Health Care Cost Transparency Board meeting

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board
AGENDA

June 21, 2023
2:00 p.m. – 4:00 p.m.
Hybrid Zoom Meeting

Board Members:					
☐	Susan E. Birch, Chair	☐	Bianca Frogner	☐	Margaret Stanley
☐	Jane Beyer	☐	Leah Hole-Marshall	☐	Kim Wallace
☐	Eileen Cody	☐	Jodi Joyce	☐	Carol Wilmes
☐	Lois C. Cook	☐	Mark Siegel	☐	Edwin Wong

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome, new member introduction, roll call	1 2	Sue Birch, Director Health Care Authority
2:05 – 2:10 (5 min)	Approval of April meeting summary	3	Mandy Weeks-Green, Board Director Health Care Authority
2:10 - 2:55 (45 min)	Analytic Support Initiative Presentation	4	Joseph L Dieleman, Associate Professor for Health Metrics and Evaluation | University of Washington
2:55 – 3:10 (15 min)	Public comment	5	Sue Birch, Director Health Care Authority
3:10 – 3:30 (20 min)	HCCTB's Legislative Reports • Cascade Select • Annual Update Report **Vote to adopt with the understanding that Board and stakeholder feedback will be incorporated into the final drafts**	6 7	Mandy Weeks-Green, Board Director Health Care Authority Laura Kate Zaichkin & Kristin Villas Health Benefit Exchange
3:30 - 4:00 (30 min)	Primary Care Claims Based Measurement Recommendations **Discussion and vote**	8	Dr. Judy Zerzan-Thul, Medical Director Health Care Authority
4:00	Adjourn		Sue Birch, Director Health Care Authority

Tab 2

Published on *Peterson Center on Healthcare* (https://petersonhealthcare.org)

Peterson Center on Healthcare Announces a $1.7 Million Grant to Washington State Health Care Authority to Identify and Address Drivers of Healthcare Cost Growth

May 31, 2023

Contact: Nina Grigoriev
ngrigoriev@petersonhealthcare.org

NEW YORK (May 31, 2023)— The Peterson Center on Healthcare today announced a two-year, $1.7 million grant to the Washington State Health Care Authority (HCA) to support a new partnership with the Institute for Health Metrics and Evaluation (IHME), an independent health research center at the University of Washington.

In Washington and across the U.S., healthcare spending continues to rise unsustainably, putting a strain on individuals, families, state healthcare systems, and government budgets. This partnership will provide policymakers with timely, actionable data and research to improve access to quality, affordable care for Washington residents by supporting analytic capacity and transparency about healthcare costs and outcomes.

Washington State's HCA will use the grant, funded jointly by the Peterson Center on Healthcare and Gates Ventures, to create a new Analytic Support Initiative that will combine in-house expertise in healthcare spending, state data, and policy with world-class analytics capabilities at IHME. This partnership with IHME builds on Washington's efforts to improve healthcare affordability and transparency through the Health Care Cost Transparency Board (Board). The Board is charged with evaluating and making recommendations to the state on ways to reduce healthcare spending. To accomplish these goals, the Board is comprised of state legislators and agencies, representatives for healthcare purchasers, employers, and Washington consumers.

Sue Birch, Director of HCA and Chair of the Health Care Cost Transparency Board, said, "HCA will be working with world-class partners to increase capacity and inform decision-making to improve Washingtonians' access to quality healthcare at a lower cost. This initiative will strengthen the Health Care Cost Transparency Board's efforts to create transparent recommendations based on data."

The Board has already collected its first set of data from insurance carriers about the benchmark for calendar years 2017, 2018, and 2019. This data will help the Board determine how much Washington spends on healthcare and set the baseline for tracking spending growth in future years. Later this year, the Board expects to publicly report Washington spending trends.

The Analytic Support Initiative will provide additional data and evidence for the Health Care Cost Transparency Board to guide the Board's recommendations in addressing healthcare costs.

"Policymakers need better, more actionable data on healthcare utilization, spending, and outcomes to inform decision making. When armed with this information, states are better positioned to improve the performance of their healthcare systems," said Caroline Pearson, Executive Director of the Peterson Center on Healthcare.

"We are thrilled to partner with the HCA in leveraging our team's deep expertise in rigorous analysis of healthcare data towards the goal of improving health outcomes and reducing costs in our home state," said Dr. Christopher Murray, Director of IHME.

This grant builds on prior research by IHME on the drivers of healthcare cost growth, funded by the Peterson Center on Healthcare and Gates Ventures, as well as the Peterson-Milbank Program for Sustainable Health Care Costs that helps states build capacity to set and track health cost growth targets.

"We are excited to bring this additional data and analytic capacity to bear in order to build consensus around drivers of cost and potential solutions to inform progress in Washington," said Dr. Niranjan Bose, Managing Director of Health & Life Sciences at Gates Ventures, the private office of Bill Gates.

Lois Cook, Managing Member, America's Phone Guys and small business representative of the Health Care Cost Transparency Board, said, "As a small business co-owner in Washington state, we have a vested interest in managing rising healthcare costs that have a direct impact on our employees. The Analytics Support Initiative will be an important tool to assist the Board in this effort."

For more information, please visit hca.wa.gov.

# # #

About the Peterson Center on Healthcare
The Peterson Center on Healthcare is a non-profit organization dedicated to making higher quality, more affordable healthcare a reality for all Americans. The organization is working to transform U.S. healthcare into a high-performance system by finding innovative solutions that improve quality and lower costs, and accelerating their adoption on a national scale. Established by the Peter G. Peterson Foundation, the Center collaborates with stakeholders across the healthcare system and engages in grant-making, partnerships, and research.

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Source URL: https://petersonhealthcare.org/announces-grant-washington-state-health-care-authority

Tab 3

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board meeting summary

April 19, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the board are available on the Health Care Cost Transparency Board webpage.

Members present

Sue Birch, Chair
Eileen Cody
Lois Cook
Bianca Frogner
Leah Hole-Marshall
Molly Nollette
Margaret Stanley
Kim Wallace
Edwin Wong

Members absent

Jodi Joyce
Mark Siegel
Carol Wilmes

Call to order

Sue Birch, Board Chair, called the meeting to order at 2:01 p.m.

Agenda items

Welcome, roll call, and agenda review

Chair Birch called the meeting to order and reviewed the agenda. Chair Birch introduced the new board member, Eileen Cody.

Approval of February meeting summary

The board approved the Meeting Summary from the February 2023 meeting.

Topics for Today

The main topics were: Data Committee new member application; Primary Care Committee: claims-based measurements; an overview of data projects; Washington hospital costs, price, and profit analysis: second level analysis methodology; a historical review of the data collected and methodology for the benchmark; and updates to the 2023 benchmark call.

Public Comment

Tamara Cesena, Regional Vice President, and Chief Financial Officer of Skagit Regional Health (SKR) noted SKR's understanding that they will be subject to the health care cost benchmark, but it's unclear if that's accurate. If individual providers haven't been defined, it seems unreasonable to hold them accountable without notice. How does the board account for factors that impact the ability to meet the benchmark? Additionally, how are mandated expenditures accounted for? A 3.2 percent benchmark is unreasonable given the current environment. SKR asked the board for other ways to assist providers with managing costs by helping to control the drivers over which health systems have little influence. Tamara encouraged a clear process for setting the benchmark and adjustments that account for increases in services, utilization, population acuity, and inflation. Unless there are unexplained and unjustifiable variances after considering all factors, hospitals shouldn't be named, shamed, or worse.

Katerina LaMarche, Washington State Hospital Association (WSHA) remarked on the uncertainty as to how the hospital cost analysis will be used in conjunction with the benchmark work. The proposed methodology only adjusts for wage index and adjusted discharges and compares the remaining measures of case mix index and teaching status independently. From there, the proposed analysis suggests using peer group comparisons on several different variables, but these factors should be used in combination. WSHA's recommended analysis centers around standard adjustments including wage index, case mix index, and teaching status. WSHA requests both clarification of how this hospital cost analysis will be used, and a consideration of WSHA's analytical approach described in their previously submitted letter to be used along with what the consultants will provide.

Jeb Shepard, on behalf of physicians and physician assistants (PAs), director of policy at the Washington State Medical Association (WSMA) noted that providers and carriers were provided a schedule of the board's activities planned for 2023. It appears that the group has deviated from the schedule. Jeb requested an updated schedule of meeting items to understand the trajectory of this work. Jeb requested clarity around which entities are subject to the benchmark, which will be publicly reported on, and when. Reducing administrative waste should be the highest priority of the board, given that patients, physicians, insurance carriers, and state budgets would benefit from lower costs. Administrative costs aren't included in the APCD and Jeb urged the board to examine administrative cost drivers as permitted by the authorizing legislation. OnPoint could help us understand the limitations in the absence of Employee Retirement Income Security Act (ERISA) plan data. Many state residents are covered by commercial ERISA plans and this seems like a large blind spot.

Data Committee New Member Application

Chair Birch

Chair Birch introduced Christa Able, from Virginia Mason Franciscan Health, who was recommended to fill the vacancy left by Scott Juergens on the Advisory Committee on Data Issues. Board member Eileen Cody made a motion to approve Christa Able's appointment and the motion passed.

Primary Care Committee: Claims-Based Measurements

Jean Marie Dreyer, Senior Health Policy Analyst, Health Care Authority

Jean Marie Dreyer updated the board on the Advisory Committee on Primary Care's progress with methodologies to measure primary care spending. The board approved the committee's proposed definition of primary care at the February 2023 meeting. The committee is in the process of finalizing a measurement methodology to assess claims-based spending. Thus far, providers and facilities have been approved, and the committee is wrapping up its choices for primary care service code selection. The committee is in the process of defining services for claims-

based measurements and has decided to focus primarily on those services that are core to primary care, rather than attempting to include every possible code.

There are several additional steps once the primary service codes have been selected by the committee. In May, the committee will hear presentations from Oregon and Bailit Health on non-claims-based spending. In June, the committee will present its claims-based measurement recommendations to both the Advisory Committee of Health Care Providers and Carriers and the Advisory Committee on Data Issues for feedback. Also in June, the board will hear a presentation of the committee's final claims-based recommendations, including any input from the other two subcommittees, for the board to approve. Finally, the board's annual August report to the legislature will include an update on the Advisory Committee on Primary Care's progress-to-date.

Board member Bianca Frogner asked about a letter to the board from WSMA requesting a modification to the board approved primary care definition. Jean Marie Dreyer clarified that the committee would vote on the proposed amendment mentioned in WSMA's letter at the April 27 meeting.

Data Projects Overview

Ross McCool, Data Analyst, Health Care Authority

Ross McCool presented an overview of the board's current data projects. The data projects chart is meant to serve as a reference/answer to frequently asked questions for the board. The cost growth benchmark is the metric/goal ceiling for health care growth and reflects the affordability of healthcare for consumers and purchasers. Performance against the benchmark is aggregate with adjustments made for age and sex. The cost driver analysis is a drill down analysis into the APCD to see what claims produce the highest costs. The analysis started with a high-level examination and will proceed with multiple, more detailed analyses. It only uses claims-based data.

Bianca Frogner asked for clarification regarding performance, specifically around the severity of illness risk adjustment and why this was marked as not applicable. Ross McCool clarified that the intent is to provide transparency. Cost growth benchmark states have also moved away from clinical risk adjustment due to unsubstantiated increasing risk scores that didn't correspond with changes in underlying population health. Vishal Chaudhry added that adjusting risk at the provider level is apples and oranges. There have been proxy measures used, e.g., inpatient Medicare case mix index (MCI), though all chosen measures have sufficient deficiencies because they only capture part of the population. The benchmark analysis is done at a business entity level. Risk adjustment will apply for the cost driver analysis which looks at disease level.

Board member Leah Hole-Marshall requested removal of the sentence about what's not included and suggested instead stating what is being adjusted. Ross McCool noted that when risk adjustment is applied depends on the type of cost driver analysis. Leah Hole-Marshall requested specifying when it might be applicable, and when it might not.

Board member Edwin Wong requested asked as to the completeness of the Washington state population. There wasn't Medicare fee for service (FFS) data. What other gaps are there in the APCD? Vishal Chaudhry clarified that Medicare data is delayed and most self-funded data isn't included. The analysis still represents close to 70 percent of the state's population. Edwin Wong asked if the cost driver analysis would be lagged or would skip Medicare data. Vishal Chaudhry replied that the intent is to make Medicare data available but that it will be lagged compared to other sources. This board has limited ability to impact Medicare purchasing paradigms. It's not clear to what degree inclusion of Medicare data is helpful. Chair Birch requested staff consider incorporating footnotes and other feedback into the chart.

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

John Bartholomew and Tom Nash, Bartholomew-Nash & Associates

John Bartholomew and Tom Nash (Bartholomew Nash& Associates) reviewed their first level analysis. The phase two analysis of Washington hospital costs, price, and profit analysis would build upon the initial report with additional metrics. The first analysis looked at hospitals with more than 25 beds. Of the 45 total hospitals analyzed, 15 were found to be high-price and 12 of those were high-cost. Two of the 12 high-cost hospitals were high-profit. Of those that were not high-priced, there were four hospitals that were high-profit but normal cost, six hospitals that were not high-price but were high-cost, and at least one hospital that wasn't high-priced but was high-profit.

