The Health Care Cost Transparency Board's

Advisory Committee on Data Issues

June 12, 2024

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

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

Wednesday, June 12, 2024
4:00 – 5:00 PM
Hybrid Zoom and in-person

Agenda

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

Chair of the Advisory Committee on Data Issues	Bianca Frogner

Time	Agenda Items	Tab	Lead
4:00-4:07 (7 min)	Welcome, Roll Call, Introduction of New Chair, Agenda, Purpose & Charter	1	Marty Ross, HCA Bianca Frogner, Chair Health Care Cost Transparency Board Member (HCCTB)
4:07-4:10 (3 min)	Approval of Meeting Summary	2	Bianca Frogner, Chair
4:10-4:15 (5 min)	Public Comment (Data Issues Meeting)	3	Marty Ross, HCA
4:15-4:35 (20 min)	Facility Fees: Data Needs	4	Liz Arjun Health Management Associates
4:35-5:00 (25 min)	Business Oversight: Data Needs	5	Jeanene Smith Health Management Associates
5:00	Adjourn		Marty Ross, HCA

Meet Chair Bianca Frogner, PhD

Advisory Committee on Data Issues

- Dr. Frogner is a health economist (NIH T32 trainee) with expertise in health services delivery, health workforce, labor economics, health spending, health insurance coverage and reimbursement, and international health systems.
- Her current research focuses on allied health and the training and education of health professionals to address health equity.
- Associate Professor, Department of Family Medicine
- Director, Center for Health Workforce Studies
- Deputy Director, Primary Care Innovation Lab, UW
- Current member of the Health Care Cost Transparency Board

Purpose of the Data Committee

Assist the Health Care Cost Transparency Board (Cost Board)		
Collaboration	**Communication**	**Participation**
• Provide the Cost Board with subject matter expertise and support, on data calls, in the analysis of existing data sources, and other issues identified by the Cost Board. • Collaborating with the Cost Board and HCA staff to help create buy-in across the various markets	• Serve as a liaison between the Cost Board and health care community, relaying essential information and bringing feedback to the Cost Board • Ensure all parties involved have an opportunity to address slowing cost growth and growing affordability concerns for Washington	• Attendance and participation in Advisory Committee meetings • Review meeting materials before scheduled meetings, coming prepared to engage with other members • Give input to help keep the conversation moving forward

Review of the Data Committee Charter

- Cost Board's Advisory Committee of Data Issues Charter (attached)
- Includes:
  - Committee Purpose
  - Membership requirements specified in HB 2457
  - Responsibilities
  - Meetings needed
  - Quorum specifications
  - Accountability and reporting

HEALTH CARE COST TRANSPARENCY BOARD'S

Advisory Committee on Data Issues

What is the Purpose of the Advisory Committee on Data Issues?

The role of the Advisory Committee on Data Issues is to assist the Health Care Cost Transparency Board ("Board") by providing subject matter expertise and support to the Board on data calls and in the analysis of existing data sources. The Advisory Committee on Data Issues will also assist with the Board's efforts by proving subject matter expertise on other data issues as identified by the Board.

Membership:

As indicated in House Bill 2457, section 4 and related RCWs, the Advisory Committee of Data Issues will be appointed by the Board. Members of the Advisory Committee must have expertise in health data collection and reporting, health care claims data, analysis, health care economic analysis, and actuarial analysis.

Member Responsibilities:

Members of the Advisory Committee on Data Issues are responsible for:

- Providing subject matter expertise in relation to the growth benchmark, including understanding for outliers or unexplained trends with the cost growth and benchmark data analysis.
- Collaborating with the Board and HCA staff to help create buy-in across the various markets and organizations and offering suggestions that may help with the data collection and analysis.
- Serving as a liaison between the Board and health care community by relaying essential information and bringing forth feedback as needed to the Board to ensure all parties involved have an opportunity to address how to slow cost growth and to address growing affordability concerns for the state of Washington at various levels.

