Joint Meeting of the Health Care Cost Transparency Board's

Advisory Committee of Health Care Stakeholders

&

Advisory Committee on Data Issues

November 20, 2024

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Joint Meeting of the Health Care Cost Transparency Board's

Advisory Committee on Data Issues *and*
Advisory Committee of Health Care Stakeholders

Wed., November 20, 2024
3:00 – 4:00 PM
Hybrid Zoom and in-person

Agenda

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

Members of the Advisory Committee of Health Care Stakeholders		
☐ Emily Brice	☐ Jodi Joyce	☐ Sulan Mylnarek
☐ Patrick Connor	☐ Louise Kaplan	☐ Michele Ritala
☐ Bob Crittenden	☐ Stacy Kessel	☐ Paul Schultz
☐ Paul Fishman	☐ Eric Lewis	☐ Jeb Shepard
☐ Justin Gill	☐ Vicki Lowe	☐ Dorothy Teeter
☐ Adriann Jones	☐ Natalia Martinez-Kohler	☐ Wes Waters

Chair of the Advisory Committee on Data Issues	Bianca Frogner
Chair of the Advisory of Health Care Stakeholders	Eileen Cody

Time	Agenda Items	Tab	Lead
3:00-3:03 (3 min)	Welcome, Agenda, and Roll Call	1	Bianca Frogner, Chair
3:03-3:05 (2 min)	Approval of June 2024 Meeting Summary	2	Bianca Frogner, Chair
3:05-3:10 (5 min)	Update of 9/19 and 11/7 Cost Board Meetings	3	Bianca Frogner, Data Issues Chair
3:10-3:45 (35 min)	Analytic Support Initiative (ASI) Disease Expenditure Report and Dashboard (Presentation & discussion)	4	Joe Dieleman, Institute for Health Metrics Evaluation
3:45-3:55 (10 min)	2025 Committee Meeting Dates	5	Rachelle Bogue, HCA
3:55	Adjourn		Bianca Frogner, HCA

Tab 2

Washington State Health Care Authority

Joint Meeting of Advisory Committee on Data Issues and Advisory Committee of Health Care Stakeholders summary

June 12, 2024

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
3–4 p.m.

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

Advisory Committee on Data Issues

Members present

Christa Able
Megan Atkinson
Amanda Avalos
Jonathan Bennett
Jason Brown
Chandra Hicks
Leah Hole-Marshall
Lichiou Lee
David Mancuso
Ana Morales
Hunter Plumer
Mark Pregler
Russ Shust

Members absent

Bruce Brazier
Mandy Stahre
Julie Sylvester

Advisory Committee of Health Stakeholders

Members present

Patrick Connor
Justin Gill
Adriann Jones
Jodi Joyce
Eric Lewis
Natalia Martinez-Kohler
Sulan Mylnarek
Paul Schultz
Dorothy Teeter
Wes Waters

Members absent

Emily Brice
Bob Crittenden
Paul Fishman
Nariman Heshmati
Louise Kaplan
Stacy Kessel
Vicki Lowe

Call to order

Rachelle Bogue, committee facilitator, called the meeting of the Joint Meeting of Advisory Committee on Data Issues and Advisory Committee of Health Care Stakeholders (committee) to order at 3:03 p.m.

Washington State Health Care Authority

Agenda items

Welcoming remarks, Introduction of New Chairs, Agenda, Roll Call, Approval of Meeting Summaries

Rachelle Bogue, HCA

Rachelle welcomed the committee members with an overview of the agenda. Hope Kilbourne and Marty Ross were introduced as HCA staff facilitators for the Advisory Committee of Health Care Stakeholders (Stakeholders Committee) and Advisory Committee on Data Issues (Data Issues Committee), respectively. The new chairs for each committee were also introduced. Eileen Cody for the Stakeholders Committee and Bianca Frogner for the Data Issues Committee.

The committee **voted to approve** the March 7, 2024 meeting summary.

Review of May Cost Board Meeting and 2024 Workplan Review

Liz Arjun, Health Management Associates (HMA)

The Health Care Cost Transparency Board (Cost Board) met in February to discuss policy options for further evaluation throughout the year addressing health care costs. During the May 15, 2024, meeting, the Cost Board discussed issues for the Stakeholders Committee and Data Issues Committee to specifically address. The meeting also included updates on the strategies from Primary Care Advisory Committee to achieve the 12% goal, findings from the Washington hospital spend analysis, and an Analytic Support Initiative update. Over the next few meetings, the Cost Board will go more into depth on the policy options in preparation for recommendations to the Legislature or other implementations with the support of committee efforts. The Cost Board requested the Stakeholder Committee focus on policy options providing more immediate protection to consumers from medical debt. The Data Issues Committee will provide data concerning facility fees and business oversight. The goal for each committee is to gather more information on their respective topics to bring back to the Cost Board for consideration.

Analytic Support Initiative Disease Expenditure Report

Joe Dieleman, Institute for Health Metrics and Evaluation (IHME)

A Washington-centric summary of health care spending based on the estimates of IHME's Disease Expenditure Project (DEX) was presented to the Joint Committees, covering the years 2010 – 2019. The modeling is constructed from 60 billion insurance claims (550 million from WA) and various other data sources. 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 this initial set of estimates. The report is being brought forth to elicit feedback to both finalize this report, and deliver an impactful final report in the fall.

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, although the size of this population is very small. 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. It was clarified to board members that both out-of-pocket and total spending was estimated *per capita* while Medicare, Medicaid, and Private Insurance were estimated *per member/beneficiary*.

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. One member sought to understand the extent to which price disincentivises utilization, but Dr. Dieleman stipulated that understanding this phenomenon granularly would require extensive survey data, but DEX could provide hints.

The DEX Report also breaks down spending down by disease, with Oral disorders, Joint pain, and Diabetes seeing the highest growth. One member was curious regarding dental in Medicaid and Nursing Facilities in Out-of-pocket, and this will be re-examined prior to report finalization. Another member was very keen to understand how the breakdown of Ambulatory care, comprised of Outpatient facilities and primary care clinics and accounting for 43% of all health care spending. In future versions of DEX, it is expected that this category will be stratified. This request for granular readout was echoed by another member wondering is this approach could work by attribution by disease condition. Another suggestion from members was to break apart price *from* intensity as two separate drivers rather than one combined driver

Additional feedback was asked to be submitted via email.

Methodology Update

Sheryll Namingit, Health Economics Research Manager, HCA

Sheryll provided an update on provider reporting including an overview of methodologies used and feedback collected. A webinar on provider reporting was presented on June 6, 2024, showing the provider reporting template that will be sent to the providers in the summer for the data collected in for 2020 – 2022. The webinar also included the provider performance against the benchmark in this first reporting year of the benchmark. The intention is to compare the confidence interval of the growth of adjusted total medical expense (TME) per-member-per-month (PMPM) to the benchmark growth. The benchmark, as voted by the Cost Board, is a combination of the weighted average of the growth rate of the median wage rate and Washington's per capita gross domestic product. The adjusted TME PMPM is the age-sex adjusted, aggregated, and truncated claims PMPM plus the unadjusted non-claims PMPM. For the confidence interval, different variances that carriers submitted were compiled to produce a single variance for each provider.

The four methodologies included truncating claims spending, age-sex risk adjusting truncated claims spending PMPM, pooling standard deviation and variances, and confidence interval of cost growth of adjusted TME PMPM.

Method 1: Truncating claims. Spending does not include spending above a certain threshold to ensure spending from very few high-cost individuals does not disproportionately affect the cost growth of a provider or carrier. The threshold was set so the total amount of per-member spending above the threshold is about 5% of overall market spending based on an OnPoint analysis of 2019 all-payer claims databases data. Truncation is applied on a per-member basis and based on this data less than 1% of members have truncated spending. More details and examples are available in the Implementation Manual.

