HCA Legislative Symposium

November 8, 2023

Washington State Health Care Authority

Community Behavioral Health

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Framing the day

How best to serve people in the community behavioral health system

Supporting and building out the service continuum

Beds are not the only answer

With efforts to transform the behavioral health system like

- Integrated Care
- Increased inpatient capacity

It is essential that we ensure our ability to also meet the needs of people living with serious mental illness in the community

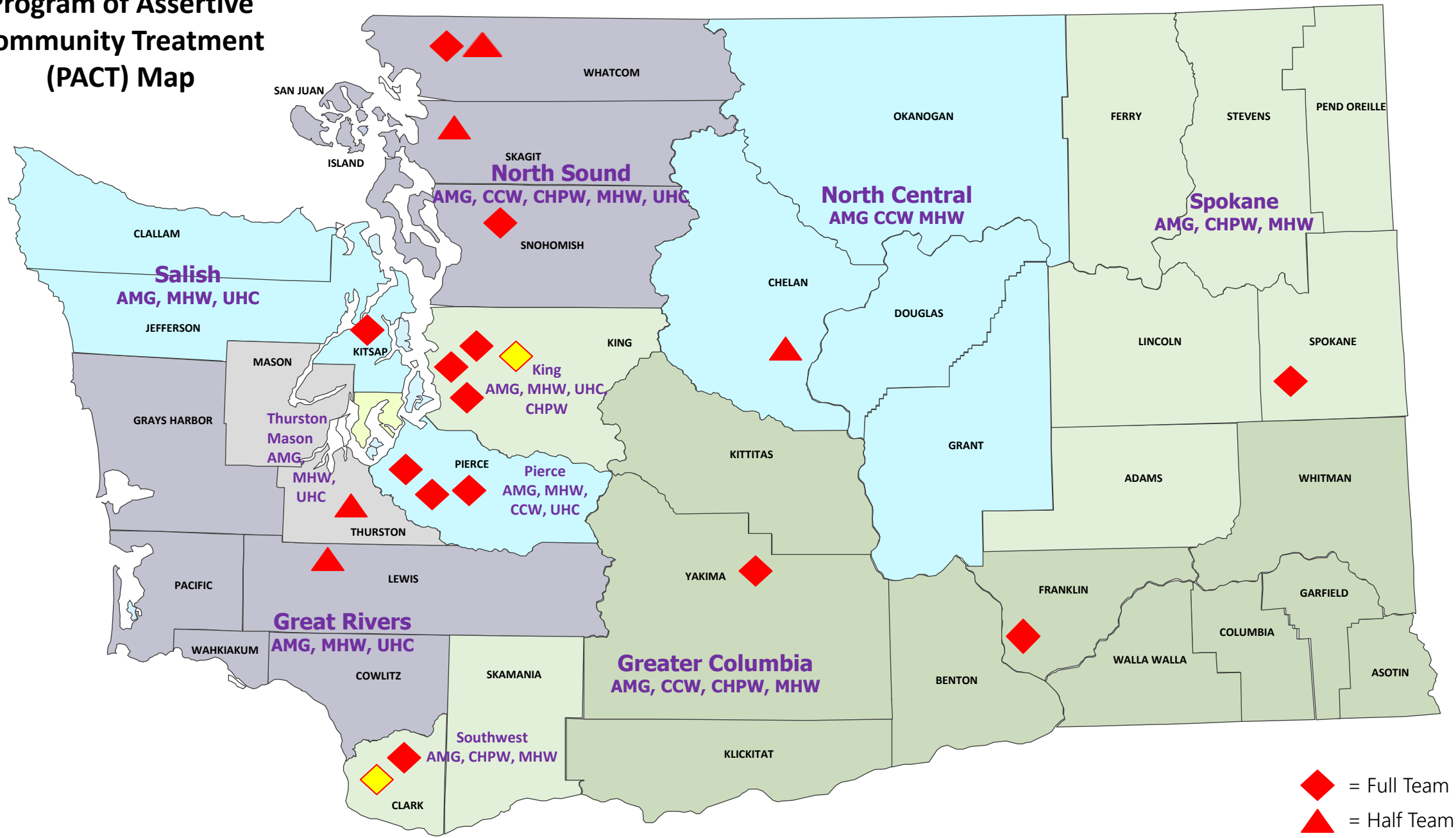
Stabilizing community behavioral health agencies (CBHAs)

- CBHAs are the main providers for people living in the community with serious mental illness.
- Workforce supports that have helped CBHAs, in the 23-25 biennium, the legislature invested $5.1B in BH Investments over the past four years include:
  - 9% increase in Medicaid rates with an additional 15% going into effect Jan. 24.
  - $130M in provider relief funds, targeted at workforce recruitment and retention.
  - The creation of a Joint Legislative Executive Committee on behavioral health with workforce in its scope.
  - Legislative bills to streamline and align licensing requirements across professions.
  - Behavioral health careers campaign www.StartYourPath.org

Stabilize Program of Assertive Community Treatment (PACT)

- PACT is characterized as multidisciplinary approach serving people with extensive histories of hospitalization and complex behavioral health needs in their community.
  - Team-based
  - Outreach-based
  - Evidence-d based
- Better coordination between care settings than routine services.
- If utilized early through a person's illness it may reduce hospital usage.
- PACT programs have taken a hit during the pandemic and need special support to restore their previous level of operation.

Program of Assertive Community Treatment (PACT) Map



Intensive Residential Treatment (IRT) model

- Currently piloted in 3 communities
- Serves as a community wraparound support similar to PACT
- Need to expand to more communities to serve people well in their community

Intensive behavioral health treatment facilities

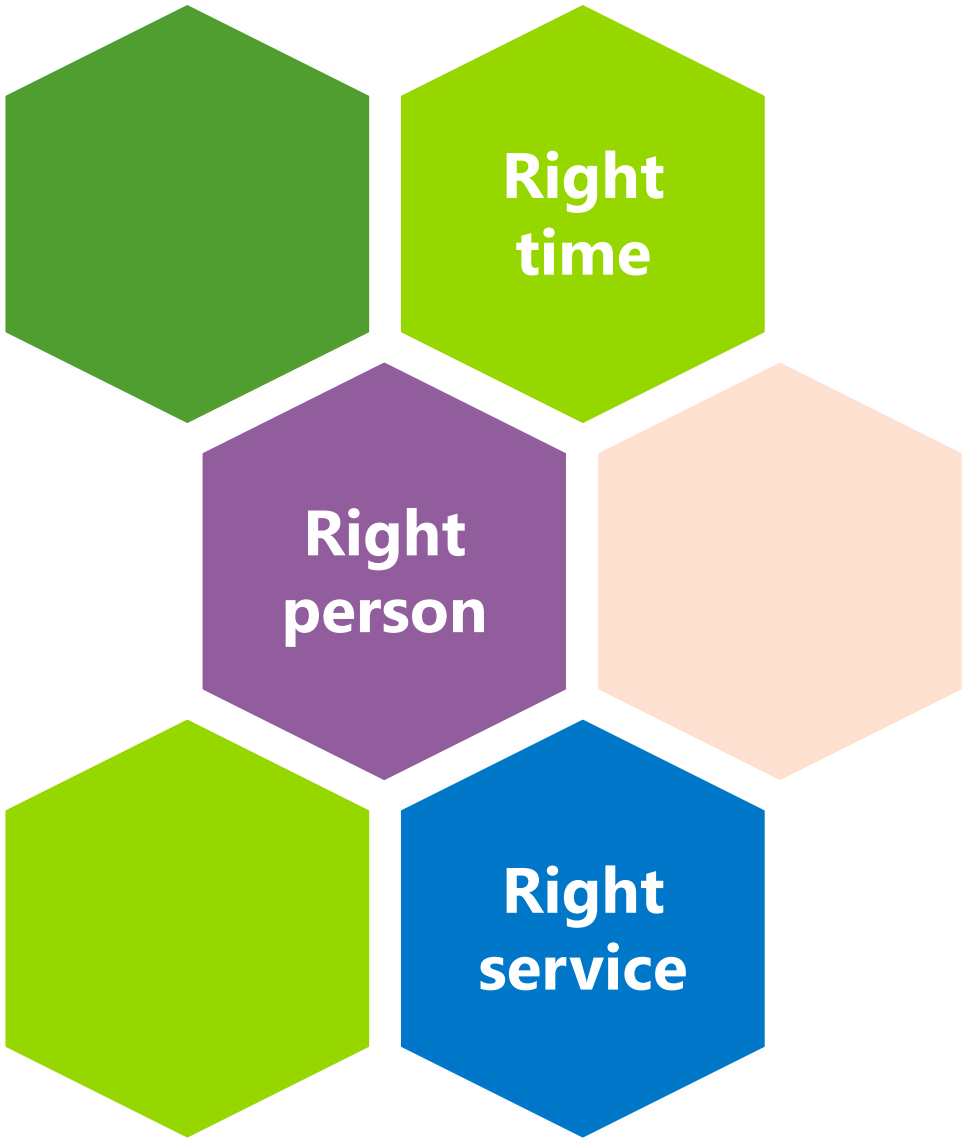
- This is an important new provider type needed to fill the gaps in the service continuum
  - Continued support of this new provider type as it launches in Washington
- Rate increases
- Technical assistance and training to ensure successful implementation of the model

Housing is health

Housing is foundational for people with SMI to live successfully in their community.

- HCA housing supports
  - Foundational community supports (FCS)
  - Housing and Recovery through Peer Services (HARPS)
  - Apple Health and Homes (AHAH)
  - Housing First

Not all beds are alike



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Long Term Civil Commitment

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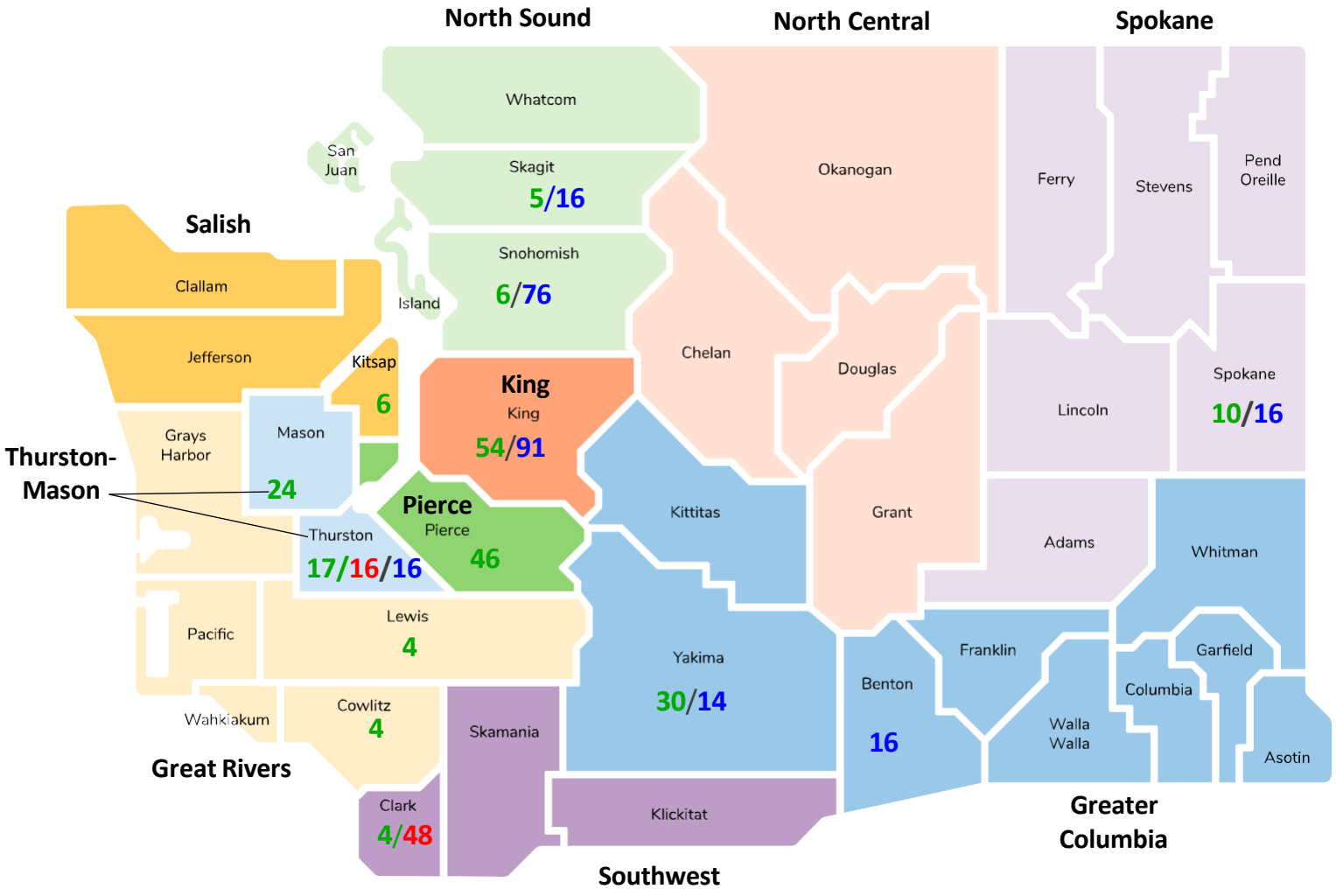
HCA 90- or 180- day civil commitment beds



Location of beds per County

- **210 current contracted beds** for FY 2024; **75** beds may be used for civil conversions
- **DSHS Owned** (16 on line, 48 future)
- **245 HCA contracted future beds**

Projected future total = **455**

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Long term civil commitment (LTCC)

Rates are not keeping pace with the cost of service

Funded future state of 90-to-180-day beds

Funded future state – 245 beds

- **University of Washington Teaching Hospital – 75 beds**
- **Commerce funded sites from 17-19 budget, 19-21, 21-23 budget - 170 beds**
  - Thurston County – 16 (Recovery Innovations (19-21 budgets)
  - King County – 16 (Recovery Innovations) (19-21 budget)
  - Snohomish County – 76 (Compass Health 16, Public Hospital District No. 1 14, Evergreen Health 14, Unity Evaluation and Treatment 16, HCA 16 (17-19, 19-21, 21-23 budgets)
  - Skagit County – 16 (Pacific Healthcare) (21-23 budget)
  - Yakima County – 14 (Astria Hospital) (19-21, 21-23 budgets)
  - Benton County – 16 (Aristo Healthcare) (21-23 budget)
  - Spokane County – 16 (Relief Health E&T) (21-23 budget)
- **DSHS owned site-64 beds**
  - Clark County – 48 (proposed DSHS owned site with three 16 bed facilities)
  - Thurston County – 16 (DSHS owned site with a 16-bed facility)

LTCC Future vision

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Complex needs

- Complex medical and/or behavioral needs
  - TBI
  - Dementia
  - Co-occurring
  - I/DD
  - Neurocognitive
- Account for the true cost of care

Discharge planning

- Peer Bridger model to serve people in the LTCC beds

Funding complexities

Takeaway

- A full continuum of behavioral health services includes
  - Crisis
  - Outpatient
  - Social determinants of health
  - More intensive services when needed
- Supporting crisis and outpatient community services prevents overutilization of more intrusive and extensive deeper end services like hospitalization or negative outcomes like arrests

Questions

HCA's opioid and fentanyl epidemic background and response

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State opioid and overdose response plan

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State opioid and overdose response plan

- Has served as the state's collaborative framework for addressing opioid and SUD related issues for many years. Led by Executive Sponsors from DOH, HCA, and UW.
- Workgroups are organized around 5 goals –
  1. Prevention opioid misuse
  2. Detect and treat opioid use disorders
  3. Ensure health and wellness of people who use drugs (PWUD)
  4. Use data to inform process
  5. Support people in Recovery
- Population focused WGs: AI/AN, criminal justice, pregnant and parenting
- Support WGs – Communications, Data

Confirmed overdose deaths among Washington residents

Drug Type	2017	2018	2019	2020	2021	2022
Any Drug	1163	1181	1259	1731	2264	2703
Any Opioid	739	744	827	1194	1619	2048
Heroin	306	329	347	384	344	154
Synthetic Opioids	142	224	337	672	1214	1850
Rx Opioid (not Fentanyl)*	342	305	267	328	402	303
Psychostimulants	390	473	540	728	1142	1363
Cocaine	111	129	132	187	232	361

