care Plans	One member representing a managed care organization that contracts with

				the Health Care Authority to serve medical assistance enrollees
Eric Lewis	Chief Financial Officer	Premera Blue Cross	Washington State Hospital Association	One member representing hospitals and hospital systems
Vicki Lowe	Executive Director	American Indian Health Commission	American Indian Health Commission	One member representing tribal health providers
Natalia Martinez-Kohler	Chief Financial Officer	MultiCare Behavioral Health Network and South King Region	Washington Council for Behavioral Health	One member representing behavioral health providers
Sulan Mlynarek	Lead Research Analyst	Service Employees International Union (SEIU), Healthcare 1199NW	Washington State Labor Council	At least two members representing the interests of labor purchasers
Paul Schultz	Executive Director, Actuarial Services	Kaiser Foundation Health Plan, Inc (WA)	Peggi Fu, ED, Association of WA Health Plans	One member representing a health maintenance organization
Dorothy Teeter	Consultant	Teeter Health Strategies	Self-nominated	At least two members representing the interests of consumers
Wes Waters	Chief Financial Officer	Molina Healthcare of Washington	Association of Washington Health Care Plans	One member representing a health care service contractor

Washington State Health Care Authority

Former Members

Member	Title	Agency/Organization	Nominating Entity	Committee Member Position	Replaced By
~~**Ross Laursen**~~	Vice President of Healthcare Economics	Premera Blue Cross	Association of Washington Healthcare Plans		
~~**Justin Evander**~~	~~Executive Director Care Delivery Finance~~	~~Kaiser Permanente~~		~~One member representing a health maintenance organization, selected from a list of three nominees~~	Paul Schultz
~~**Todd Lovshin**~~					Eric Lewis
Nariman Heshmati	President	Washington State Medical Association	Washington State Medical Association	One physician, selected from a list of three nominees	

Vacancies

# Of members	Committee member position	Nominating Entity
1	One member representing pharmacists and pharmacies, selected from a list of three nominees	Washington State Pharmacy Association
1	One physician, selected from a list of three nominees	Washington State Medical Association
1	One member representing an ambulatory surgery center selected from a list of three nominees	Ambulatory Surgery Center Association
3	Three members, at least one of whom represents a disability insurer, selected from a list of six nominees	America's Health Insurance Plans

Washington State Health Care Authority

Advisory Committee of Data Issues

Member roster

Member	Title	Agency/Organization
Megan Atkinson	Chief Financial Officer	Health Care Authority
Christa Able	Division Director, Payer Strategy and Relationships	Virginia Mason Franciscan Health
Amanda Avalos	Deputy, Enterprise Analytics, Research, and Reporting	Health Care Authority
Jonathan Bennett	Vice President, Data Analytics, and IT Services	Washington State Hospital Association
Bruce Brazier	Administrative Services Director	Peninsula Community Health Services
Jason Brown	Budget Assistant	Office of Financial Management
Chandra Hicks	Assistant Director of Delivery System Analytics	Cambria Health Solutions
Leah Hole-Marshall	General Counsel and Chief Strategist	Health Benefit Exchange
Lichiou Lee	Chief Actuary	Office of the Insurance Commissioner
David Mancuso	Director, Research and Data Analysis Division	DSHS, Research and Data Analysis
Ana Morales	National Director, APM Program	United Healthcare
Hunter Plumer	Senior Consultant	HealthTrends
Mark Pregler	Director, Data Management and Analytics	Washington Health Alliance
Russ Shust	Senior Director of Medical Economics	OptumCare Washington
Mandy Stahre	Senior Forecast and Research Manager	Office of Financial Management
Julie Sylvester	Senior Consultant, Contracting and Payer Relations	University of Washington Medicine

Applying for a Health Care Cost Transparency Board Advisory Committee - June 2024

Based on direction from SSHB 2457 passed during the 2020 legislative session and updated in 2024 by the legislature in 2ESHB 1508 the Health Care Cost Transparency Board (Cost Board) is required to establish the following advisory committees (Committee) to advise and make recommendations as requested to the Cost Board on technical and policy issues.

The Cost Board's Advisory Committee on Data Issues is open to those who have experience and knowledge in health care data and is open to self-nomination. The Health Care Stakeholder Committee, with a few exceptions, are nominated by associations or groups that are called specified in the legislation above.

Introduction

Any person may nominate a qualified candidate(s) for one or more of the Cost Board committees. Self-nominations are also accepted. All nominations will be forwarded to the appropriate nominating body if required by law. HCA seeks nominees from various stakeholder and tribal perspectives, including but not limited to those with experience in the health care ecosystem by being a patient, consumer, provider/clinician, data professional, small or large group business purchaser, union trust, community-based organization, carrier, tribal entity and other groups that represent health care or the health care industry.

Nominee Qualifications

Nominees should have subject matter expertise in their field and must have experience and/or professional perspectives related to the specific topics assigned to the Committee for deliberation.

Nominations of qualified individuals must be emailed to HCAHCCTBoard@hca.wa.gov and include the following information and shouldn't be longer than one page double spaced 11 pt size font:

- Short biography;
- Short statement on how the nominee's experience and/or professional perspective relates to the committee for which the nominee is applying.
- Nominating entity
- Details of expertise (for Data Committee) or which area of membership based on membership list (for Stakeholder Advisory Committee)
- Reason for interest in serving
- Geographical location
- Representation of Washington's diversity

For more information about the Cost Board

The Cost Board will solicit nominations on a quarterly basis when there is a need to replace vacancies. To learn more information about the Cost Board, or to receive email notifications, please sign-up to be included on the mailing list at: Health Care Cost Transparency Board | Washington State Health Care Authority

Cost Board Health Care Stakeholder Advisory Committee Requirements

As indicated in House Bill 2457, section 4 and related RCWs, and updated House Bill 1508, the Advisory Committee of Health Care Stakeholders will be appointed by the Board. What follows is the language called out in both bills.

Appointments to the Advisory Committee of Health Care Stakeholders must include the following membership:

i. One member representing hospitals and hospital systems, selected from a list of three nominees submitted by the Washington State Hospital Association;
ii. One member representing federally qualified health centers, selected from a list of three nominees submitted by the Washington Association of Community Health Centers;
iii. One physician, selected from a list of three nominees submitted by the Washington State Medical Association;
iv. One primary care physician, selected from a list of three nominees submitted by the Washington State Academy of Family Physicians;
v. One member representing behavioral health providers, selected from a list of three nominees submitted by the Washington Council for Behavioral Health;
vi. One member representing pharmacists and pharmacies, selected from a list of three nominees submitted by the Washington State Pharmacy Association;
vii. One member representing advanced registered nurse practitioners, selected from a list of three nominees submitted by ARNPs United of Washington State;
viii. One member representing tribal health providers, selected from a list of three nominees submitted by the American Indian Health Commission;
ix. One member representing a health maintenance organization, selected from a list of three nominees submitted by the Association of Washington Health Care Plans;
x. One member representing a managed care organization that contracts with the Health Care Authority to serve medical assistance enrollees, selected from a list of three nominees submitted by the Association of Washington Health Care Plans;
xi. One member representing a health care service contractor, selected from a list of three nominees submitted by the Association of Washington Health Care Plans;
xii. One member representing an ambulatory surgery center selected from a list of three nominees submitted by the Ambulatory Surgery Center Association; and
xiii. Three members, at least one of whom represents a disability insurer, selected from a list of six nominees submitted by America's Health Insurance Plans.

As indicated in House Bill 1508, the Advisory Committee of Health Care Stakeholders shall also have the additional members:

i. At least two members representing the interests of consumers, selected from a list of nominees submitted by consumer organizations;

ii. At least two members representing the interests of labor purchasers, selected from a list of nominees submitted by the Washington state labor council; and
iii. At least two members representing the interests of employer purchasers, including at least one small business representative, selected from a list of nominees submitted by business organizations. The members appointed under this subsection (3)(p) may not be directly or indirectly affiliated with an employer which has income from health care services, health care products, health insurance, or other health care sector-related activities as its primary source of revenue.

Relevant experience and expertise in one or more of the following areas for the Data Issues Advisory Committee:

i. Knowledge and understanding of the health care industry, including the commercial insurance market, Medicaid, and other health care delivery systems
ii. Thorough knowledge and understanding of cost growth, data systems, and the different entities and complexities that make up the health care ecosystem.
iii. Understanding of means and methods for gathering data to annually calculate total health care expenditures and health care cost growth, and to establish the health care cost growth benchmark.
iv. Consumer perspectives and experiences with the high cost of health care.
v. Health equity

DISCUSSION & VOTE

- Any questions?
- Vote to approve recommended nominees

Tab 8

Washington State Health Care Authority

Strategies to Increase and Sustain Primary Care

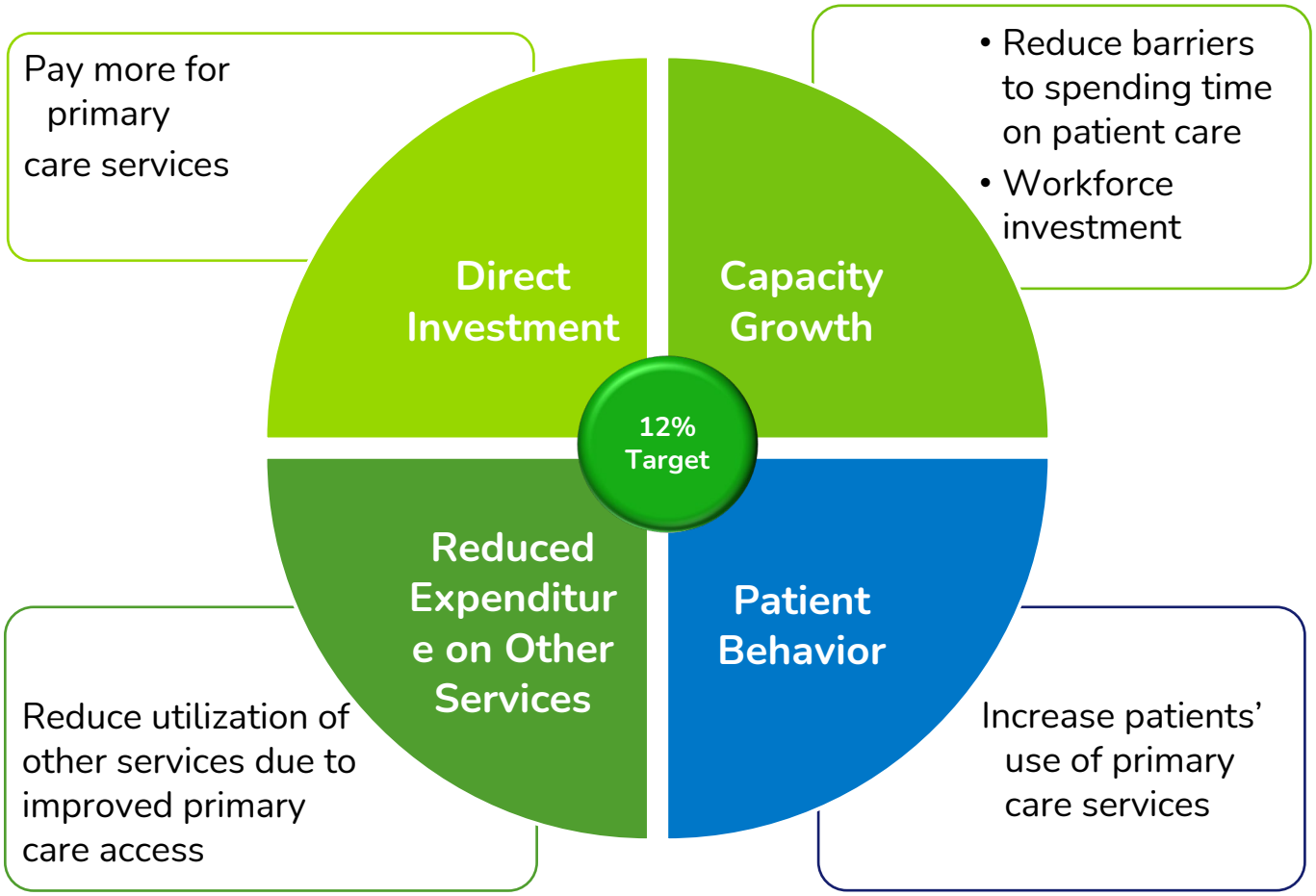
Background

- In 2022, the Legislature directed the Board to build on previous efforts to define and measure primary care spending, and to develop recommendations on how to achieve Washington's target to increase primary care expenditures to 12% of total health care expenditures.

Why increase primary care expenditures to 12% of total health care expenditures?

- Primary care is a fundamental component of the health care system.
- Primary care provides patients with an entry point into the health system, and a source of early detection and health management for chronic diseases.
- Research continues to show that access to primary care is associated with improved health outcomes, increased equity, and higher life expectancy by addressing health concerns early through health education and preventive services. Primary care delivery also results in lower health care costs by decreasing hospital utilization.
- Over time, expectations related to primary care service delivery have increased, while practitioners remain understaffed and underpaid compared to other medical specialties. This has led to multiple issues with primary care delivery, including sharp reductions in the primary care workforce, and limited access to care.
- Strong evidence supports the value of investing in primary care to deliver higher quality health outcomes and lower total health care costs.