Market	Truncation Level	% of Health Expenditures Removed w/ Truncation	% of Members Exceeding Threshold
Commercial	$200,000	5.02%	0.12%
Medicaid (MC)	$125,000	5.47%	0.12%
Medicare (Adv)	$125,000	4.85%	0.64%

Method 2: Age-sex risk adjusting truncated claims spending PMPM. The adjustment is based on age and sex risk factors, the weight of each age-sex combination, and the population weight of each age-sex combination. Age and sex risk factor weights is calculated by getting the ratio of PMPM in an age and sex by each category and overall PMPM of insurance category. This is fixed at the baseline year when calculating the cost growth and does not influence the cost growth of a provider or carrier. What does influence the cost growth is the population weight of each age-sex combination. If there are more members in age-sex bands with higher PMPM, growth is adjusted downwards. If there are more members in age-sex bands with lower PMPM, growth is adjusted upwards. This standardizing adjustment is performed to ensure that the cost growth reflects what costs would be if a risk profile were that of the overall insurance category.

Method 3: Pooling variance. For each provider in each market, standard deviation of truncated claims PMPM is different across carriers because carriers are submitting data for the providers. It' is necessary to pool these

standard deviations to get a single variance. This serves as an input to calculating the confidence interval of the growth rate.

Method 4: Calculating the confidence interval of the growth rate of adjusted TME PMPM. The risk adjusted truncated claims spending PMPM is summed with the non-claims PMPM to get the adjusted TME PMPM. Then the pooled variance serves as an input to calculate the confidence interval, specifically the 95% confidence interval, to get the lower and upper bound as well as point estimate. The confidence interval is compared to the benchmark. If the lower bound is greater than the set benchmark, then the cost growth of the provider exceeds the cost growth benchmark.

Committee members were invited to provide feedback for collection to Sheryll by June 26, 2024.

Public Comment – Stakeholders and Joint Committee Meetings

Rachelle Bogue called for comments from the public. There were no public comments.

Adjournment

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

Tab 3

Washington State Health Care Authority

Cost Board Update to Committee

Meeting held on Thursday, September 19, 2024

- Primary Care Committee update and approval of recommendations
- Facility Fees
  - Massachusetts Health Policy Commission's site-based neutral recommendations
  - Board discussion and vote
  - Intersections of All-Payers Claims Database data
- OIC Final Health Care Affordability Report presentation and discussion
- Legislative Affordability Priorities from State Agencies
  - Health Benefit Exchange
  - Health Care Authority
- Next meeting: Thursday, December 12, 2024

Cost Board Update to Committee

Meeting held on Thursday, November 7, 2024

- Best Practices Report
  - The legislature directed the Washington State Health Care Cost Transparency Board to study best practices from other states
  - HMA conducted survey highlighting best practices across eight states
  - The full report is found in the meeting packet and is also part of the legislative report
- Business Oversight of Mergers and Acquisitions
  - Presenters discussed model legislation for overseeing healthcare mergers and acquisitions emphasizing the need for transparency, particularly with private equity and other large healthcare consolidations
  - The board was advised to consider a phased approach or targeted legislation that could address high priority mergers without overwhelming regulatory structures
- National Academy for State Health Policy
  - Board members discussed NASHP's recommendations as a potential roadmap, particularly provisions for monitoring private equity investments and implementing transparency measures
- Discussion and Recommendations Regarding Business Oversight
  - Board members acknowledged gaps in current oversight suggesting to incorporate NASHP model recommendations
  - Board members also recommended developing stronger ties with the Attorney Generals office to ensure careful review of healthcare mergers and acquisitions

Cost Board Update to Committee (Continued)

- Analytic Support Initiative (ASI) Report
  - The ASI report presented updated cost growth data from 2019-2022, helping the Board access recent healthcare spending trends
- Facility Fees
  - Board members agreed on the need for increased transparency in facility fee structures and private equity ownership disclosures
- 2024 Legislative Report
  - High level overview of the 2024 report was presented
  - One board member suggested moving the recommendations to the executive summary
  - Board members supported adopting the report
  - Board members supported including reference-based pricing policies to address high provider cost
- Next meeting: Thursday December 12, Public Hearing, 2024

Tab 4

Washington State Health Care Authority

Analytic Support Initiative

WA Health Care Cost Transparency Board

November 7, 2024

HCA & Institute for Health Metrics and Evaluation

ASI

Analytical Support Initiative Overview

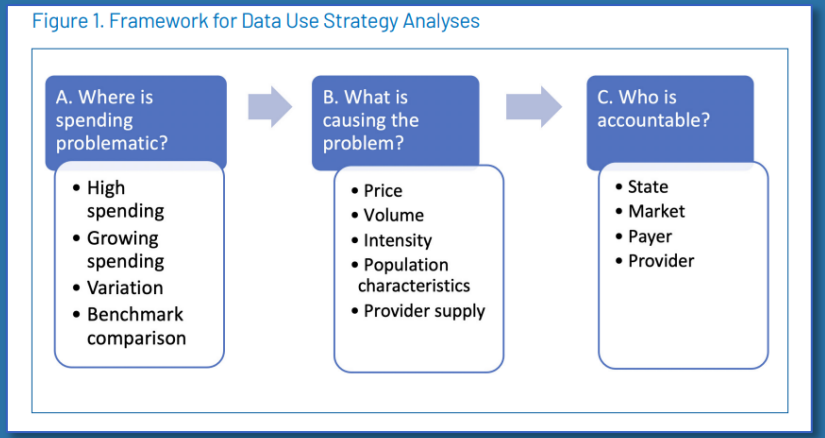
Condensed objective:

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

Philanthropic funding for July 2023-July 2025

Timeline:

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



Update

1. In December 2023, the **Cost Board endorsed the *ASI Analytic Strategy*** containing three key analyses to be completed in 2024
   - ✓ **Estimate spending and utilization per capita and prevalent case** for key diseases disaggregated by age, sex, type of care, location, payer group, and health condition
   - ❑ **Direct age- and indirect risk-adjustment** of spending and utilization estimates for comparison across counties, states, and time
   - ✓ **Decompose differences in spending** across counties and time

Update

1. In December 2023, the **Cost Board endorsed the *ASI Analytic Strategy*** containing three key analyses to be completed in 2024

2. In April, IHME produced a draft of the **Preliminary Disease Expenditures Report**

    Caveats about the Preliminary Disease Expenditure Report

    - *It is based on previous research focused on estimating spending by county in the US*
    - *It is a model of the type of research that could be done for the ASI*

Update

1. In December 2023, the **Cost Board endorsed the *ASI Analytic Strategy*** containing three key analyses to be completed in 2024

2. In April, IHME produced a draft of the **Disease Expenditures Report**

3. In October, IHME produced an updated draft of the **Disease Expenditures Report**
    - *Estimates extend through 2022*
    - *Professionally laid out report*