2022 data are finalized
* Rx Opioid: T40.2 and T40.3

Source: WA DOH death certificates
Data as of: 18Sept2023

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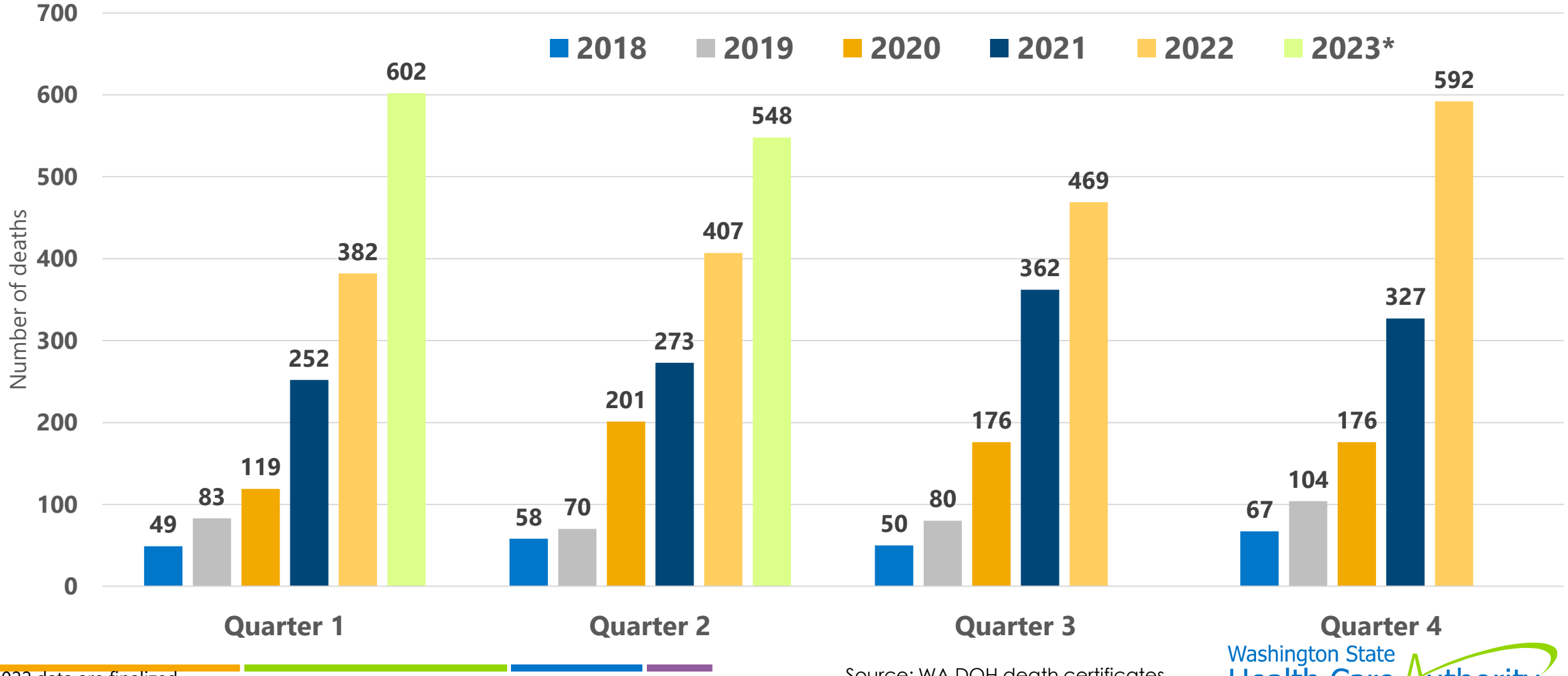
Number of Overdose Deaths Involving Fentanyl and Fentanyl analogs by Quarter among Washington Residents



2022 data are finalized.
*2023 data are preliminary and will change.

Source: WA DOH death certificates
Data as of 18Sept2023

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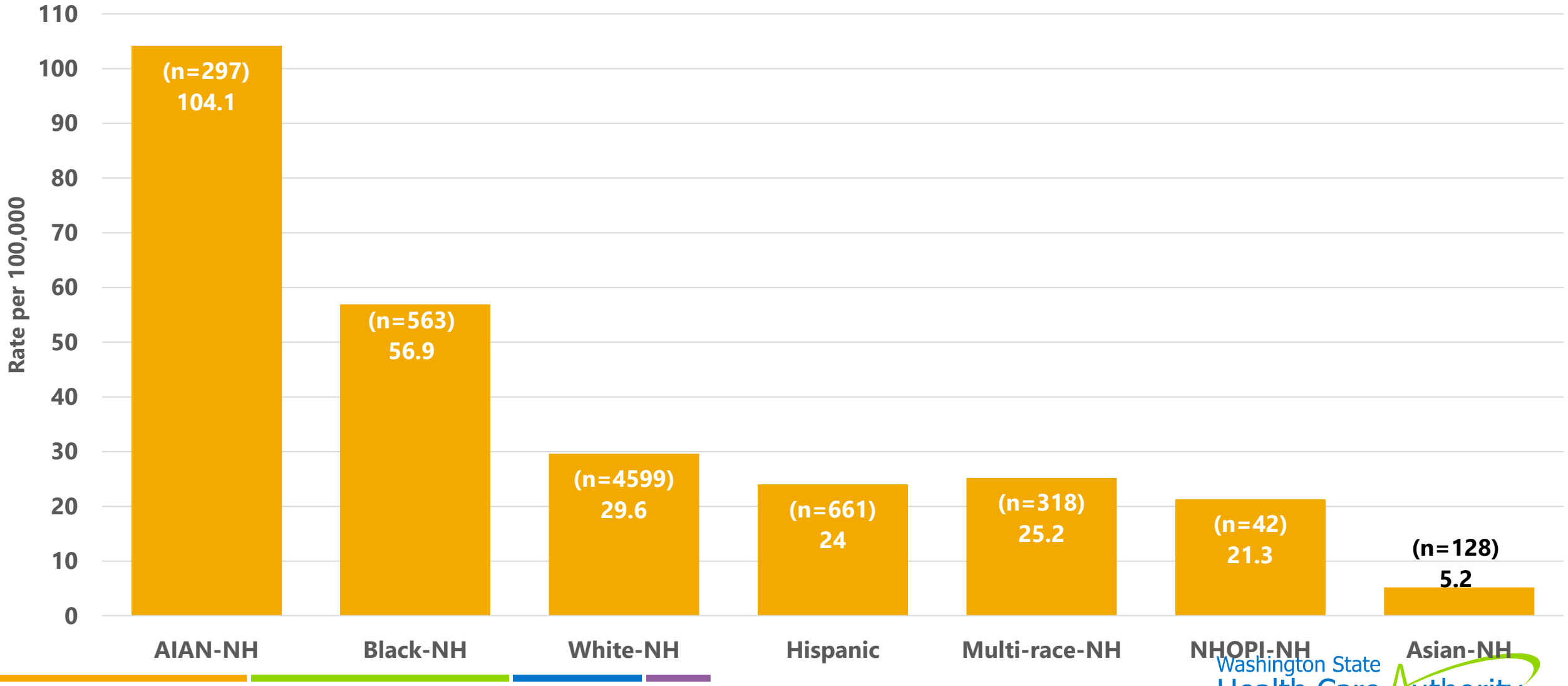
Drug overdose death rates by race/ethnicity among Washington residents(2020-2022)



2022 data are finalized.

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Source: WA DOH death certificates

Opioid response and strategy

Strategies

Collaboration

Appropriations

Response

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Strategies for addressing fentanyl crisis

- Capacity – we need to ensure we have capacity to provide a variety of services across the continuum – prevention, harm reduction, treatment, recovery supports
- Low barrier access to services
  - Access to Medications for Opioid Use Disorder
  - Access to harm reduction services
  - Access to basic primary/physical health care services
- Workforce – resources needed to ensure adequate workforce exists to provide these services
- Ready access to naloxone – community based settings, hospitals, clinics, harm reduction settings, schools/universities, etc.

Increasing access to OUD services

- Increases in access to OUD services have been made, however, more work is needed to increase capacity to meet growing demand.
- Opioid Treatment Program (OTP) locations have increased across the state service utilization – there are now 36 OTPs and 4 mobile methadone units across the state serving more than 14,000 clients
- Hub and Spoke Service utilization has increased significantly across the state over the last 5 years, with each site inducting 25 new clients each month

Tribal engagement

- $15.5 Tribal Distribution appropriated from Opioid Abatement Account
- WA Tribal Fentanyl/Opioid Summit – Strengthening Pathways to Healing
- National Tribal Opioid Summit – Resource Hub

Opioid funding

- Medicaid, PEBB, SEBB
- General Funds State -
- Opioid Settlements – multiple settlements with varying payment structures and requirements
- Federal Grants –
  - Substance Use Prevention, Treatment, Recovery Block Grant
  - State Opioid Response
  - Strategic Prevention Framework
  - WA PDO
  - RSAT

Response highlights

- OUD prevention campaigns
- Hub and Spoke
- Opioid Treatment Program Expansion / Mobile Units
- Expansion of Medication for Opioid Use Disorder
- Naloxone Distribution
- Health Engagement Hubs (New)
- Expanded Housing Options / Supports

Questions

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Medicaid Transformation Project (MTP) 2.0

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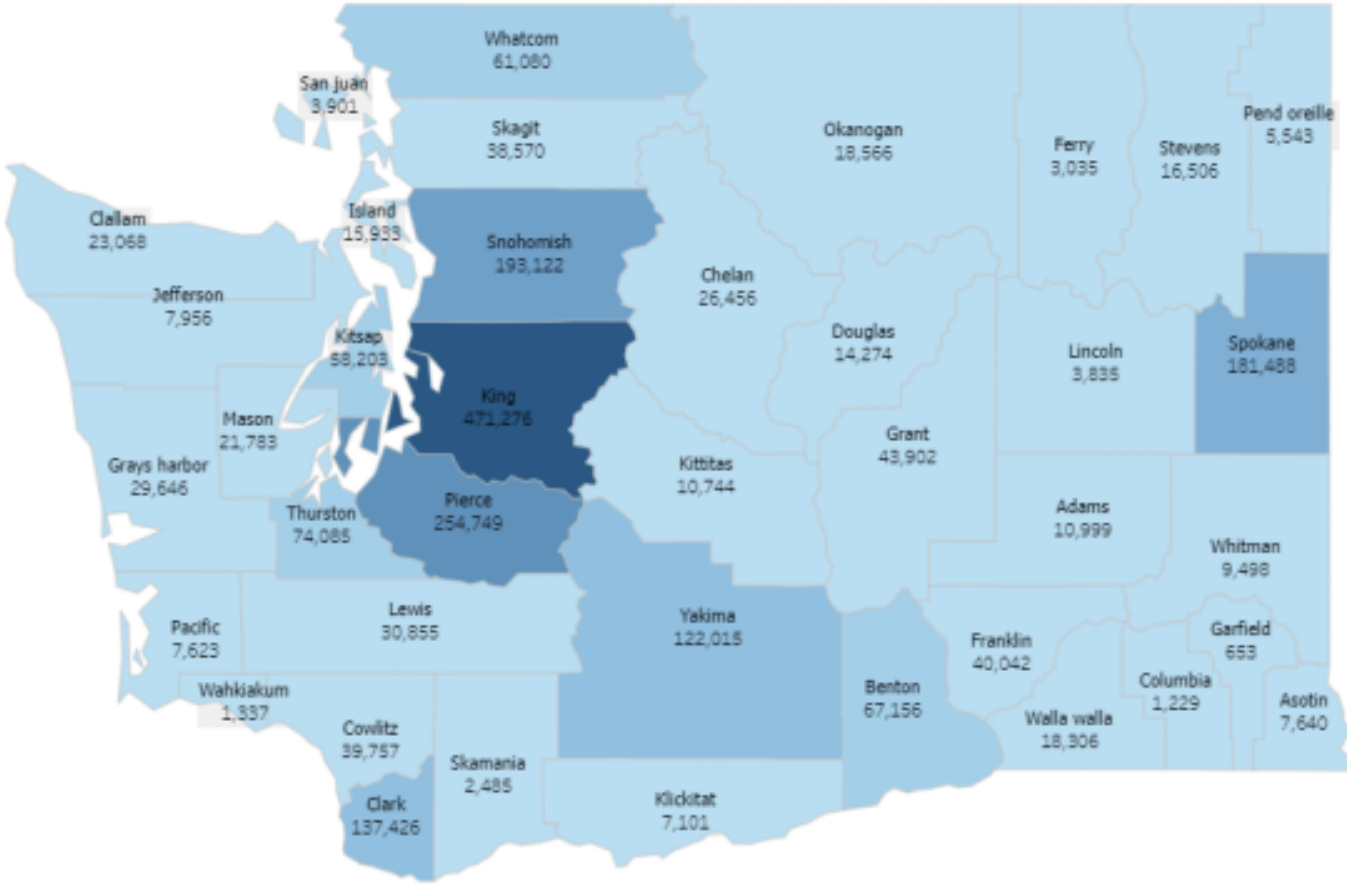
The state's largest health care purchaser

- Of the 3 million lives that HCA purchases coverage for, over 2 million are currently enrolled in Apple Health.



Section 1115 Waiver: MTP 2.0

- MTP 2.0 is an agreement between HCA and CMS that allows our state to implement and test new policies through use of federal Medicaid funds to improve Apple Health.
- The MTP demonstration ended June 30, 2023, and the renewal was approved by Centers for Medicare & Medicaid Services (CMS) that day.
  - The renewal is the Medicaid Transformation Project (MTP) 2.0: the state's Section 1115 Medicaid demonstration waiver.
  - July 1, 2023 – June 30, 2028, and invests $4B in federal & local funds in Apple Health (Washington's Medicaid program) over the five-year renewal.

Started with Medicaid Transformation Project (MTP) 1.0

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MTP 1.0 initiatives

- Transformation through Accountable Communities of Health (ACHs) and Indian Health Care Providers (IHCPs) - *Transitioning*
  - ACHs and IHCPs implemented projects that change health care delivery in their region.
- Long-Term Services and Supports (LTSS) - *Continuing*
  - Supported Washington's aging population and family caregivers through Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs.
- Foundational Community Supports (FCS) – *Continuing, with enhancements*
  - Vulnerable adults find and maintain stable housing and employment

MTP 1.0 initiatives

- Substance use Disorder (SUD) IMD - *Continuing*
  - Allows Washington State to make improvements and use federal financial participation for Medicaid SUD treatment services in facilities that are “institutions for mental diseases” (IMDs)
- Mental health IMD – *Continuing*
  - Allows Washington State to purchase acute inpatient services for Medicaid clients between the ages of 21 and 65 who reside in a dedicated psychiatric facility that qualifies as an IMD

MTP 1.0: What we've learned

- ACHs
  - Well-positioned to support social determinates of health (SDoH)
  - Not well-positioned to drive value-based payment
  - Original delivery system reform incentive payment (DSRIP) focus was too broad
- Health equity and SDoH
  - Need attention, support, and funding for community-based organizations
  - Statewide implementation of integrated managed care (IMC), but clinical integration requires more time
- FCS, and MAC and TSOA are providing critical supports

Examples of ACH activities in MTP 1.0

- Responded to opioid use disorder (OUD)/substance use disorder (SUD)
- Supported many interventions and projects, including:
  - Maternal and child health, access to health services, and chronic disease prevention and management
  - Efforts to identify and address health care workforce challenges
- Provided Community-based Care Coordination (CBCC) by building linkages among clinical settings and CBOs to serve families

MTP 2.0:
Newly approved programs

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Newly approved programs

- Continuous Apple Health enrollment for children, ages 0-5
  - Provides continued benefits for children ages 0 through five, who are eligible for continuous eligibility up to their sixth birthday
- Apple Health postpartum coverage expansion
  - Provides continued benefits for individuals from the end of the pregnancy through twelve months of postpartum
- Contingency management for SUD treatment
  - Implements a new contingency management benefit, an evidence-based program incentivizing success in managing SUD.

Newly approved programs

- Re-entry coverage for individuals leaving a prison, jail, or youth correctional facility
  - Provides pre-release services up to 90 days prior to the expected date of release to their communities
  - Phased services based on facility readiness and pre-defined Service Levels.
  - Minimum required services will include:
    - Case management; care transitions
    - Medication-assisted treatment (MAT)
    - 30-day supply of prescribed medication

Newly approved programs

- Program innovations that support older adults, including expanded eligibility and presumptive eligibility to support access and enrollment.
  - Expands income eligibility limits to enable more support and services for aged, blind and disabled adults who are applying for and receiving home and community-based services
  - Presumptive eligibility for individuals applying for LTSS
- Programs that address health-related social needs (HRSN) *(within CMs approved framework)*

A closer look:

Justice-involved pre-release services

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Reentry program summary

Eligible Population: All Medicaid-eligible individuals within 90 days of release from a state prison, jail, or youth correctional facility.

Implementation Approach: Phased services based on facility readiness.

Capacity funding will be provided to support readiness (EHR, billing systems, staff and other needs).