- Attendance and participation in Advisory Committee meetings. This includes reviewing meeting materials in advance of the scheduled meeting, coming prepared to engage with other members, working collaboratively with other members and the Board, being sensitive to the impact that high health care spending growth has on Washingtonians, and providing input to help the conversation continue moving forward.
- If a member cannot attend a meeting, they are requested to advise HCA before the meeting and contact staff for a recording of the meeting.
- Members will adhere to the requirements of the Open Public Meets Act and Public Records Act. Records related to the Advisory Committee on Data Issues are public records.

Meetings:

The Advisory Committee on Data Issues will meet as needed (likely no more than six times annually) to fulfill its mandate to the Board by providing subject matter expertise and support to the Board.

Quorum:

A majority of the Advisory Committee on Data Issues members constitutes a quorum for a meeting of the committee. If a meeting does not have a quorum of members present or does not maintain a quorum, the meeting may be cancelled or rescheduled so that there are sufficient members to fulfill the Advisory Committee's responsibilities.

Accountability and Reporting:

The Advisory Committee on Data Issues is accountable to the Board and to report its activities and to provide subject matter expertise at the request of the Board or to follow up on requests of the Board.

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board's

Advisory Committee on Data Issues meeting summary

October 3, 2023

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

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

Members present

Christa Able
Amanda Avalos
Jonathan Bennett
Bruce Brazier
Leah Hole-Marshall
Lichiou Lee
Ana Morales
Hunter Plumer
Mark Pregler
Russ Shust
Julie Sylvester

Members absent

Megan Atkinson
Allison Bailey
Jason Brown
Chandra Hicks
David Mancuso
Mandy Stahre

Call to order

Mandy Weeks-Green, committee facilitator and Cost Board & Commissions Director, HCA, called the meeting to order at 2:03 p.m.

Agenda items

Welcoming remarks

Mandy Weeks-Green welcomed committee members and provided an overview of the agenda.

Washington State Health Care Authority

Meeting summary review from the previous meeting

The members present voted by consensus to adopt the April and June 2023 meeting summaries.

Public comment

Theresa Tamura, Operations and Engagement Strategist, HCA, called for comments from the public.

There were no public comments.

Washington Hospital Costs, Price, and Profit Analysis: Second Level Finalized Analysis Methodology

John Bartholomew and Tom Nash, Bartholomew-Nash & Associates

The goal of the Washington Hospital Costs, Price, and Profit Analysis is to assess how the Washington hospital industry compares to the nation in terms of costs and margins/profits and to identify Washington hospital outliers on cost and margins/ profits. The analysis will complement the Board's other data projects and will provide insight into the effects of hospital costs on total health care cost growth, as well as which hospitals have normal versus high profits, which have normal versus high costs, and which have normal versus high cost trends. The two approaches/perspectives to identifying cost drivers include that of the patient/member, and that of the provider.

Committee members discussed what regional medians for benchmarking (core-based statistical areas (CBSAs)) should be created for meaningful comparisons of Washington regions with other regions in the U.S. More information on the CBA discussion can be found at timestamp 33:35.

The various methodologies were reviewed, including the cost and price adjustment methodology, the peer group comparisons methodology, and the peer selection criteria methodology. More information and the committee's discussion on these methodologies begin at timestamp 41:30.

Analytics Support Initiative (ASI)

Mandy Weeks-Green, Boards and Commissions Director, HCA
Amanda Avalos, Clinical Quality and Care Transformation, HCA
Theresa Tamura, Operations and Engagement Strategies, HCA
Joe Dieleman, Institute for Health Metrics and Evaluation (IHME)

The goals of ASI were reviewed. These include analyses being as simple as possible, that analytic products be in support of the Board's needs, and that results be granular enough for action. Amanda Avalos reviewed the seven data projects under the Board, including the cost growth benchmark; assessment of growth against the benchmark; cost driver analysis; primary care spend measurement; hospital cost, profit, and price analysis; ASI; and consumer affordability. This committee will provide input in identifying analytical products that advise the Board. Considerations are products that have or are high probability of influence, high impact, or novel approach.