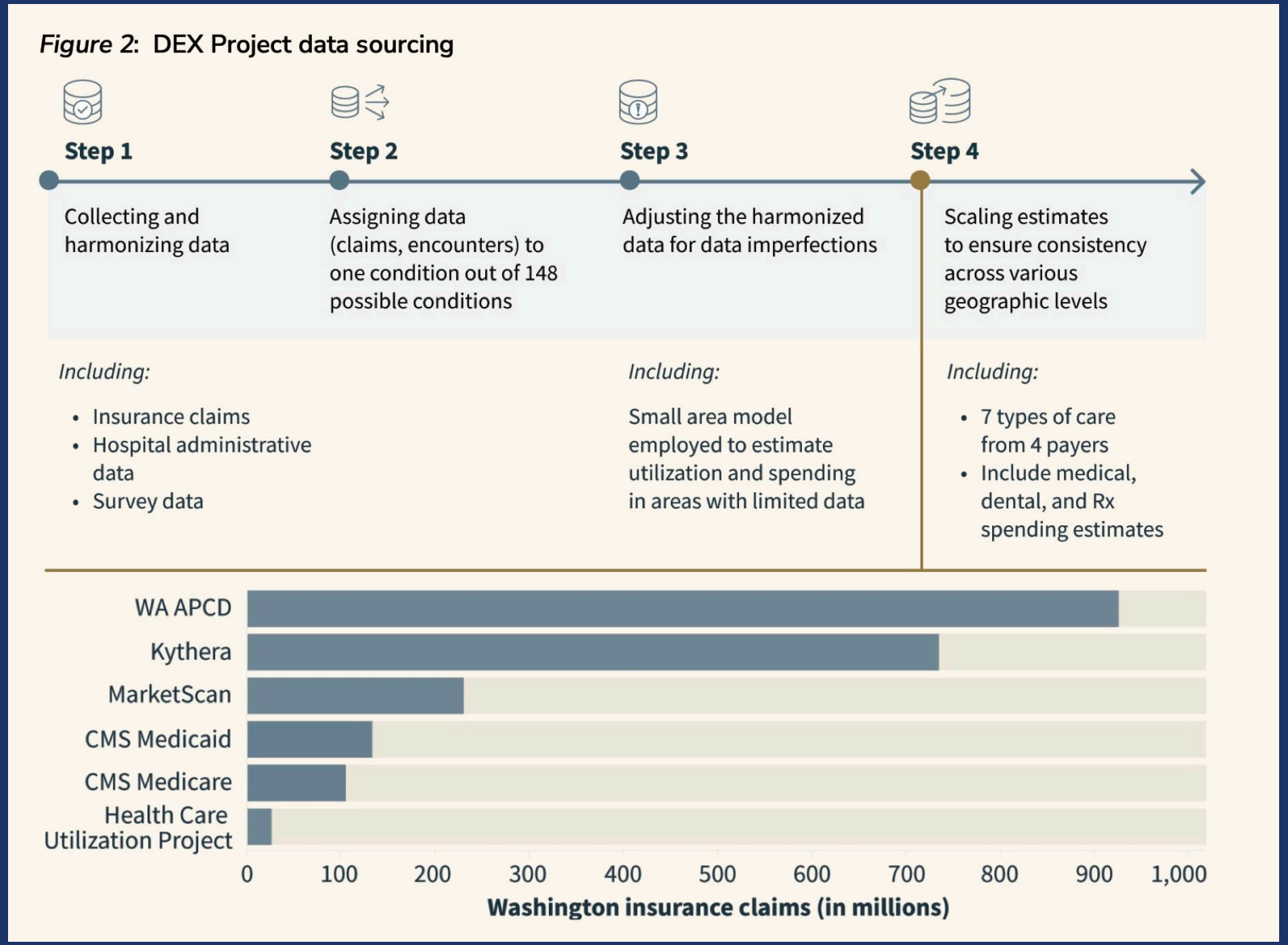
Objective for today

1. Review the updated report

2. As we go into the last part of this grant are there specific things you would like the ASI to focus on?

Estimates extend to 2022

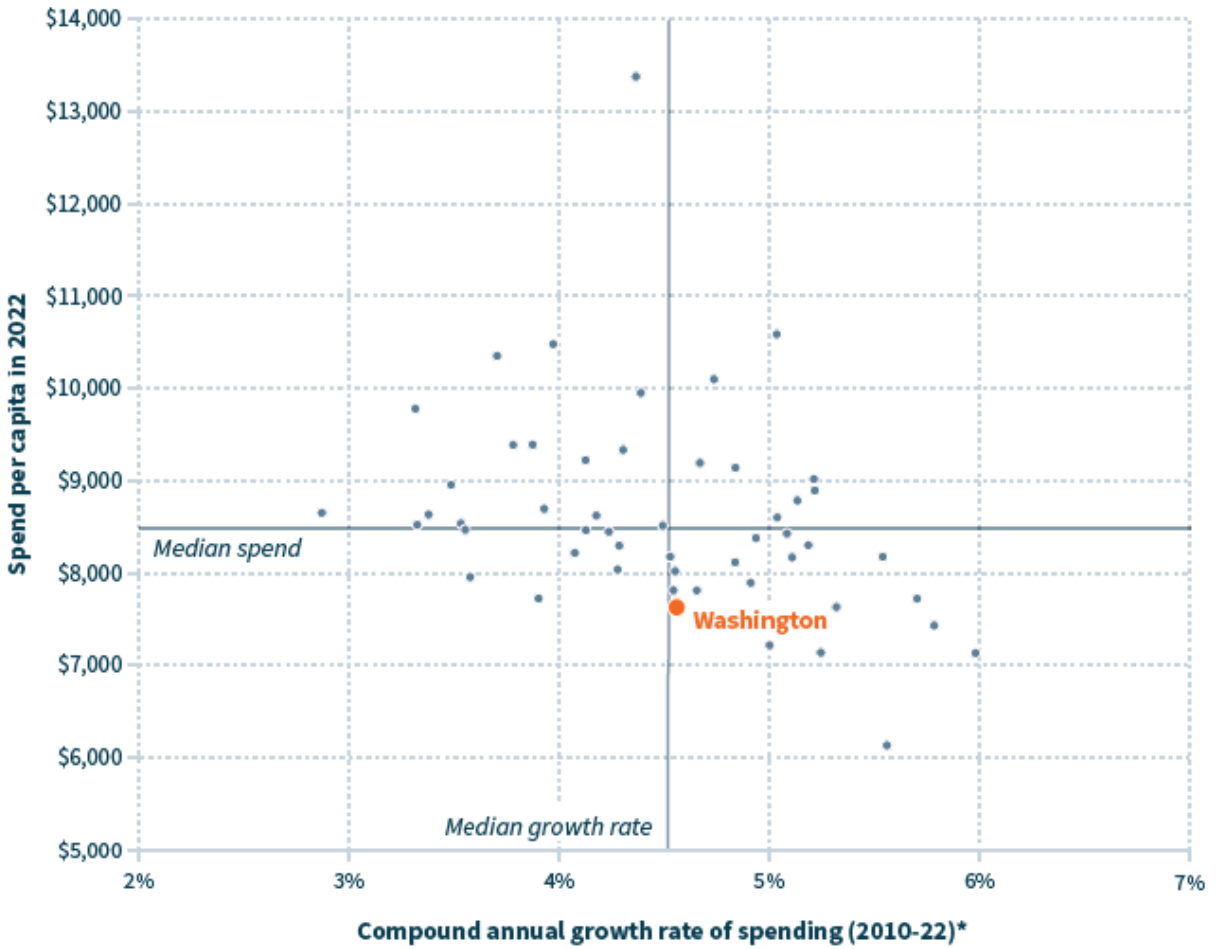
Incorporated WA APCD



Comparing WA to the other US states

- WA has the 6th lowest spending per capita
- WA has roughly average health care spending growth

Figure 4: State-level spend and long-term growth performance



*Not adjusted for inflation

Source: IHME Disease Expenditure (DEX) estimates

Health care spending by type of care and payer

- We estimated $60.1 billion of health care spending in 2022**
  ** Not official WA estimates
- Nearly half is from private insurance and over a quarter is from Medicare
- Medicaid and especially Medicare spending is increasing
- Half of that spending was on ambulatory care