A deeper dive is needed to further understand price, cost, and profit variations from the national median over time. Measures such as case mix, service intensity, teaching intensity, payer mix, and other financial measures are needed to enable better comparisons between hospitals. The goal of the analysis is to adjust service intensity, acuity, location, and other differences so that cost variation is isolated to either business decisions or price discrimination.
The second level analysis will include two types of methodology enhancements and additional financial review, consisting of the following: calculated adjustments to the first level analysis of costs; creation of additional groupings beyond bed size, to allow for comparisons to the national database; and a Washington hospital margin analysis.

Bartholomew-Nash & Associates formed a workgroup to review the assumptions to address methodology enhancements for the second level hospital financial analysis with a collection of Washington state subject member experts. Workgroup members included representatives from WSHA, HealthTrends, UW Medicine, HCA leadership, Tom Nash, and John Bartholomew. The workgroup held a series of meetings and conversations in early 2023. At the conclusion of the workgroup meetings, Bartholomew-Nash & Associates summarized their recommendations based on the group's discussions.

Adjustments to the cost data will include an adjustment to hospital-only operating expense by removing Council for Community and Economic Research (C2ER) as a cost-of-living adjustment. The analysis will utilize the labor wage index information from Centers for Medicare and Medicaid (CMS) wage index files and from the Medicare Cost Report at the hospital level. The labor wage index will be applied to the salary amount of costs of each hospital, with remaining costs applying the C2ER statistic.

The second analysis will contain additional groupings to create more informed peer groupings for hospital comparisons, both within Washington and nationally, using data from the Medicare Cost Report. In addition to bed size, the secondary analysis will utilize one or a combination of the following measures to further refine the ability to compare "like" hospitals: teaching intensity measure; service intensity measure; and MCI. The second level analysis will also review the payer mix measure. The second level analysis will be completed and presented to the board in July 2023.

Board member Margaret Stanley asked how useful it is to compare Washington to other states that don't have Washington's lower admission rates. John Bartholomew responded that the analysis looks at utilization and profit which are comparable between Washington and other states. Each state needs to hold their individual hospitals accountable. The information used for the second level analysis will inform the work around the cost growth benchmark, particularly around the cost driver analysis. The data for this second analysis are the inputs into the APCD data.

Bianca Frogner noted hospitals' challenges discharging patients. How will this analysis help the board differentiate between system capacity and patient health? Tom Nash acknowledged that capacity has affected discharges and this could be added. Bianca Frogner requested adding length of stay and occupancy rates. John Bartholomew noted that occupancy rates are reported as a measure in the cost board report. The measure discharges per 1,000 won't be looked at in this analysis because it won't assist in the second level review.

Edwin Wong asked about the MCI and expressed concerns around groupings. The MCI is only constructed from inpatient among Medicare patients which highlights potential issues like misrepresenting patient populations. The analysis will be used for grouping but not adjusting data. Edwin Wong cautioned using the MCI even for groupings. Tom Nash noted that WSHA has observed a correlation between MCI and all-payer case mix, but that may not be the case for individual hospitals. For the analysis, the choice was made to use case mix as a grouping factor rather than an adjustor. John Bartholomew added that as the margin analysis is done, the profits can be compared with adjustments for payer mix, case mix, or other metrics.

Bianca Frogner asked for further clarification on the C2ER metric. Tom Nash explained that in the analysis, there is an attempt to recognize that the cost of doing business differs between states and that C2ER isn't used for inflation, but the Consumer Price Index (CPI) is. An adjustment for cost-of-living would only be used for out-of-state comparisons. For Washington hospitals, the analysis will look at unadjusted data.

Chair Birch asked the board whether the analysis work should continue into phase two. The board endorsed pursuit of a second analysis.

Benchmark: Historical Review of the Data Collected & Methodology

January Angeles, Bailit Health

January Angeles reviewed the purpose and methodology of the cost growth benchmark analysis. The data types and sources used by the cost growth benchmark analysis are different from those used in the cost growth analysis. The benchmark analysis uses aggregate data from insurers and public payers. The cost driver analysis is more granular and comes from claims/encounters from the APCD. The benchmark calculates health care cost growth over time, while the cost driver analysis looks at cost drivers to identify opportunities to reduce cost growth and inform policy decisions.

To assess performance against the benchmark, the performance analysis looks at total medical expenses (TME), which includes all payments on providers' claims, non-claims-based payments, and cost-sharing paid by members and adds the net cost of private health insurance (NCPHI) to add up to total health care expenditures (THCE). THCE are measured at the state level and compared against the benchmark. Performance against the benchmark is assessed at four levels, including state (TCHE), market, payer, and large provider entity (for TME only) levels.

Most data for performance comes from payer-submitted reports, including claims and non-claims-based spending, pharmacy rebate information, and fees from income of uninsured plans to calculate NCPHI. Other data sources include CMS for Medicare FFS claims and standalone Part D spending, State Medicaid agency data for non-managed care payments, other sources of public coverage and regulatory reports used to calculate NCPHI.

There are both member and data specifications for insurer benchmark submissions. The population represented by benchmark calculations includes all members who reside in Washington. Insurers aggregate report spending and membership data by large provider entity and insurance type. For members not attributable to a large provider entity, members are aggregated by insurance type. Other data specifications include a run-out period of

180 days (data is run six months after the conclusion of the performance period) and adjustments made to lines of business for which the insurer doesn't have all claims information (e.g., carved=out benefits).

There are different measurement situations which necessitate adjustments to performance data. When reporting spending and spending growth at the state and market levels, no adjustments are made. When reporting data at the insurer and large provider entity levels, HCA applies four different methodologies: 1) risk-adjusting aggregate spending data by age and sex 2) truncating spending for high-cost outliers 3) using confidence intervals around cost growth rates to determine benchmark performance 4) reporting performance only for insurers and large provider entities that meet a minimum threshold (still to be determined) for attributed lives.

Margaret Stanley asked about payer submission of data for self-insured and insured lives. Would third party administrators (TPAs) not report? January Angeles said HCA likely doesn't require data from TPAs but would need to confirm. Margaret Stanley asked what percentage of claims expense the upper limit of the commercial threshold would eliminate? January Angeles wasn't sure but thought maybe it was seven percent. Ross McCool mentioned that these limits were brought to the data committee.

Updates to 2023 Benchmark Data Call

Ross McCool, HCA

The data team completed updates to the 2023 benchmark data call. Changes to the 2023 data call include: 1) inclusion of calendar years 2020, 2021, and 2022 in the submission, and 2) the performance against the benchmark will be calculated using 2021 and 2022.

There will be updates to reference categories to clarify submission data. These updates include: 1) an additional insurance category for Federal Employee Health Benefits (FEHB) and 2) implementation of a new method to associate non-claims-based spending to providers without age/sex stratification.

These changes are incorporated into the technical manual for submitters. Training will be provided for submitters through a webinar beginning in July or early August. Submissions for 2023 benchmark data are due September 1.

Adjournment

Chair Birch adjourned the meeting at 4:00 p.m.

Next meeting

June 21, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Tab 4

Washington State Health Care Authority

IHME
Measuring what matters

The HCA/IHME Analytical Support Initiative

Joseph Dieleman, PhD
dieleman@uw.edu

UNIVERSITY of WASHINGTON
Institute for Health Metrics and Evaluation

Agenda – Introductions and feedback

I. Introductions
   A. Myself and IHME
   B. Analytical Support Initiative
   C. IHME's Disease Expenditure Project

II. Next steps

III. Early feedback and/or considerations

Joseph (Joe) Dieleman

- Associate Professor in Dept of Health Metric Sciences at UW
- Lead Resource Tracking research team at Institute for Health Metrics and Evaluations
- Background is in Economics, while my work has focused almost exclusively on health financing
- dieleman@uw.edu

The Institute for Health Metrics and Evaluation

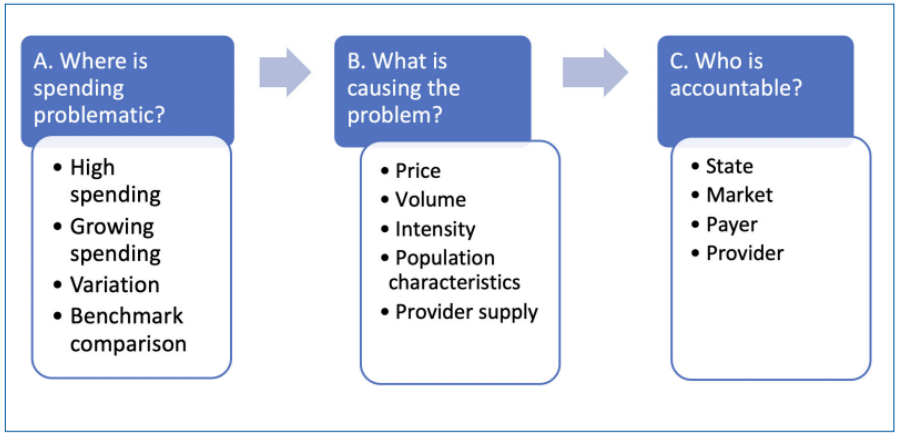
- 16 years
- 450+ full-time professionals
- 30+ full-time faculty
- 30-member Scientific Council
- Multidisciplinary
- 7,000+ international collaborators
- www.healthdata.org

Peterson-Milbank
Program for Sustainable
Health Care Costs

JUNE 2021

A Data Use Strategy for State Action to Address Health Care Cost Growth

Figure 1. Framework for Data Use Strategy Analyses



IHME | UNIVERSITY of WASHINGTON

Stage 1: Describing utilization and spending

Measure	Description	Analysis
1	Spend by Market	N/A
2	Trend by Market	Price, volume, intensity
3	Spend by Geography	Price, volume
4	Trend by Geography	Price, volume, intensity
5	Spend by Service Category	Price, volume
6	Trend by Service Category	Price, volume, intensity
7	Spend by Health Condition	Price, volume
8	Trend by Health Condition	Price, volume, intensity
9	Spend by Demographic Variables	Price, volume
10	Trend by Demographic Variables	Price, volume, intensity

Stage 2: Trends analysis

- How does growth compare to other states and counties?
- Which geographic units, health conditions, markets, service category have most growth?
- How do changes in population, changes in disease prevalence, changes in service utilization, and changes in prices contribute to spending growth?

Analytical Support Initiative

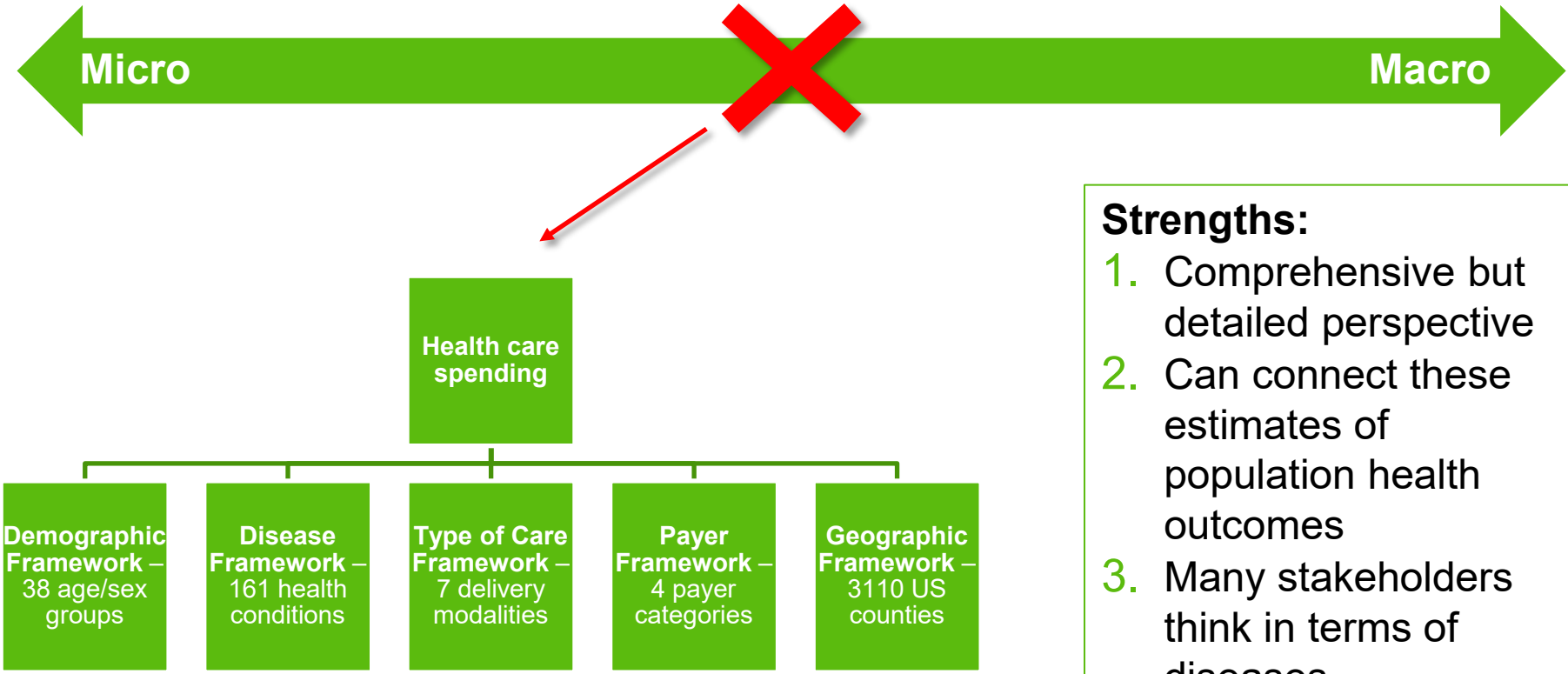
- Sole source contract between HCA and IHME
- HCA is externally funded by Peterson Center on Healthcare and Gates Ventures
- June 2023 – July 2025
- Objective: *The goal of the Analytic Support Initiative is to develop Washington specific analyses of cost growth trends that will identify specific areas of focus for discussion, additional analysis, and development of cost mitigation strategies. HCA expects the project to provide information that will result in actionable recommendations on reducing health care cost growth in the state.*