Approved Scope of Services
Mandatory:
Case management/care coordination
Medication-assisted Treatment (MAT) pre-release
For post-release: 30-day supply of medications and durable medical equipment
Secondary:
Medications during the pre-release period (HepC)
Lab and radiology
Services by community health workers
Physical and behavioral clinical consultations (as needed)

- Winter-Spring 2024: Statewide readiness assessment
- Spring 2024: Reentry capacity building applications
- March 29, 2024: Reentry Implementation Plan submission
- Fall 2024: Reentry capacity building funding available
- July 2025: Reentry service delivery launch through first cohort

Builds off years of previous work such as Medicaid billing (P1), EHR and eligibility and enrollment systems

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Reentry planning and implementation funds

- To support the following activities:
  - Technology and IT Services
  - Hiring of Staff and Training
  - Adoption of certified EHR technology
  - Purchase of Billing Systems
  - Development of Protocols and Procedures
  - Additional Activities to Promote Collaboration
  - Planning
  - Other activities to support a milieu appropriate for provision of prerelease services

A closer look:

HRSN
Community Hub & Native Hub

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HRSN services approved by CMS

Phase One Services
Case management, outreach, and education (CHW work administered through hubs)
Recuperative care and short-term post-hospitalization housing (Medical respite)
Housing transition navigation services*
Rent/temporary housing*
Future Phases
Stabilization Centers
Day Habilitation Programs
Caregiver respite services
Environmental accessibility and remediation adaptations
Nutrition supports
Community Transition Services (Personal Care and Homemaker Services; and Transportation)**

**Delivered primarily through FCS*
*** Funded outside HRSN Services framework*

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Community hubs and community health workers

- Community-based care coordination: Community Hubs
  - Regional community hubs managed by Accountable Communities of Health (ACHs) to support social needs screening and referrals.
  - Regional infrastructure for a network of Community-Based Organizations (CBOs) and Community Health Workers.
  - Role for Hub to support reentry and connecting to community.

Native Hub

- A statewide network of IHCPs, tribal social service divisions, and Native-led, Native-serving organizations in service to whole-person care coordination.
- Participation in the Native Hub allows for:
  - Identifying the types of care that already exists, or what will be needed, for patient
  - Knowing if the patient has a care coordinator and where that care coordinator is located
  - Providing closed-loop referrals
  - Connection and alignment to others doing similar work across the state, as a source of information and best practices

Community Information Exchange (CIE)

- CIE allows community partners to identify available services and connect clients to community resources and programs.
- CIE supports screening for health-related social needs, sharing data, and completing successful referrals.
- MTP 2.0 provides federal expenditure authority for CIE within the HRSN framework, estimated at $23m for the first two years of implementation.

Foundational Community Supports (FCS)

- Foundational Community Supports
- Supportive housing and supported employment services for Apple Health beneficiaries who have a qualifying social risk factor and a needs-based factor
  - Enhancements under MTP 2.0
    - Expanded eligibility from 18 and older to 16 and older for Supportive Housing services
    - Transition costs/one-time costs and deposits
    - Temporary rental assistance for up to six months

FCS & Apple Health and Homes (AHAH)

- Joint initiative with the Department of Commerce and Social and Health Services
- Capital funds and rent assistance to create long-term housing and rental assistance for FCS target population
- FCS provides funding for Supportive Housing services (through 1115 waiver) to help find and maintain housing
- AHAH designed to provide long-term support for recipients of HRSN-funded rental assistance

MTP 2.0 next steps

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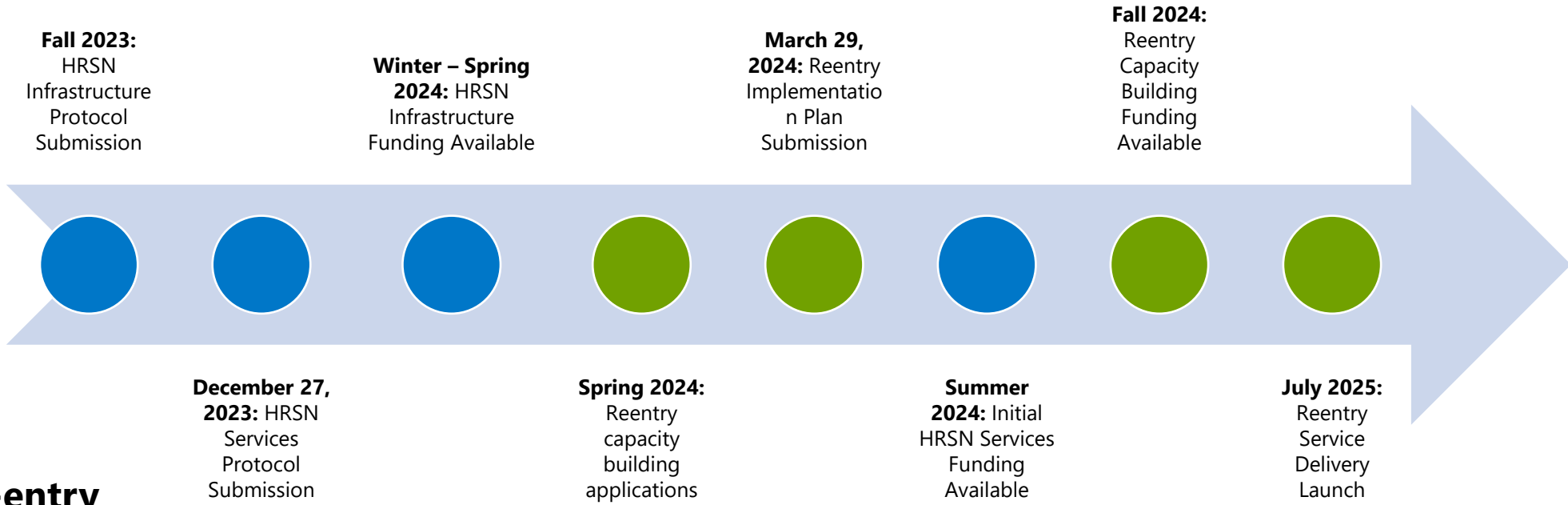
HRSN and reentry timeline estimates



Re-entry

HRSN

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MTP 2.0 Decision Packages

Building on Legislative spending authorization provided in the budget last year, there are spending refinements that reflect new programs and CMS modifications:

- Re-entry pre-release services and capacity/infrastructure funding
- CHIP Continuous Enrollment 0-6 to align with existing Medicaid authority
- Health-related social needs (HRSN) services to increase expenditure authority based on federal approval
  - HRSN infrastructure, including Community Information Exchange (CIE)
- Foundational Community Supports (FCS), including rental subsidies
- LTSS: MAC and TSOA, rental subsidies and presumptive eligibility
- MTP 2.0 administrative expenditures

Resources

- MTP 2.0 Summary
- Approval letter from CMS
- MTP renewal page
- MTP website section

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Questions

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Affordability Panel

HCA, OIC, HBE

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Presentation outline

- Cost trends and impacts on consumers
- National and state approaches to transparency and cost-containment
- Looking ahead

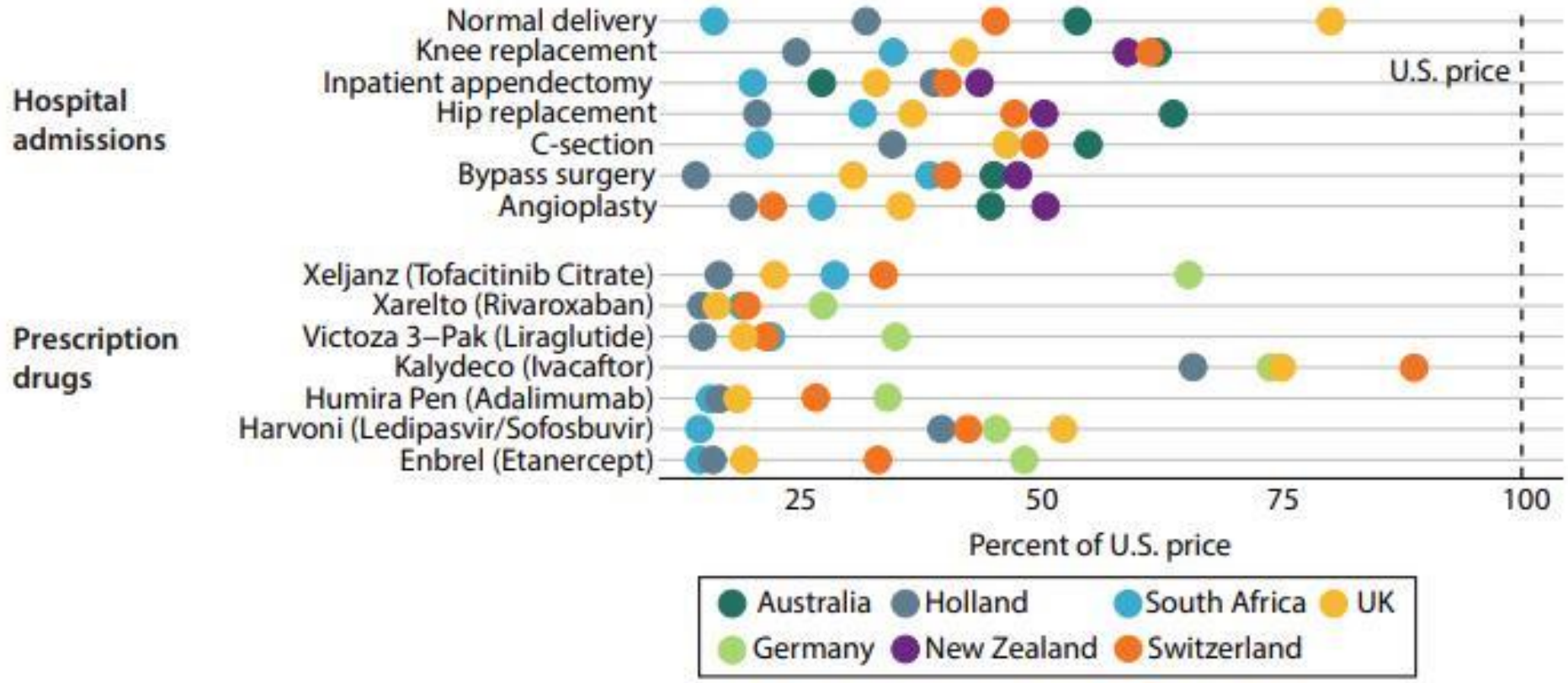
Cost trends

- For decades, health expenditures in the United States have risen faster than the pace of economic growth, tripling from 2000 to 2020.
- Rising health care spending places a fiscal burden on people, employers, and the state.

National health care prices

FIGURE 8.

Prices of Services and Prescription Drugs, by Country



https://www.brookings.edu/wp-content/uploads/2020/03/HealthCare_Facts_WEB_FINAL.pdf#page=15

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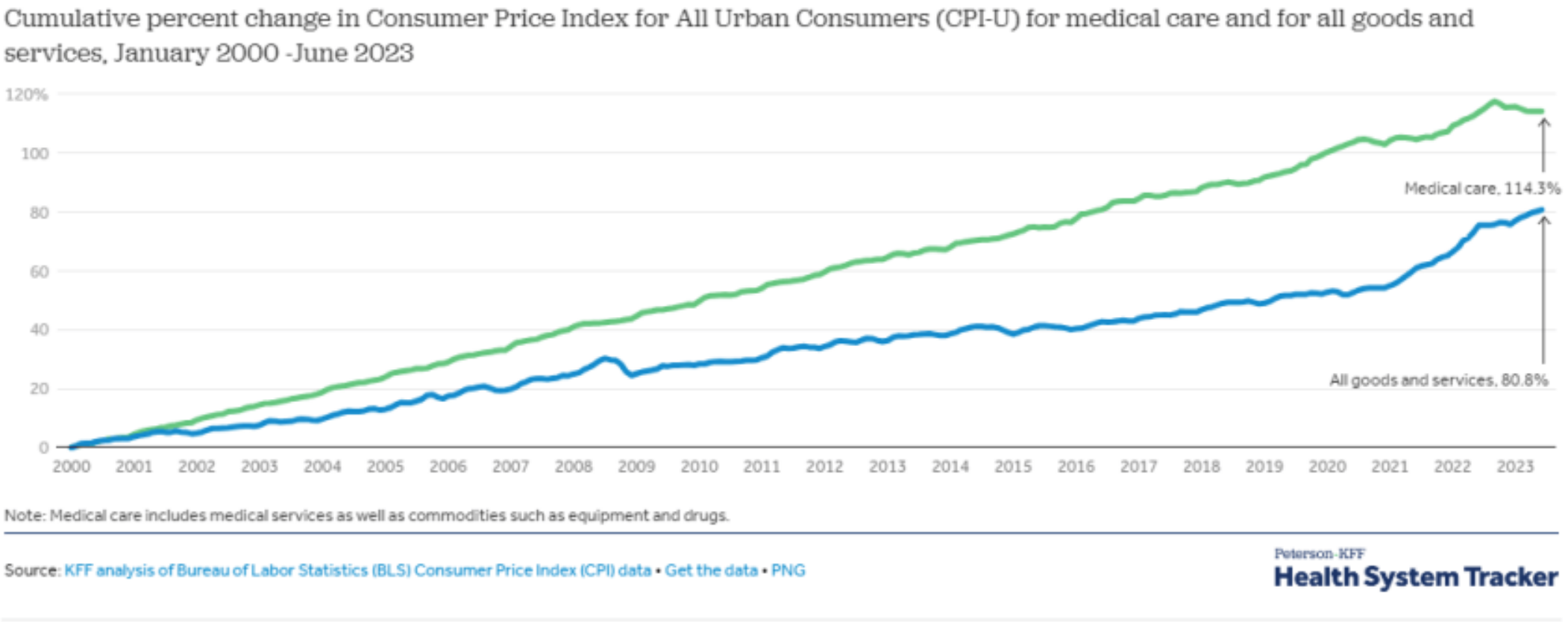
U.S. health care prices



https://www.healthsystemtracker.org/brief/how-does-medical-inflation-compare-to-inflation-in-the-rest-of-the-economy/

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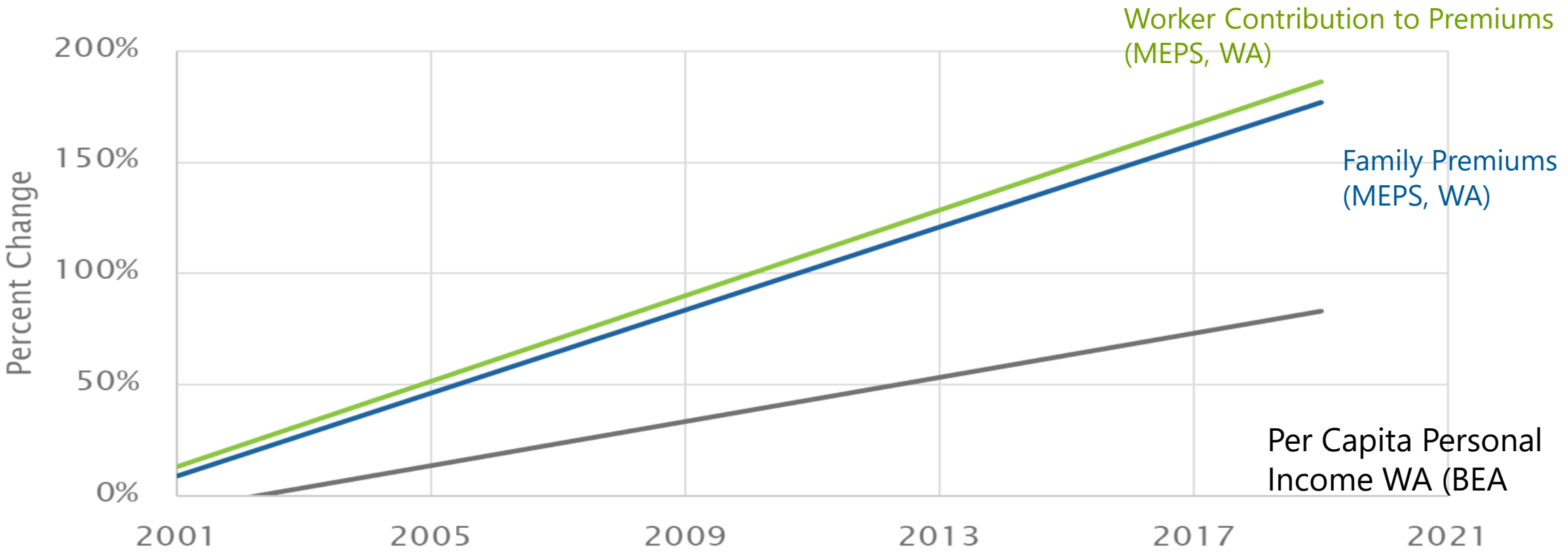
Health care costs outpace income



*Graphs are linear trendlines of the data

Sources: AHRG's Medical Expenditure Survey, Tables D.1 and D.2 for 2001-2019 and Bureau of Economic Analysis