***Pharmaceutical spending estimates are only for retail pharmaceuticals

Figure 6: Total spending by payer and type of care, 2022

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

*Age-standardized growth rate (2010-22)** -3.6–2.2% 2.2–4.2% 4.2–5.9% 5.9–23.8%

Type of care	Medicaid	Medicare	Out-of-pocket	Private	All payers
Pharmaceutical	$0.8	$2.2	$0.6	$2	$5.6
Nursing facility	$0.9	$0.9	$1	$0.7	$3.5
Inpatient	$2.7	$4.3	$0.3	$5.3	$12.6
Home health	$0.9	$0.9	$0.1	$0.3	$2.2
Emergency department	$0.1	$0.7	$0.1	$0.8	$1.7
Dental	$0.5	<$0.1	$2.1	$2.3	$5
Ambulatory	$4.6	$7	$3	$15	$29.5
All types of care	$10.4	$16	$7.3	$26.4	**$60.1**

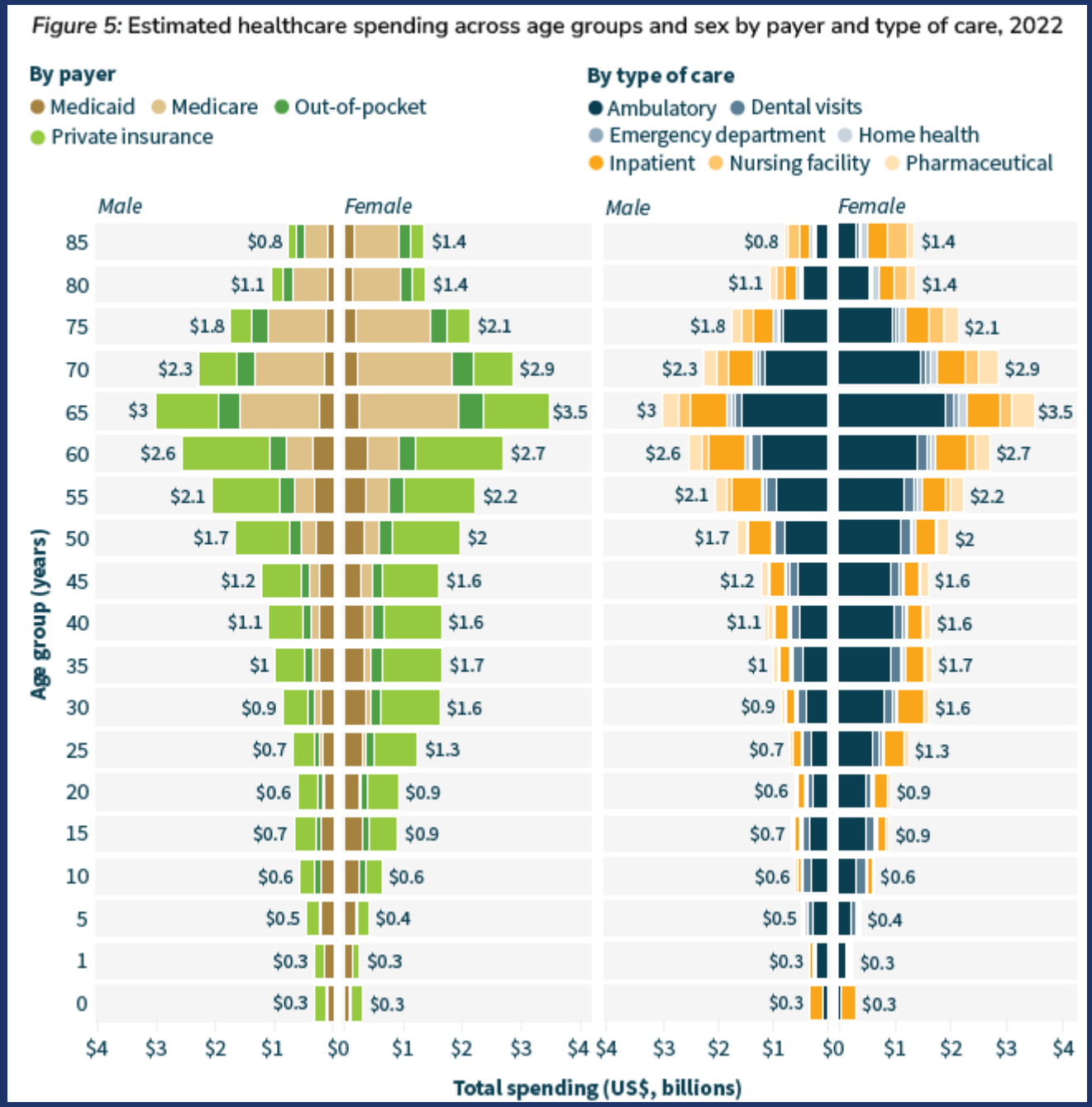
Payer

**Not adjusted for inflation*

Source: IHME Disease Expenditure (DEX) estimates

Health care spending by age, sex, payer, and type of care

- More spending is on 65–69-year-olds than any other group
- Ambulatory care makes up nearly half of spending
- Private insurance makes almost half of health care spending, with most but certainly not all spending on those less than 65 years

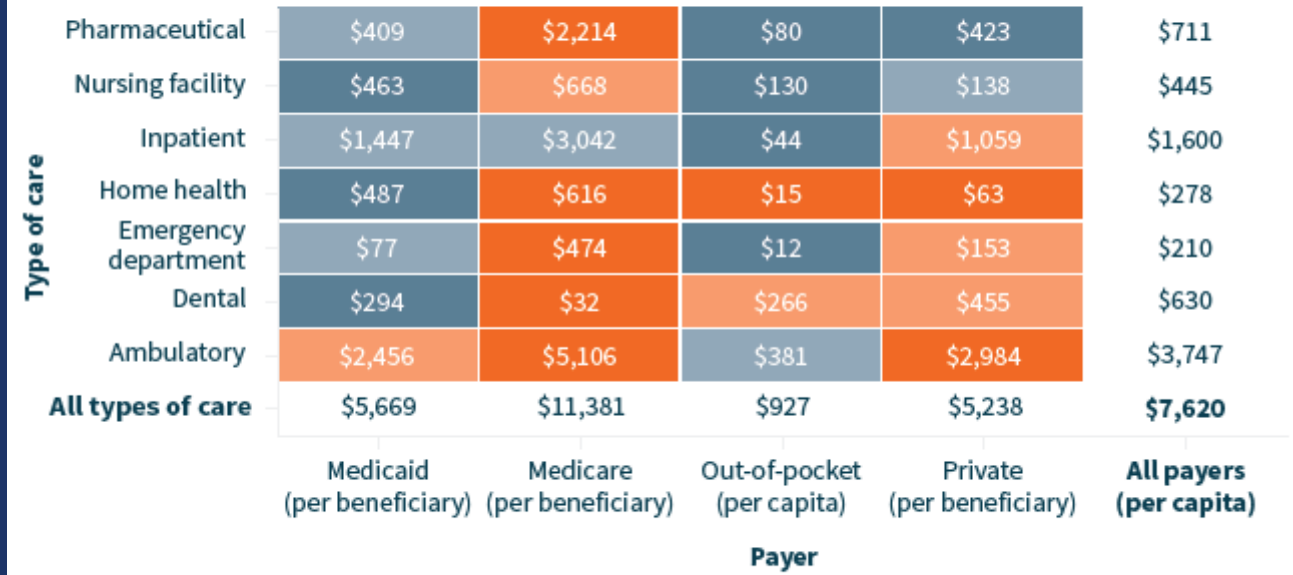


Health care spending per beneficiary by type of care and payer

- In per beneficiary terms, Medicare spending is nearly double Medicaid and Private insurance
- Medicare spending and private insurance spending per beneficiary is growing the most