Analytical Support Initiative

- Key deliverables:
  - Analytical Strategy 1.0 (December 2023)
  - Initial cost growth report based on IHME's previous research (March 2024)
  - Preliminary results and observations (October 2024)
  - Initial results, observations, and recommendations for HCCTB – report, charts, tables, graphs, and presentation (December 2024)
  - Analytical Strategy 2.0 (January 2025)
  - Cost drivers report (January 2025)
  - Formal recommendations for HCCTB (May 2025)

- Purposefully dynamic and collaborative

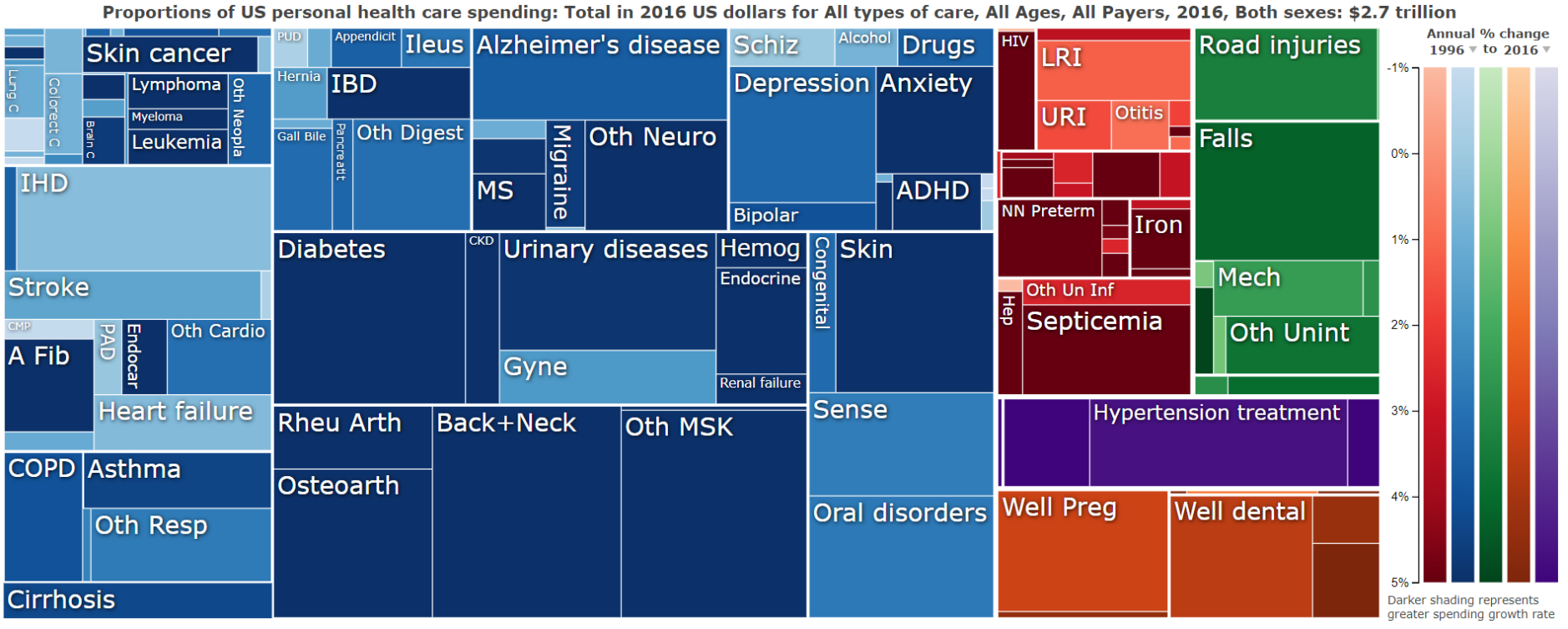
Disease Expenditure (DEX) research project



Strengths:

1. Comprehensive but detailed perspective
2. Can connect these estimates of population health outcomes
3. Many stakeholders think in terms of diseases

Results: https://vizhub.healthdata.org/dex/



Measuring *changes* in health care spending

Measure effect of 5 drivers:

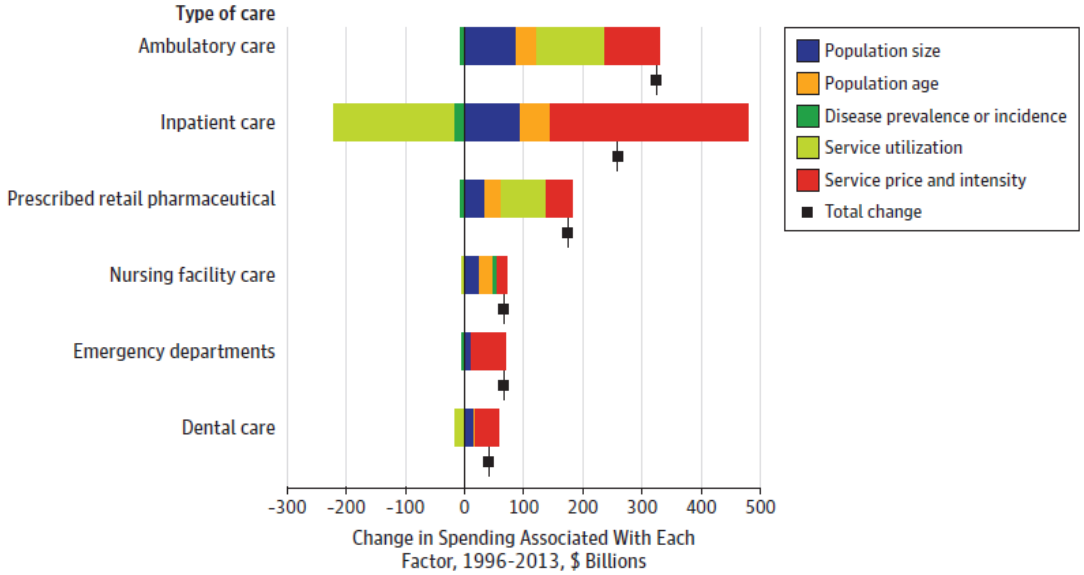
i. population size

ii. population age structure

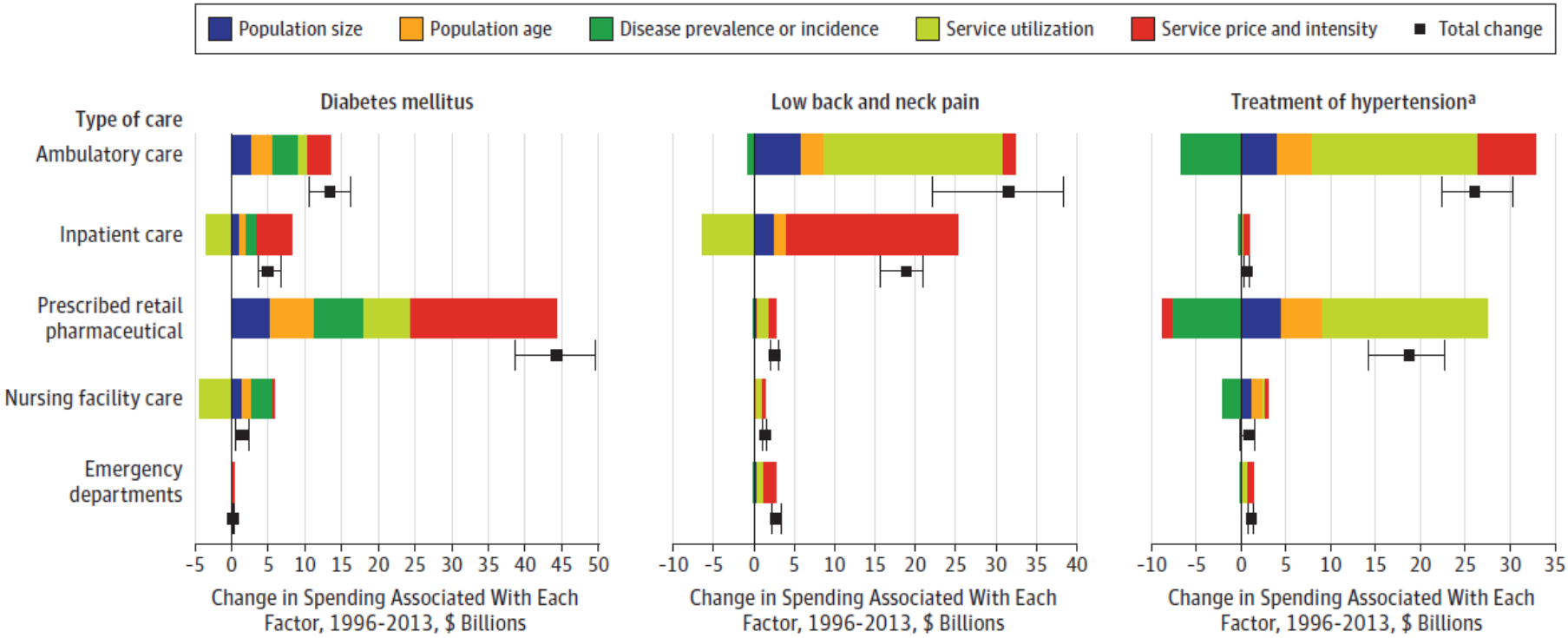
iii. disease prevalence

iv. service utilization

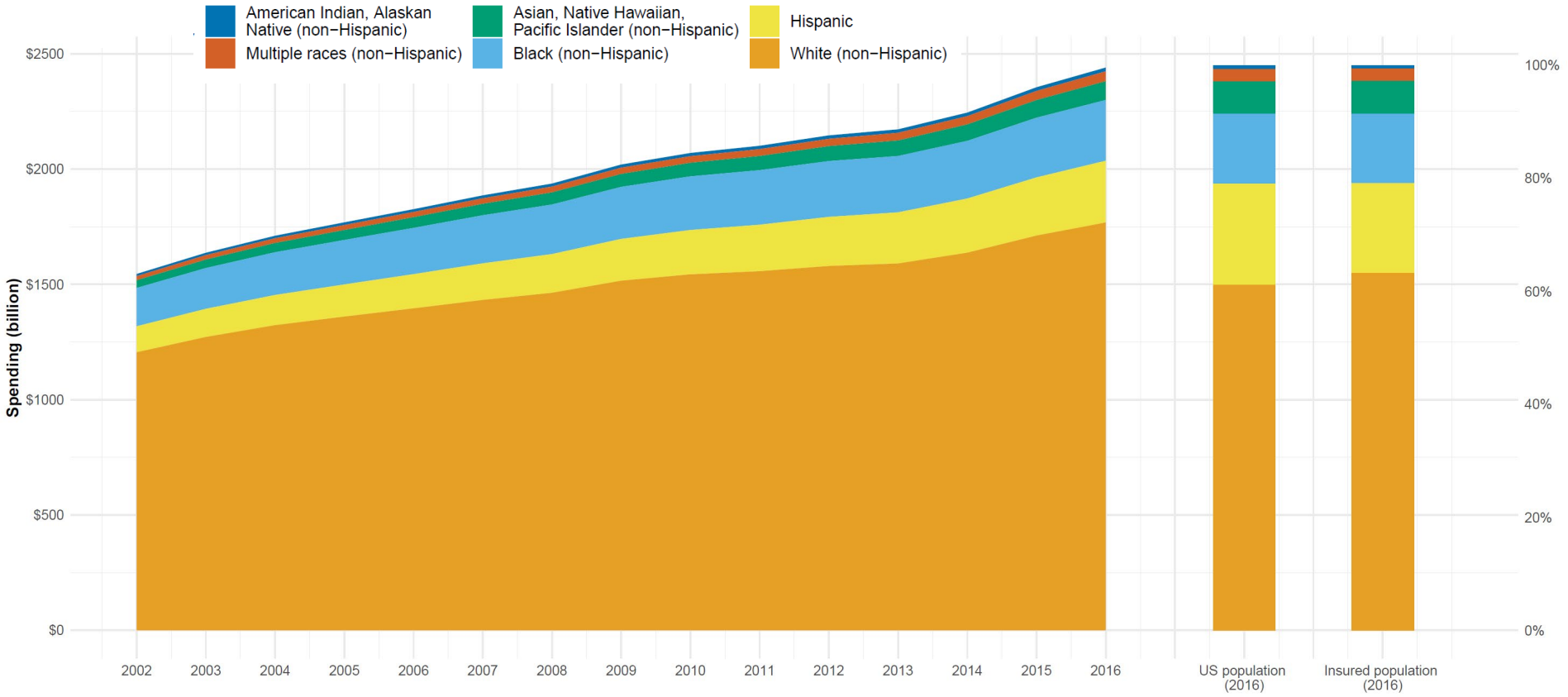
v. service price and intensity



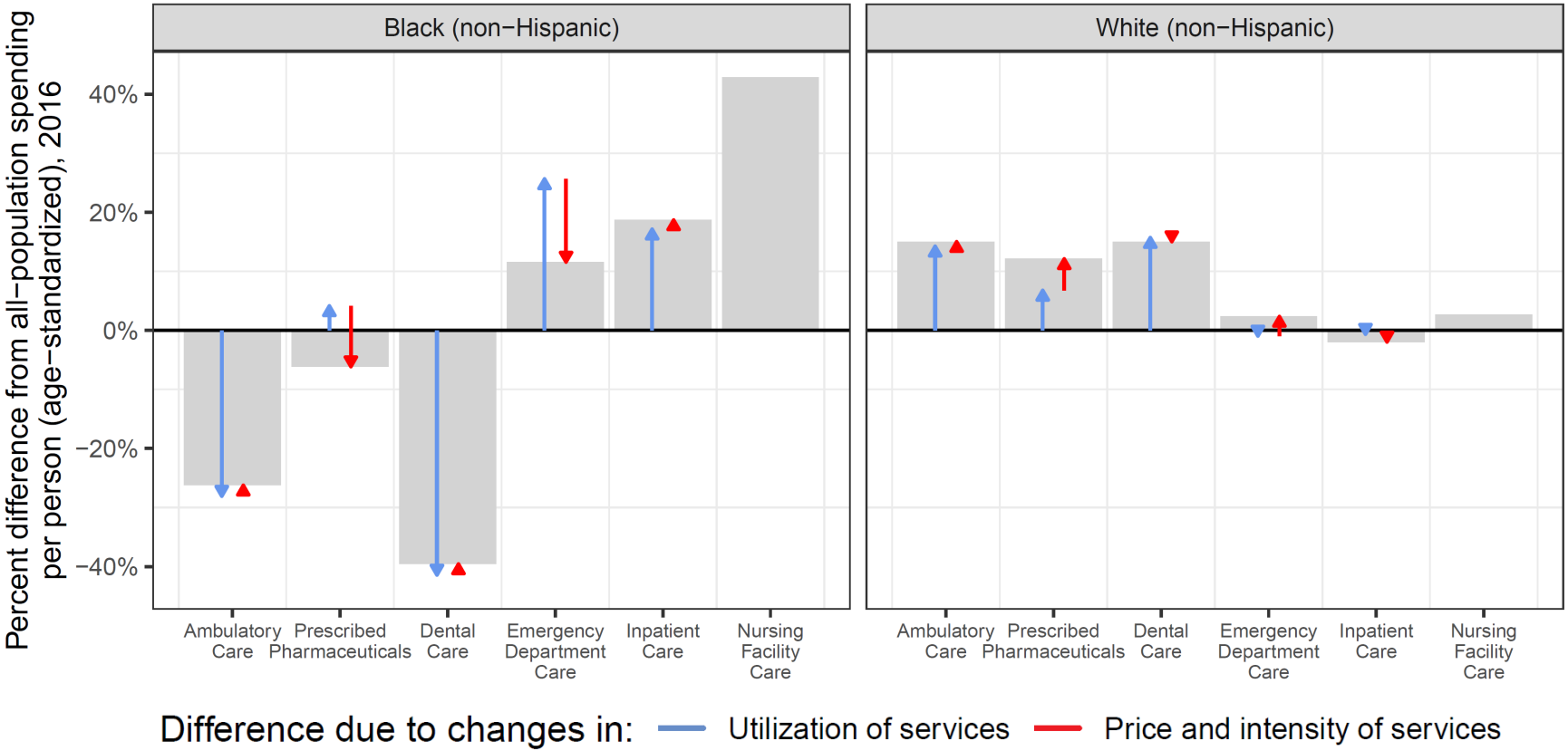
Explaining factors driving increases in spending



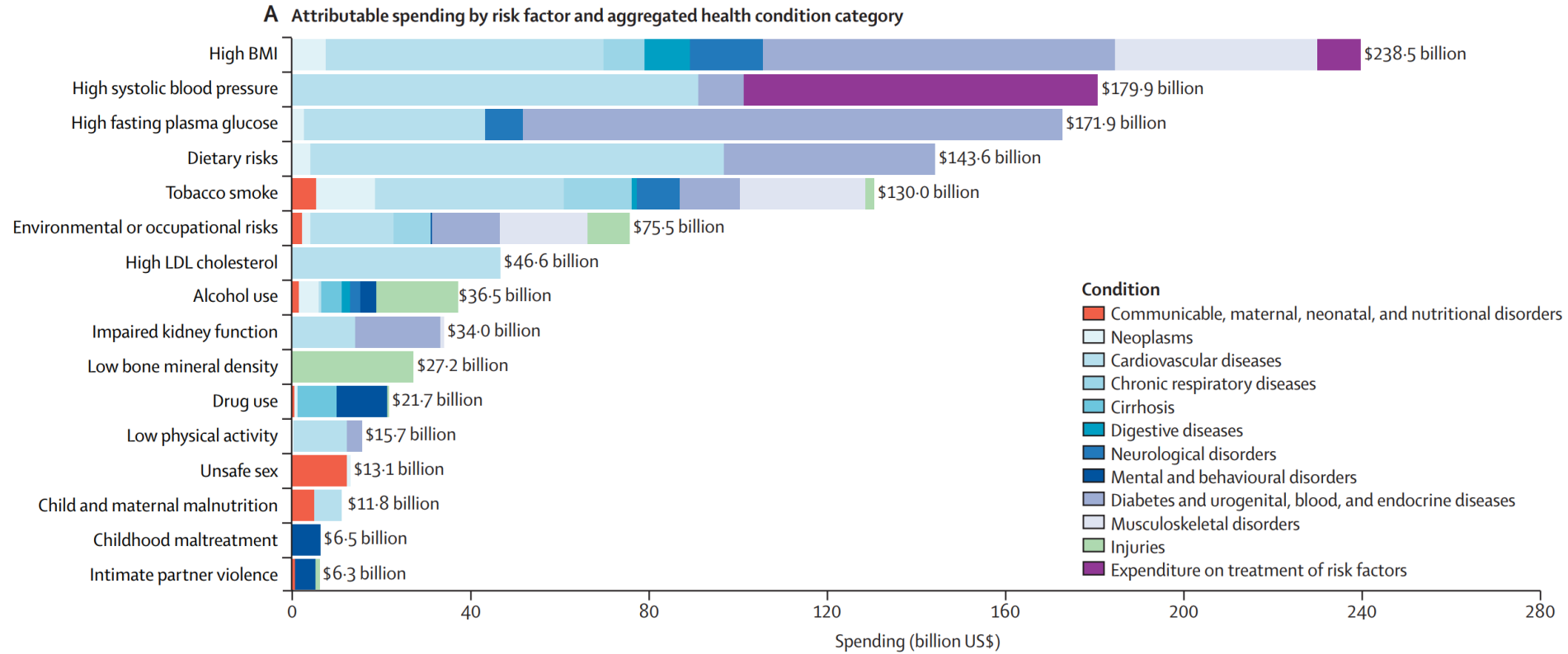
Estimating spending for 6 race/ethnicity groups



Decomposing differences in spending, 2016



Health spending attributable to risk factors



First steps

1. Accessing WA All Payer Claims Database
2. Data landscaping
3. Learning
4. Analytical Strategy 1.0

IHME
Measuring what matters

Thank you.

Joseph Dieleman, PhD
dieleman@uw.edu

UNIVERSITY of WASHINGTON
Institute for Health Metrics and Evaluation

Tab 5

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board

Written Comments

Received Since Last Meeting

Written Comments Submitted by Email

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

June 9, 2023

Dear Members of the Health Care Cost Transparency Board:

The Washington State Hospital Association and Washington State Medical Association support the Board's work to address our shared goal in understanding health care spending and promoting affordability for health care while maintaining appropriate, effective, affordable, and accessible care.

The Board set a health care cost growth benchmark to help encourage providers and payers to keep costs at or below a certain growth rate – 3.2 percent for 2022. We note that the benchmark is keyed to growth in historical median wage and potential gross state product (PGSP). For 2022, the annual growth rate for median wages in Washington is estimated at 11.67% and the growth in state PGSP is 7.09%. The estimated cost growth benchmark when weighting at 70/30 (Wage - PGSP) is 10.3%. (See enclosure for calculation.)

During the April 2023 Board meeting, the state's consultants provided an overview of how performance for providers would be measured against the benchmark. The overview was helpful in providing a broad picture understanding but left us with many questions – both general and specific to providers. A number of questions about how provider performance will be measured remain and it is still unclear to us even which providers will be measured against the benchmark.

To improve understanding of the performance measurement process by both the Board and providers, we respectfully request that HCA staff provide a follow-up presentation to provide additional clarity. Advisory committee representatives from WSHA and WSMA introduced a motion, included as an enclosure below, at the June 6 combined Provider and Data Advisory Committee meeting that also made this request of the Board. Unfortunately, the course of the meeting did not allow for the committee members to act on the motion.

We urge the Board not to wait for a formal motion from those committees, but to quickly move ahead with having consultants and HCA staff provide the requested clarifications. We believe it is important for the Board to have a comprehensive understanding of the methodology, including both its strengths and weaknesses, since it is one of the primary tools being used to help control cost growth. Additionally, it is imperative that providers understand how they are being measured. We hope the following elements can be addressed:

1. **Methodology.** What is the methodology used to attribute members to a provider network and how accurate is this approach? Is there consistency across plans? What is the process by which members are attributable to a provider network?
2. **Data accuracy.** What happens when data is wrongly attributed or omitted? What is the mechanism for providers to vet the data provided by the plans? What types of data checks will HCCTB be performing, if any, to ensure the plan data are accurate? Has it already done any checks on the baseline data set?
3. **Risk adjustment.** How is risk adjustment handled for the attributable members? Is this data also risk adjusted for age and sex? If so, is that calculation done by HCCTB or by the plans, and is it a standard methodology?
4. **Analysis on provider performance.** Is it possible to attribute growth in the provider increase to cost or use factors? Or, is that analysis only being done on the APCD historic data

comparisons? Will the data provide a clear path for a provider to undertake reforms if the provider has exceeded the target rate of growth?

Clarification and further explanation will help facilitate a better understanding of measurement and expectation, both for the Board and providers. Being able to ensure the accuracy of data is also of great importance. Considering what is at stake, providers must be able to understand how they are being measured and trust that data findings are reliable. As a recent Seattle Times article shows, hospitals and physicians are already struggling to provide even essential care to patients in communities across the state. A tight benchmark on growth could further threaten access to care. Washington must avoid any additional well-intended but flawed cost-saving options that inadvertently diminish access or curtail high-value care our communities have come to expect.

Sincerely,

Cassie Sauer
CEO
Washington State Hospital Association

Jennifer Hanscom
CEO
Washington State Medical Association

Enclosures:
1. Calculation of the Cost Growth Benchmark.
2. Proposed motion at the June 6 combined Provider and Data Advisory Committee meeting.
3. Seattle Times article on closure of essential services.

1. **Calculation of Cost Growth Benchmark:**

Year	Median Hourly Wage	% Increase in Median Hourly Wage	GSP (in Millions)	% Increase In GSP	Annual Cost Growth Using Benchmark Weights
2011	$19.30		$379,539		
2012	$19.47	0.88%	$400,863	5.62%	2.3%
2013	$19.67	1.03%	$419,345	4.61%	2.1%
2014	$19.76	0.46%	$442,442	5.51%	2.0%
2015	$20.28	2.63%	$469,944	6.22%	3.7%
2016	$20.87	2.91%	$492,251	4.75%	3.5%
2017	$21.36	2.35%	$524,323	6.52%	3.6%
2018	$22.17	3.79%	$565,831	7.92%	5.0%
2019	$23.15	4.42%	$612,997	8.34%	5.6%
2020	$24.81	7.17%	$604,254	-1.43%	4.6%
2021	$24.25	-2.26%	$677,490	12.12%	2.1%
2022	$27.08	11.67%	$725,514	7.09%	10.3%

Median Hourly Wage
https://www.bls.gov/oes/tables.htm
Computed by State Table in May of each year

Annual Gross Domestic Product (GDP) (State PGSP) by State - Bureau of Economic Analysis
https://apps.bea.gov/itable/?ReqID=70&step=1#eyJhcHBpZCI6NzAsInN0ZXBzIjpbMSwyNCwyOSwyNV0sImRhdGEiOltbIlRhYmxlSWQiLCI1MzIiXSxbIkNsYXNzaWZpY2F0aW9uIiwiTm9uLUluZHVzdHJ5Il1dfQ==

2. **Proposed motion at the June 6 combined Provider and Data Advisory Committee meeting:**

The joint committees respectfully request that the Board address the following critical operational elements as they relate to the health care cost growth benchmark process at an upcoming Board meeting:

- Methodology – how will we fairly attribute members to providers, BECAUSE providers will be held accountable to the benchmark for those patients.