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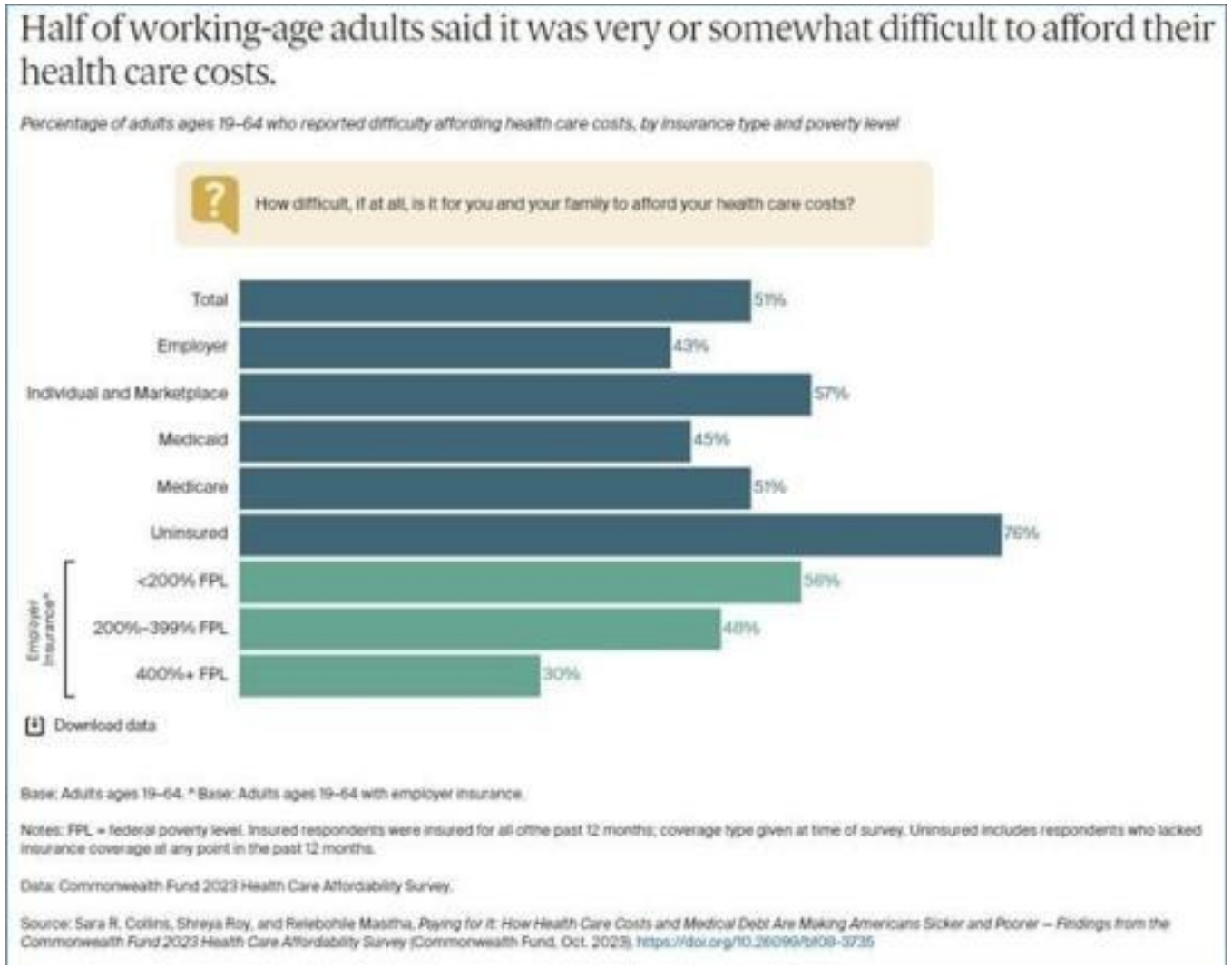

Consumer affordability

- From 2023 Commonwealth Fund health care affordability survey
- Over 40% of individuals with employer-sponsored insurance and nearly 60% of individuals with individual market coverage found it difficult to afford their health care costs

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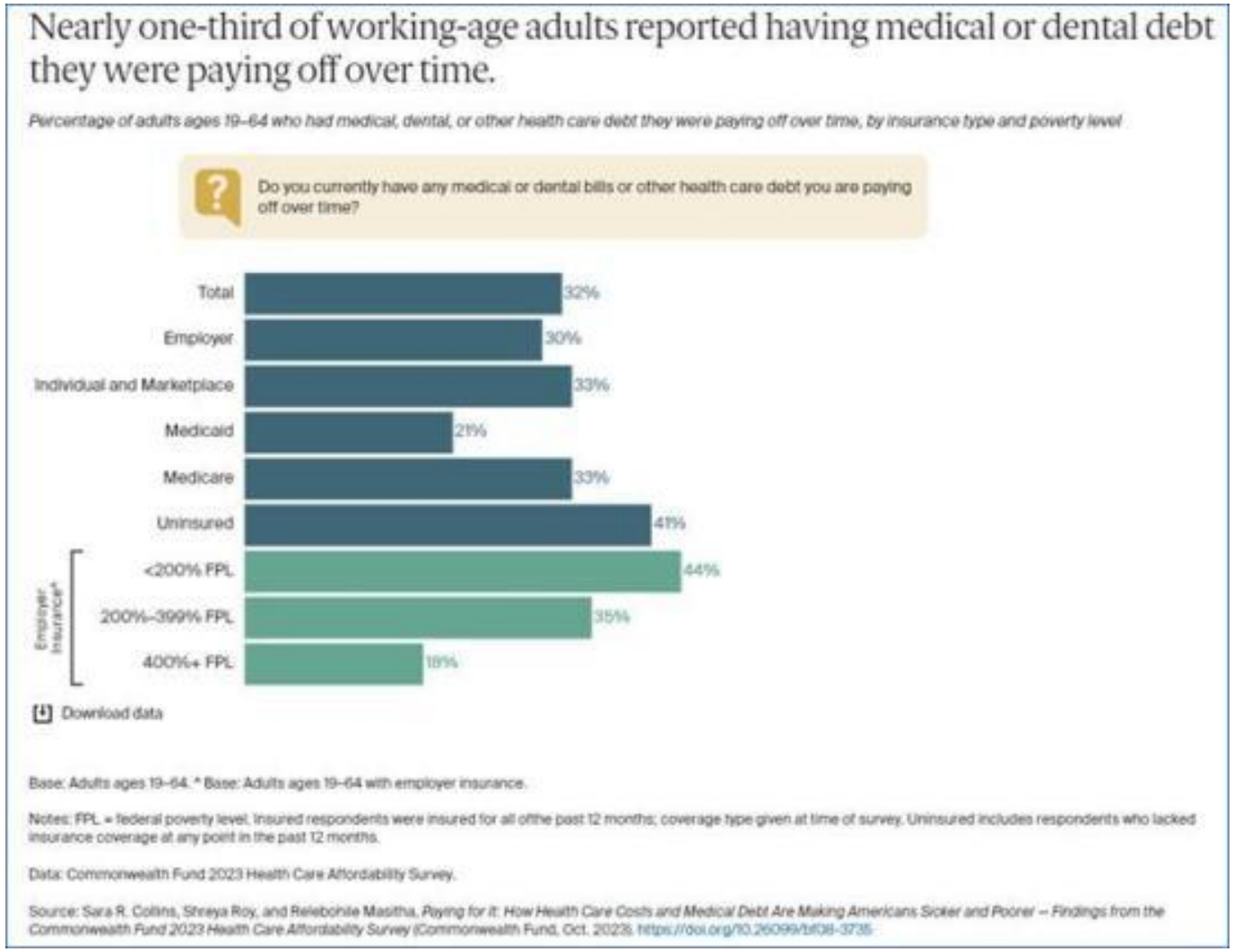
Medical debt

- American's collective medical debt totaled at least $195 billion in 2019 *(Source: KFF health care debt survey)*



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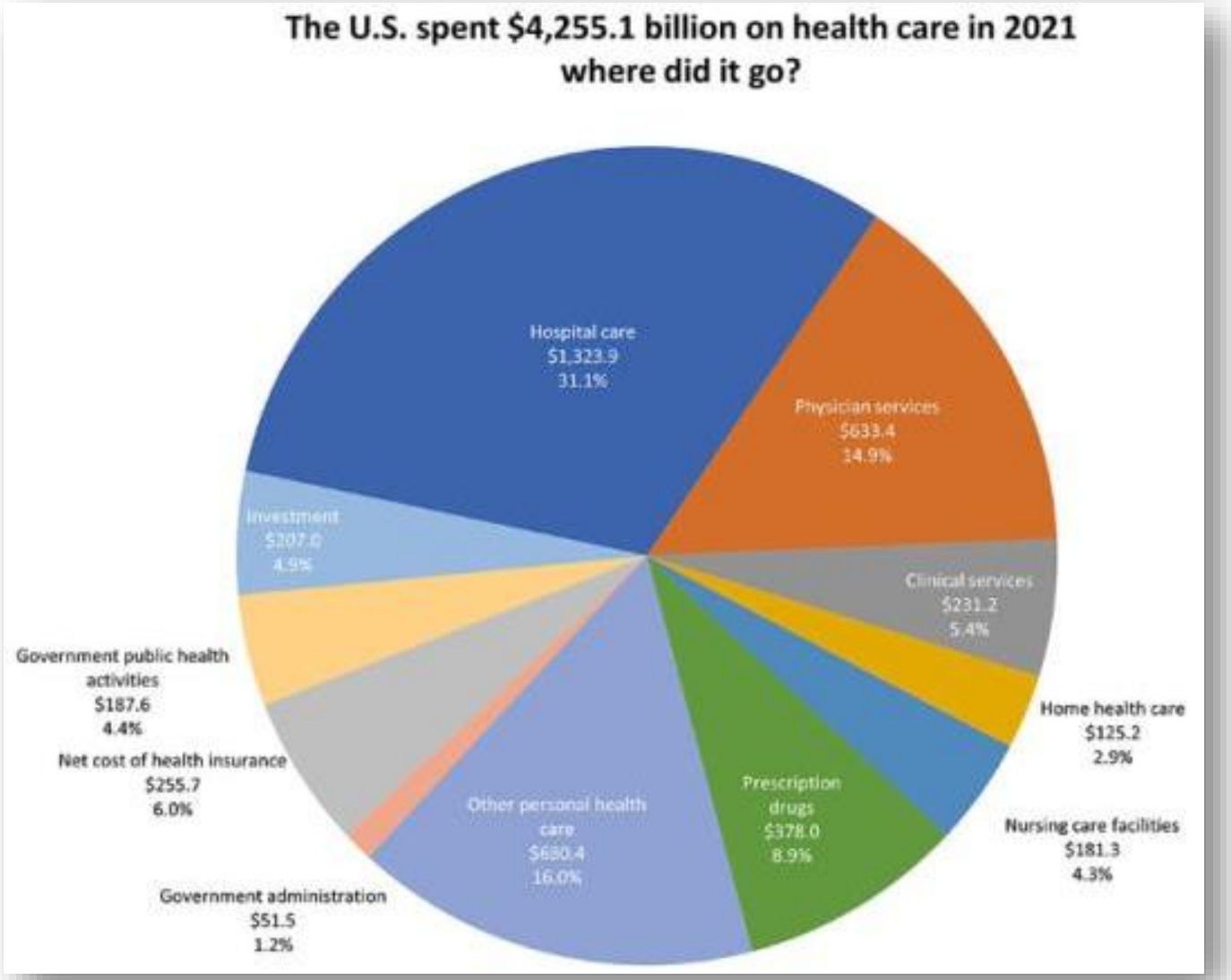
Health Care spending by sector

Source: American Medical Association – Trends in health care spending



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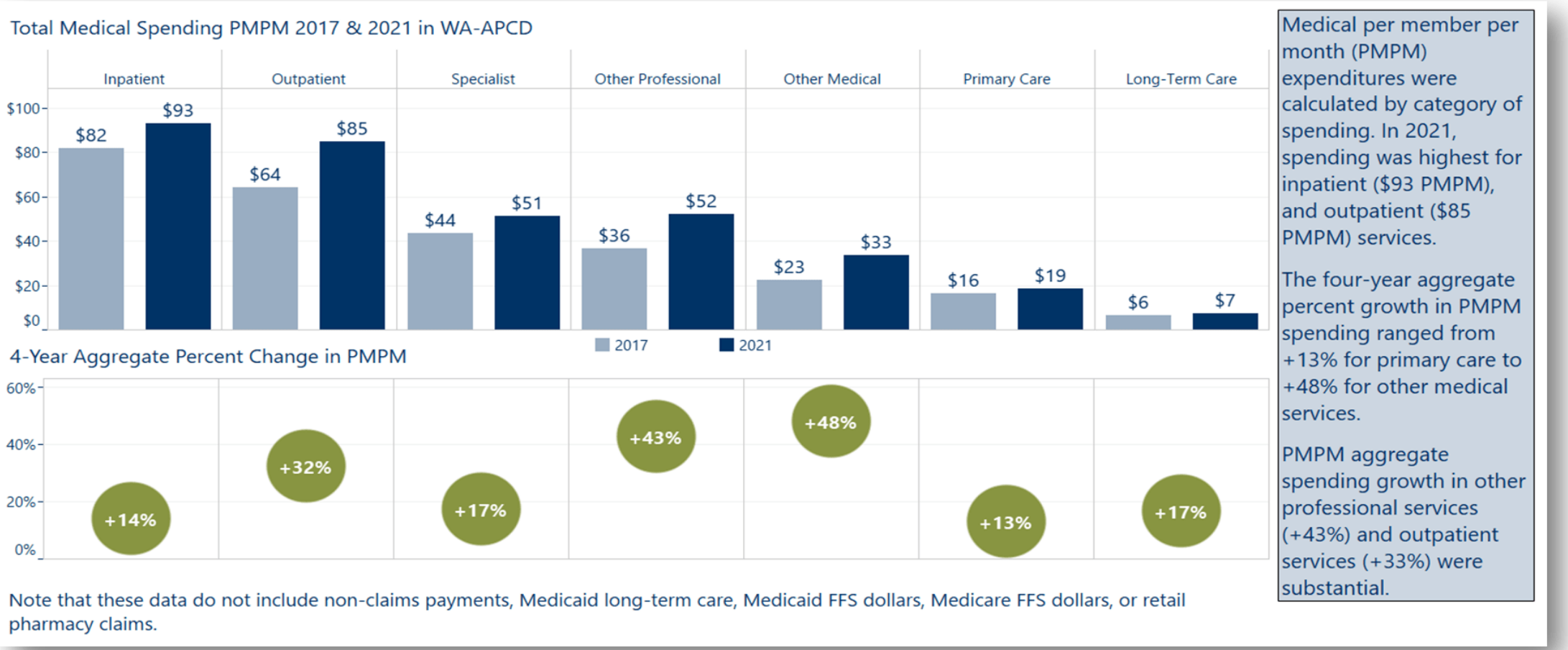
Medical Spending Changes Between 2017 and 2019 By Category of Medical Services Including Hospital Inpatient



Note that these data do not include non-claims payments, Medicaid long-term care, Medicaid FFS dollars, Medicare FFS dollars, or retail pharmacy claims.

Medical per member per month (PMPM) expenditures were calculated by category of spending. In 2021, spending was highest for inpatient ($93 PMPM), and outpatient ($85 PMPM) services.

The four-year aggregate percent growth in PMPM spending ranged from +13% for primary care to +48% for other medical services.

PMPM aggregate spending growth in other professional services (+43%) and outpatient services (+33%) were substantial.