Joe Dieleman introduced the IHME initiative, which is charged with completing work related to measurements and health. IHME developed the Disease Expenditure (DEX) research project. The methodologies used to reflect both spending and price, and utilization were outlined. Other IHME background methods applicable to this work can be found at timestamp 1:06:42. The committee was asked to discuss which of the eight analytic products reviewed (review at timestamp 1:09:28) would be most helpful for understanding and controlling cost drivers in Washington, how the data sets should be crafted so as to not overlap with existing data projects, and whether anything should supplement the reviewed analytic products. The committee's discussion on this topic can be found at timestamp 1:13:20. Committee members agreed to submit additional feedback on the analytic products via email.

Washington State Health Care Authority

Updated Motion for Consideration

Theresa Tamura, Operations and Engagement Strategies, HCA

Committee member Jonathan Bennett brought to the committee an updated motion for the committee's consideration. The updated motion included four issues pertaining to the health care cost growth benchmark process: attribution methodology, risk adjustment for attributable members, analysis for specific provider performance, and notifying the large provider entities that will be subject to benchmark performance measurement. To help prevent redundancy on this publicly available information, HCA is gathering information to answer these questions which will be shared with the Board at their next meeting and brought back to this committee. Jonathan Bennett's comments and committee members' discussion on the motion can be found at timestamp 1:36:46. Committee members amended the motion for staff to bring back the information to this committee to inform and develop recommendations for the Board. The motion was approved as amended.

Primary Care Data Collection and Reporting Strategy

Jean Marie Dreyer, Senior Health Policy Analyst, HCA

The Board's Advisory Committee on Primary Care continues to work on their legislative charge to create a definition of primary care. They're currently focused on developing measurement methodologies to assess both claims-based and non-claims-based spending, and identifying data issues, e.g., barriers to access and use of primary care data and how to overcome them. The All-Payer Claims Database (APCD) and HCA's aggregate benchmark data call are used to collect information from payers; however, there are gaps. Additional information on data collection mechanisms and gaps can be found at timestamp 1:55:00. To address these gaps, HCA proposes a hybrid data collection process – primarily using the APCD for claims-based expenditures, and the benchmark data call for non-claims-based expenditures. Members of this committee are welcome to submit feedback for the Advisory Committee on Primary Care's further consideration via email. The hybrid solution proposal will be presented to the Board for their approval which if approved, would begin the data collection process.

Benchmark Schedule Review

Amanda Avalos, Clinical Quality and Care Transformation, HCA

The benchmark schedule (fall 2023 to summer 2028) was shared with the committee. The benchmark schedule can be found at timestamp 1:59:50.

Adjournment

Meeting adjourned at 4:05 p.m.

Next meeting

January 18, 2024
Meeting to be held in-person and on Zoom
2–4 p.m.

Tab 3

Washington State Health Care Authority

Public Comment

Washington State Health Care Authority

Tab 4

Washington State Health Care Authority

HMA

Facility Fees: Preliminary Areas of Focus and Data Needs

Examining Facility Fees

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: ALREADY REPORTED

- 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.
- The reported data lacks does not include how many times high facility fees are being charged to consumers
- Providers are only required to report the minimum and maximum facility fee charged each year.
- It is likely that significant amounts of these fees are not being reported to the state.

POTENTIALLY ADDRESSING FACILITY FEES

Increase Transparency

- Modify advance notice requirements before providers charge a facility fee
- Modify reporting requirements to include all providers and facilities e.g., provider offices, labs, x-rays, therapies…) and improve reporting detail to account for all facility fees (each charges, all locations, etc.).

Limitations or Prohibitions on Facility Fees

- Prohibited entirely
- Limited by type of service, or by location of service.