Figure 7: Spending per beneficiary by payer and type of care, 2022

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



*Not adjusted for inflation

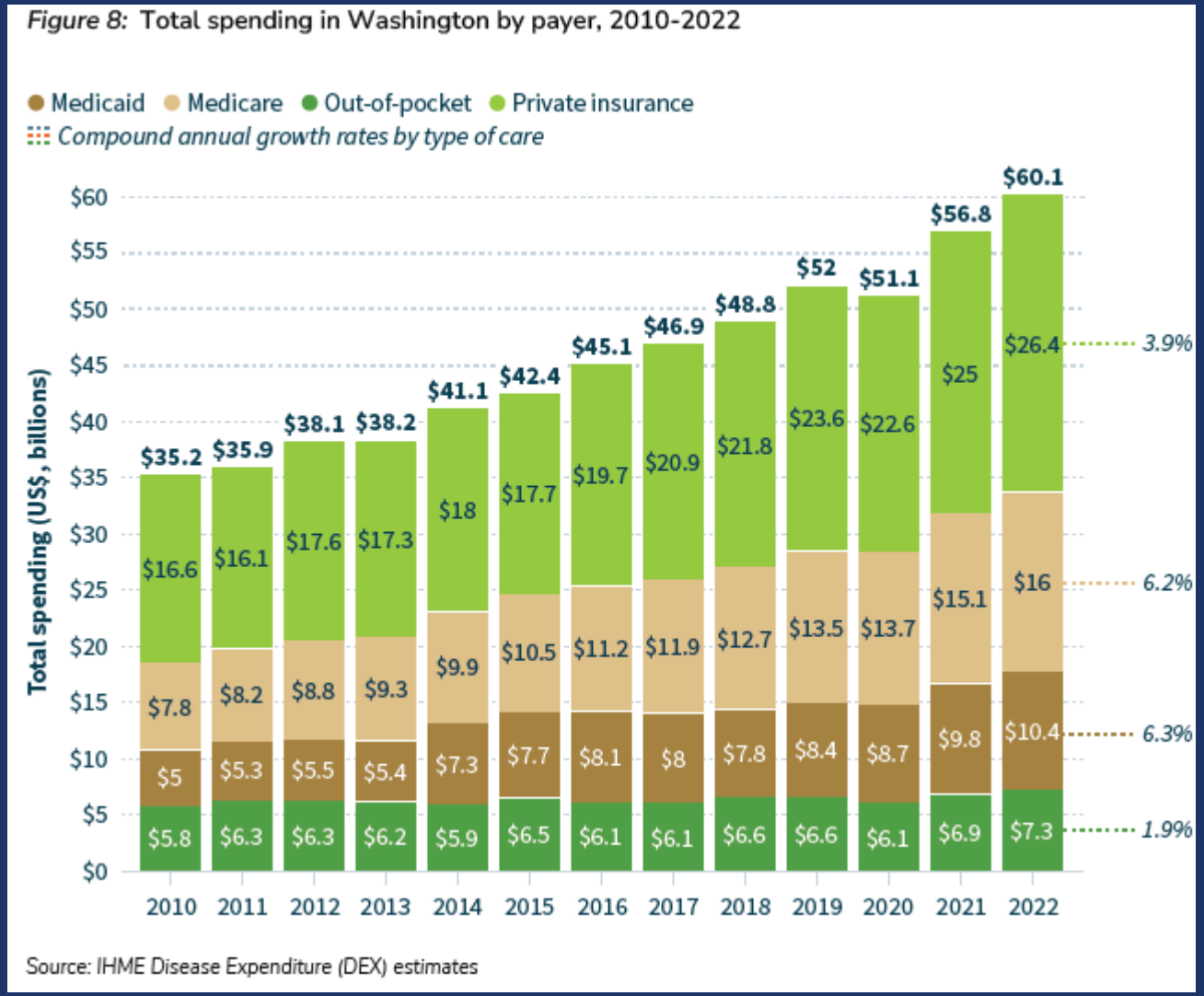
Source: IHME Disease Expenditure (DEX) estimates

Health care spending by payer over time

- Health care spending has increased from $35.2 billion in 2010 to $60.1 billion in 2022**