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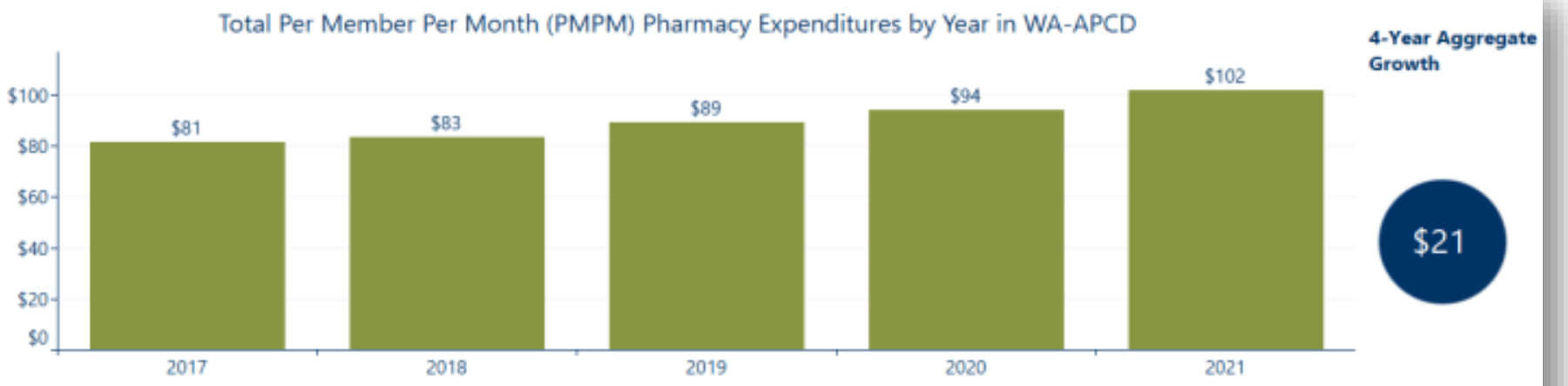
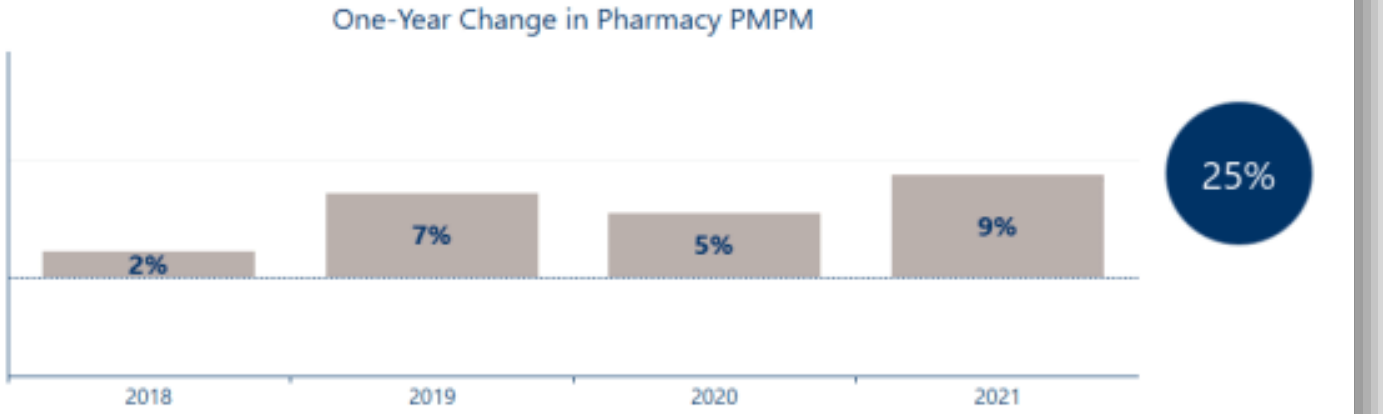
WA Pharmacy Cost Trends for Per Member Per Month from 2017-2019

Per member per month (PMPM) is a way to adjust expenditures for the number of patients in the group.

For members in the APCD (excluding Medicare), total pharmacy PMPMs increased from $81 PMPM in 2017 to $102 PMPM in 2021, a total of $21 PMPM.



Between 2017 and 2021, the rate of PMPM spending growth was 25%, similar to medical spending growth.



Note: These figures do not include spending for Medicare FFS or Medicare Advantage members. Retail pharmacy expenditures in this analysis are gross of rebates.

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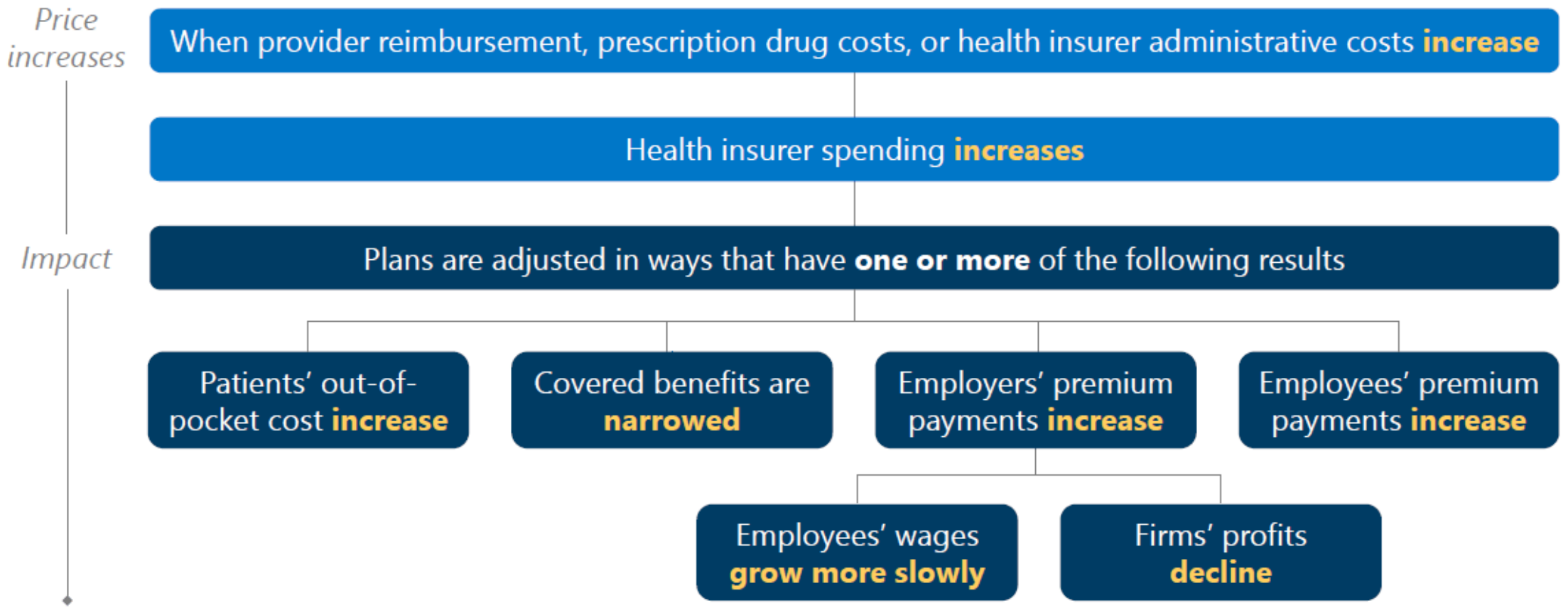
Effects of higher prices on health insurance premiums, benefits, out-of-pocket costs and wages



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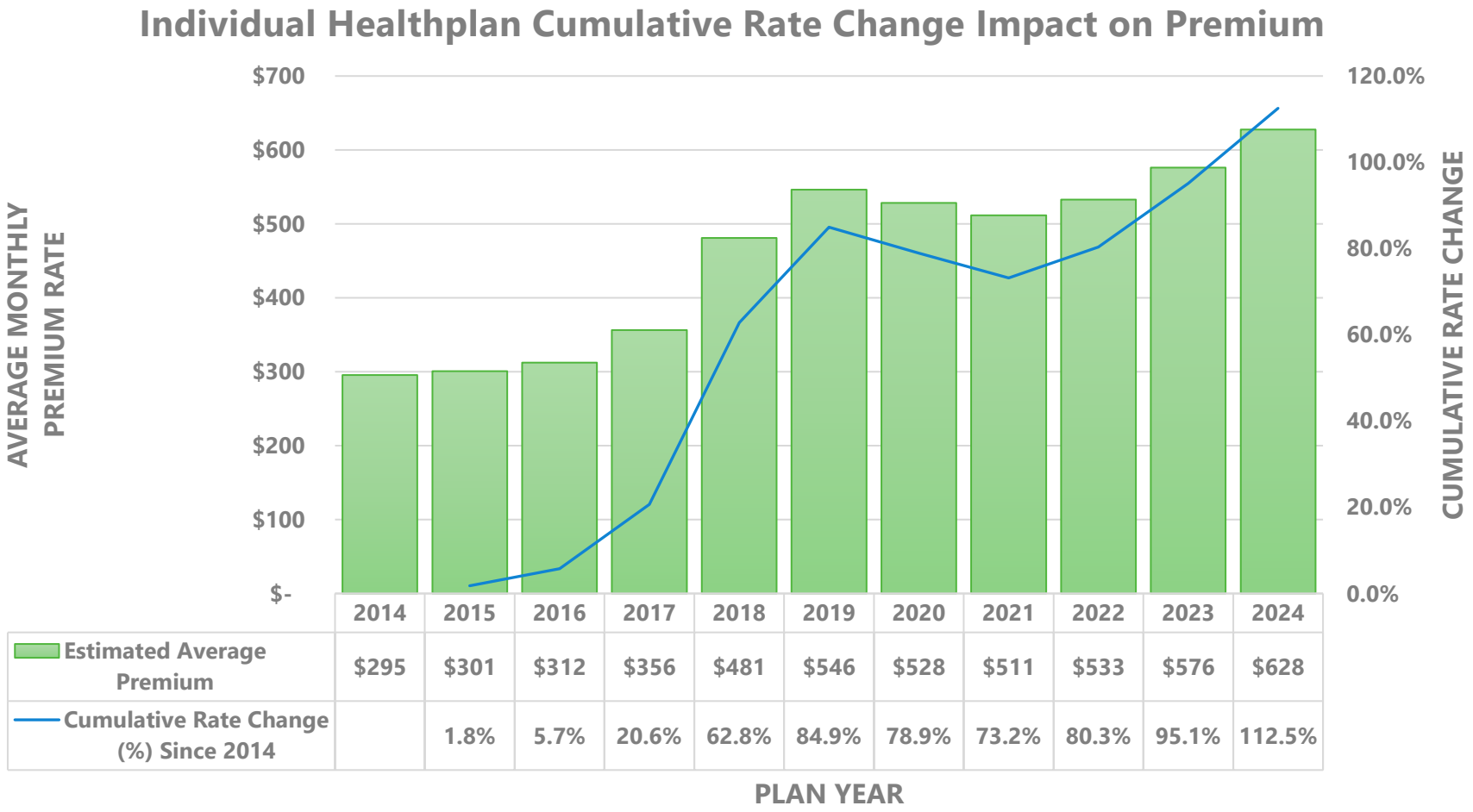
Cumulative impact of individual market rate changes

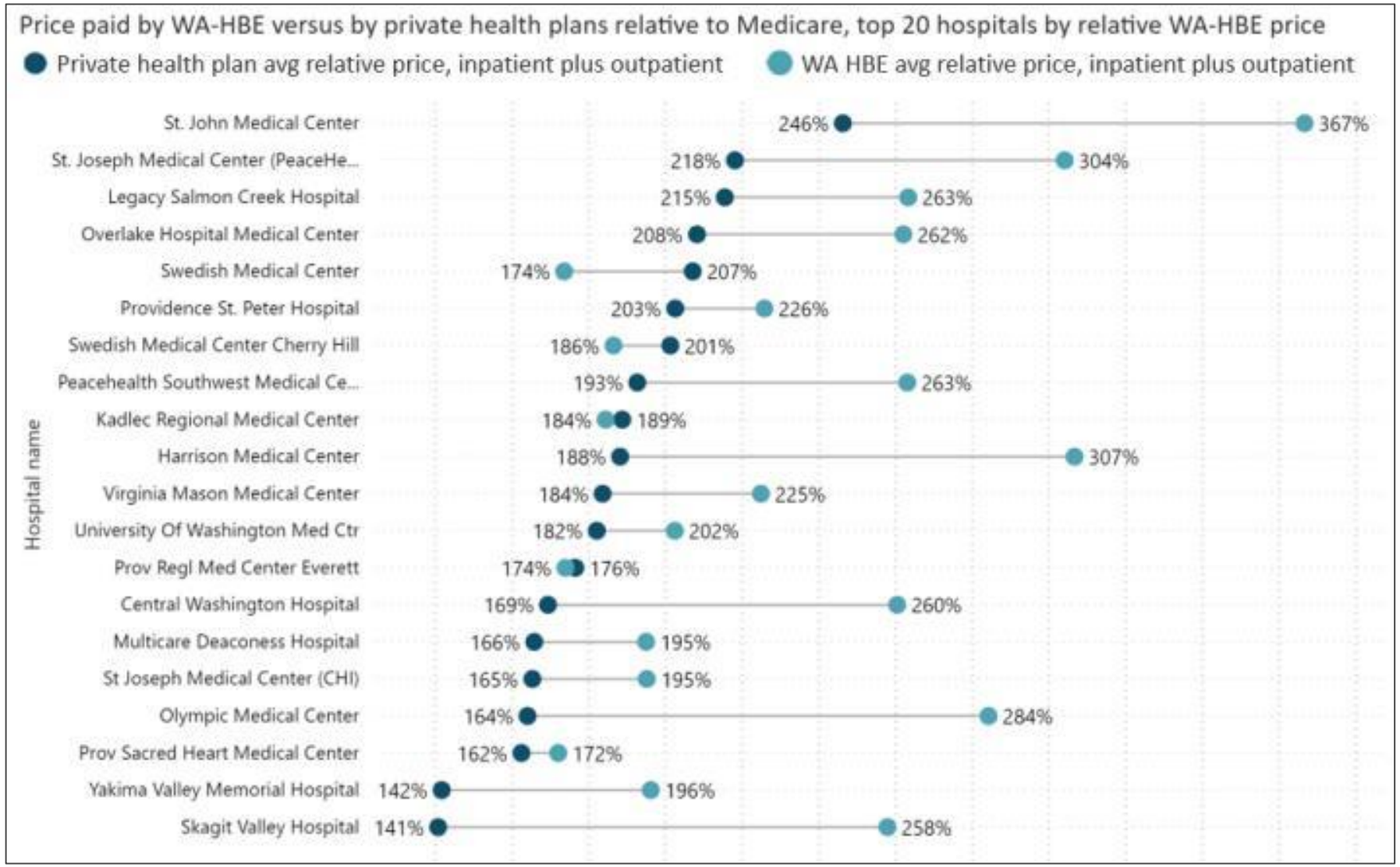


	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Estimated Average Premium	$295	$301	$312	$356	$481	$546	$528	$511	$533	$576	$628
Cumulative Rate Change (%) Since 2014		1.8%	5.7%	20.6%	62.8%	84.9%	78.9%	73.2%	80.3%	95.1%	112.5%

Exchange Customers Pay More For Health Care

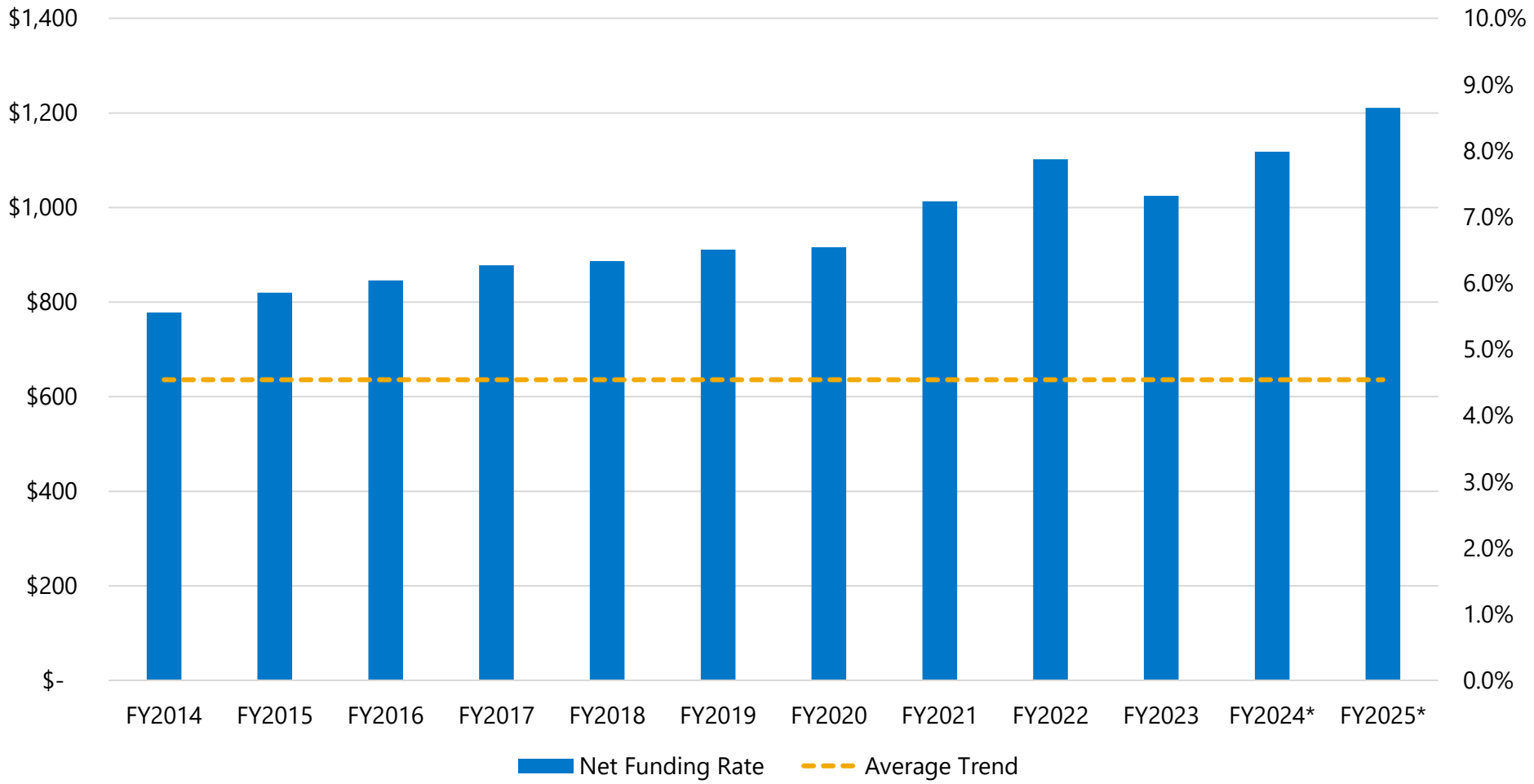
Exchange customers pay 35% more for their hospital care than other commercially insured WA residents.