FACILITY FEES: ADVANCE NOTICE & DATA COLLECTION

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*

- Does not include:
  - Clinics designed for/providing labs, X-rays, testing, therapy, pharmacy or educational services or if is designated as rural health clinics*
- Also does not include ambulatory surgical centers or other providers unaffiliated with hospitals/health systems

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

FACILITY FEES: ADVANCE NOTICE & 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.

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

FACILITY FEES: DISCUSSION

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

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)?
- Should **non-hospital affiliated facilities** be required to report their fees?
- Should **greater detail be provided** about the amount of the fees, frequency of charging higher fees, etc.?

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/

CERTIFICATION OF ENROLLMENT

ENGROSSED SUBSTITUTE HOUSE BILL 2582

Chapter 184, Laws of 2012

62nd Legislature
2012 Regular Session

HEALTH CARE FACILITIES--BILLING PRACTICES

EFFECTIVE DATE: 01/01/13

Passed by the House March 3, 2012
Yeas 95 Nays 1

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate February 29, 2012
Yeas 49 Nays 0

BRAD OWEN

President of the Senate

Approved March 29, 2012, 7:18 p.m.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE HOUSE BILL 2582** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BARBARA BAKER

Chief Clerk

FILED

March 29, 2012

Secretary of State
State of Washington

ENGROSSED SUBSTITUTE HOUSE BILL 2582

AS AMENDED BY THE SENATE

Passed Legislature - 2012 Regular Session

State of Washington 62nd Legislature 2012 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Johnson, Cody, Ross, Jinkins, Green, Walsh, Hinkle, Clibborn, Liias, Kenney, Klippert, Smith, Alexander, Warnick, Fagan, Bailey, Ahern, Asay, Dahlquist, Kretz, DeBolt, Angel, Kelley, Hunt, Dickerson, Ladenburg, Orcutt, Zeiger, Wilcox, Finn, Wylie, Probst, Darneille, Moscoso, Kagi, and Tharinger)

READ FIRST TIME 01/31/12.

AN ACT Relating to billing practices for health care services; adding a new section to chapter 70.01 RCW; and providing an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** A new section is added to chapter 70.01 RCW to read as follows:

(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) Each health care facility must post prominently in locations easily accessible to and visible by patients, including its web site, a statement that the provider-based clinic is licensed as part of the hospital and the patient may receive a separate charge or billing for the facility, which may result in a higher out-of-pocket expense.

(3) Nothing in this section applies to laboratory services, imaging services, or other ancillary health services not provided by staff employed by the health care facility.

(4) As part of the year-end financial reports submitted to the department of health pursuant to RCW 43.70.052, all hospitals with provider-based clinics that bill a separate facility fee shall report:

(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.

(5) For the purposes of this section:

(a) "Facility fee" means any separate charge or billing by a provider-based clinic in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses.

(b) "Provider-based clinic" means the site of an off-campus clinic or provider office located at least two hundred fifty yards from the main hospital buildings or as determined by the centers for medicare and medicaid services, that is owned by a hospital licensed under chapter 70.41 RCW or a health system that operates one or more hospitals licensed under chapter 70.41 RCW, is licensed as part of the hospital, and is primarily engaged in providing diagnostic and therapeutic care including medical history, physical examinations, assessment of health status, and treatment monitoring. This does not include clinics exclusively designed for and providing laboratory, x-ray, testing, therapy, pharmacy, or educational services and does not include facilities designated as rural health clinics.

NEW SECTION. **Sec. 2.** This act takes effect January 1, 2013.

Passed by the House March 3, 2012.
Passed by the Senate February 29, 2012.
Approved by the Governor March 29, 2012.
Filed in Office of Secretary of State March 29, 2012.

Tab 5

Washington State Health Care Authority

Business Oversight: Data Needs

Mergers/Acquisitions, Private Equity Investments
and Provider Ownership/Closure

BUSINESS OVERSIGHT STRATEGIES: MERGERS AND ACQUISITIONS, PRIVATE EQUITY INVESTMENTS AND PROVIDER OWNERSHIP/CLOSURE

Why Is This Important?