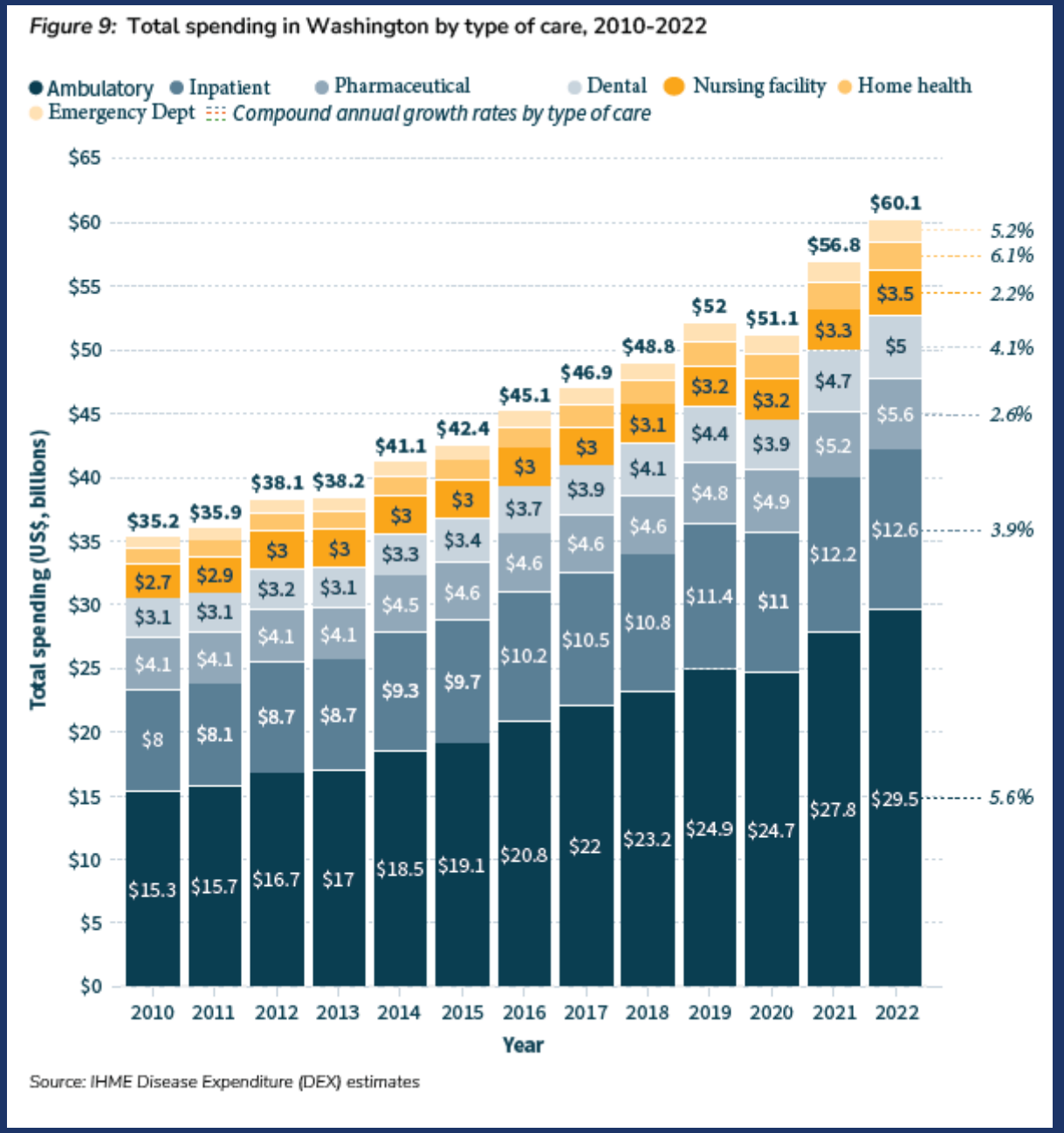
  **Not official WA estimates

- Medicare and Medicaid spending is growing the fastest



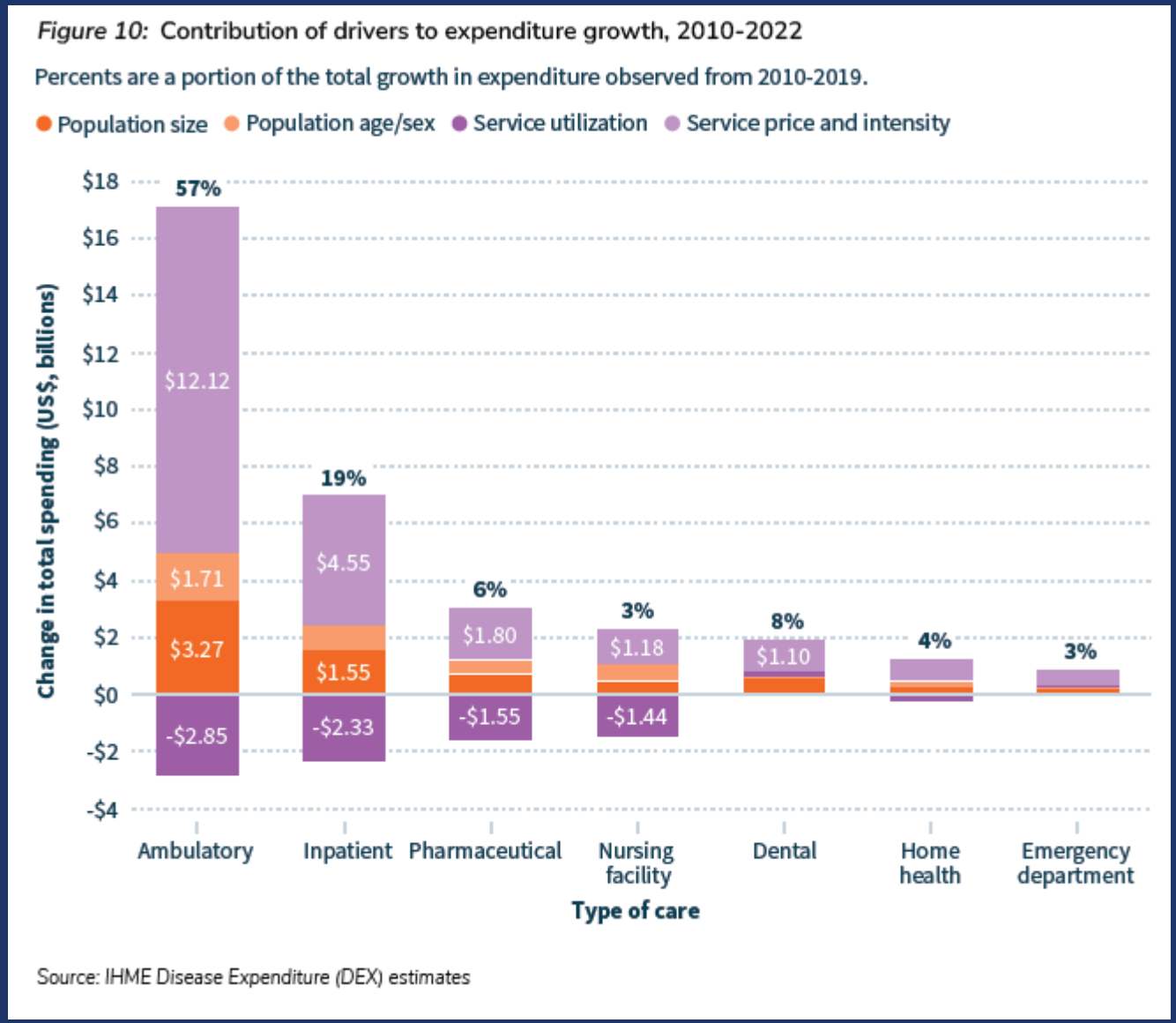
Health care spending by type of care over time

- Spending on ambulatory care is large and growing quickly
- Spending home health care and ED are a small amounts ($2.2b and $1.7b) but are types of care that are growing the quickly



Assessing drivers of increases in spending

- 57% of the increase in spending was because of increases in ambulatory spending. While ambulatory utilization was down, the spending per visit was way up
- Increases in price and intensity of care was responsible for much of spending increases
- Larger and older population also increased spending



Assessing drivers of increases in spending for each payer

- There was a lot of similarities across payers
- Increases in price and intensity of care seem to be driving increases in spending in most types of care for most payers. Especially true for ambulatory care, inpatient care, and private insurance

Health care spending by disease

- Musculoskeletal disorders make up 14% of all health care spending, while cancers and cardiovascular diseases each make up 12%
- Spending on mental disorders and substance abuse disorders is growing the fastest of all aggregate health conditions

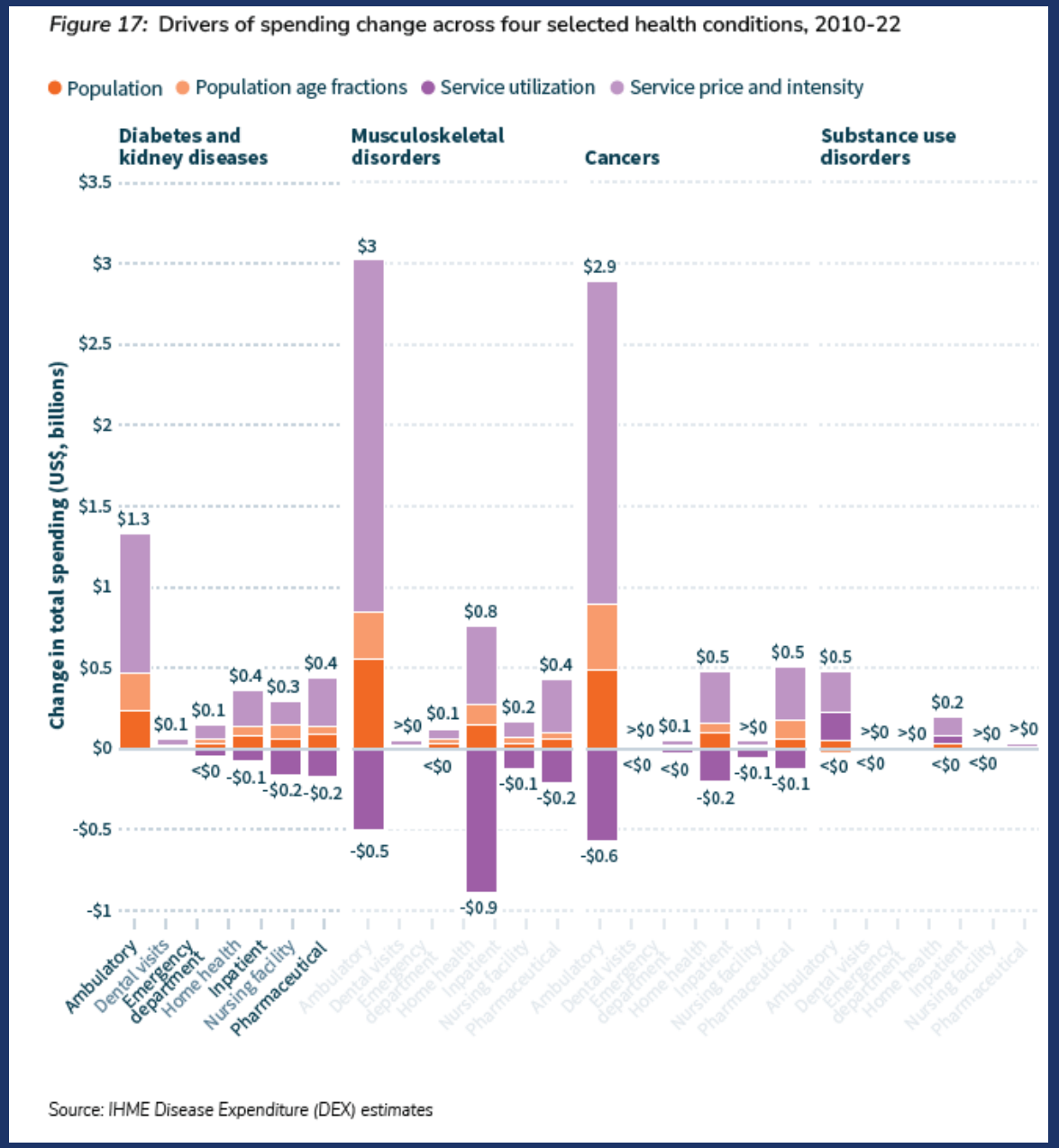
Aggregated health condition categories	Total spending (billions)	Growth rate; 2010-2022*	Percent of state spending
Musculoskeletal disorders	$ 6.91	4.4%	13.5%
Cancers	$ 6.33	5.6%	12.4%
Cardiovascular diseases	$ 6.26	4.5%	12.2%
Other non-communicable diseases	$ 5.07	3.7%	9.9%
Diabetes and kidney diseases	$ 4.47	5.7%	8.7%
Mental disorders	$ 4.18	6.9%	8.2%
Oral disorders	$ 3.46	3.7%	6.8%
Digestive diseases	$ 3.27	3.6%	6.4%
Well care	$ 3.22	4.5%	6.3%
Neurological disorders	$ 2.83	3.6%	5.5%
Injuries	$ 2.21	3.5%	4.3%
Skin and subcutaneous diseases	$ 1.71	3.8%	3.3%
Chronic respiratory diseases	$ 1.66	3.4%	3.2%
Respiratory infections and tuberculosis	$ 1.66	3%	3.2%
Other infectious diseases	$ 1.57	5.6%	3.1%
Sense organ diseases	$ 1.43	5.5%	2.8%
Risk factors	$ 1.20	2.9%	2.3%
Maternal and neonatal disorders	$ 1.18	6.2%	2.3%
Substance use disorders	$ 1.08	9.4%	2.1%
HIV/AIDS and sexually transmitted infections	$ 0.24	3.4%	0.5%
Enteric infections	$ 0.15	1.8%	0.3%