- WA relative price: 174% of Medicare.
- Exchange customer relative price: 210% of Medicare.



Source: RAND 4.0, Prices Paid to Hospitals by Private Health Plans

State spending trend on Public Employees' Benefits Board (PEBB) Program



Active approaches to transparency and cost containment

Washington State Health Care Authority

Sample of **National** transparency and cost containment efforts

- **All-Payer Claims Databases**
- **Cost Boards & Growth Benchmarks: Peterson-Milbank Program for Sustainable Costs – CT, DE, MA, NV, NJ, OR, RI, and WA**
- **No Surprises Act**
- **Inflation Reduction Act & Medicare Prescription Drug Negotiation**
- **Hospital and Payer Price Transparency**
- **Public Option Programs**

Sample of **Washington** transparency and cost containment efforts

- Rx Price Transparency (2019) - RCW 43.71C
- DOH Hospital financial reports – RCW 43.70.052
- All Payer Claims Database – RCW 43.371
- Health Care Cost Transparency Board (2020) – RCW 70.390
- Prescription Drug Affordability Board (2022) – RCW 70.405
- Cascade Care – RCW 43.71.095 & 41.05.410
- Balance Billing Protection Act – RCW 48.49

Health Care Cost Transparency Board's legislative charge – HB 2457

House Bill 2457 (2020) established the Health Care Cost Transparency Board (the Board) and charged it with the following tasks:

1. Establishing a health care cost growth **benchmark** or target percentage for growth
2. Analyzing total **health care expenditures**
3. Identifying **trends** in health care cost growth
4. Identifying **entities** that exceed the health care cost growth benchmark

Cost growth benchmark

The ceiling/ goal for the growth of spending on health care year over year.

Performance against benchmark

Assessment of cost growth against the benchmark target.

Cost driver analysis/cost experience

Assessment of key drivers of cost growth.

Primary care spend measurement

Measurement of expenditure on primary care in relation to overall health care expenditure.

Hospital cost, profit, and price analysis

How to assist hospitals in controlling rising health care costs.

Analytic support initiative

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.

Consumer and affordability

Washington State Health Care Authority

Cost growth benchmark

What is a cost growth benchmark?

- A health care cost growth benchmark is a per annum rate-of-growth benchmark for health care costs for a given state.

Why pursue a cost growth benchmark?

- To establish a common goal to curb health care spending growth.
- The benchmark is a specific target rate that carriers and providers should try to stay under to make health care more affordable.

1. Calendar Year	Cost Growth Benchmark Value
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

Prescription drug affordability boards

- Independent bodies empowered to analyze the high cost of drugs and suggest effective ways to lower costs
  - Maine, New Hampshire, Oregon, Ohio, Colorado, Washington, and Minnesota
- Certain state Boards are permitted to set upper payment limits (UPLs)
- Focused on cost transparency and containment
- Variation in price thresholds across states

WA Prescription Drug Affordability Board

- **History**
  - SB 5532 assed during the 2022 Legislative Session
  - Based on NASHP model legislation
  - Codified in Chapter 70.405 RCW
  - First Board meeting October 20th, 2023
- **Board**
  - Five-member board appointed by Governor
  - Conflicts of interest prohibited
- **Purview**
  - Affordability Reviews RCW 70.405.030-.040
  - Upper Payment Limits RCW 70.405.050

Cascade Care

Cascade Care makes health insurance accessible and affordable for every *Washington Healthplanfinder* customer.

- **Lower premiums**
- **Higher quality benefits**
- **Lower copays**
- **Easier plan shopping**
- **Available in all counties**
- **Extra savings for those who qualify**

2 in 3

Washington Healthplanfinder QHP customers are enrolled in Cascade Care plans

55,000+

Washington Healthplanfinder customers have lowered their monthly premiums with Cascade Care Savings

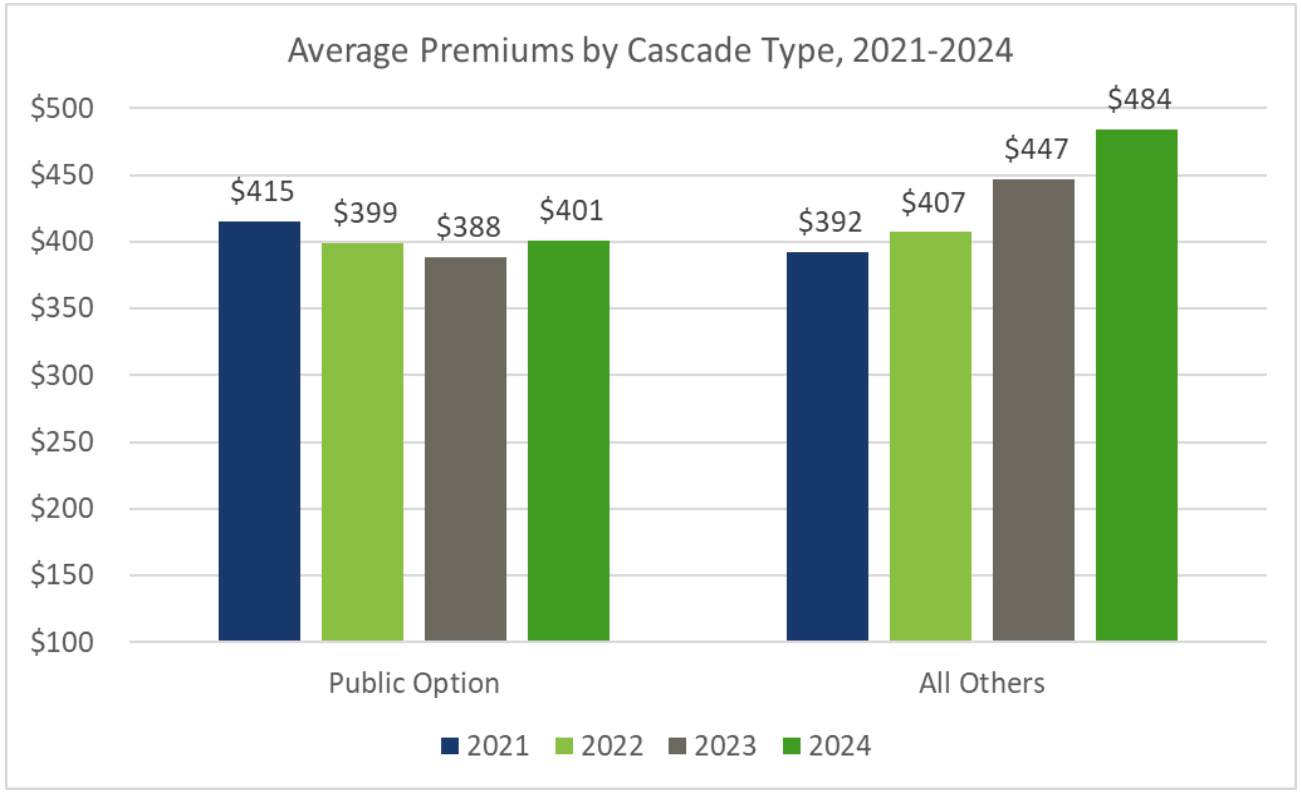
14%

Lower premiums before subsidies in public option plans, on average, compared to non-Cascade plan premiums

Data as of 5/2023

Public option shows promise, but needs strengthening

Public option plans supporting customer affordability compared to other Exchange plans, but premiums still not meaningfully lower.



Plan Type	Last Year	This Year	2022-2024
Cascade Public Option	-3%	3%	**0.5%**
All Others	10%	8%	**19%**

Rates for 40-year-old nonsmoker, inclusive of all counties, and are not weighted for enrollment. Rates are before any available state or federal subsidy.

Source: 2021-2024 OIC Carrier Rate Filings

CASCADE CARE

Looking ahead

Washington State Health Care Authority

Additional affordability studies

HBE: Health Benefit Exchange
HCA: Health Care Authority
HCCTB: Health Care Cost Transparency Board
PDAB: Prescription Drug Accountability Board
OIC: Office of the Insurance Commissioner
UHHC: Universal Health Care Commission

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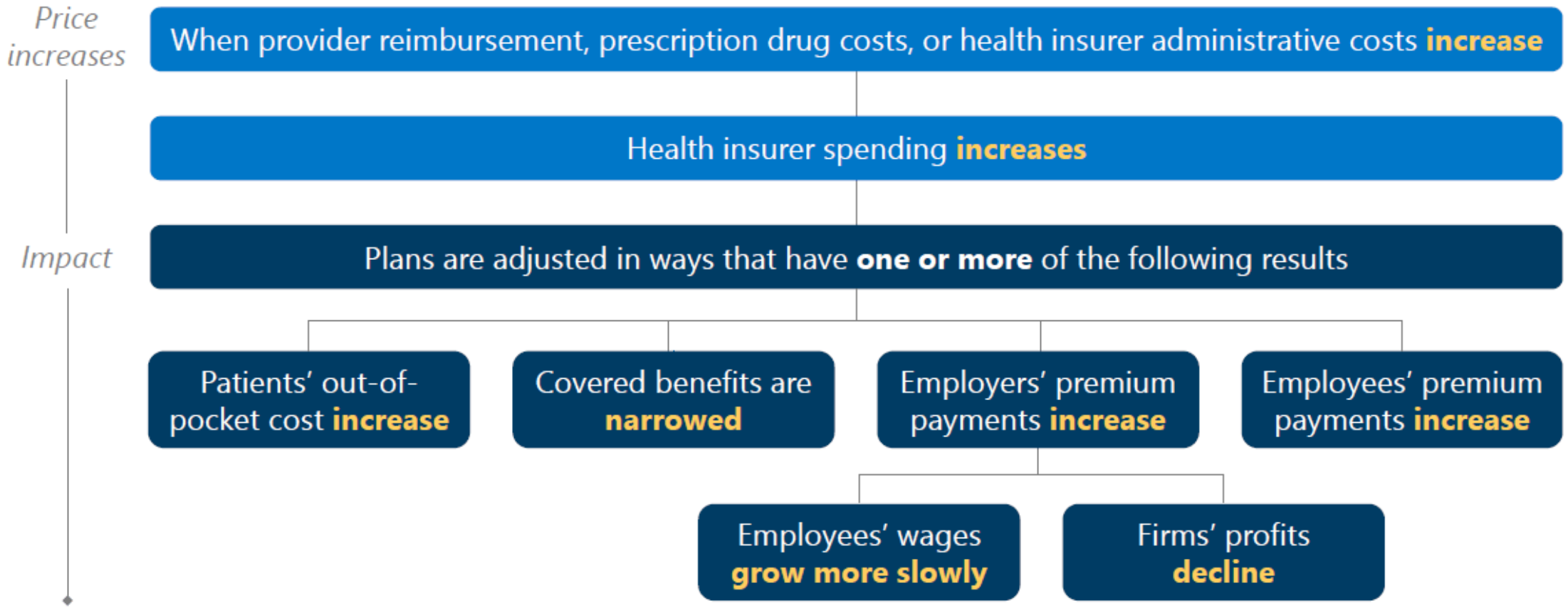
Additional analysis

Cost Board Analytic Support Initiative

- HCA received grant, funded jointly by the Peterson Center on Healthcare and Gates Ventures
- Will support additional analytic work, combining in-house expertise in health care spending, state data, and policy with analytics capabilities at the Institute for Health Metrics and Evaluation (IHME) at the University of Washington.
- Continuing deeper analysis on costs, driver, specific hospital data

Diving into policy interventions – state options to address health costs

Effects of higher prices on health insurance premiums, benefits, out-of-pocket costs and wages



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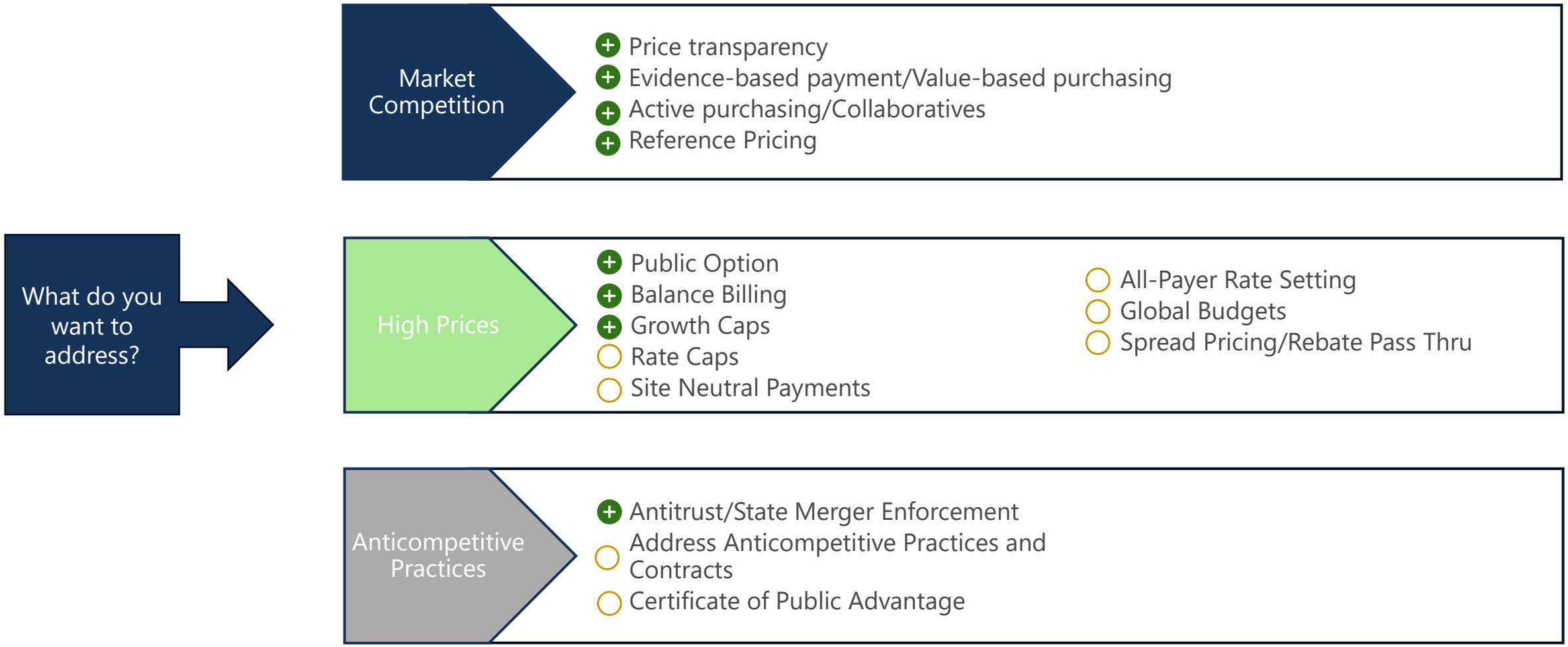
State Options to Address Health Costs



Questions

Appendix

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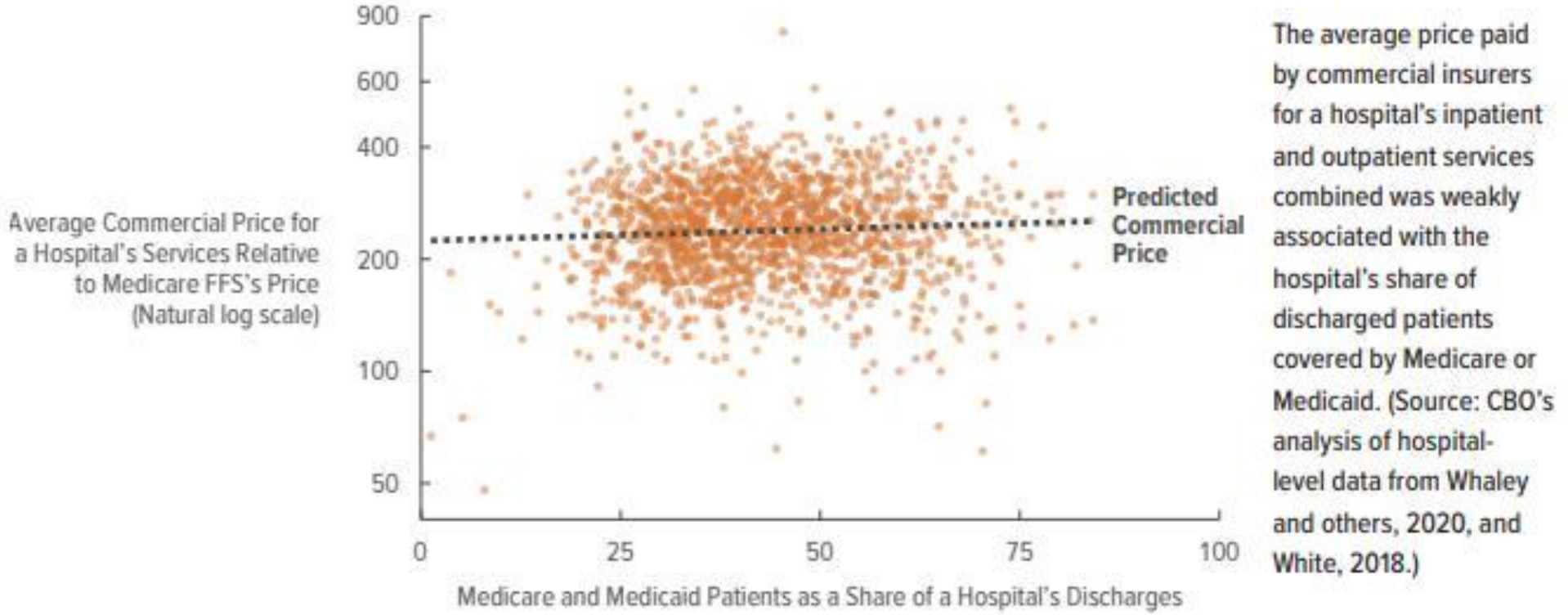
Various affordability efforts and policies considered by cost boards in other states