Four key areas used to evaluate primary care expenditures



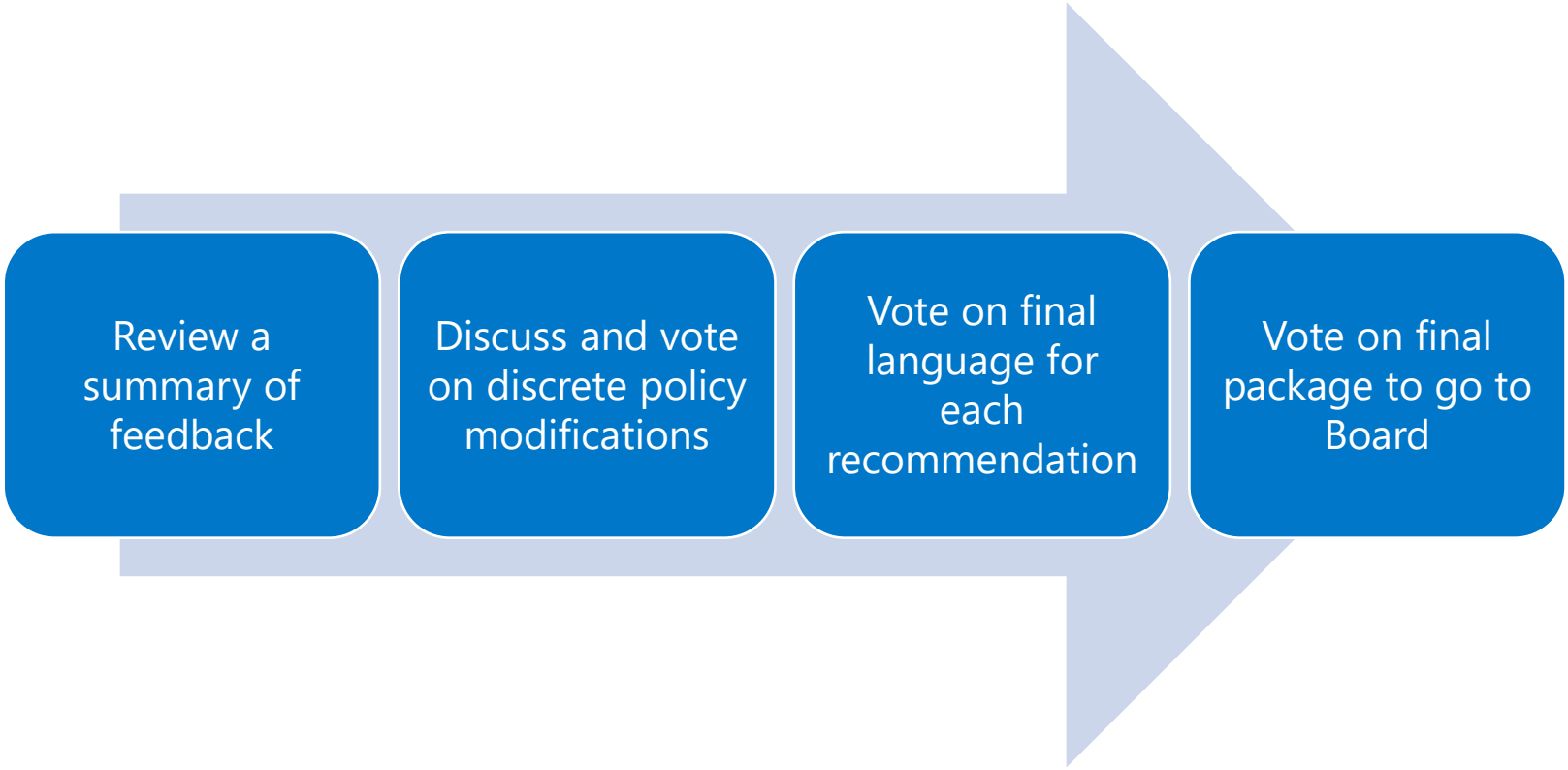
Policy development principles

- Policy recommendations should adhere to the following principles:
  - Unambiguous linkage between policy and achieving 12% primary care expenditure target
  - Clearly defined action and actors
  - Policies are financially, operationally, and politically feasible
  - Policies result in improved access and quality, not just expenditure

Current Policies HCCTB's Advisory Committee on Primary Care has been evaluating to increase and sustain investment in Primary Care.

1. **Increase primary care expenditures** as a percentage of total health care spending by one percentage point annually until a primary care expenditure ratio of 12% is achieved.
2. **Increase Medicaid reimbursement** for primary care to no less than 100% of Medicare no later than 2028.
3. **Multi-payer alignment policy** - support for the Multi-payer Collaborative's alignment efforts.
4. **Patient engagement policy** – payer and purchaser education and incentives to promote utilization of primary care and preventive services.
5. **Workforce development** – prioritize funding for state primary care workforce initiatives as collaboratively identified through the Health Workforce Council.
6. Following the 2024 reporting of primary care expenditures by HCP-LAN category, the **committee may make recommendations to the Cost Board for the portion of primary care expenditures that must be tied to alternative payment methodologies** for spending to count towards the expenditure growth target.
7. The Cost Board should **identify primary care expenditure targets that are based on per capita expenditures** instead of an aggregate ratio of 12% of total health expenditures.

Policy Finalization Process



Recommendation #1: Increase Primary Care Expenditures

- Recommend that the Legislature codify a goal to increase primary care spending by **two** percentage points per year.
- Recommend that the Legislature require agencies t publicly report primary care expenditure ratios of all carriers (HCA, HBE, OIC)
- Recommend that the Office of the Insurance Commissioner (OIC) submit a report to the Legislature by 2026 proposing how payers will be held accountable for achieving primary care expenditure targets, beyond publicly reported transparency measures. This report should include making recommendations for changes to the OIC's regulatory oversight authority if necessary.

Recommendation #1: Increase Primary Care Expenditures: Why is this important?

- Small increases in percent of total spend require significant increases in primary care reimbursement when holding utilization and total expenditures constant

- Total expenditures include many moving pieces.

- Ideally: Increasing primary care reimbursement would increase utilization of primary care services

- Increasing primary care access would decrease utilization of other service categories (e.g., emergency, inpatient)

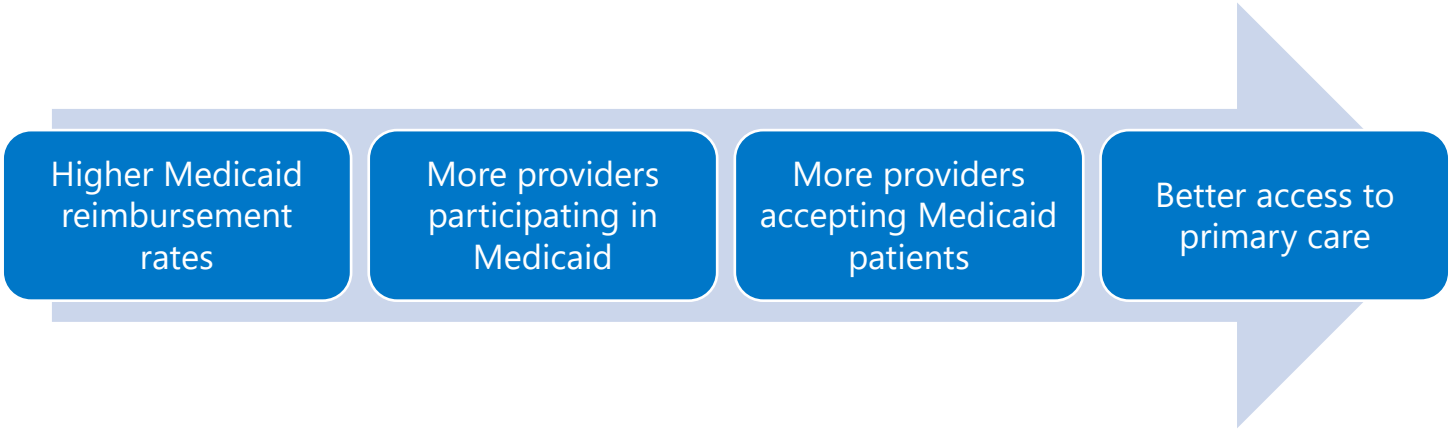
- Dynamic interactions impact primary care percentage of total expenditure

Recommendation #2: Increase Medicaid Reimbursement

- The Legislature should increase Medicaid reimbursement for primary care services to no less than Medicare rates by **2026**.
- **The Legislature should direct HCA to:**
  - **Implement the increase by using the Enhanced Adult Primary Care and Enhanced Pediatric fee schedules.**
  - **Revise those fee schedules to more closely align with the service codes in the Cost Board's adopted definition of primary care services.**
- **The payment rate for any services on the enhanced fee schedules already reimbursed at or above Medicare equivalent rates should not be changed.**
- The Legislature should implement the fee schedule increase no later than **2026**.

Recommendation #2: Increase Medicaid Reimbursement
Why is this important?

- Evidence suggests that the connection between higher reimbursement and better access is plausible.
- Evidence suggests that the connection between higher reimbursement and an increased ratio of primary care expenditures to total health expenditures is plausible.
- There may be additional positive effects for equity and workforce stability.



Recommendation #3: Multipayer Alignment

- The Committee **endorses:**
- The Multi-payer Collaborative's work in aligning standards, quality metrics, practice supports, and payment models.
- The Collaborative's efforts to align the Primary Care Transformation Initiative with the federal Making Care Primary program.
- Legislature advance multi-payer primary care alignment efforts, particularly for state-funded plans to participate in a Making Care Primary aligned transformation model.

Recommendation #3: Multipayer Alignment: Why is this important?

- Drive momentum toward a common direction with shared goals
  - Sharing of best practices and working together towards shared goals
- Reduce avoidable utilization and costs
  - Alignment of payment, quality, and data to promote larger improvements in practice performance
- Reduce burden for providers & payers
  - Use of common primary care definition, aligned requirements, coordinated supports to reduce burden
- Enact change for more than one payer's portion of patient population served by provider

Recommendation #4: Patient Engagement

The Committee **endorses**:

- HCA's efforts to participate in Making Care Primary and the Primary Care Transformation Initiative including support for pursuing resources for eligible primary care practices to grow capacity to provide comprehensive, whole person ~~primary~~ care.
- **Any state agency efforts to support availability of incentives for employee or member to access primary care services.**

Recommendation #4: Patient Engagement: Why is this important?

- Employers, insurance carriers, providers, and patients all have a role in patient engagement, which includes:
  - Seeking preventive care through primary care.
  - Actively participating in own care to increase the likelihood of successfully managing a condition at the primary care level.
- Patient engagement plays a critical role in improving health outcomes and can contribute to achieving the state's 12% primary care expenditure target when utilization of primary care services is encouraged.

Recommendation #5: Workforce Development

The Committee endorses Health Workforce Council recommendations that would increase access to primary care services.

Recommendation #5: Workforce Development: Why is this important?

- Workforce shortages create lack of access to primary care and burnout among primary care and other health care providers.
- Washington has fewer physicians per capita, including primary care physicians compared to the U.S. Of those Washington physicians, only 35% work in primary care who provide direct patient care, are not federally employed, and are under the age of 75.
- Patients lacking access to care due to shortages seek care in the ED which burdens hospital workforce.
- Behavioral health workforce shortages burden primary care clinics serving patients with complex behavioral health needs
- Shortages at long-term care facilities lead to discharge issues at hospitals.

Recommendation #6: Use of Alternative Payment Models

Endorse Health Care Authority (HCA) efforts to track and set targets for primary care expenditures using the Health Care Payment & Learning Action Network (HCP-LAN) Alternative Payment Model (APM) Framework categories, with the goal of increasing the percent of primary care expenditures paid through population based or shared financial risk-based payments. HCA will annually report expenditures by HCP-LAN APM category to any future Primary Care Advisory Committee with the intent of developing recommendations for a statewide APM expenditure targets and achievement timeframes, aligned with the HCP-LAN targets.

Recommendation #6: Use of Alternative Payment Models: Why this is important?

- Value -based payment (VBP) describes a range of payment strategies intended to contain costs while improving outcomes by tying payment to care quality.
  - VBP is typically accomplished through contracting between plans and providers. These contracts are called alternative payment models (APMs).
  - APMs tie payment for services to the quality of those services or create financial penalties or rewards for providers that spend more or less than anticipated.
  - There are a variety of types of APMs, detailed in the Health Care Payment Learning and Action Network (HCP-LAN) APM Framework.

Recommendation #7: Measurement Strategy

The Committee endorses an effort by HCA to measure expenditures both on a PMPM or per capita basis and primary care expenditures as a percent of total expenditures and to make future recommendations to improve primary care expenditure tracking based on any findings.

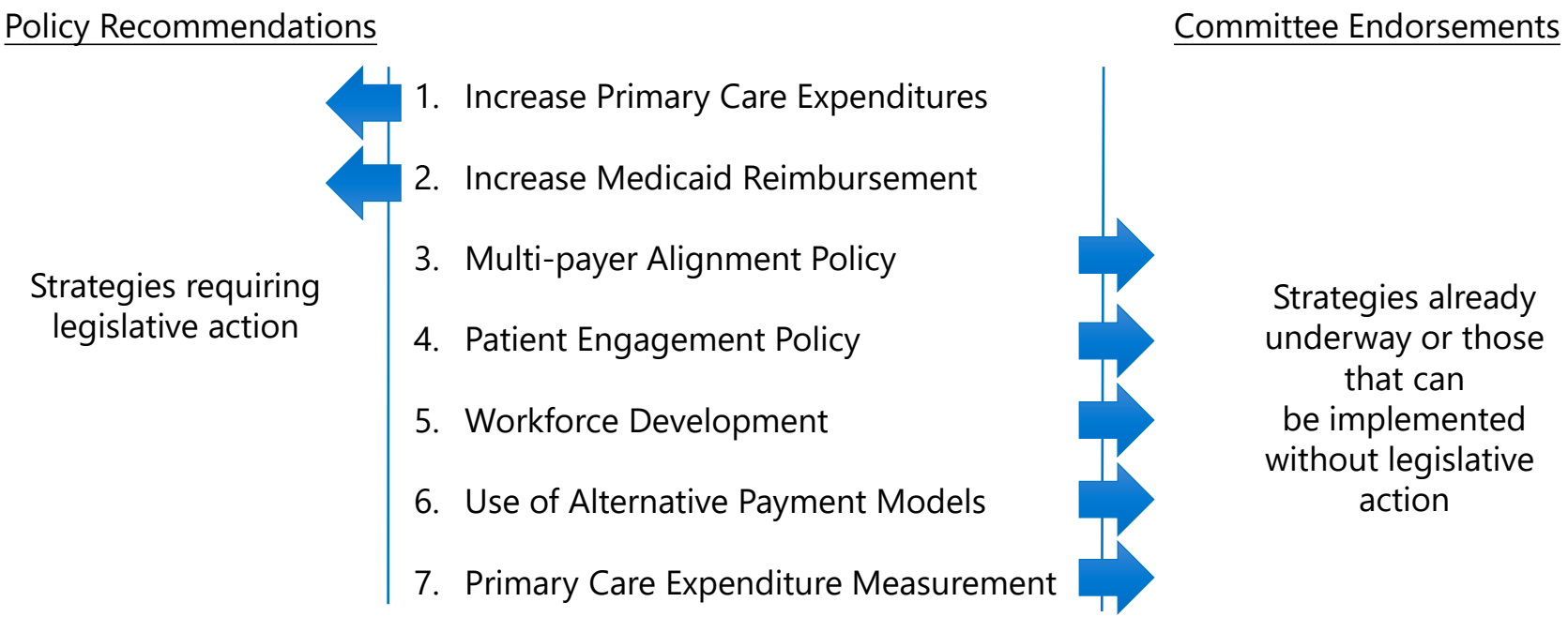
Recommendation #7: Measurement Strategy: Why is this important?