**Not adjusted for inflation*

Source: IHME Disease Expenditure (DEX) estimates

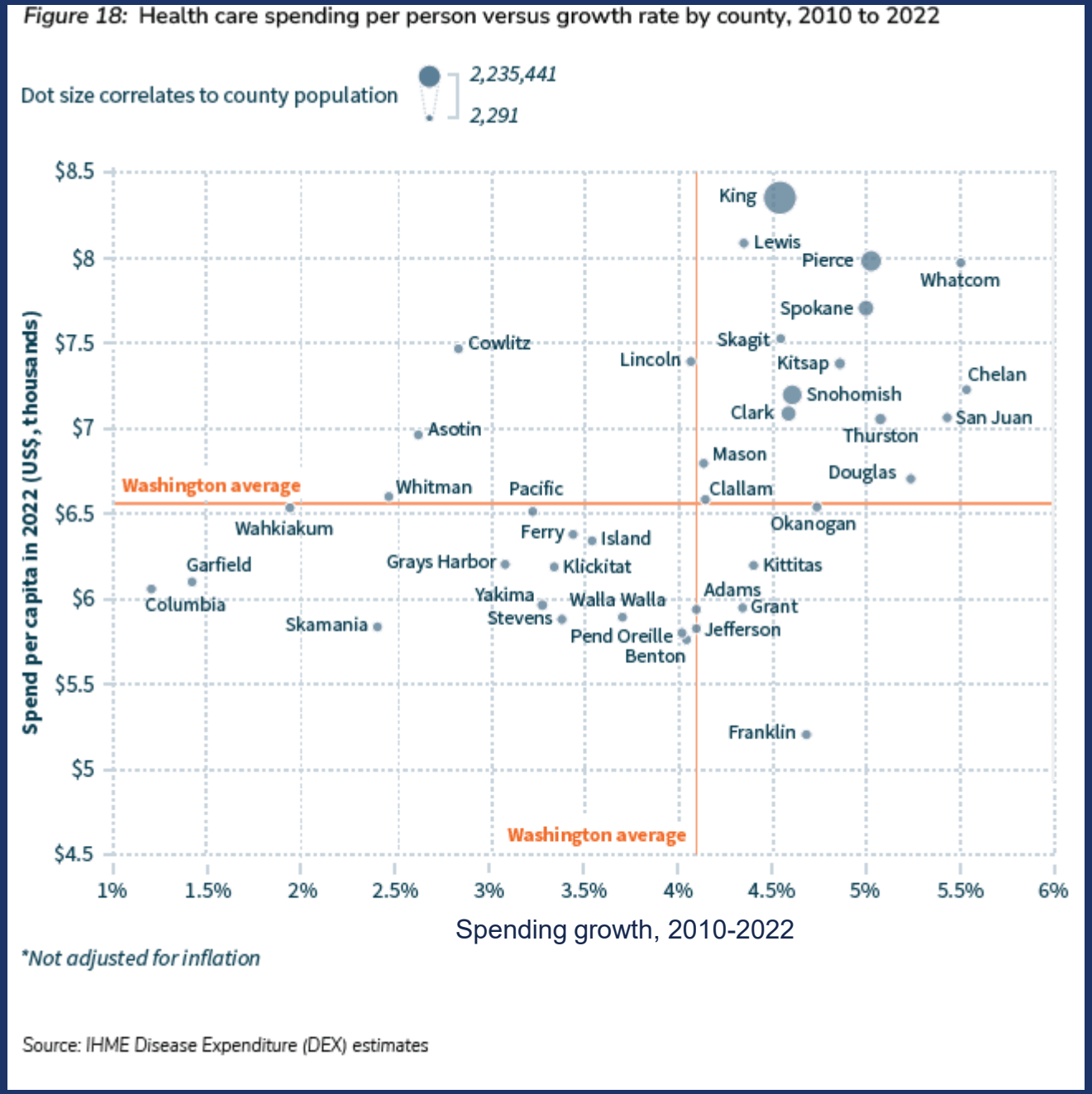
Assessing drivers of health care spending by disease

- Each category of diseases has spending being driven by something different, but across all diseases price and intensity of care is the largest contributor to growth in spending