- Data Accuracy - how will data be attributed (AND verified) to providers, BECAUSE this will determine compliance with the benchmark.

- Risk Adjustment - an essential requirement to account for the appropriate healthcare intensity of attributable members, BECAUSE risk adjusted health status will impact the scope and magnitude of services, cost, and outcome and MUST be fair, equitable, and consistent.

- Metrics for Provider Performance - what key metrics will be considered the contributors to cost growth, BECAUSE an underperforming provider MUST be able to understand WHY and see HOW to fix it.

3. **Seattle Times Article on closure of essential services:** https://www.seattletimes.com/seattle-news/health/wa-hospitals-close-labor-and-delivery-units-raising-fears-for-new-parents/

WA hospitals close labor and delivery units, raising fears for new parents

May 14, 2023 at 6:00 am

1 of 15 | Emma Argo, of Toppenish, had planned to deliver her third child at Astria Toppenish, but it closed four months before her due date. After the closure, Argo said she felt an "emotional toll." (Erika Schultz / The Seattle Times)

By

Elise Takahama

Seattle Times staff reporter

Deciding where to have a baby is often intensely personal for new parents: Do you want to go to a hospital or give birth at home? Are you comfortable with the doctor? Is it close enough to make it in time if complications arise?

These choices — a decision about where and how to bring new life into the world — are dwindling for some expectant parents across Washington. Labor and delivery units, particularly in rural areas, have been among the first services to be cut as Washington hospitals face financial turmoil.

When Yakima County resident Emma Argo became pregnant with her third child last summer, she hoped to deliver at Astria Toppenish, a community hospital less than 10 minutes from her home in Zillah. She was taken aback when the hospital abruptly closed its labor and delivery unit in December, four months before her due date. After the closure, Argo said she felt an "emotional toll."

"The time I should be spending packing a hospital bag or washing baby clothes is spent sorting this out," she said a few weeks before giving birth. "It just feels like one more thing."

A mural decorates Astria Toppenish. The hospital has been a community staple for decades, and its maternity center was well-loved. (Erika Schultz / The Seattle Times)

Labor and delivery units have been on the front lines for cuts because they're expensive for hospitals to operate. They require specialized staff, services like neonatal intensive care units are particularly costly, and government-paid insurance plans often don't reimburse hospitals for the full cost of care.

At the same time, hospitals are desperate: Hospitals in the state had collectively lost about $2.1 billion by the end of 2022, largely due to dried-up federal pandemic relief, rising costs and low Medicaid reimbursement rates. But as labor and delivery units close, parents in those areas are left with fewer options — and the possibility that it could take them longer to access obstetric care in an emergency, when every second counts.

Maternity care deserts emerging in Washington

Hospital labor and delivery services are in crisis nationwide, at risk of closing down when units become financially unsustainable. In Washington, some communities are seeing that firsthand.

- Hospitals that still have labor and delivery units
- Hospitals that have closed their labor and delivery units in the past year

YAKIMA VALLEY

KITSAP PENINSULA

Source: Washington State Hospital Association

Reporting by ELISE TAKAHAMA, map by MARK NOWLIN / THE SEATTLE TIMES

Reducing options for expectant parents in Southeast King County, MultiCare Covington Medical Center shuttered its birth center in September. The same happened at Forks Community Hospital on the Olympic Peninsula last December, about 60 miles from the nearest hospital birthing center in Port Angeles, though the hospital is working to restaff the unit.

Washington health care leaders have warned of hospitals' financial problems for at least a year now, and other services have been cut in recent months: At Providence Everett, admissions to its pediatric inpatient unit have been paused since last fall. Astria Sunnyside lost its cardiology services in the winter. But the labor and delivery cuts may have sparked the most public pushback.

Some relief for pregnancy care is on its way after the state Legislature, which recently wrapped up its 2023 session, boosted Medicaid rates and funded a new doula program. At the same time, communities are scrambling to prevent these losses.

"Losing hospital services is something every Washingtonian should be concerned about," Cassie Sauer, CEO of the Washington State Hospital Association, said in a news conference in November. "When these resources leave a community, it's nearly impossible to get them back."

A group of runners passes Toppenish City Hall. (Erika Schultz / The Seattle Times)

How we got here

Apple orchards, hops farms and rolling hills stretch over more than 4,000 square miles of Central Washington. At the northeast edge of the Yakama Reservation, the town of Toppenish is home to about 9,000 people in the lower Yakima Valley, with farmland surrounding a small downtown dotted with murals. The town's hospital, Astria Toppenish, has been a community staple for decades, and its maternity center was well-loved.

The December 2022 closure came as a shock, said Dr. Jordann Loehr, an OB-GYN who used to deliver out of Astria Toppenish.

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"I still don't understand this decision," she said. "It's heartbreaking to our community, many whose mothers, grandmothers and great grandmothers had their babies at Toppenish."

The December closure of Astria Toppenish's labor and delivery center came as a shock, said Dr. Jordann Loehr, an OB-GYN who used to deliver her patient's babies at the small hospital. (Erika Schultz / The Seattle Times)

According to the hospital, however, its labor and delivery unit had struggled all year. Astria Toppenish reported it brought on nearly 200% more travel nurses, contracted workers who typically move from hospital to hospital in response to demand and often get paid more than staff nurses. The hospital also saw increases in supply costs due to inflation. Efforts to hire permanent pediatricians, who also worked in the unit, were unsuccessful, the hospital said.

Astria Toppenish's reimbursement rates for Medicaid services, temporarily boosted in 2020 thanks to a one-year budget provision, were slashed by a third the following year when lawmakers denied an extension, according to the hospital. The drop meant providers were not getting reimbursed for the complete cost of their services by federal Medicaid programs, and would ultimately lose money when treating Medicaid patients, who made up more than 75% of Astria Toppenish's obstetrics clients.

For example, while a standard vaginal delivery, usually a one-day stay, costs about $8,000 to $10,000 per day, the hospital was only getting reimbursed about $3,765 for Medicaid patients, said Jane Winslow, an Astria Toppenish spokesperson.

A cesarean, or C-section, usually costs about $35,000 for a three-and-a-half-day stay in the hospital, while the Medicaid reimbursement amounted to about $4,933, Winslow said, using an example of a "snapshot in time" from December 2022.

By the end of the year, Toppenish's labor and delivery services had lost $3.2 million, the hospital said.

"It is a very challenging service line to keep open when you're facing the financial losses that many of the hospitals are right now," said Chelene Whiteaker, senior vice president of government affairs at the Washington State Hospital Association. "You're thinking, 'If you keep that open, what else are you going to have to close instead?'"

Historically, obstetrics is considered a particularly resource-intensive field, said Dr. Tanya Sorensen, a maternal and fetal medicine doctor at Providence Swedish in Seattle, one of the more popular delivery units in the state.

The field requires significant hands-on nursing, Sorensen said. Labor and delivery nurses usually spend more one-on-one time with their patients compared, for example, to a nurse caring for someone gradually recovering from surgery.

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Obstetrics also has become more specialized over the years, Whiteaker added: In the past, babies were commonly delivered by doctors who worked as general practitioners or family physicians. Now, it's more typical for hospitals to employ doctors and other staff who are trained specifically in infant and pregnancy care and are prepared to address the wide variety of challenges that can arise in deliveries.

That means labor and delivery units need to have larger staffs with specialized experience — which costs more money. At the same time, hospitals, especially those in rural areas, are struggling to retain and recruit a limited number of health care workers, which means staffing costs overall have increased dramatically.

"We're in a spot now where we're using travel nurses, which are far more expensive, costing millions of dollars compared to our [permanent] nurses," Sorensen said. "Swedish is able to cope with that … but if you're a little community and trying to staff for a small labor and delivery unit, that becomes super challenging and super expensive."

She's particularly worried about the growing lack of obstetric care in Yakima Valley, she said, noting Swedish's transfer rate from rural areas rose about 8% between 2021 and 2022.

"There's a huge amount of concern about these obstetric deserts where there's limited local care for pregnant women," Sorensen said.

Yakima Valley is a rich agricultural region growing a variety of crops, including hops, grapes and tree fruit. (Erika Schultz / The Seattle Times)

The fight back

Since several hospitals closed their labor and delivery units, few have provided updates on plans to bring services back. In the Yakima Valley, residents are determined to keep the issue from being forgotten.

At a town hall meeting in Toppenish in early January, the room was crowded with former hospital employees and patients hoping to voice their concerns about the labor and delivery closure.

“I was a senior in high school and pregnant with my first child when I suffered a miscarriage and almost died,” Semone Dittentholer, a Wapato resident and Yakama tribal member, said at the podium, recalling her experience at Astria Toppenish more than 20 years ago. She knew her community suffered disproportionately worse birth outcomes, adding to her fear.

“I was minutes from bleeding out,” she said. “There was no way I was going to make it to Yakima [Memorial],” the largest hospital in the county, about twice as far from her home as Astria Toppenish.

When Dittentholer arrived at Astria Toppenish, she couldn’t stop shaking and her skin was almost translucent. She was told she might not make it through the night.

After hours in the maternity center, Dittentholer woke up, but her baby didn’t.

“If it wasn’t for Toppenish labor and delivery, I wouldn’t have made it,” she told City Council members. “It makes me stressed and sad to think about all the women who couldn’t — and won’t be able to — make it out to Yakima.”

RELATED
Black, Native infants in King County die at higher rate than white babies

Since the closure of Toppenish's maternity center, community members have continued to brainstorm ideas on how to return obstetric care to their area. They held community gatherings. They wrote to their City Council members. They advocated for new legislation.

Then, last month, a group working on maternity solutions in Washington stumbled on an old state law that mentions "maternity care distressed areas." Ears perked up.

According to the law, enacted in 1989 and revised in 2011, the Washington state Health Care Authority would pay for contracted maternity care providers, if an area is considered to be maternity care distressed — which could mean a higher-than-average percent of people in the area received late or no prenatal care or had to travel out of the area to receive maternity care.

"We're not sure if this is going to apply to us yet," Loehr said, "but if this ends up working in our favor and we could get some state relief, that would be big."

Some relief is on the way for Toppenish. Gov. Jay Inslee last week approved legislation that will raise the hospital's Medicaid rates starting next year. In the meantime, the hospital will receive a short-term grant this summer to "bridge the gap until that reimbursement kicks in," Winslow said.

Still, it likely won't be enough for the hospital to reopen its maternity center, Winslow said, adding that it's an "exceptionally expensive service" and the extra funding will likely go toward maintaining existing services, like behavioral health, instead.

Jenifer Rhea, a registered nurse, works at MultiCare Yakima Memorial's Family Birthplace, which offers labor, delivery and maternity services. (Erika Schultz / The Seattle Times)

Loehr is also leading efforts to introduce a public hospital district to the area, a fairly common designation in Washington. The state has 56 public hospital districts, community-created entities authorized by the state to deliver health services.

"We're like a library district or a school district," said Matthew Ellsworth, executive director of the Association of Washington Public Hospital Districts. "Local constituents voted to draw a circle around themselves and ultimately they can choose to tax themselves for revenue."

Most public hospital districts in the state have hospitals, while a handful provide specific care, like emergency services, urgent care and nursing homes. Once a district is created, residents elect a board of commissioners to govern the district and decide which health-related projects to fund.

“To have health care decisions executed on a policy basis by elected officials is a big benefit,” Ellsworth said. “Ultimately, the people running your hospital are accountable to you. … But I don’t want it to be viewed as a panacea.”

For example, he said, “If you want to build a billion-dollar hospital, that’s not going to happen.” Tax revenue from public hospital district levies don’t come close to the amount needed to run a health care facility, he said.

But in places like Vashon Island, the state’s newest public hospital district, residents were able to raise enough funds to preserve some clinical services.

St. Michael Medical Center in Silverdale serves the Kitsap Peninsula communities. (Karen Ducey / The Seattle Times)

What’s at risk

Across the Puget Sound, similar challenges have complicated the search for pregnancy care.

As of this year, only one hospital in Kitsap County — St. Michael Medical Center in Silverdale — is staffed to deliver babies. The Naval Hospital, near a base in Bremerton, closed the doors to its labor and delivery unit in April 2022, citing staffing and resource shortages. Peninsula Community Health Services, also in Bremerton, followed suit a few months later.