- When establishing the primary care expenditure target of 12%, the Legislature relied on the experience of other states
  - Rhode Island implemented similar policies
- A 12% expenditure target will drive investment in primary care:
  - Consistent with the statutory direction
  - But may not be the best target to use indefinitely
  - Changes in expenditures in other service categories (e.g.. Hospitals) would dictate the level of primary care investment independent of actual need
- WA could should transition to a per-member-per-month (PMPM) or per-capita expenditure target.
- When using these types of statistics, the amount of primary care investment needed to achieve the target would not be inappropriately influenced by changed in price and utilization of other services.

Recommendation Package

Potential Proposal Advancement Strategy

Staff recommendation: Instead of prioritizing 2-3 action items out of the 7, consider submitting a package where there are 2-3 action items and a suite of endorsements for other policies. The final recommendations and feedback have created a natural delineation between the two categories.



Questions?

Vote to adopt the recommendations of the Primary Care Advisory Committee

Appendix

Washington State Health Care Authority

Version 1 | July 2024 | hca.wa.gov

Analytic Support Initiative Preliminary Disease Expenditures Report

This Analytic Support Initiative (ASI) report for the Cost Board assesses health care spending by county, health condition, and type of care, while controlling for key demographic and epidemiological trends.

Washington State Health Care Authority

Analytic Support Initiative Preliminary Disease Expenditures Report

Version 1 | July 2024

The Analytic Support Initiative (ASI) is a collaborative effort between the Washington State Health Care Authority (HCA) and the Institute for Health Metrics and Evaluation (IHME), supported by a grant from the Peterson Center on Healthcare and Gates Ventures.

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About the Analytic Support Initiative

HCA and IHME were awarded a 2-year grant to leverage the Disease Expenditure Project's health care data expertise to inform the policy study of the Health Care Cost Transparency Board of Washington..

The primary goal of the Analytic Support Initiative (ASI) is to address the unsustainable rise in health care spending by providing policymakers with timely, actionable data and research to enhance access to quality, affordable care for Washington residents.

The ASI benefits from combining the HCA's in-house expertise in health care spending, state data, and policy with IHME's analytic capabilities. This partnership builds on Washington's existing efforts to improve health care affordability and transparency through the Health Care Cost Transparency Board (Cost Board). The Cost Board, comprised of public and private purchasers and health care experts, aims to analyze total health care expenditures, identify drivers of cost growth, establish benchmark growth rates, and pinpoint providers and payers exceeding the benchmark.

The ASI's contributions are intended to complement several other data initiatives supporting the Cost Board. These include setting and measuring performance against the cost growth benchmark, the cost drivers analysis, the primary care spending analysis, hospital cost and profit analysis, and the overall consumer and affordability initiative. The value add of the ASI is its analysis of the Washington All-Payer Claims Database, ability to complete county-level analyses, and ability to tie underlying disease prevalence to spending estimates.

Figure 1: Data initiatives supporting the Washington Health Care Cost Transparency Board

	Cost growth benchmark	Performance against benchmark	Cost driver analysis/cost experience	Primary care spend measurement	Hospital cost, profit, and price analysis	Analytics support initiative	Consumer and affordability
Description	The ceiling/goal for the growth of spending on health care year over year.	Assessment of cost growth against the benchmark target.	Assessment of key drivers of cost growth.	Measurement of expenditure on primary care in relation to overall health care expenditure.	Hospital financial analysis to create cost, price and profit trends.	Analysis of the drivers of WA health care cost growth by University of Washington's IHME. IHME will use its deep analytic capacity as well as expertise in data integration.	The ability for a consumer to afford their health care insurance.
Data sources	Reported through benchmark data collection from carriers and providers.	Reported through benchmark data collection from carriers and providers.	Washington All Payer Claims Database.	Washington All Payer Claims Database.	Medicare Cost Report Data.	Connecting findings to the health care cost transparency board's key priorities.	Survey results gathered from external sources such as KFF, BRFSS, Altarum, etc., giving context to aforementioned datastreams.

About this report

Through a series of data views, the ASI will give the Cost Board useful data to estimate and understand drivers of historical health spending in the state of Washington.

This report is a product of the ASI for the Cost Board. It assesses health care spending with stratification by county, health condition, and type of care at a granular level while controlling for key demographic and epidemiological trends. The analytics that support this report were developed from previous research conducted by the Institute for Health Metrics and Evaluation for the Disease Expenditure Project (DEX). These existing estimates are being leveraged to (a) provide information about health care spending to the Cost Board, and (b) to facilitate Cost Board discussion regarding the type of future analysis that the ASI can complete. The ASI will provide materials to the Cost Board in an iterative fashion.

This initial report was developed for, presented to, and edited based on feedback from ASI's key advisors and the Cost Board during the first half of 2024. An updated version of this report will be available to the Cost Board in late 2024. That report will be built from the Washington All-Payer Claims Database extending through at least 2022. Future analyses will address trends over time, quantify attributable drivers of health care spending, and explore factors associated with key drivers of spending growth.

Data source and methods

Using various data sources such as claims and administrative data, DEX modeling produces granular health condition-and county -specific estimates of health care spending.

The IHME Disease Expenditure (DEX) Project generates estimates of health care spending and encounters for each US county for 2010-2019 stratified by age, sex, type of care, payer, and health condition. These estimates are generated using a four-step process. The first step entails collecting and harmonizing data from various sources, including 45 billion insurance claims billed to Medicare, Medicaid, and private insurance companies (including data from Health Care Cost Institute, Kythera, Fluent, and Marketscan). In Washington, 552 million claims and 33 million administrative records were used for 2010 through 2019 to inform these estimates. The DEX project also uses hospital administrative data, from the Healthcare Cost and Utilization Project, and survey data from the Medical Expenditure Panel Survey. The second step of the DEX project involves assigning each claim or encounter to one of 148 health conditions, while the third step focuses on adjusting for data imperfections, such as reallocating spending for comorbidities that increase costs. Additionally, a small area model is employed to estimate utilization and spending in geographic areas with limited input data. In the fourth step, the estimates are scaled to ensure internal consistency across county, state, and national levels, and alignment with official U.S. government estimates of health care spending.

These estimate are slated to be updated to reflect the integration of WA-specific APCD data as well.

Estimates produced for the DEX project include spending on seven types of care – ambulatory care, hospital inpatient care, retail-prescribed pharmaceutical, nursing facility care, home health care, emergency department care, and dental care – from

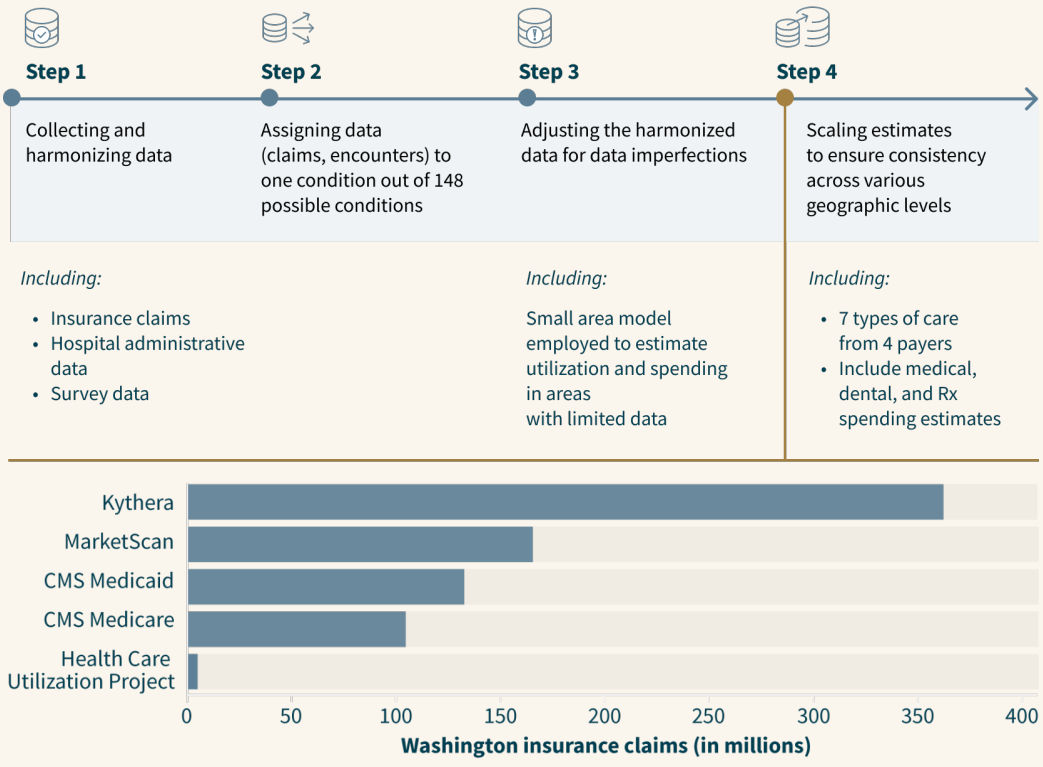
Across seven types of care, four payer categories, DEX estimates use disease and location-specific attribution methodology to assess spending levels over time, space, and disease.

four payers – private insurance, Medicare, Medicaid, and out-of-pocket spending. Spending on over-the-counter drugs, durable medical equipment, public health, and from Tri-care, Indian Health Services, and Veterans Affairs are excluded. These estimates include medical, dental, and prescribed pharmaceutical spending estimates. For prescribed retail pharmaceuticals, we track spending paid by the patient or third -party payers (i.e. insurance companies) prior to any rebates or discounts being provided. Finally, the disease-specific spending estimates highlighted in this report are spending that has been attributed to each health condition. It is not based merely on the primary diagnosis, but rather when a health condition is a secondary diagnosis but leads to excess spending on the primary diagnosis, that excess spending is attributed to the secondary diagnosis.

Unless otherwise indicated, all estimates in this report are extracted from the existing IHME DEX project database. The second report of the ASI will include additional Washington-specific data and custom analytics for the Cost Board.

In this report, all estimates are reported in nominal currency, meaning they are not adjusted for inflation. Age-standardization is conducted using direct age-standardization, relative to the 2019 national or Washington age-profile. Rates of change are all annualized, so they are comparable across different length time periods. Decomposition of variation or change across time was calculated using demographic decomposition methods based on Das Gupta (1993).

Figure 2: DEX Project data sourcing



Source: *IHME Disease Expenditure (DEX) Project*

Executive summary

This report provides an analysis of health care spending in Washington state from 2010-2019 based on the Institute for Health Metric and Evaluation's DEX Project. In 2019, the DEX project assessed $51.2 billion of health care spending in Washington, which amounted to $6,715 per person. (See Data Source and Methods section above regarding what is specifically included and excluded from this estimate.) This is 7% less than the DEX project's estimate of national spending per person, which is $7,201. Across the 50 states and the District of Columbia, Washington was the state with the 16th lowest spending per person. However, when age-standardized to account for the state's younger population, Washington's spending per person positioned it as the 18th lowest state. The findings outlined in the remainder of this report substantiate and build upon the results from other analytic efforts by the Health Care Cost Transparency Board.

WA healthcare expenditure shows growth in line with national average in aggregate, but reveals material variation by type of care, location, and payor type.

Between 2010 and 2019, total per person spending increased to $6,715. The specific health conditions with the greatest increase in spending included oral disorders, type 2 diabetes, joint pain, skin and subcutaneous disease, and lower back and neck pain. Ambulatory care was the spending category with the greatest spending increase, growing by $7.0 billion between 2010 and 2019.

The DEX project showed that ambulatory care, which includes all outpatient care regardless of whether it is provided in a hospital, clinic, or surgical or rehabilitation center, emerged as the dominant category, constituting 48% of the total spending, amounting to $24.6 billion. The report highlights the significant role of private insurance, contributing 46% of total spending, with the majority allocated to ambulatory and inpatient care. The DEX project estimated that out-of-pocket spending reached $5.7 billion in 2019, covering expenses like deductibles and co-pays.

The DEX project estimated that between 2010 and 2019, Washington had an overall spending increase of $17.1 billion, reaching $51.2 billion. Even after adjusting for population size increases, health care spending increased above and beyond the inflation rate. Ambulatory care witnessed the most substantial increase, fueled by population growth, an aging population, and higher spending per visit. Hospital inpatient care also saw significant growth, mainly attributed to increased spending per admission.

The report further delves into spending variations based on health conditions, with the DEX project identifying oral disorders[1], type 2 diabetes, hip and knee pain and other musculoskeletal disorders, skin and subcutaneous diseases, and lower back and neck pain as the top five conditions with the highest attributable spending[2]. Notably, hip and knee pain and other musculoskeletal disorders exhibited a substantially higher annualized growth rate compared to other top conditions.

Policies with strongest interest for HCCTB recommendations in 2024: Price growth caps and provider rate setting, limiting facility fees, restricting anti-competitive clauses in health care contracting, and review of mergers and acquisition, private equity, and health care facility closures.