All these activities can contribute to **consolidation** in the health care market resulting in:

1. Increased leverage in negotiations for contracts with health plans by the larger players
2. Increased leverage can lead to increases in prices for visits and raise premiums
3. Consolidation can have mixed implications for access to care for Washingtonians

BUSINESS OVERSIGHT STRATEGIES: MERGERS AND ACQUISITIONS, PRIVATE EQUITY INVESTMENTS AND PROVIDER OWNERSHIP/CLOSURE

Activities that lead to consolidation

- **Horizontal integration:** between hospitals, other facilities, between physician groups, other health care industries that offer same types of services
- **Vertical integration:** hospitals or insurers purchasing physician practices, urgent care entities or others that offer different services along the same supply chain.
- **Cross-sector mergers:** Providers that operate in different geographic markets merge for patient care
- **Private equity:** Pool funds from investors to invest in various industries
- **Closures** of providers of health care services (i.e. rural hospitals, provider practices, etc.)
- Other “soft” forms: Accountable Care Organizations or other joint ventures that clinically integrate into networks are often designed to improve care coordination, but this can contribute to consolidation

Washington State already has a significant degree of consolidation and integration, but many of the activities identified above are likely to continue

POLICIES UNDER DISCUSSION BY THE COST BOARD FOCUSED ON BUSINESS OVERSIGHT

Enhance Current Washington State Health Care Business Oversight and Strengthen Enforcement

a) **Expand the Review/Approve Authority of the Attorney Gene**ral – require prior notice of a broader scope of transactions and/or establishing the ability to block or impose conditions upon the transaction without a court order.

b) **Give Authority to Review/Approve Transactions to Additional Oversight Entities** – vesting another state entity (in addition to the state attorney general) with the authority to review and report on a proposed transaction's broader health care market impact, and include in the authority the ability to block or impose conditions upon the transaction without a court order

c) **Comprehensive and Transparent Provider Business Ownership and Closure reporting/Database**
Require certain categories of health care entities, such as hospitals, physician practice groups of a specified size and private equity firms, to report on who owns them, what other health care entities they own, and the number and types of health care professionals they employ.

DO WE COLLECT THE DATA WE NEED TO IMPROVE OVERSIGHT?

These business oversight efforts require data and information to better understand the business practices to then develop strategies to strengthen authorities and enforcement efforts.

- What does Washington State collect already in these areas?
- What is needed to enhance understanding, oversight and enforcement?

BUSINESS OVERSIGHT: MERGERS AND ACQUISITIONS

Washington State has authority to require Notice and Review:

What? Required reporting based on criteria, often financial value of the entities, and could include analysis of trends in the market and report publicly

Who? Office of the Attorney General

Who needs to report?

- All hospitals**, hospital systems or provider organizations** (if greater than 7 in the group) with a proposed material change if did not previously have common ownership or a contracting affiliation;
- "Material Change" transactions between 2 WA State entities or between WA State and an out of state entity (if out of state entity has > $10 million in revenue in last 12 months from WA State patients)
- Also, if required to provide a premerger notification to the FTC or US DOJ – must submit a copy
- Focus is on capturing anticompetitive transactions

What Data is Collected?

- Names of parties, current business addresses
- All locations where health care services are currently provided by each party
- Brief description of the nature and purpose of the changes
- Anticipated effective date
- The AG may ask for additional information

BUSINESS OVERSIGHT: PRIVATE EQUITY

Washington State is not collecting information specifically regarding private equity, unless is part of merger/acquisition required reporting by hospitals, health systems or provider groups to the Attorney General or related to health plan required OIC financial filings.

What do we know?