Because of the growing gap in care, many patients have started to rely on local midwives, said Ashley Jones, a licensed midwife and executive director of True North Birth Center in Poulsbo, the only out-of-hospital birth center on the peninsula. The practice has seen a huge influx in patients since last July, Jones said.

“The unfortunate thing is that I know there are those who do qualify (for a low-risk birth) who may actually choose our option and just don’t know about us,” Jones said. “We’re a big military

community, so some people are coming from states like Virginia and Texas, or somewhere where midwifery is not as common may not even know that we're an option."

She's hoping to continue to spread the word about her practice in case St. Michael's obstetric unit does fill up. In the last year, many of Jones' new patients transferred to her practice after experiencing or hearing stories of long waits at St. Michael, she said.

Because of recent changes to the state's landscape of labor and delivery care, patient numbers have fluctuated at different hospitals, making clear trends in demand difficult to identify.

1 of 3 | Erik Rodriguez and Maria Mendoza, of Wapato, leave MultiCare Yakima Memorial with daughters Grezia, 1 day old, and Italia, 3. (Erika Schultz / The Seattle Times)

While the number of MultiCare Yakima Memorial's monthly deliveries has slowly increased since Astria Toppenish's unit closure, signaling some absorption of patient volume, St. Michael hasn't necessarily seen the same rise on the Kitsap Peninsula.

St. Michael's president, Chad Melton, says its unit does have room and staffing has "stabilized" in the past four to five months, though it still does partially rely on contract travel nurses. Demand has actually dropped from an average of about 200 deliveries a month during most of the pandemic to now about 130 per month.

“It’s a service we need to provide,” Melton said.

Meanwhile, patient demand at Kitsap OB-GYN, one of the few independent practices on the peninsula, has been growing for months, said administrator Megan McDermaid.

“There’s not a lot of choice in the county,” McDermaid said.

Morgan Runge, 27, mother of two, lives on Chinook Pass. She delivered her son at Astria Toppenish just days before its maternity center closed, instead of MultiCare Yakima Memorial. While Yakima was much... (Erika Schultz / The Seattle Times)More

Morgan Runge, 27, a mother of two who lives on Chinook Pass, said she’s concerned for other new parents in the Yakima area who now may be far from the nearest hospital, or may no longer have a choice in where they deliver their baby.

She said she felt fortunate to have options: She delivered her son at Astria Toppenish just days before its maternity center closed, instead of MultiCare Yakima Memorial. While Yakima was much closer to her home — about 30 minutes, compared to an hour’s drive to Toppenish — she was willing to make the hourlong trip because of a traumatic experience delivering her first child at Yakima Valley.

She was in labor the entire drive, she said.

“It’s a terrifying thought that these types of services are drying up in some parts of our state,” she said.

Correction: A previous version of a graphic in this story incorrectly indicated that Harborview Medical Center has a labor and delivery unit. UW Medicine’s birth centers are located at Valley Medical Center, UW Medical Center-Northwest and UW Medical Center-Montlake.

Elise Takahama: *206-464-2241 or etakahama@seattletimes.com; on Twitter: @elisetakahama.*

Washington State Hospital Association

June 9, 2023

Dear Members of the Health Care Cost Transparency Board,

WSHA wants to weigh in on the discussion from the Board's April meeting on case mix. We think it is critical the Board understands the import of case mix on hospital costs and what may or may not be demonstrated by the next stage of work being done by the Board's consultants using Medicare cost report data.

First, we believe case mix is a key driver of hospital costs. We heard discussion at the meeting that case mix may not be that significant, but we do not understand the basis for these statements. The types of patients treated have a major impact on expenses. A hospital treating severely injured burn and trauma patients with long lengths of stay and performing complex procedures is going to incur higher costs in care delivery than a hospital delivering normal babies and treating easier conditions.

Second, we agree ideally an analysis should take into account the case mix of all hospital's inpatients and not just Medicare patients. However, Medicare case mix serves as a good proxy fallback. As the consultants explained, analysis could be done on Washington hospitals using all patients from information available in the WA State CHARS Database. A similar analysis could be done for other states where this type of data is also available**.** It is not possible, however, to do this analysis for hospitals in all states. The lack of data nationwide may be a barrier as well as the effort needed to undertake this task.

If the analysis is not going to use total case mix, then as a fallback, WSHA suggested (and the consultants have agreed) to use a Medicare case mix for each hospital. It is true Medicare only typically represents about a third of a hospital's patients or revenue. However, one would expect a hospital treating Medicare complex cases also probably treats complex Medicaid and insured patients. To test this hypothesis, WSHA ran a correlation on Washington hospitals between Medicare case mix and total case mix from the WA State CHARS Database. The results, provided in table 1 below, show a high degree of correlation between the two.

While we would prefer using case mix based on all patients, using a case mix based on Medicare seems preferable to a decision to not factor case mix differences into the cost analysis.

Third, there was discussion that Medicare case mix is problematic since it only reflects inpatient care. We do not agree with this conclusion given the case mix is being applied to adjusted discharges. Using no case mix indicator is also problematic.

As WSHA said at the very start of this work, there is a problem with using "adjusted discharges" in and of itself. Adjusted discharges became a basis for analysis at a time when hospitals by and large were mainly inpatient facilities. That is no longer the case, with almost half the costs and revenues now due to outpatient use. While we do not have an easy-to-use alternative, the Board needs to be wary of the conclusions it draws from the data analysis being performed, given this limitation. True cost finding can

really be done only by an extensive departmental dive into allocating departmental costs separately to inpatient and outpatient services.

Instead of a deep dive, the adjusted discharge factor gives hospitals credit for additional inpatient discharges based on the hospital's ratio of inpatient to total revenues. So, if a hospital has half its revenues from inpatient care, then its inpatient discharges are doubled. But, if a hospital has two-thirds of its revenues from inpatient care, then its inpatient discharges are increased by only 1.5. As a result, a hospital with lower proportional revenues on the inpatient side (which may be a result of its lower inpatient complexity) gets more of an inflator on its discharges. With the same volume of outpatients, the hospital with a more complex inpatient case mix will not get as much of a boost.

Choosing to not adjust for case mix at all could lead to more distortions in this type of analysis than using the inpatient case mix adjuster applied to both inpatient and outpatient. See illustrative example below.

Fourth, we think case mix is especially important for both instate and between state comparisons. As discussed at the last meeting, Washington has a low hospitalization rate per capita. One would expect fewer admissions means those admitted are the more complicated cases, with lower levels of severity shifted to outpatient care.

During the meeting we heard the low admission rate attributed to the health of the Washington population. While age and health status may explain some of the variation in admission rate, we do not believe they are the only explanation. We can think of several other factors, starting with the fact that Washington is one of the few states with strong CN control on beds resulting in a lower number of beds per capita than elsewhere. We have also heard other factors may be involved, such as training offered for physicians at the University of Washington as well as historical practice patterns.

If the low per capita admission rate is not explained simply by health status, then case mix adjusted comparisons are key.

Fifth, we want to weigh in again on the specific methodology being proposed. As we have made clear, WSHA thinks case mix is important along with several other factors, such as wage differences, teaching status and others. WSHA suggested using a combination of factors for adjustments rather than looking at each factor in isolation. Our recommendation was not accepted by the consultants or the Board as an informative alternative. We recognize analysis can be done using each factor to look at costs and revenues within a comparable peer group. Then, however, it is important to consider additional explanations. For example, if a specific hospital within a peer group has higher cost than others, is that because it still has a higher case mix index than the others in the group and/or is it because it is a teaching hospital and/or is it because of other factors? All these factors go into determining a hospital's expenses.

Finally, we want to caution the Board that hospital specific analysis is only one factor among many – especially when looking at revenues. Most Washington non-critical access hospitals are now part of hospital systems. While in general every hospital and service needs to be financially stable, health care systems use revenues from one setting to support care delivered elsewhere, both at other hospital sites as well as for non-hospital services. Our hospitals are looking to sustain a mix of needed hospital services in the community and revenues are used to support the overall system.

We appreciate the discussion at the last meeting emphasizing that this is a long journey. WSHA will continue to offer our and our members perspectives as you proceed with your work to better understand hospital costs and revenues.

Sincerely,

Jonathan Bennett

Jonathan Bennett
Vice President, Data Analytics and IT Services
Washington State Hospital Association
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Enclosures: Illustrative Example on Case Mix and Adjusted Discharges
CHARS Medicare CMI vs All Payer CMI

Illustrative Example on Case Mix and Adjusted Discharges

HCCTB will be using Medicare cost report data to look at cost comparisons among hospitals. Will the comparative metrics provide an informative picture? In the following example, consider whether hospital A or hospital B is comparatively more expensive.

Both are 300 bed hospitals in WA. Hospital A treats a range of patients but is not a high-level trauma hospital and has no psychiatric distinct part unit. Hospital B has no maternity services while it is a referral center for other hospitals in the state. It is a high-level trauma center and has a distinct part psychiatric unit.

Hospital A:

- Total revenues: $600 million with $300 million inpatient and $300 million outpatient
- 20,000 discharges per year.
- Medicare CMI is 1.0 based on its inpatient Medicare services.

Hospital B:

- Total revenues: $900 million with $600 million inpatient and $300 million outpatient
- 20,000 discharges per year.
- Medicare CMI is 2.0 based on its inpatient Medicare services.

<u>Cost per adjusted discharge calculations with or without case mix</u>

Hospital A

Adjusted discharges: ($600 million/$300 million) * 20,0000 discharges =40,000 adjusted discharges

or ***20,000 additional discharges based on $300 million of outpatient services***

Cost per adjusted discharge: $600,000,000/40,000 = $15,000 discharge

Cost per adjusted discharge CMI adjusted: $15,000/1.0 = $15,000 per CMI adjusted discharge

Hospital B

Adjusted discharges: ($900 million/$600 million) *20,000 = 30,000 adjusted discharges
or 10,000 additional discharges based on $300 million of outpatient services

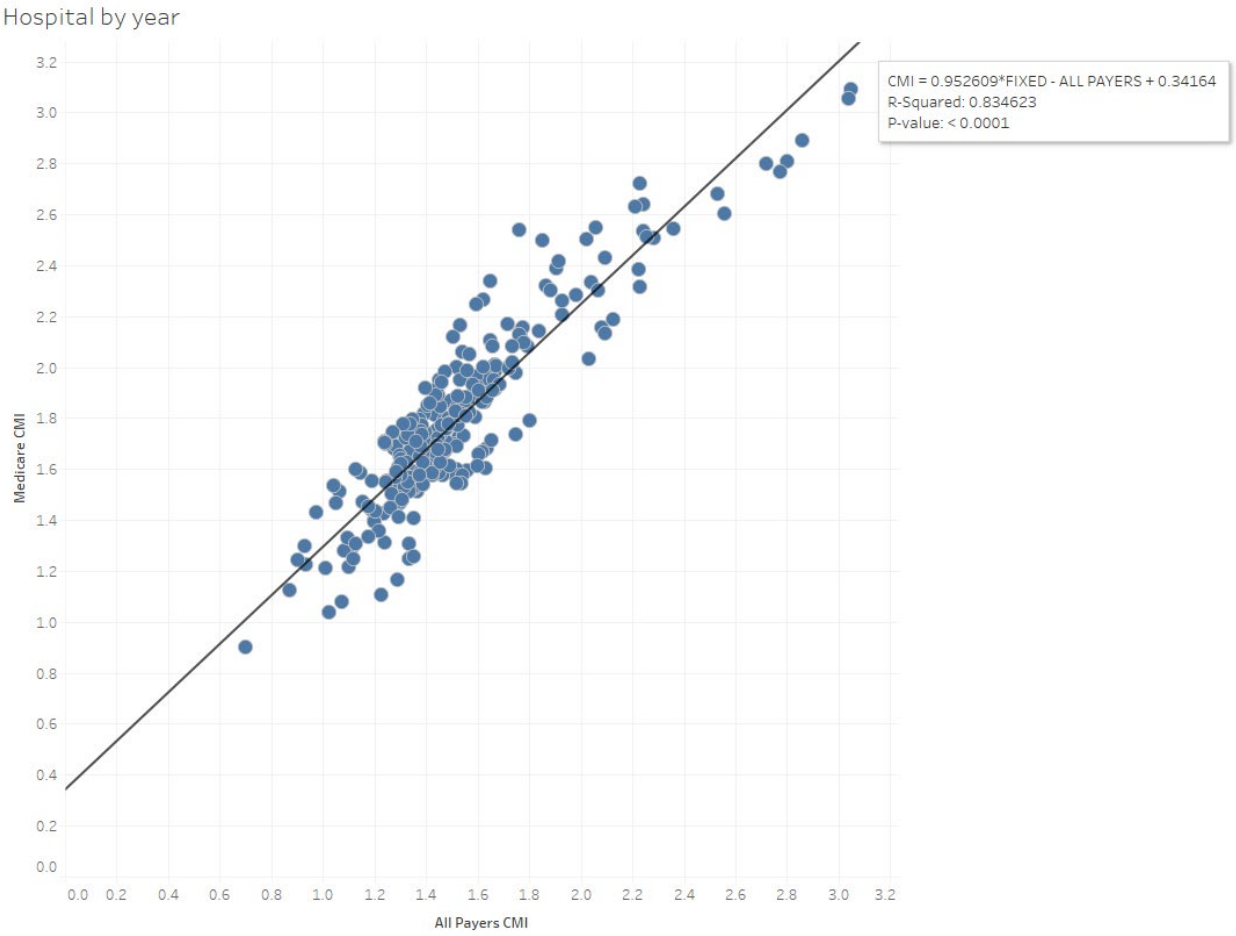
Cost per adjusted discharge: ($900 million/30,000) = $30,000 per discharge

Cost per adjusted discharge CMI adjusted: $30,000/2.0=$15,000 per CMI adjusted discharge

Issues: The additional expenses at hospital B on the inpatient side means it gets less credit for outpatient revenue than hospital A. Without adjusting for case mix, hospital B appears more expensive, but the issue may be that it simply has inpatients who use more resources.