Furthermore, the analysis explores spending variations within Washington, showcasing significant disparities across counties. The DEX project showed that Columbia, Garfield, and Pacific counties exhibited the highest spending per person, while Franklin, Whitman, and Adams counties demonstrated the lowest. The report provides a detailed breakdown of spending differences, highlighting the drivers of spending changes and offering valuable insights into the dynamics of health care expenditures at both the state and county levels. This report highlights the role prices play in driving increases in health care spending in Washington and supports the call for many of the policies being considered by the Washington Health Care Cost Transparency Board, including price growth caps and provider rate setting, restricting anti-competitive clauses in health care contracting, review of mergers and acquisitions, and limits on facility fees in some areas.

[1] This report includes medical spending on dental care as well as dental care spending (i.e. spending through dental insurance). The category of oral disorders includes treatment of dental caries, dental surgery, and orthodontia, among other categories associated with non-preventative dental treatments.

[2] In this research we reallocate spending on a claim to the health condition determining the amount of spending. When a comorbidity (a co-occurring disease that isn't the primary diagnosis) exacerbates spending the excess spending is attributed to the comorbidity, not the primary diagnosis.

Connecting findings to the Health Care Cost Transparency Board's key priorities

One of the initial and explicitly legislated tasks of the Cost Board was to establish total health spending growth targets. These targets are meant to be a goal for individual payers and providers to aim for and in later years the Cost Board will hold payers and providers accountable for reaching these targets. The benchmark growth targets established by the Cost Board range from 3.2% to 2.8% (Figure 3). These are growth targets for total aggregate expenditure on health, including claims-based and non-claims-based expenditures.

Figure 3: Washington State benchmark growth targets

Year of release	Timeline of included data	Data included
Late 2023	2017 – 2019	State and market data only; the Board will not publicly report insurance payer or provider cost growth for this period
Late 2024	2020 – 2022	For large provider entities* and payers, with cost growth target of 3.2%
Late 2025	2022 – 2023	For large provider entities and payers, with cost growth target of 3.2%
Late 2026	2023 – 2024	For large provider entities and payers, with cost growth target of 3.0%
Late 2027	2024 – 2025	For large provider entities and payers, with cost growth target of 3.0%
Late 2028	2025 – 2026	For large provider entities and payers, with cost growth target of 2.8%

**Large provider entities will be determined using 2017-2019 as a historical baseline.*

Source: *Washington Health Care Authority*

In late 2023, the Washington Health Care Authority provided a first report against these state benchmarks. The report showed that the total health care spending in Washington increased by 7.2% from 2017 to 2018, and 5.8% from 2018 to 2019. The reports also showed that when measured in terms of per member per year, growth was slowest for Medicare spending (2.9% per year in 2019), higher for private insurance (4.0%), and highest for Medicaid (11.9% in 2019), reflecting legislative investments in that program.

The DEX project builds on the HCA findings by providing increase granularity regarding age, health conditions, and county.

Findings from the DEX project, outlined in the remainder of this report, substantiate, and build upon the findings from HCA's report. Using different data sources and measuring slightly different quantities (the DEX project includes nursing facility care and out-of-pocket spending), the DEX project comes to many of the same conclusions but provides increased granularity by also assessing spending by age, health condition, and county.

This initial report and the initial Analytic Strategy for the ASI, approved on December 7, 2023, align well with the efforts of Health Care Cost Transparency Board (the Board) to control the growth of health care costs in Washington. At the Board retreat held on February 9, 2024, members discussed and were polled on what policies would be the focus for further discussion in 2024. The following four strategies received the strongest interest.

1. Price growth caps and provider rate setting
2. Limiting facility fees
3. Restricting anti-competitive clauses in health care contracting
4. Review of mergers & acquisition, private equity, and health care facility closures

Capping price growth is a method to curtail health care spending increases far in excess of inflation and wage growth, relying on oversight and enforcement mechanisms to incentivize cost savings. Along similar lines, provider rate setting is a more direct method to control spending setting payment levels of services across providers. This approach lowers the administrative burden for providers and carriers by eliminating the need for negotiations and streamlining claims processing. Together, these concepts have garnered the strongest interest from the Board.

The policies under review by the Board require detailed regional and driver-focused analysis of health care spending, and the ASI framework can help identify areas for further examination and targeted improvement.

Critically, by providing granular estimates of spending, this project offers insights into how these specific policies could be leveraged to contain the growth of health care costs. Figure 10 highlights that the primary reason for spending increases over time in the state, other than increases in the population size and age, are related to increases in price and intensity of care. Increases in price and intensity led to increases in spending across all types of care except emergency department care. In ambulatory care and inpatient care, increases in price and intensity led to an increase in annual spending of $6.4 and $1.9 billion between 2010 and 2019.

Looking ahead to 2024, the impacts of the policies of most interest to the Board will be examined by a broad set of analytic efforts. The data products produced by the ASI project will take a more comprehensive examination of pricing by in-corporating data from the HCA's All Payer Claims Database. Building on the solid foundation of IHME's nationally focused DEX project, the ASI analysis will generate valuable insights with a report and data products specific to Washington. The baseline analysis will generate state- and county-level health care spending estimates across 148 health conditions and four payer categories. These estimates will also be adjusted by leveraging demographic and disease prevalence data, examining drivers by county and examining specific extraordinary spending when identified. An interactive dashboard will leverage the estimates produced in the ASI analysis to highlight the impact of policies of most interest to the Board. Together, the report and dashboard will offer in-depth examination of spending across markets, equipping the Board with needed information to evaluate policies which could curb the growth of health care spending in Washington.

Data summary

Health care spending in Washington state in 2019

Washington state's performance, in aggregate, is middle-of -the-pack versus national comparators – but is beginning to face headwinds given an aging population.

The distribution of expenditure in Washington State is consistent with national trends – with outpatient expenditure representing the bulk of expenditure v. other sites of care. Growth in this broad category represents a combination of factors – including progress in shifting services historically exclusive to inpatient setting (e.g, changing mix of services), rising prices for the same services, and growing volumes.

While the plurality of spend still sits within private insurance markets, it is worth noting the rising per capita costs of Medicare – which lead all payers – suggests a sustainability challenge in the future.

Adjusting for age, Washington ranks 18th lowest among US states in age-standardized health care spending per person..

In 2019, the DEX project estimated $51.2 billion was spent on health across seven types of care - hospital inpatient care, ambulatory care, emergency department care, pharmaceuticals, nursing facility care, home care, and dental care – in Washington.[3] This was $6,715 per person. During the same year, the DEX project estimated that national spending on the same types of care was $7,201 per person on the same types of care. Across the 50 states and the District of Columbia, Washington was 16th least and less than California, Oregon, and Montana. Washington has a relatively young population. Since spending increases with age, a fairer state comparison uses age-standardized spending per person. Age-standardized spending reports what spending in the state would be if Washington had the same age profile as the US as whole. Once age-standardized, Washington has the 18th lowest spending amount across the US (Figure 4).

[3] Spending on durable medical equipment, over-the-counter drugs, R&D and other investments, and spending on public health are excluded from these estimates.

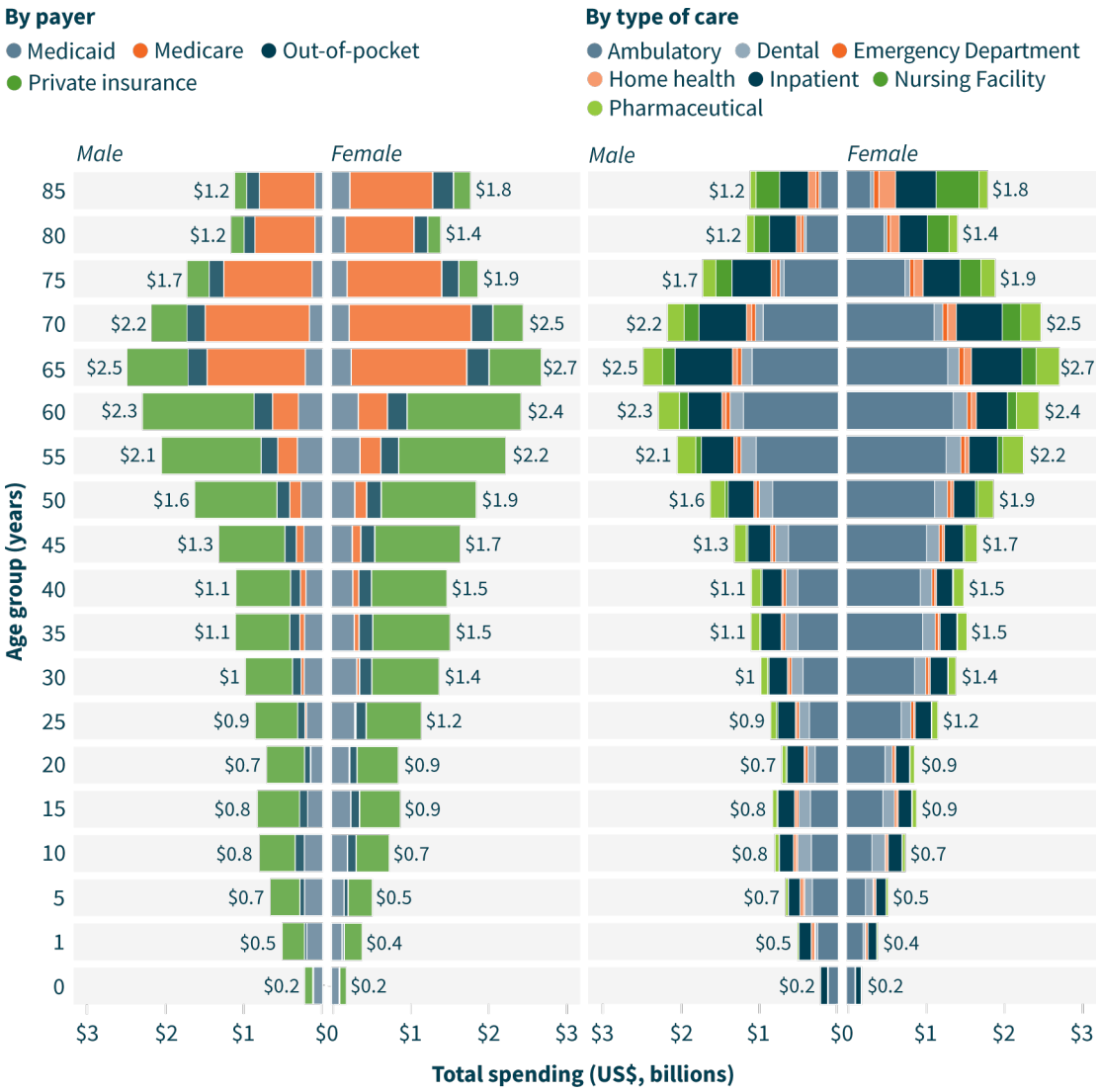
Figure 4: State-level per-capita spend and growth performance

Source: *IHME Disease Expenditure (DEX) Project*

Health care costs increase with age, peaking at $23,115 per year for males and $21,809 for females aged 85+.

As it is in all US states, health care spending in Washington is greater for individuals as they age, with the DEX project showing that spending per person in Washington state reached $23,115 per year for males 85 and older and $21,809 for females 85 years and older (Figure 5). At the oldest age group, the most spending is on nursing facility care and ambulatory care, with a great amount of spending on hospital in patient care as well. Despite spending going up with age, there is more spending in Washington on 60- to 64-year-olds than any other age group. While there are fewer people in the oldest age groups, it is also true that there is a dramatic shift in spending at 65 from spending on private insurance, which tends to have higher prices, to Medicare, which has lower prices.

Figure 5: Healthcare spending across age groups across payer and type of care, 2019



Source: *IHME Disease Expenditure (DEX) Project*

Ambulatory care had the highest spending at $24.6 billion (48%).

Private insurance was the largest payer at $23.6 billion (46%).

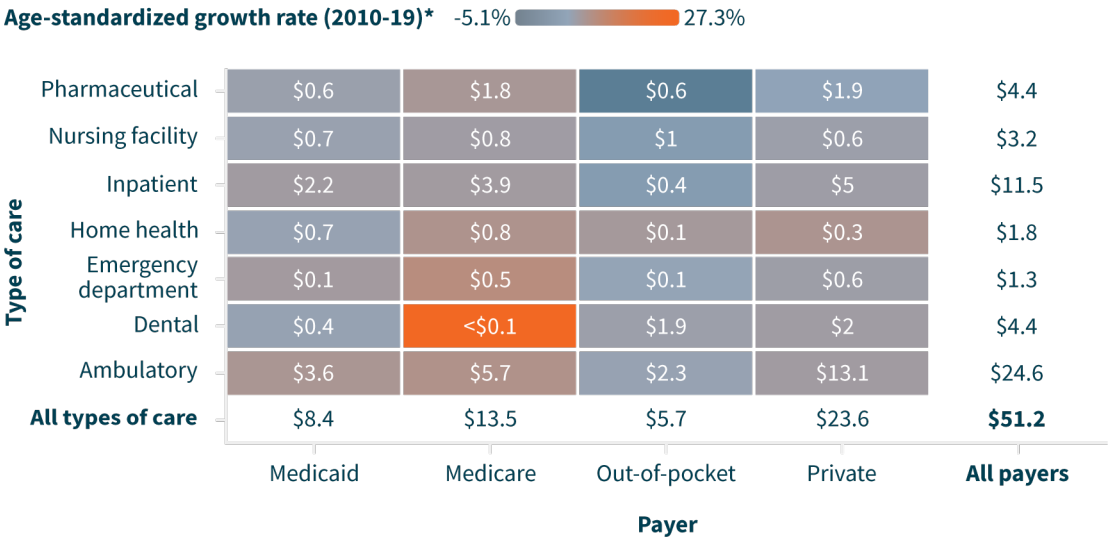
Across the seven types of care analyzed, the DEX project reports that more was spent on ambulatory care than any other type of care - $24.6 billion in 2019. This is 48% of the spending considered in this study. The type of care with the second most spending was hospital inpatient care, which has $11.5 billion or 22% of the total. The DEX project shows that more than $4 billion was spent on both prescribed retail pharmaceutical[4] and on dental care. $3.2 billion was spent on nursing facility care, while less than $2 billion was spent on emergency department care and home health care (Figure 6). Across the seven types of care analyzed, the DEX project reports that more was spent on ambulatory care than any other type of care - $24.6 billion in 2019. This is 48% of the spending considered in this study. The type of care with the second most spending was hospital inpatient care, which has $11.5 billion or 22% of the total. The DEX project shows that more than $4 billion was spent on both prescribed retail pharmaceutical[4] and on dental care. $3.2 billion was spent on nursing facility care, while less than $2 billion was spent on emergency department care and home health care (Figure 6). Across the payers included in the DEX project,[5] nearly half of the spending was from private insurance companies - $23.6 billion or 46%. Most of this spending was on ambulatory care (56%) and inpatient care (21%). $13.5 billion or 26% of the spending was from Medicare, with the most spending on ambulatory care, but a relatively large share on hospital inpatient care as well.