Example Policies	Cost driver targeted	Resources required	Potential magnitude of impact
Addressing facility fees	Increased inpatient/outpatient costs	Low	+
Contain growth in provider rates through a variety of polices such as provide rate caps or rate setting	Increased provider prices	High	++
Strengthen health insurance rate review	Increased health care costs	Medium to high	?
Improve oversight of provider consolidation including mergers and acquisitions	Increased health care costs	High	?
Preventing anti-competitive contract terms in health care contracts	Increased provider prices	Low to medium	+
Limiting out-of-network charges	Increased health care costs	Medium	+
Promote adoption of population-based provider payment/exploring global budgeting	Increased health care costs	Medium	++
Contain growth in prescription drug prices	Increased drug prices	High	++

Key	
++	on the order of magnitude of 1% or more of total health care spending
+	on the order of magnitude of 0.1% of total health care spending
?	unknown/highly variable impact

Relationship Between Payer-Mix and Price



The average price paid by commercial insurers for a hospital's inpatient and outpatient services combined was weakly associated with the hospital's share of discharged patients covered by Medicare or Medicaid. (Source: CBO's analysis of hospital-level data from Whaley and others, 2020, and White, 2018.)

Source: CBO Report – The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physician's Services (2022)

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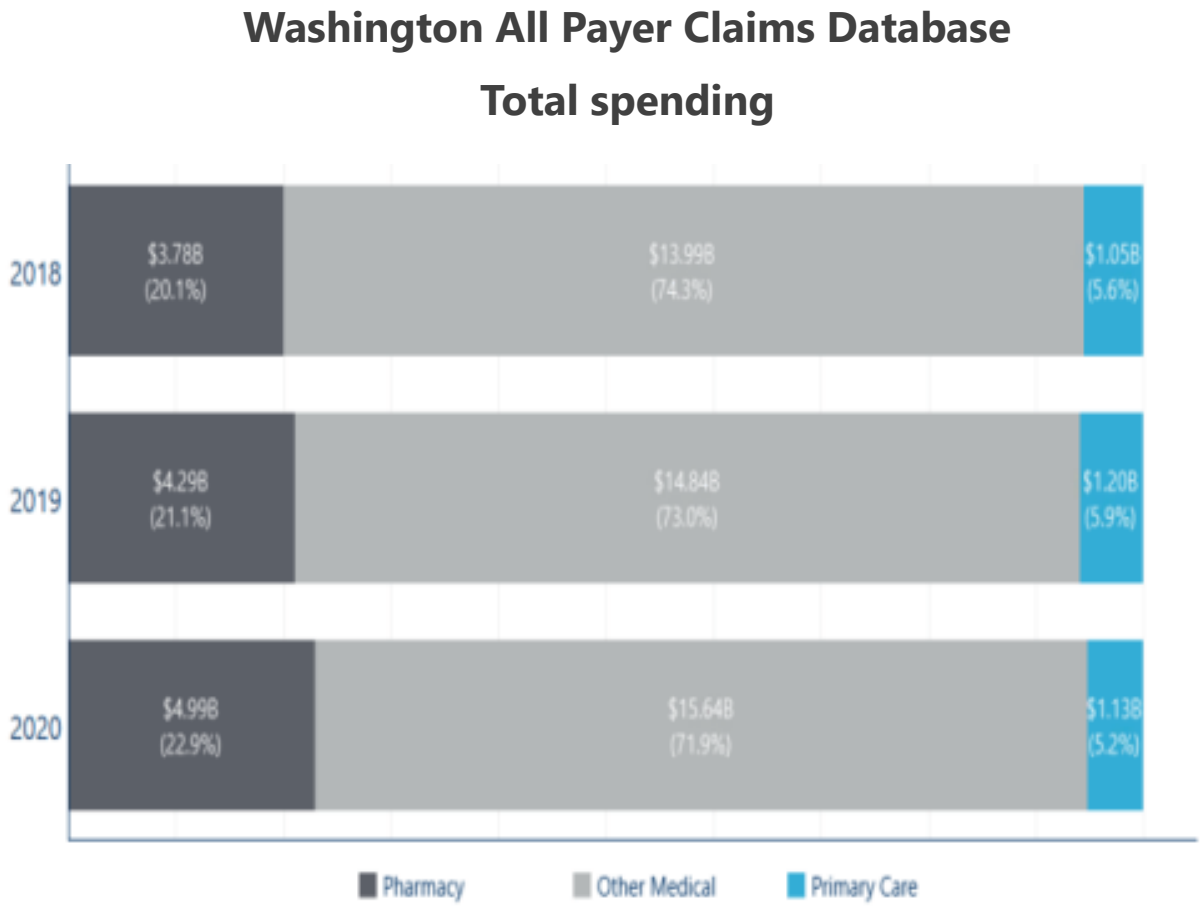
Primary Care Analysis

- **Primary care definition**
  - ✓ Definition of primary care
  - ✓ Measurement methodologies to assess claims-based and non-claims-based spending.
- **Data to support primary care**
  - ✓ Report on barriers to access and use of primary care data and how to overcome them.
  - ❑ Currently working on obtaining data
  - ❑ Track accountability for annual primary care expenditure targets
- **Policies to increase and sustain primary care**
  - ❑ Working on recommending methods to incentivize achievement of the 12 percent target.



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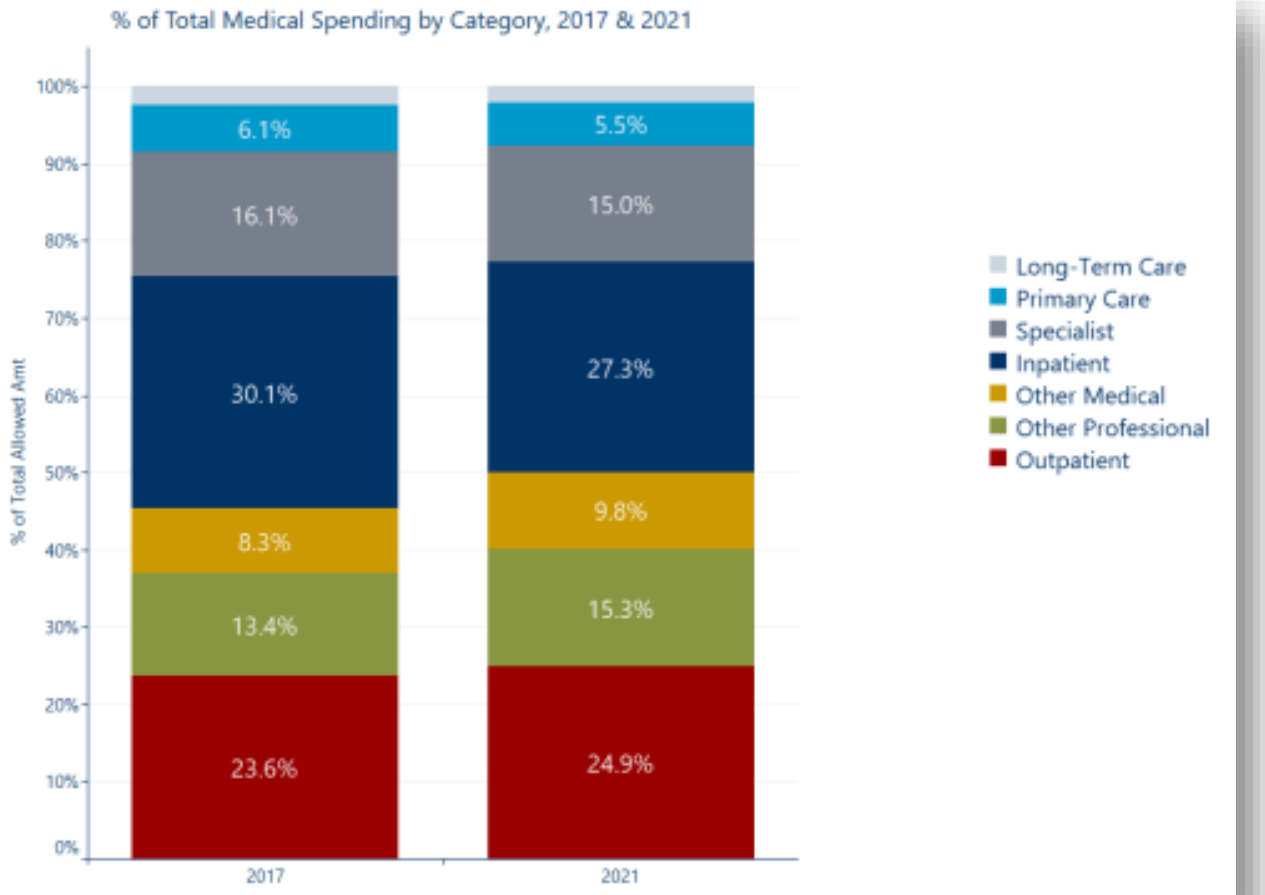
Percent of total medical spending by category
2017 & 2021

While expenditures for all categories increased between 2017 and 2021, there were some shifts in the relative spending by category.

Outpatient, other professional, and other medical spending categories increased as a percentage of total medical expenditures, while inpatient, specialist, primary care, and long-term care decreased as a percentage of total.

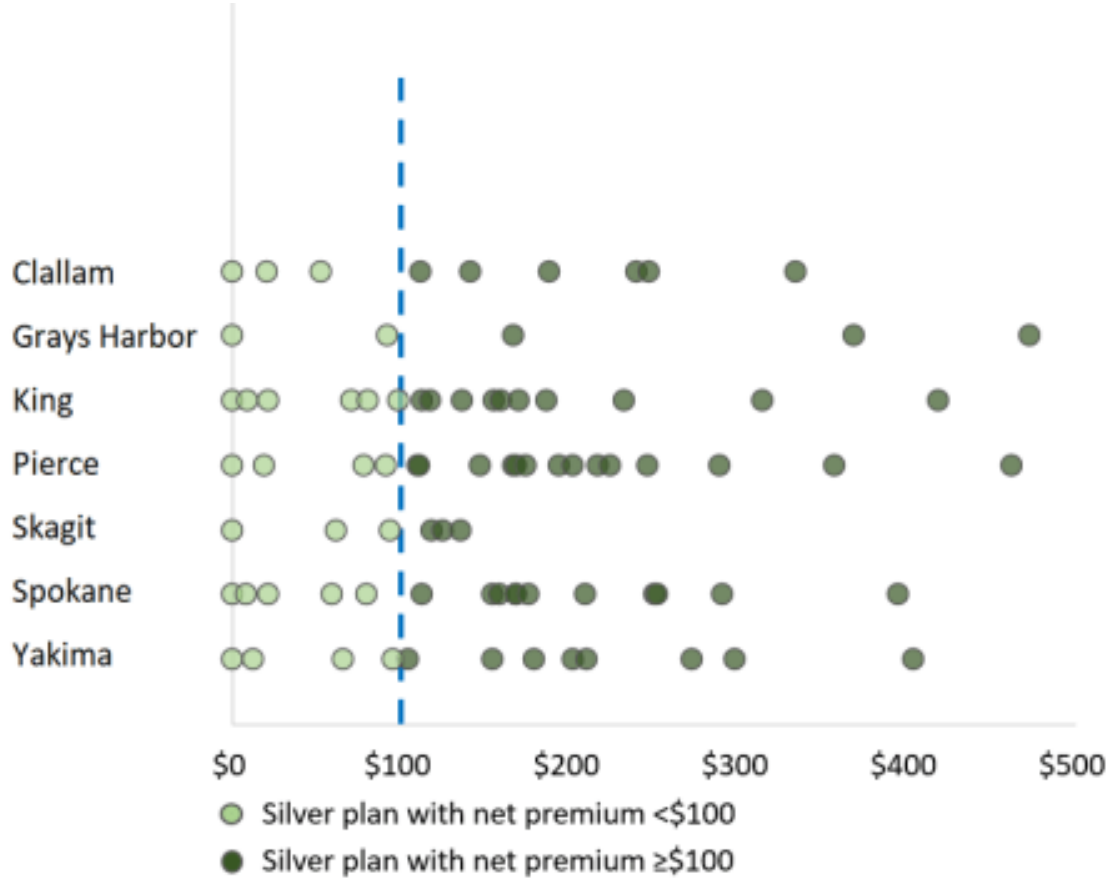
Note that these data do not include non-claims payments, Medicaid long-term care, Medicaid FFS dollars, Medicare FFS dollars, or retail pharmacy claims.



Subsidies Alone Insufficient to Address Affordability

- Almost 48,000 Exchange customers do not receive subsidies
- Majority of plans are unaffordable even after Cascade Care Savings and Federal Tax Credits are applied
- For customer at 250% FPL ($34,000 income):
  - Only a few silver plans in each county have a net premium under $100
  - Monthly premium over ~$280 is more than 10% of income spent on premiums

Net Premium after APTC and Cascade Care Savings Applied, 2024 Proposed Rates, 40-year-old Non-Smoker at 250% FPL*



*Based on Plan Year 2023 FPL and monthly customer premium contribution levels; Data will be updated once 2024 plan rates final