Spending and growth in spending for each WA county

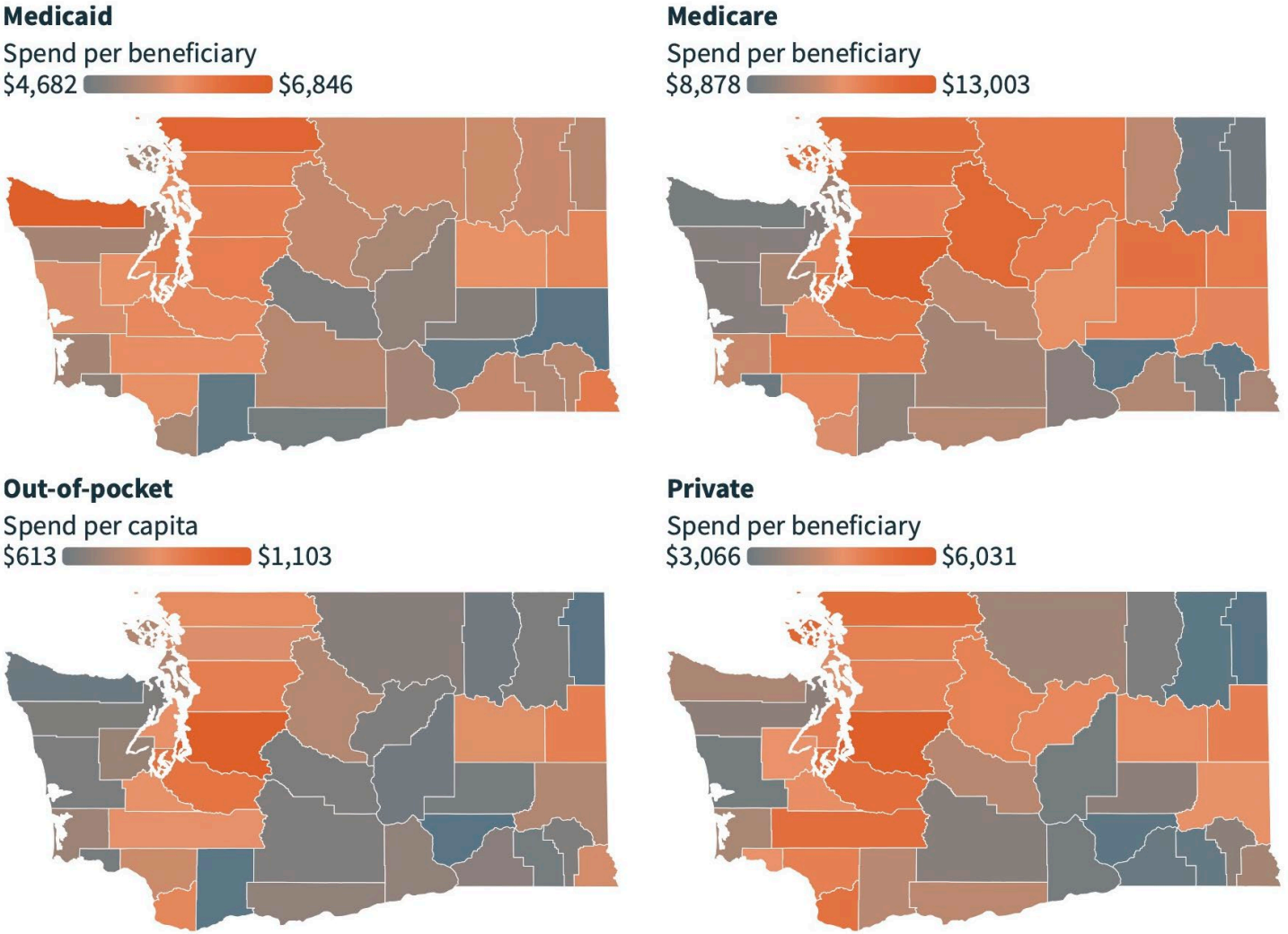
- In per capita terms, King, Lewis, and Pierce counties have the highest spending
- Chelan, San Juan, and Whatcom counties have the largest health care spending growth rates



Spending by payer and county

- Across payers, highest spending rates are I-5 corridor
- Lowest spending rates are in Olympic Peninsula, and northeast and southeast corners of the state

Figure 19: Age-standardized spending per beneficiary by payer

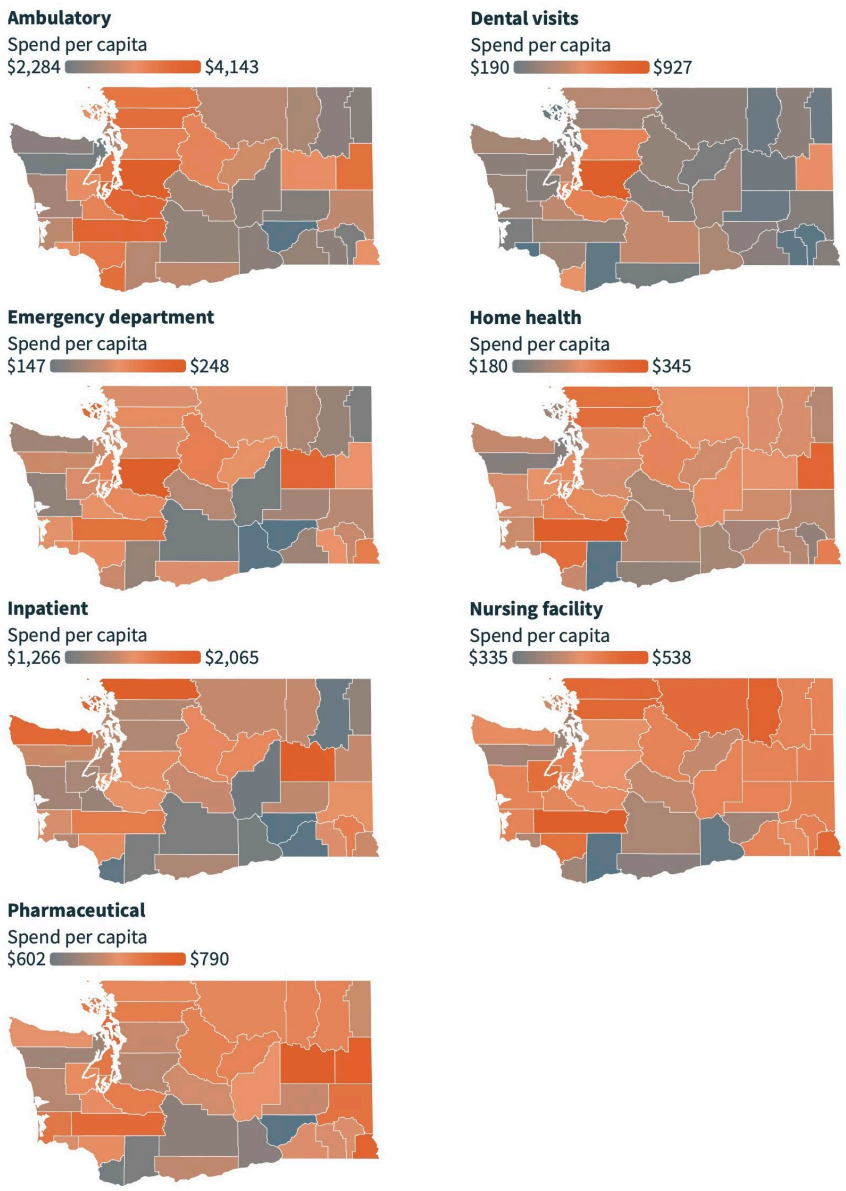


Source: IHME Disease Expenditure (DEX) estimates

Spending by type of care and county

- Dental care spending is the most concentrated across the state
- Counties in the Olympic Peninsula have relative less ambulatory care spending relative to inpatient and ED spending

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



Source: IHME Disease Expenditure (DEX) estimates

Thank you

ASI

Tab 5

Washington State Health Care Authority

Calendar of Board & Advisory Committee Meetings 2025

Health Care Cost Transparency Board

Date	Time
January 30	2-4 pm
March 5	2-4 pm
April 24	2-4 pm
June 3	2-4 pm
July 22	2-4 pm
September 25	2-4 pm
November 20	2-4 pm

Advisory Committee on Primary Care

Date	Time
August 28	2-4 pm

Health Care Stakeholder Advisory Committee

Date	Time
March 27	2-4 pm
May 22	2-4 pm
August 7	2-4 pm
October 23	2-4 pm

Advisory Committee on Data Issues

Date	Time
March 27	2-4 pm
May 22	2-4 pm
August 7	2-4 pm
October 23	2-4 pm

Universal Health Care Commission

Date	Time
February 13	2-5pm
April 17	2-5pm
June 11	2-5pm
August 14	2-5pm
October 9	2-5pm
December 11	2-5pm

Finance Technical Advisory Committee	
Date	**Time**
January 16	2-430pm
March 13	2-430pm
May 15	2-430pm
July 17	2-430pm
September 18	2-430pm
November 6	2-430pm

Nominating Committee	
Date	**Time**
March 26	830-930am
July 30	830-930am
October 2	830-930am