The DEX project tracked $8.4 billion in Medicaid spending, which was 16% of the total. Like Medicare, ambulatory care was the type of care with the most spending, but relative to private insurance, a great deal was spent on hospital inpatient care, and relative to all other payers, a large share of spending was on nursing facility care. Finally, $5.7 billion was spent out-of-pocket. This includes spending on deductibles and co-pays, and by those without insurance. While more out-of-pocket spending was on ambulatory care than any other type of care, there were relatively large amounts of spending on dental care and nursing facility care.

[4] Prescribed pharmaceuticals administered in a facility such as a hospital or clinic are included in other types of care, such as hospital inpatient care and ambulatory care, respectively. They reflect what was paid for the drugs and do not include pharmaceutical rebates or discounts.

Figure 6: Total spending by payer and type of care, 2019

The dollar values in the heatmap correlate to total spending (billions, US$) by payer and type of care, while the box colors correlate to the age-standardized growth rate



**Not adjusted for inflation*

Source: *IHME Disease Expenditure (DEX) Project*

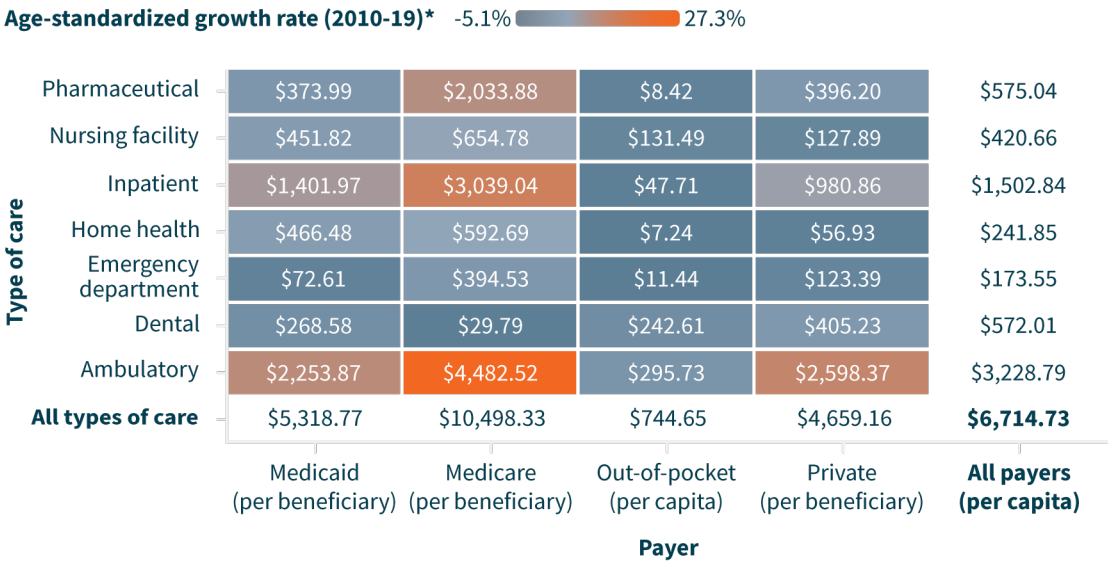
While the payer category with the most spending in Washington was private insurance, Medicare spending per beneficiary was much larger – and remained consistently so across all types of care (with the exception of dental care) – than every other payer (Figure 7). Medicare spending was $10,498 per beneficiary, while Medicaid spending as $5,319 per beneficiary and private insurance spending per beneficiary was only $4,659.

Figure 7: **Spending per beneficiary by payer and type of care, 2019 --** Medicare, Medicaid, and private insurance per beneficiary, out-of-pocket spending is reported in per person terms.

The dollar values in the heatmap correlate to spending per beneficiary by payer and types of care, while the box colors correlate to the age-standardized growth rate

Medicare spending per beneficiary was the highest at $10,498 - through a combination of pharma, inpatient, and ambulatory spend.

Out of pocket costs, in turn, are largely driven by spending in ambulatory, dental, and nursing facility expenditure.



*Not adjusted for inflation

Source: *IHME Disease Expenditure (DEX) Project*

Data summary

Changes in health care spending in Washington state: 2010-2019

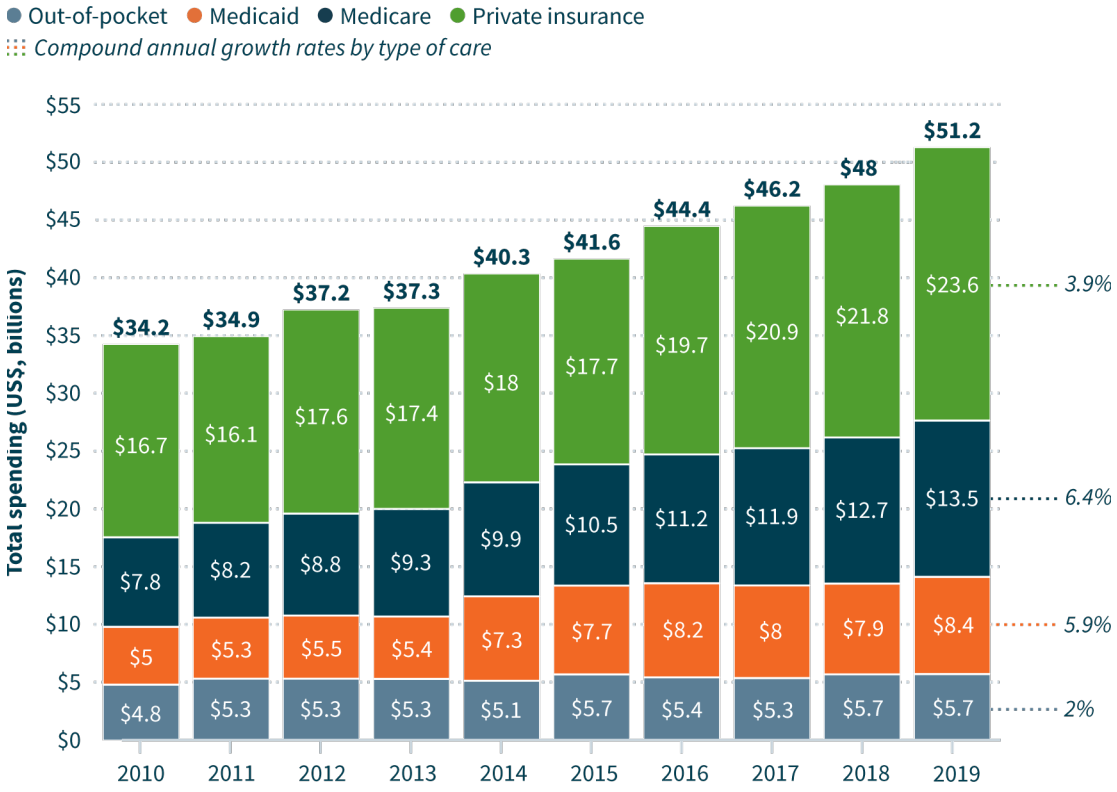
An absolute growth rate of 4.6% observed – above the established target of 3% - has been driven by a growth in Medicaid and Medicare – especially in ambulatory settings.

Furthermore, with the exceptions of Dental services and Nursing facility services – most of the growth observed has been driven by rising prices and intensity of care.

The market growth of price and intensity in the private insurance marketplace over this period may also translate into challenges around affordability observed in outpatient OOP expenditure growth – raising potential avenues of inquiry around non-covered expenses that may be worth further examination.

The DEX project estimated that from 2010 to 2019, spending steadily increased with overall growth of $17.1 billion, from $34.1 billion in spending to $51.2 billion (Figure 5). During this time, private insurance spending decreased from 49% of the total to 46%, and Medicare spending increased from 23% to 26% and Medicaid spending increased from 14% to 16%. spending across all payor types (Figure 8) and types of care (Figure 9).

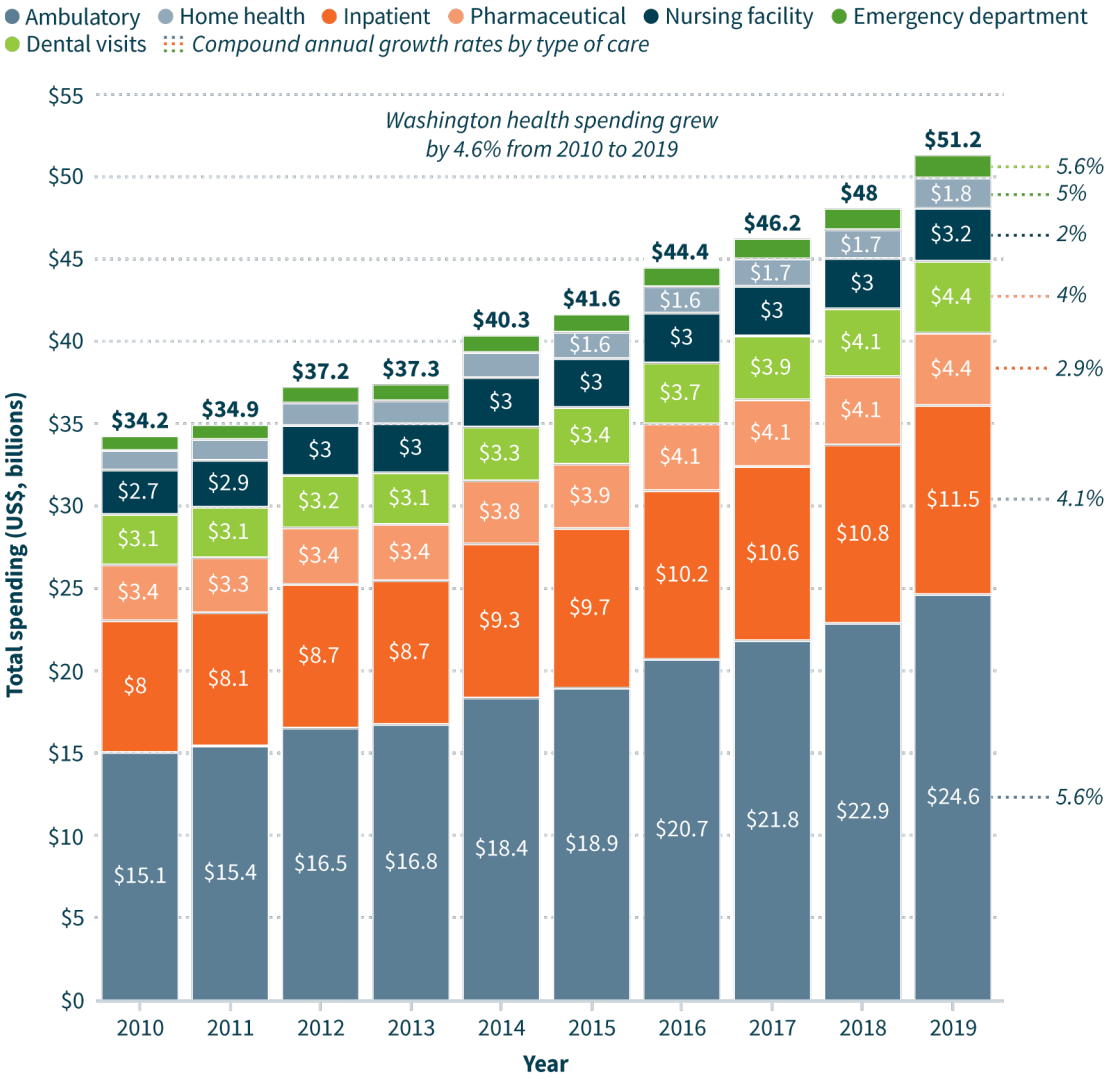
Figure 8: Total spending in Washington by payer, 2010-2019



Source: *IHME Disease Expenditure (DEX) Project*

The largest increase in spending was in ambulatory care, which rose by $9.6 billion.