CHARS Medicare CMI v. All Payer CMI

Each circle represents a hospital's Average Medicare CMI v. Average Total CMI. The R-Squared Value states that 83% of All Payers CMI can be explained by the Medicare CMI. This is an extremely strong correlation and allows us to use the Medicare CMI in place of the All Payer CMI when comparing hospitals with the Medicare Cost Report.



Tab 6

Washington State Health Care Authority

2023 HCCTB Legislative Report

Analysis of Cascade Select Public Option

Washington State Health Care Authority

The Board's Legislative Report is Part of a Series

The Legislature required three separate analyses:

- HBE must analyze public option plan rates paid to hospitals for in-network services and whether they have impacted hospital financial sustainability.
- The Board must report on the public option's effect on consumers.
- HBE will provide recommendations to the legislature based on both analyses.
  - HBE's final recommendations are due Dec. 1, 2023.

The Health Care Cost Transparency Board's Report

- The Board's report must analyze the effect that enrollment in public option plans has had on consumers including:
  - Benefits
  - Premiums paid
  - Cost-sharing amounts paid
- The Board's report does **not** include:
  - General recommendations on the public option.
  - Recommendations on procurement or standard plan design.

Strategy and approach to the report

- **Step 1: Identifying the questions and the data (complete)**
  - Board members were surveyed by email to identify areas of interest and questions for the analysis.
  - Cascade Select staff (HCA and HBE) reviewed available potential data and methodologies for the analysis.
- **Step 2: Gathering data and initial analysis**
  - HCA and HBE staff reviewed board member surveys, gathered data, performed initial analyses, and drafted the report for Board feedback.
  - Analysis presented at the June HCCTB meeting. Any feedback will be incorporated.

Analysis Development

Address Questions in the Legislation & Board Feedback

- We asked what priority consumer effects should be considered for analysis. Members highly ranked:
  - Access to care
  - Affordability – broad
  - Premiums
  - Cost sharing
- Members were also interested in:
  - Drivers of enrollment in public option plans
  - Qualitative data from consumers
  - Drivers of variability in public option premium affordability

Data Sources

Board analysis must include review of the benefits provided to, and premiums and cost sharing amounts paid by, consumers enrolled in public option plans compared to other qualified health plans.

- Exchange spring enrollment reports 2021-2023
- OIC carrier rate filings 2021-2023
- Other Cascade Care analyses:
  - "Cascade Select Public Option," December 2022 HCA Report to the Legislature
  - Exchange 2022 review of standard plan features and differences
- Qualitative information drawn from reviews of Exchange consumer surveys, reports, and enrollment partner feedback.

Cascade Care

Public Option Overview

Cascade Care: Accessible & Affordable Coverage

Aims to increase access to high-quality, affordable health coverage on a healthy individual market.

Cascade Care Plans

High-quality, low-cost plans designed exclusively for all *Washington Healthplanfinder* customers.

Cascade Plans, or standard plans, are offered by every carrier in every county.

Cascade Select Plans, or public option plans, are offered by three carriers in 34 counties in 2023.

+

Cascade Care Savings

Reducing low-income customers' premiums through state-funded premium assistance.

Cascade Care: Accessible & Affordable Coverage

Cascade Care plans include standard (Cascade) & public option (Cascade Select) plans.

- Provide apples-to-apples benefits for a simpler customer shopping experience.
- With benefit design the same, customers can focus on premium costs and whether their providers are in network.
- All Cascade Care plans let customers pay less at the doctor's office with more predictable costs, as most benefits are a co-pay.
  - Cover more health care services at lower costs through first-dollar services & low co-pays.
- Cascade Care plans (standard and public option) are the only plans through which customers can access state-based premium assistance, called Cascade Care Savings.
- Cascade Care public option plans (Cascade Select) are Cascade Care plans. They have the same predictable benefit design and are intended to be the most affordable option for customers.
  - Competitively selected by the State, public option plans are required to meet higher quality and premium affordability standards.
  - Primary differences for consumers include provider networks and lower premiums in many counties.

Cascade Select Public Option Policy Goals and Tools

Goal	Policy Lever to Advance Goal	Policy Description

Affordability	• State-defined provider reimbursement requirements.
	• Participation requirements for hospital systems that participate in other public programs.
	• Competitively procured by the State.
		• Provider reimbursement requirements:
		  • May not exceed 160% of Medicare for all covered benefits in statewide aggregate.
		  • Reimbursement floors for critical access/sole community hospitals and primary care services.
		• Hospitals must contract with at least one public option plan.
		• HCA procures and contracts for public option plans offered on the Exchange.

Statewide Access	• Participation requirements for hospital systems that participate in other public programs. • Competitively procured by the State.	
Quality & Equity	• Cost and quality transparency requirements. • Requires adoption of state quality, equity standards.	• Reporting on health improvement activities, primary care spend, quality measures. • Adoption of Bree and Health Technology Clinical Committee recommendations.

As required by SB 5526 & SB 5377

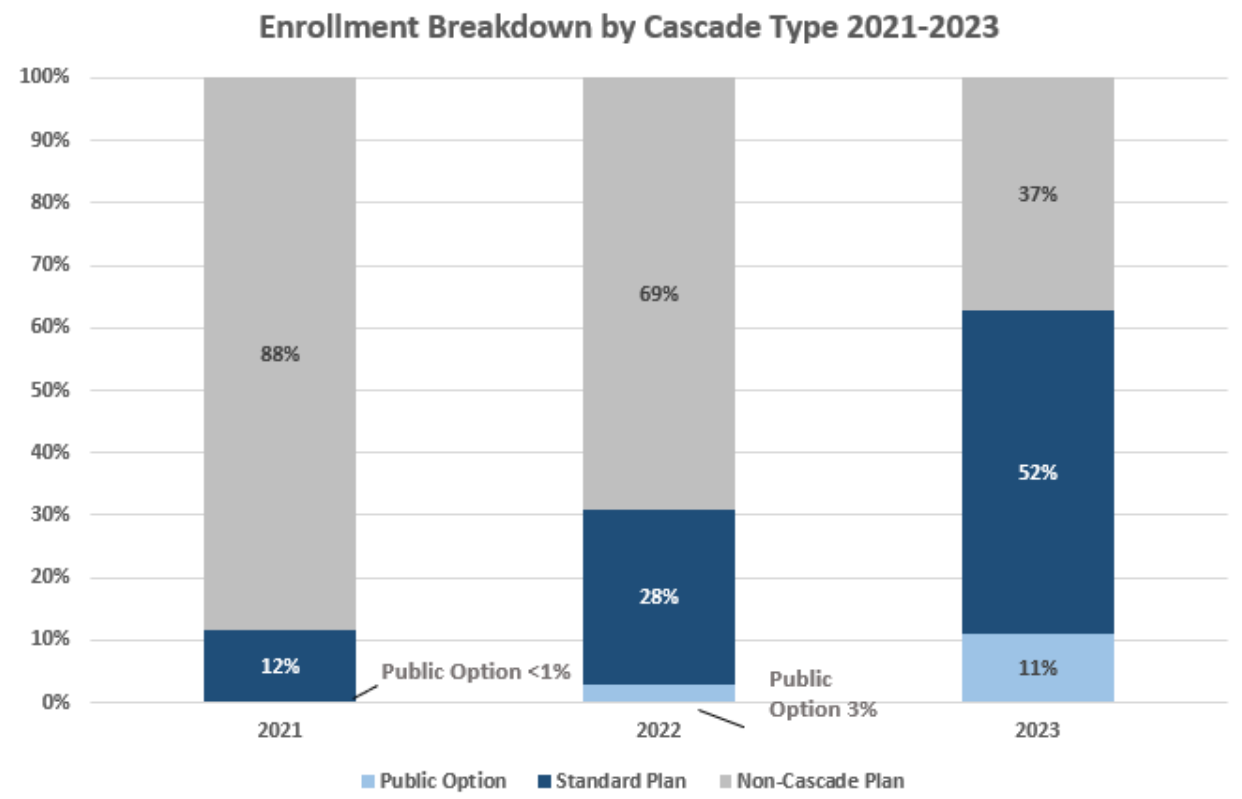
Draft Findings & Analysis

Consumer Access to Care & Coverage: A Review of Public Option Cost Sharing & Premiums

Consumers Enrolled in Cascade Select Public Option (2021-2023)

Public option enrollment has tripled every year since its launch.

- 11% of Exchange customers are enrolled in public option plans in 2023.
  - New Exchange enrollees more likely to enroll in public option.
- Demographics of public option enrollees:
  - Younger than non-public option enrollees.
  - Lower incomes in 2021 and 2023.



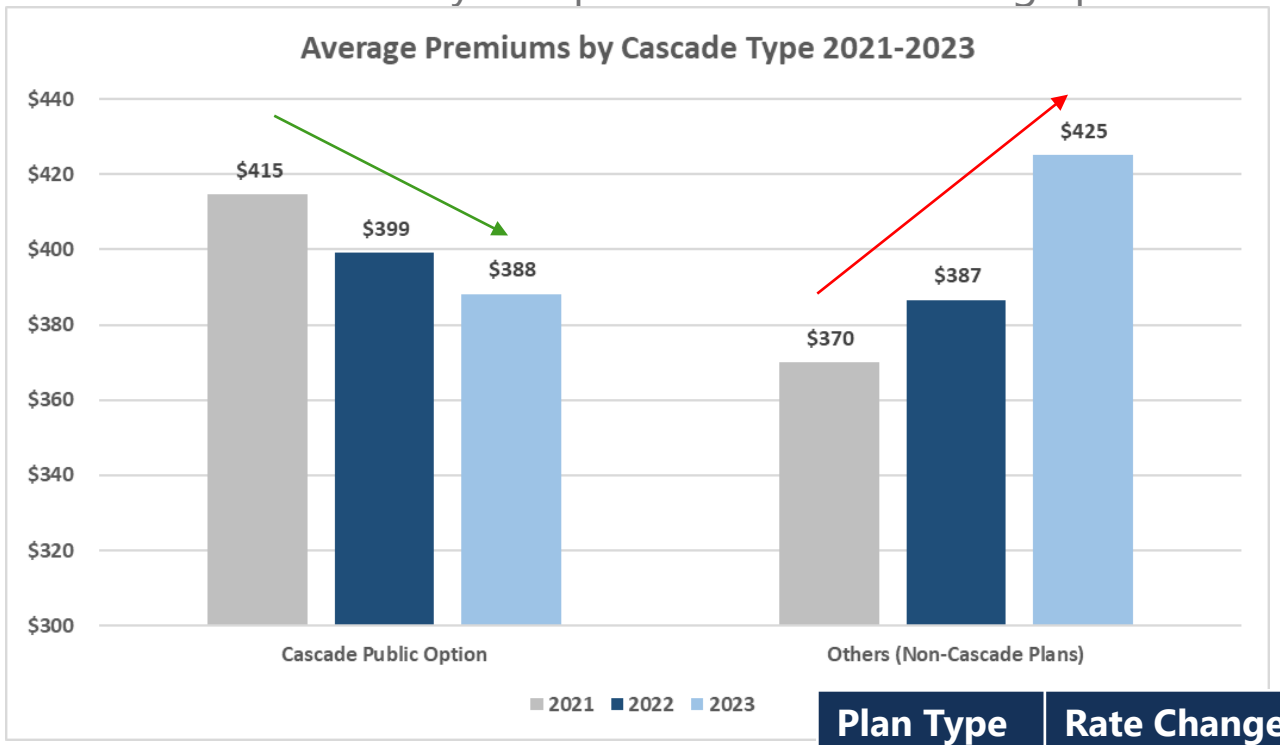
Data source: HBE Spring Enrollment Reports 2021-2023

Cascade Select Public Option Premiums Analysis (2021-2023)

Public option plans now are the most affordable qualified health plan in many Washington counties.

- While public option plan premiums were initially higher, they have consistently trended downward.
- Average public option premiums across all metal levels are lower than non-Cascade Care premiums for the first time in plan year 2023.
  - Public option plans are lowest-cost silver premium QHPs in 25 counties in 2023, up from 13 counties in 2022.

Public option premiums show promise in advancing consumer affordability compared to other Exchange plans.