- Focus is on getting a return for investors.
- Private equity firms had 97 health care acquisitions in WA State in the last decade (2014-2023)*
- WA physician staffing companies such as in anesthesia, emergency medicine and post-acute care in addition to certain specialties have been purchased by private equity.
- Corporate buyers have also come into the market such as CVS, Amazon, UnitedHealth.

* based on data sourced from PitchBook, a provider of financial data, research and analytics.

BUSINESS OVERSIGHT: PROVIDER OWNERSHIP/CLOSURE

Who Collects this Data?

- **Dept. of Health** – Hospitals/Other Facilities through Licensing and CON; also collect Hospital Financials and Utilization
- **Office of the Insurance Commissioner** – Only if a health plan is owner; through financial reporting
- **Medicaid** – Must submit an initial application to be approved to bill under Apple Health
- **WA Medical Commission** – some individual physician location information via licensing
- **Office of the Attorney General** – Only if greater than 7 in the group and represents a "material change" via merger/acquisition transactions.

Gaps:

- No comprehensive current database
- No requirement to report private equity purchasing
- No cross-market/different geographical market changes data focus
- Closure or reduction in services lines (e.g., labor and delivery or emergency services) may not be reviewed by the AG and don't always require prior notice or approval by the state.

BUSINESS OVERSIGHT: DATA COLLECTION CURRENTLY

Focus	AG	DOH	OIC	Other
Hospitals	If meet "material change" criteria for Merger	CON Licensing Financials/Utiliz	Only if related to health plan ownership	
Private Equity	If meet "material change" criteria	If changes to licensing information	Only if related to health plan ownership	
Provider Ownership/Closure	Only if part of a merger	Hospital licensing and CON; utilization and Financial Data	Health plan ownership via financial reporting	WA Medical Commission: Some location information via provider licensing Medicaid: related to application as Apple Health provider

NEXT STEPS BUSINESS OVERSIGHT DATA

Further discussion at next meeting

- Come prepared to discuss additional data that could be collected to enhance business oversight and consider potential approaches to implement that.

Useful resources to review ahead:

- Office of Insurance Commissioner's WA OIC Preliminary Report on Health Care Affordability, particularly page 11 – 12 regarding data limitations
- AG report, Preliminary Report: Healthcare Affordability (fairhealthprices.org) particularly pages 7-10, and the Appendix
- Massachusetts' Registration of Provider Organizations database - Registration of Provider Organizations | Mass.gov

BUSINESS OVERSIGHT REFERENCES

- Ten Things to Know About Consolidation in Health Care Provider Markets | KFF
- State Actions to Strengthen Oversight of Health Care Transactions at https://www.milbank.org/wp-content/uploads/2024/03/Models_Enhanced_Market_Oversight_3.19.pdf
- Consolidation Trends In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices | Health Affairs
- California Health System Consolidation Leads Higher Prices | Commonwealth Fund
- US. Department of Justice and the Federal Trade Commission, Merger Guidelines, December 18, 2023 US. Department of Justice and the Federal Trade Commission, Merger Guidelines, December 18, 2023
- Catalyst for Payment Reform: Microsoft Word - 3_Issue Brief Shore up Market Against Consolidation and Rising Prices - CLEAN_format.docx (catalyze.org)
- A Tool for States to Address Health Care Consolidation: Prohibiting Anticompetitive Health Plan Contracts – NASHP an
- Weighing Policy Trade-offs: Overview of NASHP's Model Prohibiting Anticompetitive Contracting - NASHP

BUSINESS OVERSIGHT REFERENCES (CONT.)

- COVID-19, Market Consolidation, And Price Growth | Health Affairs
- Models for Enhanced Health Care Market Oversight — State Attorneys General, Health Departments, and Independent Oversight Entities | Milbank Memorial Fund
- HCMO 2023 Annual Report.pdf (oregon.gov)
- Private Equity–Acquired Physician Practices And Market Penetration Increased Substantially, 2012–21 | Health Affairs
- Consolidation by Any Other Name: The Emergence of Clinically Integrated Networks | RAND