Figure 9: **Total spending in Washington by type of care, 2010-2019**

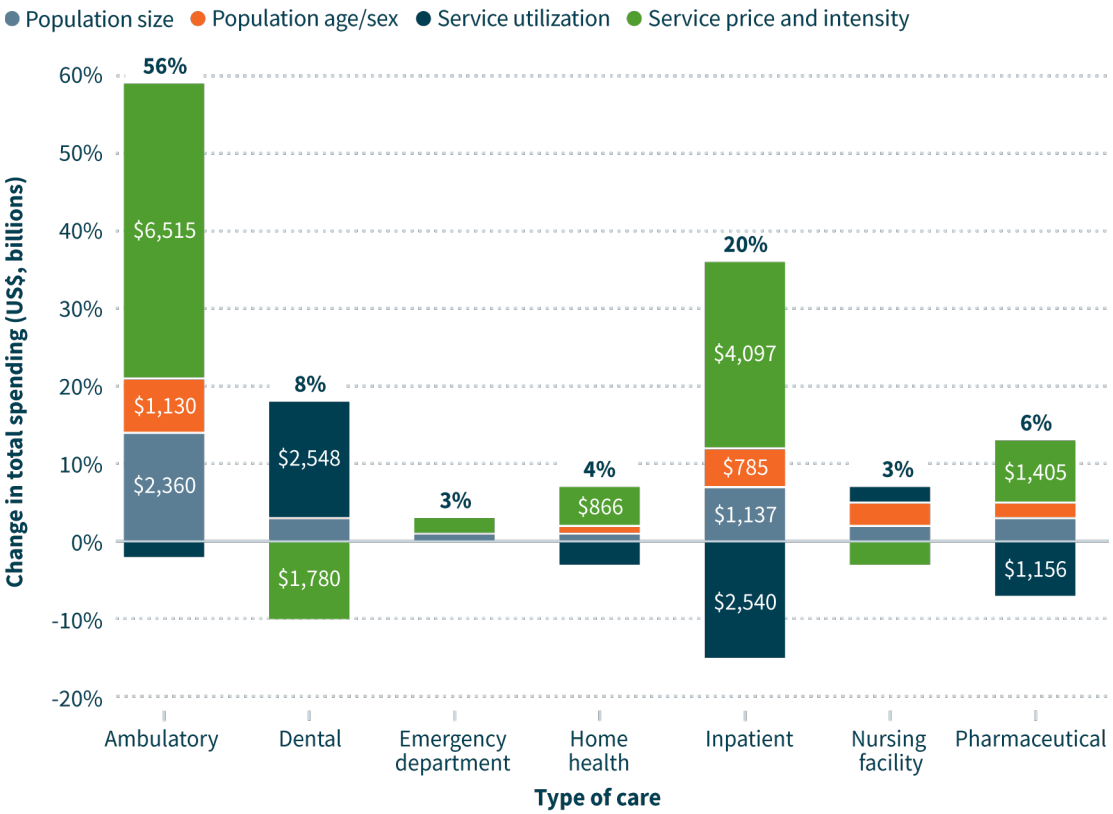


Source: IHME Disease Expenditure (DEX) Project

The DEX project estimated spending in Washington increased between 2010 and 2019 at an annualized rate of 4.6% (Figure 10). During this same period, the US increased at an annualized rate of 3.9%. Of the 50 states and the District of Columbia, Washington had the twenty-first largest growth rate.

Figure 10: **Contribution of drivers to expenditure growth, 2010-2019**

Percents are a portion of the total growth in expenditure observed from 2010-2019.



Growth in price and intensity explain the majority of growth observed, offsetting progress shifting sites away from high-acuity, inpatient settings.

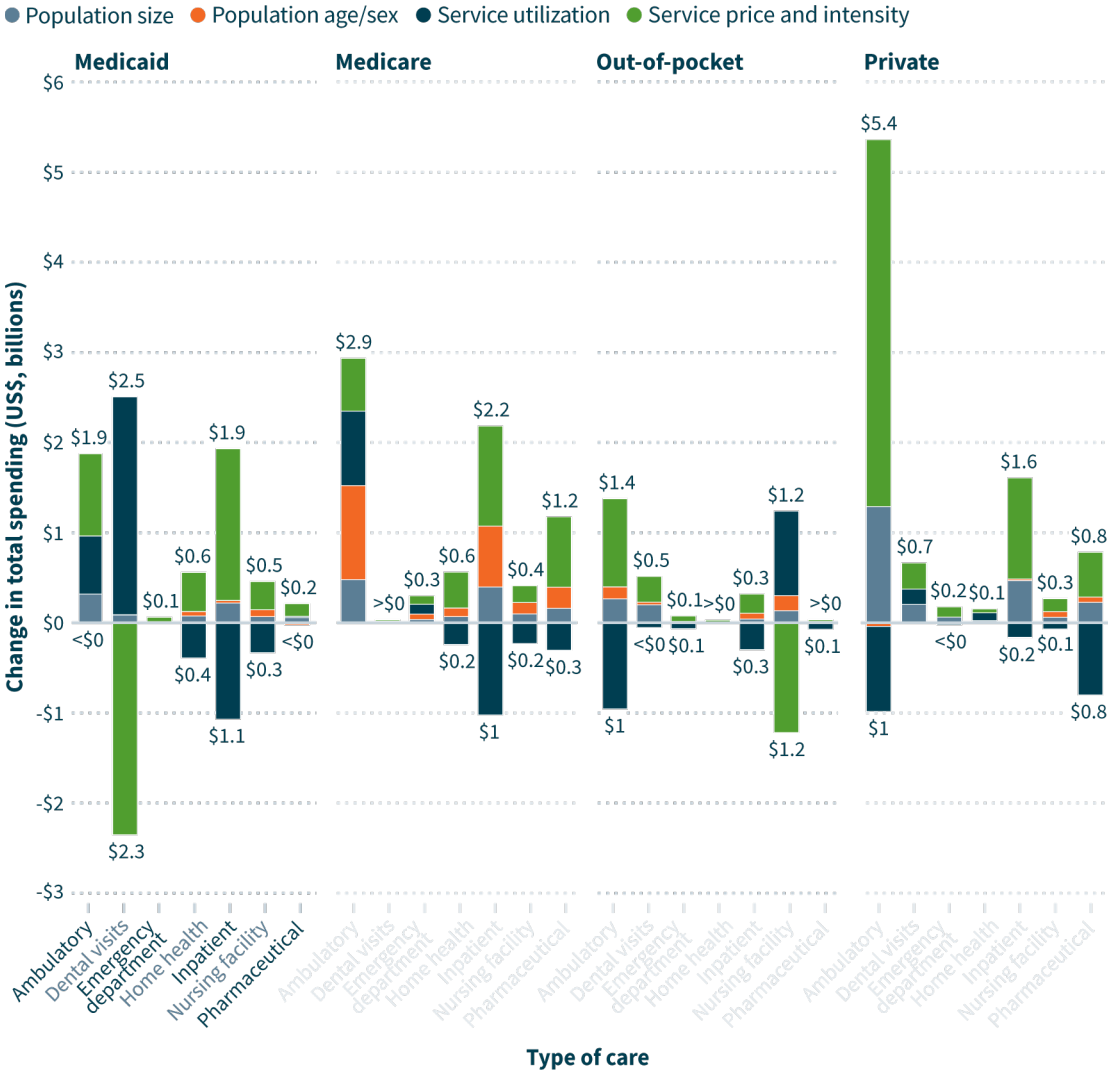
The $17.1 billion increase in spending in Washington between 2010 and 2019 can be broken apart to assess which underlying factors led to more spending (Figure 10). The DEX project shows that the type of care that had the greatest increase was ambulatory care, which increased $9.6 billion in annual spending. This increase was driven by three factors – growth in population size, aging population (bold), and higher ambulatory care spending per visit (first column). Higher spending per visit suggests that the price of care or intensity of care (or both) increased throughout this time.

Growth in ambulatory and inpatient expenditure accounts for 70% of the growth observed over this period.

Interestingly, there were fewer ambulatory care visits per person (i.e., lower service utilization) per person. The DEX project also shows that hospital inpatient care also increased a great deal – $3.5 billion increase in annual spending between 2010 and 2019. This increase was also driven partly by a larger and older population, but to a greater extent was driven by higher spending per admission. Admission per prevalent case decreased between 2010 and 2019 leading to a $2.54 billion decrease in spending, but that decrease was more than made up for by the $4.10 billion spending increase attributed to the increase in price and intensity of care. Across all types of care except emergency department spending, prices and intensity of care went up, while utilization of services went up only in dental care and emergency department care, and marginally in ambulatory care.

Source: IHME Disease Expenditure (DEX) Project

Figure 11: Drivers of spending change for each payer in Washington, 2010-2019



Source: IHME Disease Expenditure (DEX) Project

Changes in utilization were generally offset by increased price and intensity. Aging primarily affected Medicare spending, with other payers less influenced by demographic shifts.

When broken down by payer, declines in utilization were generally offset by changes in price and intensity of care. For most payer and types of care (all except Medicare ambulatory care, Medicaid ambulatory and dental care, private insurance spending on dental care, and out-of-pocket spending on nursing facility care), there were reductions in utilization (after adjusting for age and sex of the population). The aging population influenced Medicare spending but did not have much of an effect on the other payers. Increases in price and intensity of care had an especially large effect on ambulatory and inpatient care (Figure 11).

Data summary

Healthcare spending by health condition in Washington

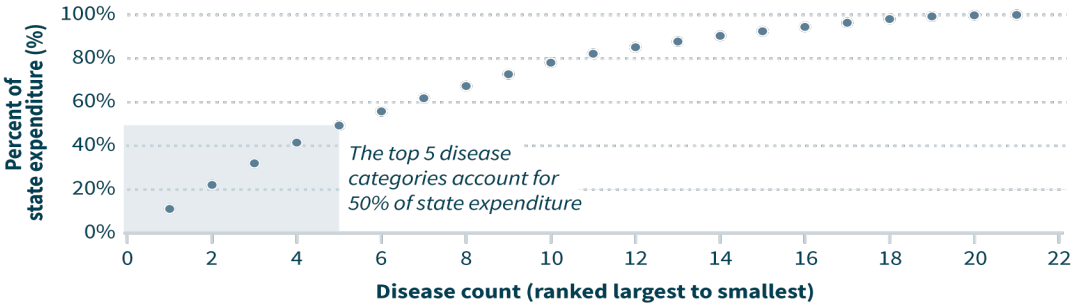
While expenditure spans a wide variety of payers, types of care and specific conditions – it is worth noting the concentration of expenditure by aggregate disease causes. When taking this view, the top 5 disease categories alone account for 50% of Washington's health expenditure.

An examination of the largest category (musculoskeletal disorders), a material and fast growing category (mental disorders), and a relatively small but rapidly growing category (substance use disorders) highlight the utility of examining a disease-specific approach to identifying growth drivers, potential solutions, and key payor / site of care combinations that must be engaged to tackle costs.

Musculoskeletal disorders had the highest health care spending in Washington in 2019, totaling $5.7 billion.

Of the 21 aggreate health condition categories analyzed in the DEX project, musculoskeletal disorders ($5.7 billion); neoplasms ($5.6 billion); cardiovascular diseases ($5.1 billion); other noncommunicable diseases, which include oral disorders ($4.9 billion); and diabetes and kidney diseases ($4.0 billion) had the largest amounts in total spending in 2019 (Table 1). Musculoskeletal disorders are unique in that much of the health care is provided to working age adults. Neoplasms has the highest growth rate of these five health conditions with annualized growth rate of 5.5%. Of all the aggregated health condition categories, substance use disorders has the greatest annualized growth rate between 2010 and 2019 at 9.4%.

Figure 12/Table 1: Estimated disease-specific healthcare spending, and growth in 2019



Level 2 cause	Total spending (billions)	Age-standardized growth rate; 2010-2019*	Percent of state spending
Musculoskeletal disorders	$ 5.7	4.1%	11.1%
Neoplasms	$ 5.6	5.5%	11%
Cardiovascular diseases	$ 5.1	4.1%	9.9%
Other non-communicable diseases	$ 4.9	3.2%	9.5%
Diabetes and kidney diseases	$ 4.0	4.5%	7.8%
Mental disorders	$ 3.3	6.8%	6.5%
Oral disorders	$ 3.1	3.1%	6%
Digestive diseases	$ 2.9	3.6%	5.6%
Well care	$ 2.8	4.6%	5.4%
Neurological disorders	$ 2.7	3.4%	5.3%
Injuries	$ 2.1	3.1%	4.1%
Skin and subcutaneous diseases	$ 1.5	3.8%	3%
Chronic respiratory diseases	$ 1.3	3.5%	2.6%
Respiratory infections and tuberculosis	$ 1.3	2.3%	2.6%
Risk factors	$ 1.1	1.1%	2.1%
Sense organ diseases	$ 1.0	4%	2%
Other infectious diseases	$ 1.0	6.1%	1.9%
Substance use disorders	$ 1.0	9.4%	1.7%
Maternal and neonatal disorders	$ 0.6	3.9%	1.2%
HIV/AIDS and sexually transmitted infections	$ 0.3	4%	0.5%
Enteric infections	$ 0.1	1.4%	0.2%

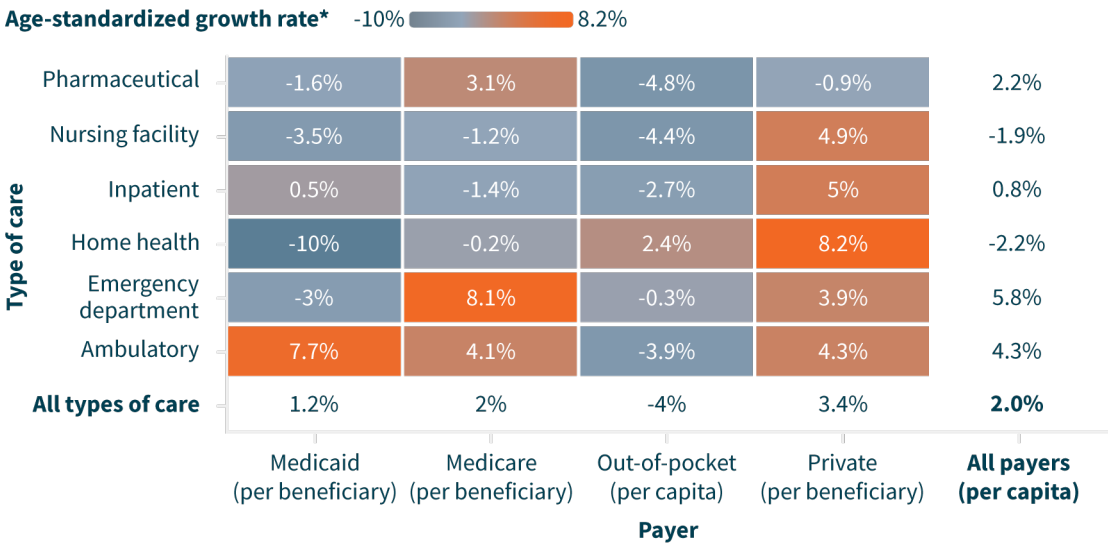
**Not adjusted for inflation*

Source: *IHME Disease Expenditure (DEX) Project*

Joint pain stands out as having a larger annualized growth rate (5%). Most of the spending growth was concentrated in ambulatory care, driven primarily by increased utilization rates.