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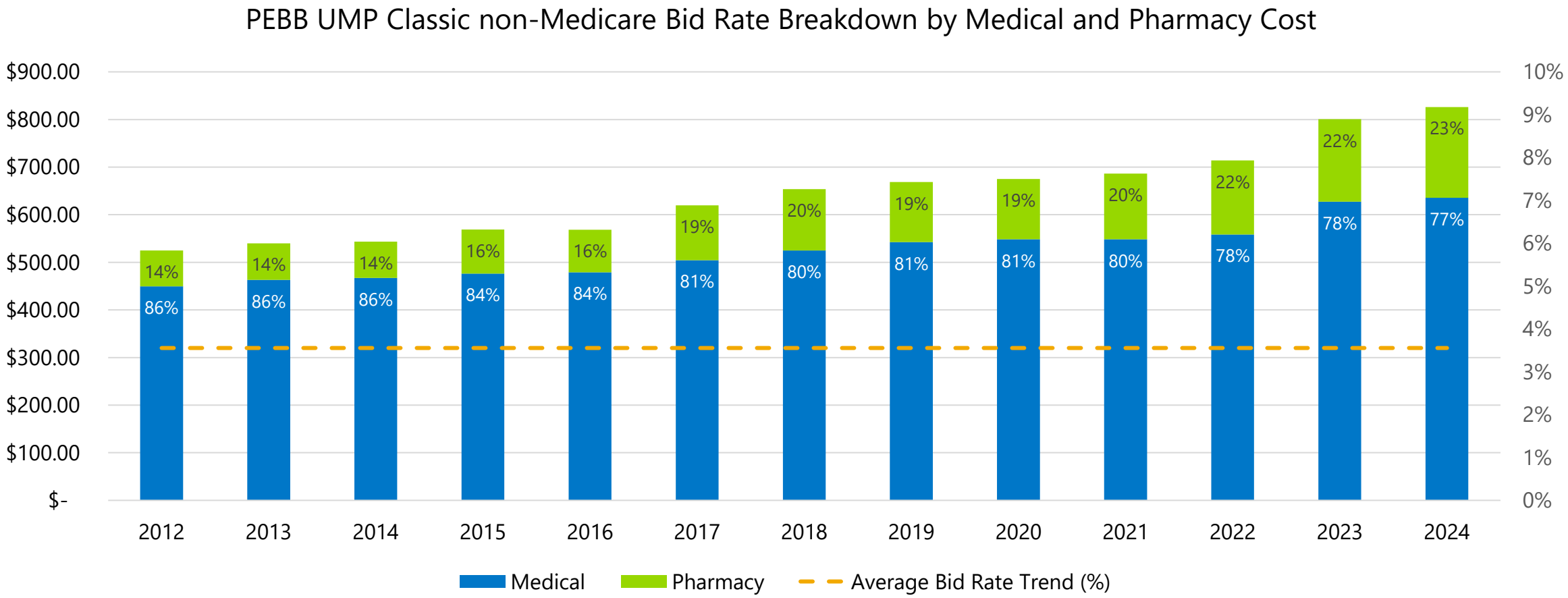
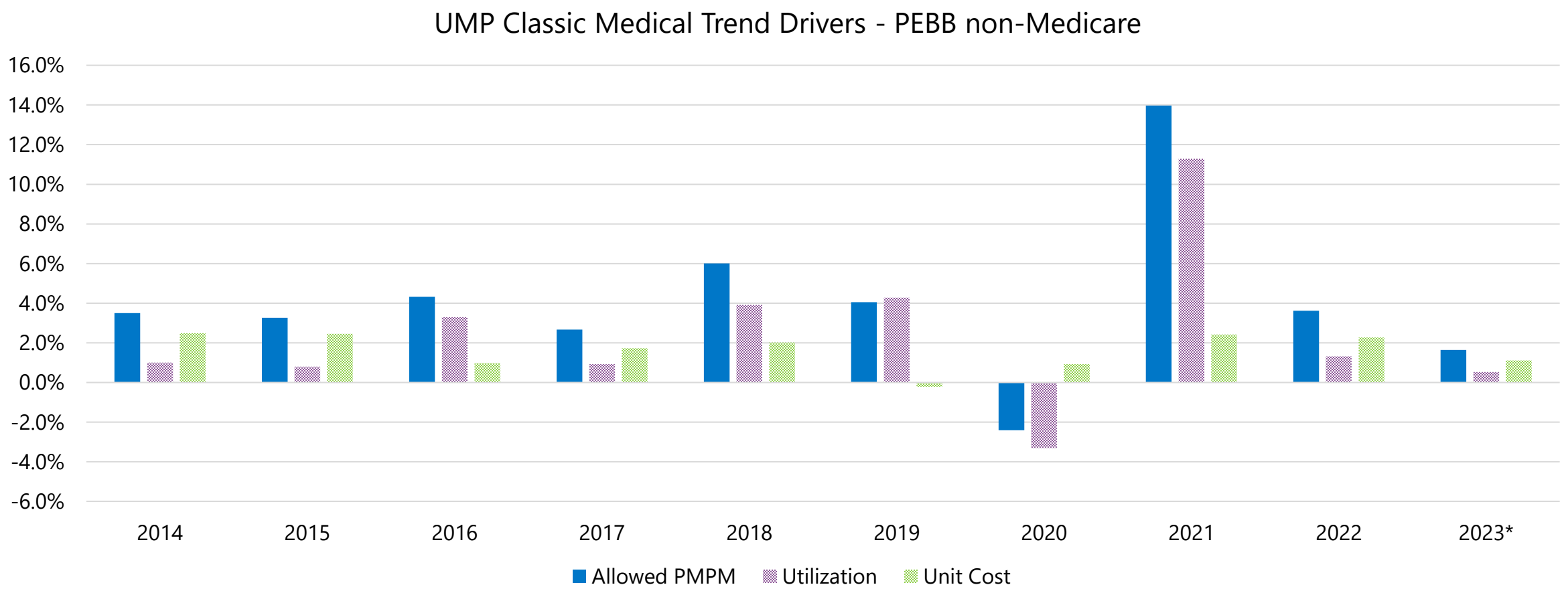
Pharmacy is growing as percentage of total cost in the state's self-insured Uniform Medical Plan

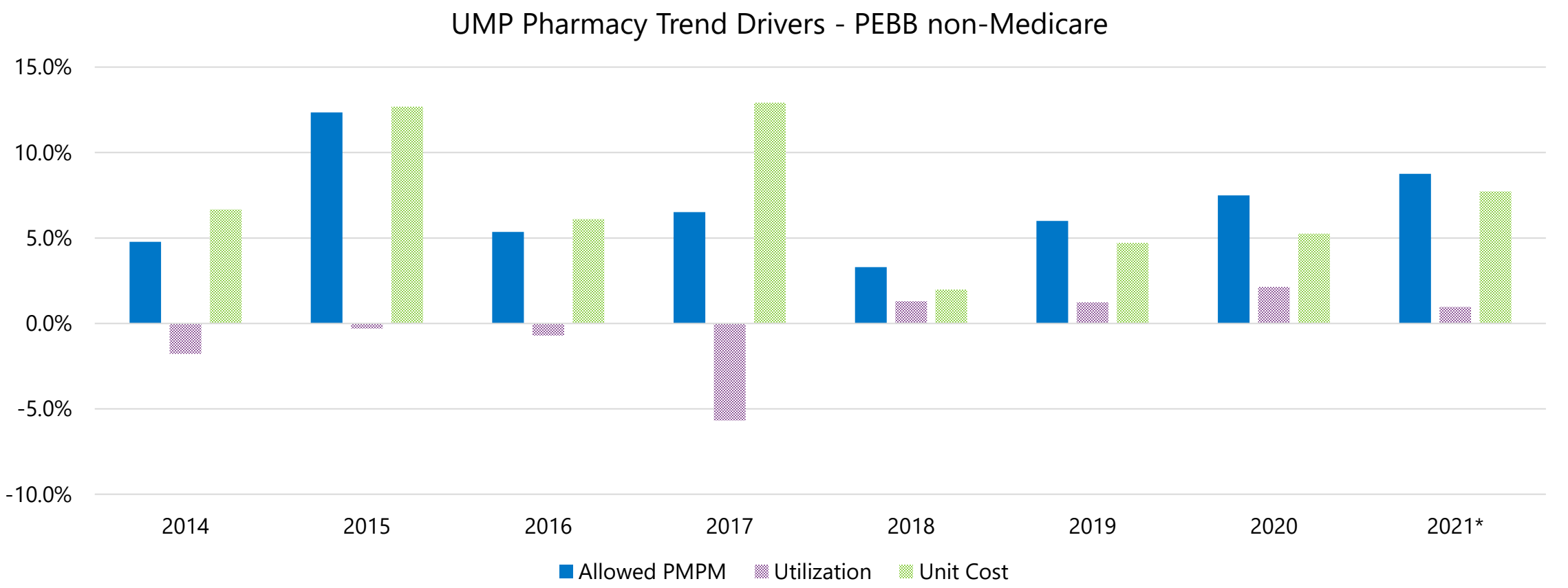


Utilization and unit cost both contributing factors to medical spending in UMP



*Partially projected period

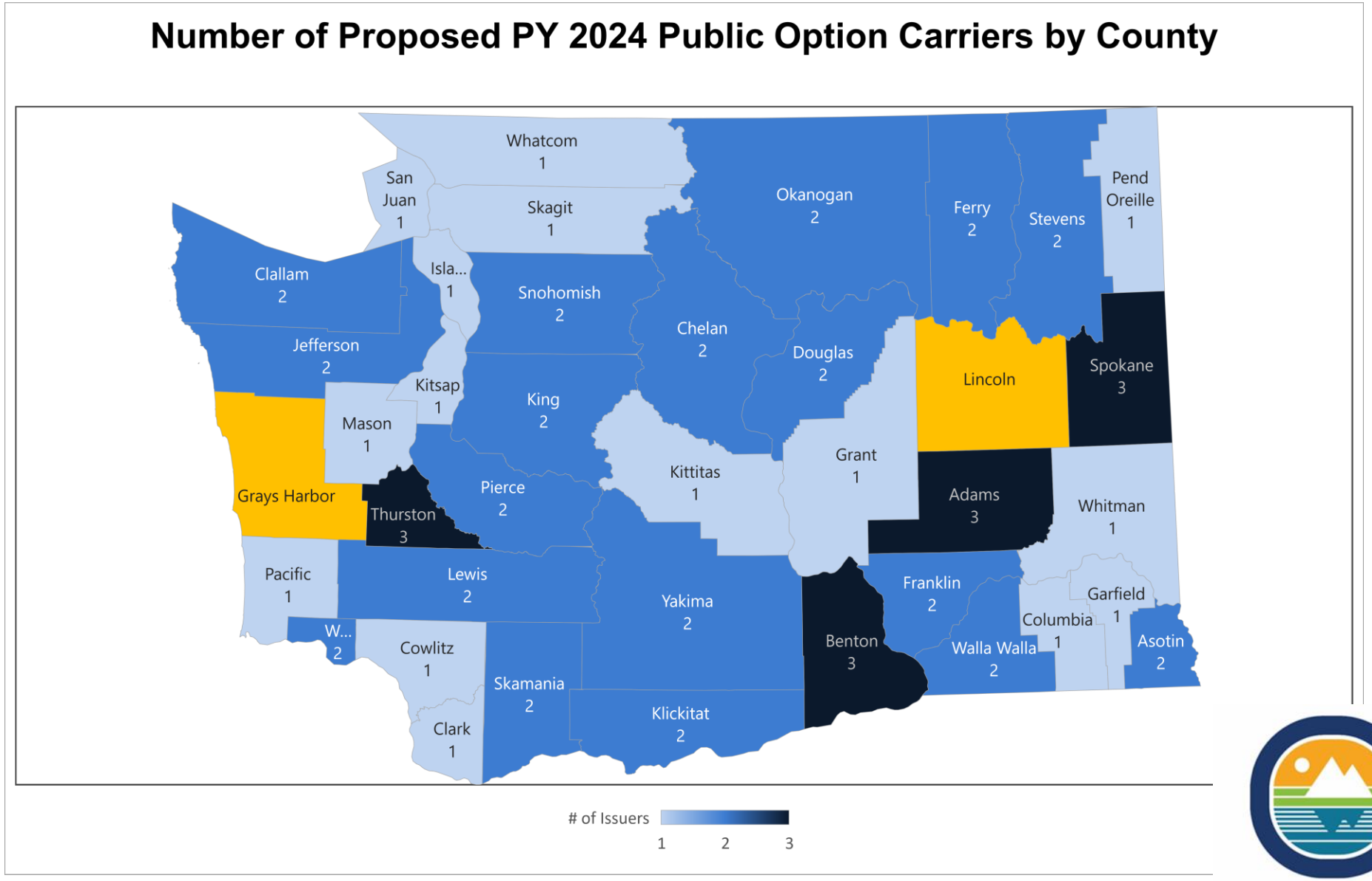
Unit cost the largest driver of UMP pharmacy spend



*Partially projected period
New pharmacy contract arrangement resulted in a significant increase in rebates effective 2022; HCA is reconciling trend for this period.

Public Option Presents Opportunity To Meaningfully Reduce Premiums, But Needs Strengthening

Strengthened provider participation requirements may be needed to ensure statewide public option access and healthy competition.



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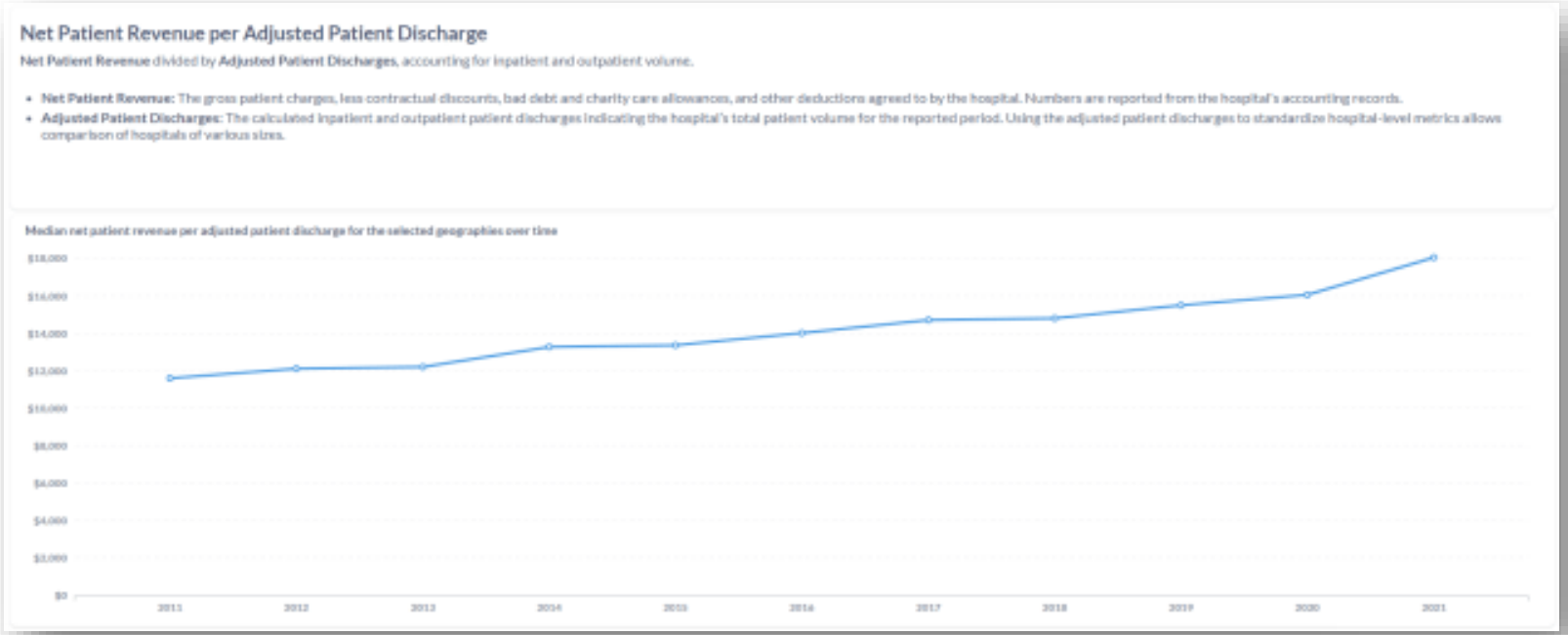
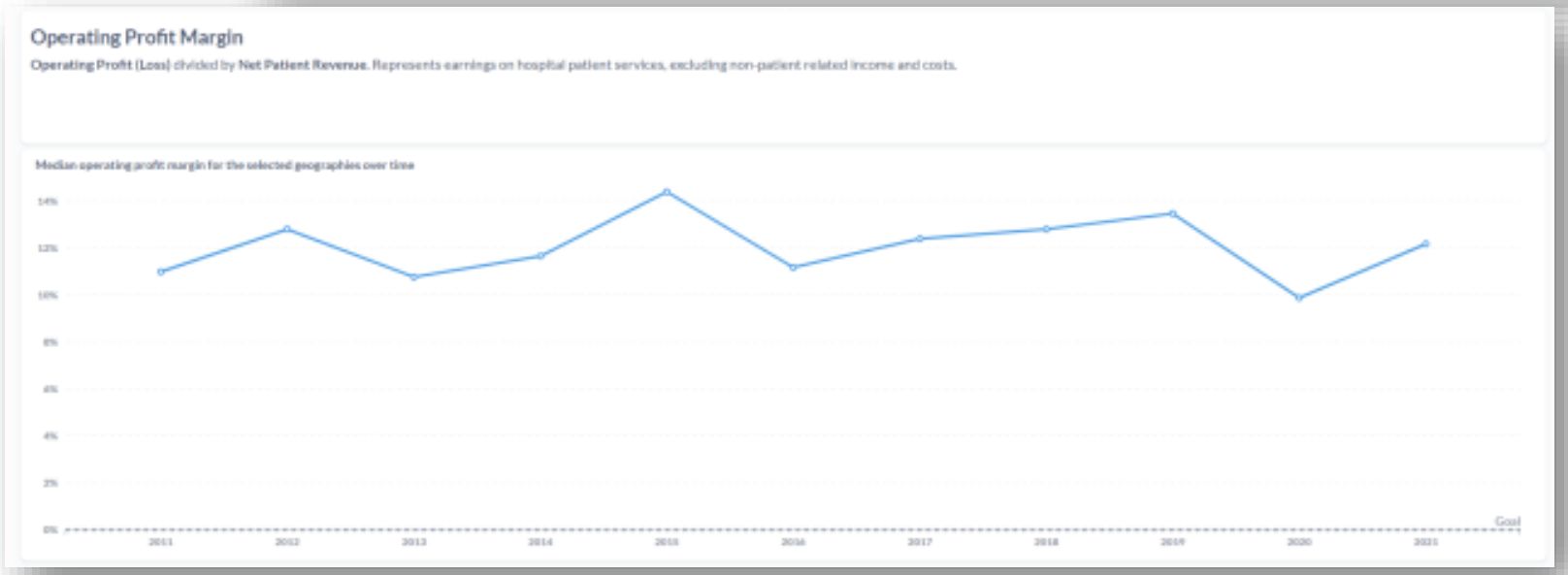
Hospital costs

NASHP Hospital Cost Tool:
https://tool.nashp.org/





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Thank you!