According to the DEX project, spending on In Washington state in 2019, $4 billion was spent on diabetes and kidney diseases. Between 2010 and 2019, the annualized growth rate was 5.1%. After adjusting for age and the number of beneficiaries covered, private insurance spending increased the fastest between 2010 and 2019, at 3.4% annually. This growth was concentrated in home health care, inpatient care, and nursing facility care. Across all payers, spending in emergency departments and ambulatory care increased the fastest. Across all the types of care, it was service price and intensity that led to the greatest increases in spending (Figure 16).

Figure 13: Age-standardized growth rate of spend per beneficiary for diabetes and kidney diseases, 2019



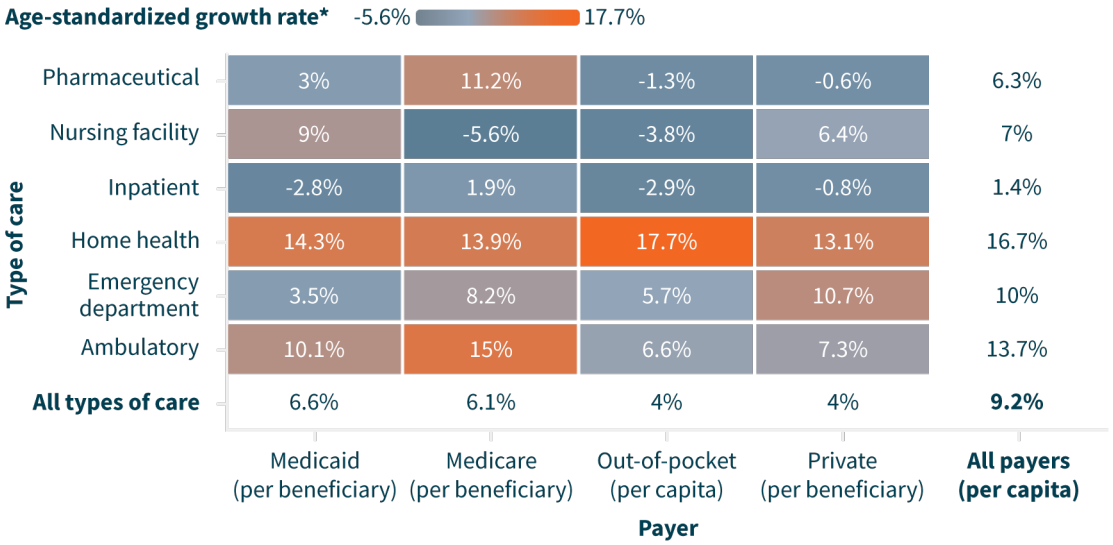
*Not adjusted for inflation

Source: *IHME Disease Expenditure (DEX) Project*

Spending on type 2 diabetes increased, with notable shifts including a rise in private insurance inpatient care and a decrease in Medicaid home health care spending.

Spending on substance abuse disorders grew faster than any other aggregate health condition category at 9.4%. When looking at spending per beneficiary, Medicaid spending increased the fastest at 6.6%, with spending on home health care, ambulatory care, and nursing facility growing the fastest. Medicare spending per beneficiary also increased dramatically, growing at 6.1% annually between 2010 and 2019.

Figure 14: Age-standardized growth rate of spend per beneficiary for substance abuse disorders, 2019



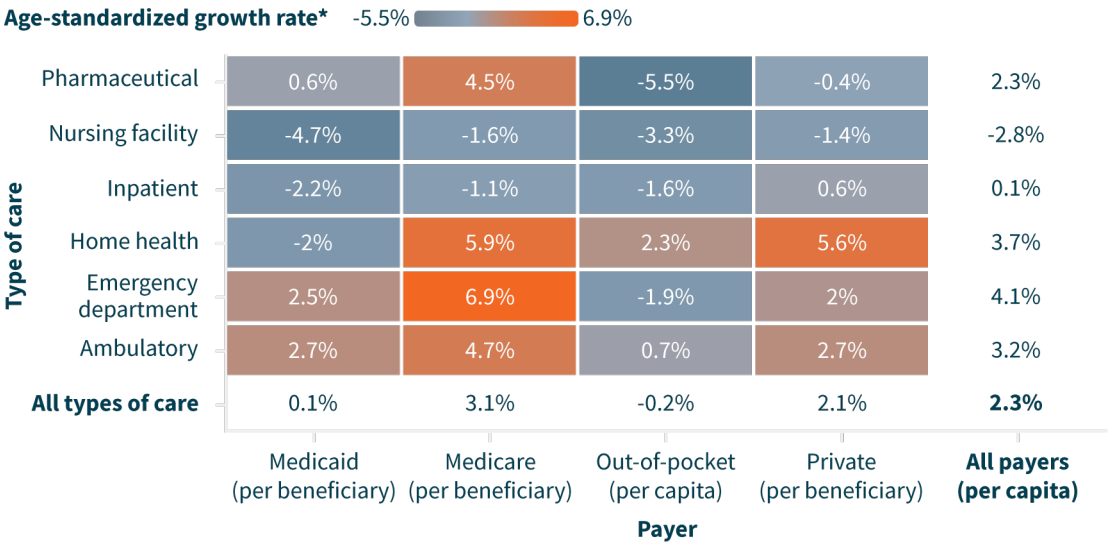
**Not adjusted for inflation*

Source: IHME Disease Expenditure (DEX) Project

Spending on oral disorders significantly increased, especially in dental care. Increased utilization drove most of the spending growth.

Musculoskeletal disorders had the most spending in 2019 at $5.7 billion. Between 2010 and 2019, spending on this aggregate health condition category increased by 4.1% annually (Figure 14). When assessing growth rates per covered beneficiary and adjusting for age, the growth in musculoskeletal disorder spending was almost completely concentrated in Medicare and private insurance spending, which grew at 3.1% and 2.1% respectively. Across all payers, emergency department care, home health care, and ambulatory care increased at the fastest rates. Spending increased the most because of increases in service price and intensity (Figure 16).

Figure 15: Age-standardized growth rate of spend per beneficiary for musculoskeletal disorders, 2019



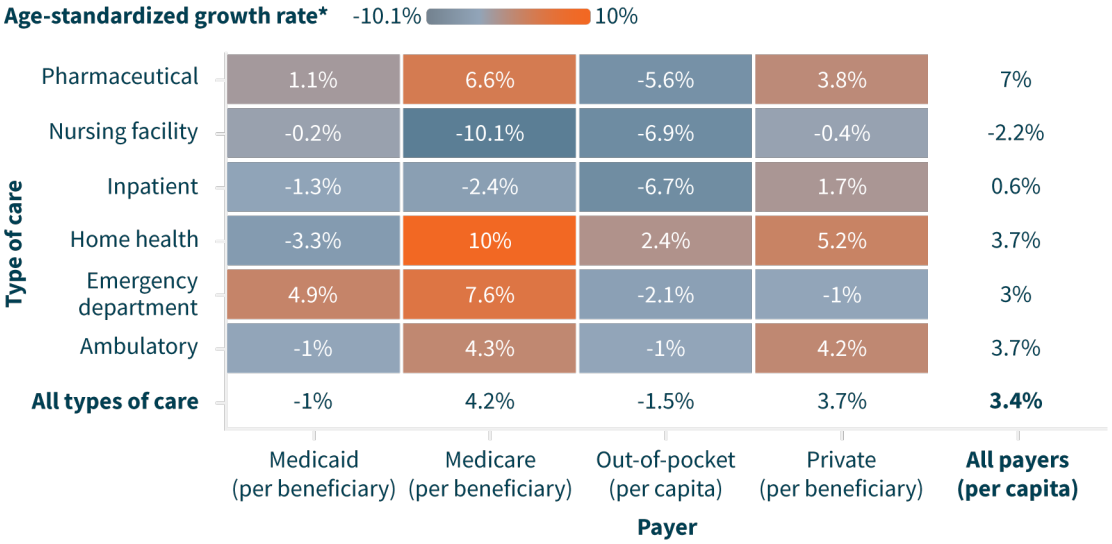
*Not adjusted for inflation

Source: IHME Disease Expenditure (DEX) Project

Across all types of care for anxiety disorders, we see a decrease in service utilization and a growth population size.

All neoplasms combined led to $5.6 billion of spending in Washington in 2019. Between 2010 and 2019, spending on neoplasms grew by 5.5% annually (Figure 15). When assessing spending per beneficiary, spending growth was concentrated in Medicare and private insurance, which grew at 4.2% and 3.7% annually. Across all payers, pharmaceutical spending increased the fastest at 7% annually. A great deal of the spending increases were driven by increases in service price and intensity (Figure 16).

Figure 16: Age-standardized growth rate of spend per beneficiary for neoplasms, 2019

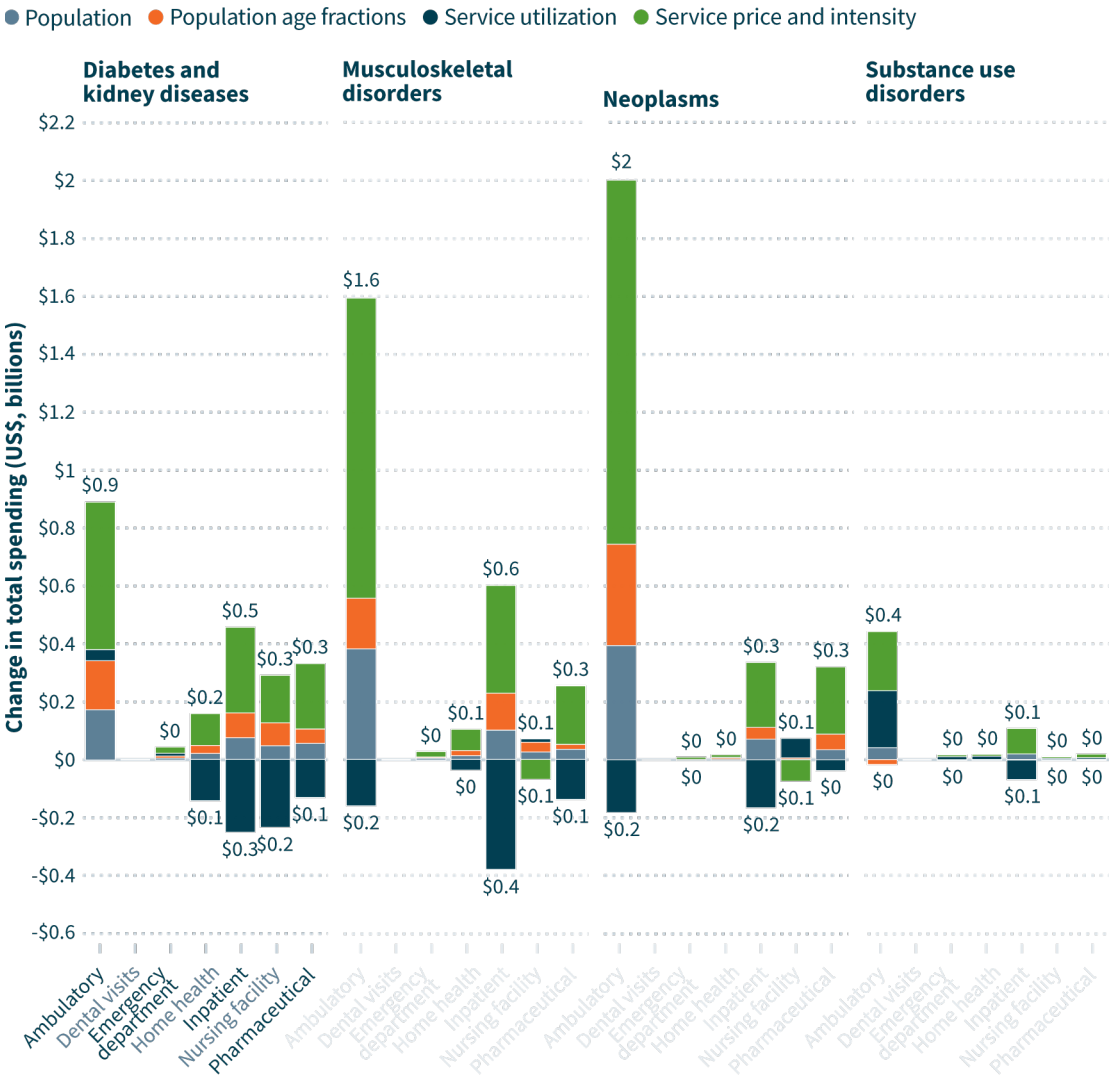


*Not adjusted for inflation

Source: IHME Disease Expenditure (DEX) Project

Figure 17: Drivers of spending change across four selected health conditions, 2010-19

Additional disease-specific views are available on request.



Source: *IHME Disease Expenditure (DEX) Project*

Data summary

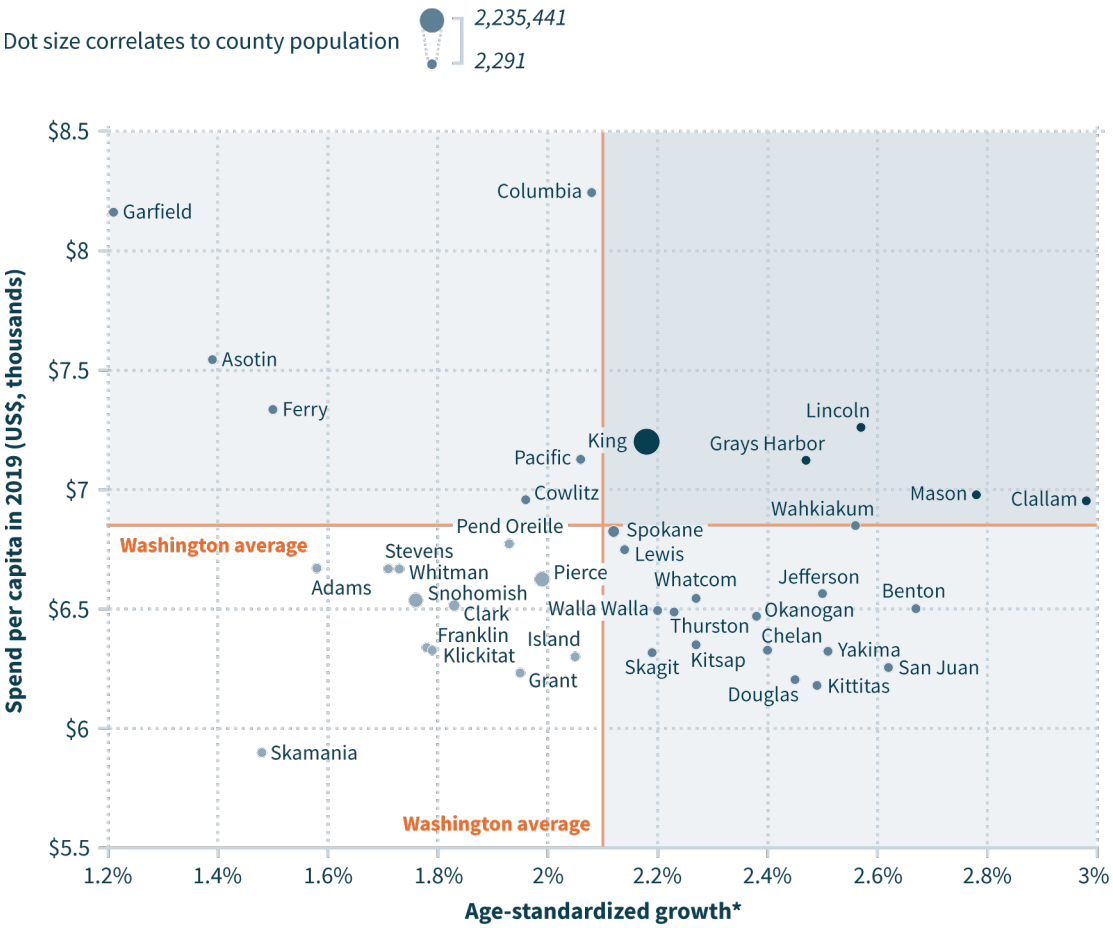
Healthcare spending variation within Washington

Variation across counties within WA state highlight the local nature of healthcare – and allow us to highlight potential “exemplars” that represent low total spend, and low growth that may be worth understanding better and potentially learning from.

While expenditure distribution can vary by county, type of care, and payor – there appear to be consistent clustering patterns across counties which validate a need to further examine price/intensity in certain sites of care, or scale up supply/access to meet growing demand à will likely be updated to be more specific after we change the distributions to reflect changes over time.

The DEX project shows that health care spending varies dramatically throughout Washington state. In 2019 the counties with the largest spending per person were Columbia County, Garfield County, and Pacific County, with $10,355, $9,964, and $9,214 health spending per person. On the other hand, Franklin County, Whitman County, and Adams County were the counties with the smallest spending per person with $5,159, $5,581, and $5,709 of health spending respectively.

Figure 18: **Health care spending per person versus growth rate by county, 2010 to 2019**



**Not adjusted for inflation*

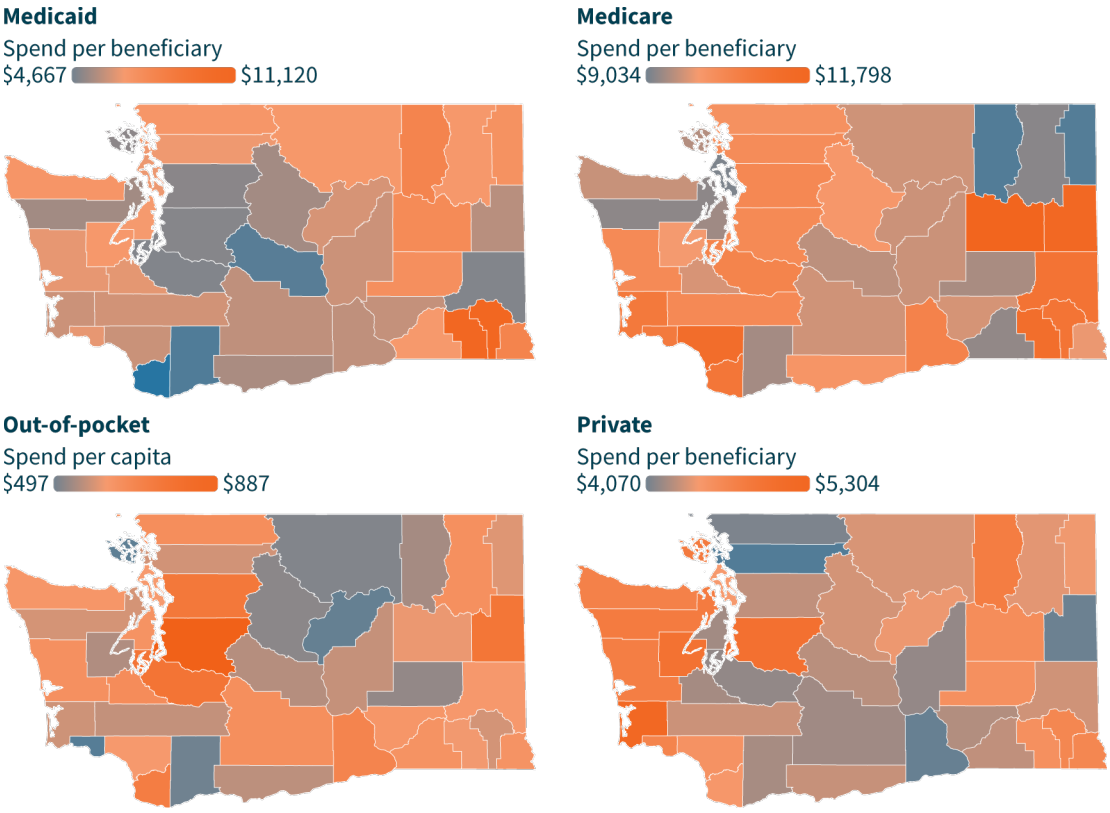
Source: *IHME Disease Expenditure (DEX) Project*

Health care spending varies dramatically throughout Washington state and spending varied dramatically for each payer category.

When age-standardized, Douglas, San Juan, and Kittitas County had the lowest spending per capita, with Columbia and Garfield County having the highest spending per capita. Clallam county had the largest growth rate in 2019 yet still does not surpass Garfield County – which experienced a near 1% growth rate of age-standardized spending (Figure 18).

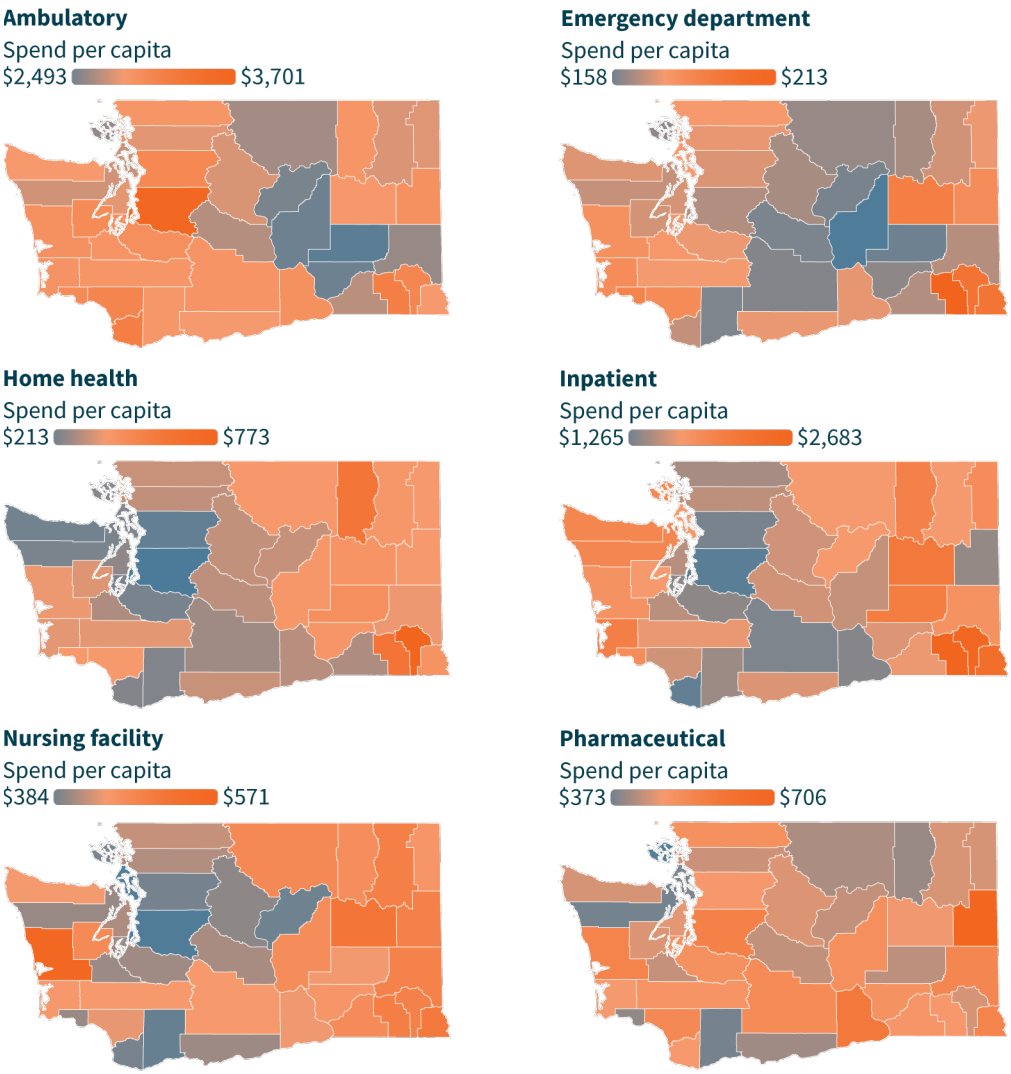
The DEX project showed that spending varied dramatically for each payer category (Figure 19) and for each type of care (Figure 20). Differences in growth drivers are explained in Figure 21 which breaks apart the difference in each county's spending per person over time.

Figure 19: Age-standardized spending per beneficiary by payer



Source: *IHME Disease Expenditure (DEX) Project*

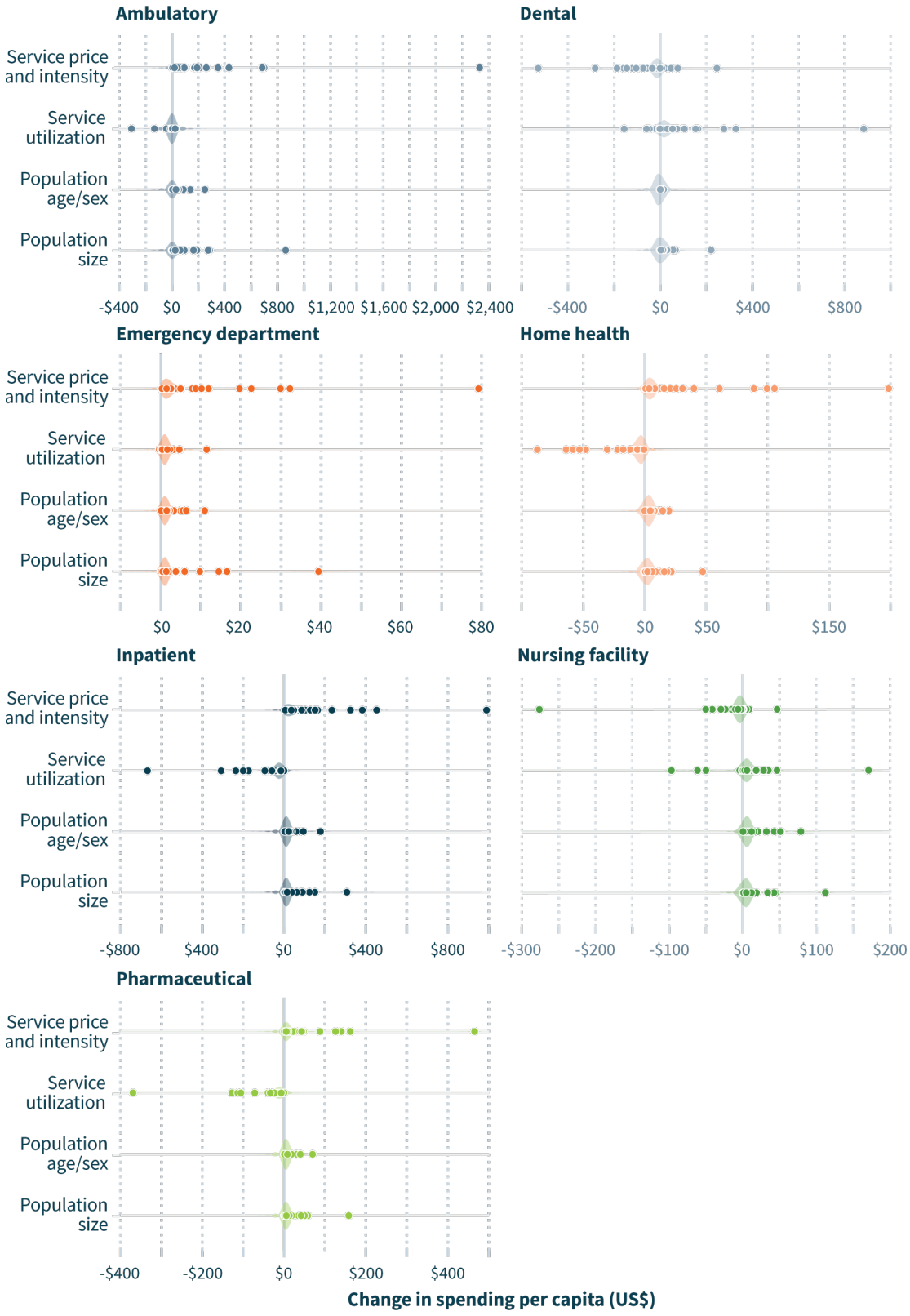
Figure 20: Age-standardized spending per person by type of care



Source: *IHME Disease Expenditure (DEX) Project*

Figure 21: Drivers of spending growth per person Washington state counties, 2010-2019

Dashboard view is planned that will offer county-identifiable views. County-specific information is available upon request.



Source: *IHME Disease Expenditure (DEX) Project*

Washington State Health Care Authority

ASI Expenditures Report

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