Rates for 40-year-old nonsmoker; not weighted for enrollment

Data source: 2021-2023 OIC Carrier Rate Filings

Plan Type	Rate Change % 2021-2023
Public Option	-6%
Non-Cascade	+15%

Cascade Select Public Option Cost Sharing Analysis (2021-2023)

Public option enrollees pay less out of pocket when using their benefits to access health care.

- Cost sharing generally is lower for high-value services like primary care.
- Deductibles are an average of $1,000 less than non-Cascade plan deductibles.
- The introduction of Cascade Care plans to the marketplace decreased deductibles across Exchange plans.

Example: Public option enrollees pay less out of pocket costs to give birth in 2023, compared to a popular non-Cascade plan.

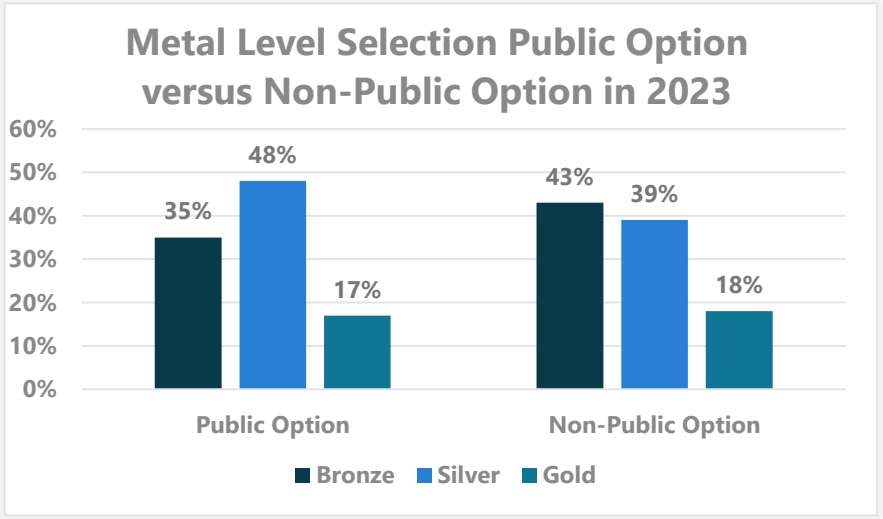
	Non-Cascade Silver plan	Cascade Silver plan
Deductible	$7,550	*$2,500*
Obstetrics Visits (15)	$450	*$450*
Ultrasounds (2)	*$343*	*$130*
Bloodwork & Other lab tests	*$1,153*	*$160*
Generic Drugs	$5	$11
Preventive Services & Vaccines	$0	$0
Inpatient Hospital Care (2 days)	$6,054	$4,100
Customer Out-of-Pocket Costs	**$8,005**	**$4,851**

Italicized cost shares indicate benefits not subject to the deductible.

Data source: 2023 Carrier Summaries of Benefits and Coverage (SBCs) and 2023 Standard Plan Benefit Charts

Other Consumer Impact Considerations

- Enrollees selecting plans with richer benefits.
  - Public option enrollees more likely to enroll in silver or gold plans.
  - Driven by marketplace premium affordability measures paired with lower 2023 public option premiums.
- Narrower networks and access watch points.



- Despite promising gains, consumer access and affordability are fragile.
  - Enhanced federal tax credits and new state premium assistance subsidize expensive premiums.
  - Proposed 2024 public option rates do not show premium affordability trends similar to 2021-2023.
  - Early affordability analysis (PY2021) suggests current provider reimbursement targets may not be enough to meaningfully reduce premiums.

Questions & Feedback

Washington State Health Care Authority

Washington State Health Care Authority

Report to the Legislature

Health Care Cost Transparency Board

Cascade Select Public Option Report

Engrossed Second Substitute House Bill 5377; Section 5; Chapter 246; Laws of 2021
Second Substitute House Bill 2457; Section 7(2); Chapter 340; Laws of 2020
Substitute Senate Bill 5589; Section 1(3); Chapter 155; Laws of 2022

December 1, 2023

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Acknowledgements

The Cascade Select Public Option program is a collaborative effort between the Health Benefit Exchange, the Health Care Authority, and the Office of the Insurance Commissioner. This report was written with support from partnering state agencies, including the Health Benefit Exchange.

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Executive summary

The Legislature established the Health Care Cost Transparency Board (Board) to reduce the state's health care cost growth and increase price transparency. In accordance with Engrossed Second Substitute House Bill 5377, the Board is also required to analyze the effect that enrollment in public option health plans has had on consumers. As required by the legislation, this report includes an analysis of:

- The benefits provided to consumers enrolled in public option plans compared to other qualified health plans; and
- Premiums and cost-sharing amounts paid by consumers enrolled in public option plans compared to other qualified health plans.

When the Legislature created Washington's public option program, it was the first ever public option program in the United States and several states have since created similar public option programs. In Washington, public option plans are qualified health plans that utilize standard benefit design created by the Washington Health Benefit Exchange and are selected through a competitive procurement process by the Health Care Authority. Since 2021, when public option plans were available to Washingtonians, these plans are offered exclusively through Washington Healthplanfinder and provide predictable benefits that are easy for consumers to compare through standardized plan design. Additionally, carriers' public option plans are required to meet higher quality standards and reimbursement rates for health care provides that were established under the legislation that created the public option.

This analysis finds that public option health plans show promise in increasing access to high-quality, affordable health coverage for Washington Healthplanfinder consumers.

1. Public option premium affordability increases consumer access to health coverage.
   - Between 2021 and 2023, public option premium costs trended down six percent, while non-Cascade Care plan premiums on the Exchange increased 15 percent during that same time period. The difference in premium rate increases between public option plans and non-Cascade Care plans is over 20 percent over two years.
   - In 2023, average public option gross premiums are lower than all other plan premiums for the first time, including non-standard/non-Cascade Care plans.
   - Also in 2023, public option plans are the lowest-cost silver premium QHPs in 25 counties before any available consumer subsidies are applied.
   - Driven by premium affordability, more Exchange consumers are enrolling in public option plans and public option enrollees are able to purchase health plans that provide greater access to services at lower out-of-pocket costs, providing more benefits to consumers.
2. Public option plan design increases access to health care through lower cost sharing when consumers use their benefits.
   - Public option deductibles are an average of $1,000 less than other Washington Healthplanfinder deductibles.
   - Compared to popular non-public option plans on the Exchange, enrollees in public option plans

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are likely to pay less out of pocket when receiving services of high clinical value such as primary care, or for a series of related health care services such as having a baby or managing a chronic health condition.

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Definitions and roles

Qualified Health Plans: Under the Affordable Care Act, a qualified health plan (QHP) is an insurance plan that has been certified by *Washington Healthplanfinder* to offer quality insurance. QHPs must provide essential health benefits, follow established limits on cost-sharing (such as deductibles, co-payments, and out-of-pocket maximum amounts), and meet other requirements. Cascade Care plans, including public option plans, are qualified health plans.

Cascade Care: Created by legislation, Cascade Care, is the state's effort to make health insurance accessible and affordable for every *Washington Healthplanfinder* consumer. Cascade Care is a three-agency effort involving the Health Benefit Exchange, the Health Care Authority, and the Office of the Insurance Commissioner which includes standard benefit design, state-funded premium assistance, and the public option.

Cascade Care plans: High-quality, low-cost QHPs designed by the Exchange and available exclusively to *Washington Healthplanfinder* consumers. All Cascade Care plans let consumers pay less at the provider's office with more predictable costs and have the same benefit design, making it easier for consumers to shop and compare plans.

Cascade Select or public option plans: Public option plans, also known as Cascade Select plans, are part of the Cascade Care program and are selected by the state. Public option plans provide the same standard benefits as all other Cascade Care plans. Additionally, health insurance carriers offering public option plans are required to meet higher quality standards and state-defined reimbursement rates for providers to ensure public option plans are affordable and provide access to quality health care.

Cascade Care Savings: State-funded premium assistance that lowers eligible consumers' premiums on *Washington Healthplanfinder*. Consumers up to 250 percent of the federal poverty level (FPL) can receive Cascade Care Savings when enrolled in Cascade Care Silver or Gold plans, including public option plans.

Office of the Insurance Commissioner (OIC): The state agency responsible for regulatory oversight of the state's insurance industry. OIC must approve all individual health plan design and rates prior to being sold on *Washington Healthplanfinder*. OIC is responsible for approving individual market and small group health plans, including Cascade Care plans, which involves reviewing plan filings annually to ensure they meet regulatory requirements including rate review, benefit design, and network adequacy.

Washington Health Benefit Exchange (Exchange): The Exchange is responsible for *Washington Healthplanfinder*, an online marketplace for individuals, families, and small businesses to compare and enroll in coverage. The Exchange is the lead organization for Cascade Care. The Exchange makes the Cascade Care plans available through *Washington Healthplanfinder*.

Washington State Health Care Authority (HCA): The state agency that is responsible for procuring and contracting for public option plans, which are offered on *Washington Healthplanfinder*. HCA is the largest purchaser of health care in Washington and also procures and administers Apple Health (Medicaid and the Children's Health Insurance Program), Public Employee Benefits, and School Employee Benefits.

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Background

The Board was established by House Bill 2457 in 2020 under the Health Care Authority (HCA). The Board is responsible for the analysis of total health care expenditures in Washington, identifying trends in health care cost growth, and establishing a health care cost growth benchmark. Recognizing that Washingtonians are paying increasingly more for their health care while income has not increased at the same level, the establishment of the Board is part of Washington state's increased focus on health care affordability strategies, including cost containment and the Cascade Select program.

Engrossed Second Substitute Senate Bill (ESSB 5377) requires the Board to analyze the effect that enrollment in public option plans has had on consumers when enrollment statewide in public option plans is greater than 10,000 covered lives in a plan year. This must include an analysis of:

- The benefits provided to consumers enrolled in public option plans compared to other QHPs; and
- Premiums and cost-sharing amounts paid by consumers enrolled in public option plans compared to other QHPs.

This year public option plan enrollment reached approximately 23,000[1] lives.[2] The Board drew primarily upon available data from The Exchange, HCA and the OIC, includes enrollment, rates, and plan data. The Board adopted this report MONTH DATE, 2023.

Additionally, as required by Senate Bill 5377, the Exchange must conduct a separate analysis of public option plan rates paid to hospitals for in-network services and whether those rates have impacted hospital financial sustainability. The Exchange will combine that analysis with this report and develop recommendations to the Legislature to address financial or other issues identified in the analyses. The Exchange will develop these recommendations in consultation with OIC, HCA, and interested parties including, but not limited to, associations for hospitals, insurers, and physicians.

Cascade Care background

The Exchange was established by the Legislature in 2011 as a public-private partnership that operates the online marketplace called *Washington Healthplanfinder* used by more than one in four Washington residents to obtain health and dental coverage.[3] Washingtonians who do not have health insurance through an employer or public programs utilize *Washington Healthplanfinder's* health insurance marketplace to buy qualified health plans, including Cascade Care plans.

Cascade Care was established by legislation in 2019[4] and 2021[5] to increase the availability of quality, affordable health coverage in the individual market. This legislation recognized that unaffordable premiums stop too many Washingtonians from securing health insurance. It also recognized that insurance coverage is insufficient if individuals and families cannot use their benefits to access health care because of high deductibles and out-of-pocket expenses.

[1] QHP data collected as of March 31, 2023: https://www.wahbexchange.org/content/dam/wahbe-assets/reports-data/enrollment-reports/Spring%20OE10%20Report%20Updated%202023.04.17.xlsx

[2] This followed the Exchange's tenth open enrollment period, which took place Nov. 1, 2022 through Jan. 15, 2023.

[3] *Washington Healthplanfinder* allows consumers to find, compare, and enroll in health insurance coverage and gain access to federal tax credits, state premium assistance, reduced cost sharing, and to determine eligibility and enrollment into Washington Apple Health (Medicaid).

[4] Engrossed Substitute Senate Bill 5526

[5] Engrossed Second Substitute Senate Bill 5377

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The state's Cascade Care efforts aim to make health insurance accessible and affordable for every *Washington Healthplanfinder* consumer by:

- Addressing costs through lower premiums, lower deductibles, and access to services before having to pay the deductible. This includes leveraging federal and state-based financial assistance, State purchasing power, and health care provider reimbursement expectations.
- Encouraging meaningful consumer choice with products of better value and similar benefits across all carriers.
- Growing enrollment by attracting new enrollees and retaining current consumers.
- Ensuring continued market health through stable carrier participation, competitive product offerings, and a larger and more diverse risk pool.

In 2019, Engrossed Substitute Senate Bill 5526 established Cascade Care plans as a type of qualified health plan (QHP) offered by health insurance carriers on *Washington Healthplanfinder*. Cascade Care plans are high-quality, low-cost, standard-design health plans that help consumers pay less at the doctor's office with more predictable costs. For example, regular check-ups and mental health office visits are covered without a deductible.

All Cascade Care plans have the same standard benefit design, making it easier to shop and compare plans from across different carriers, offering an apples-to-apples comparison. This enables consumers to focus on premium costs and evaluate provider networks.

Public option background

In 2019, Engrossed Substitute Senate Bill 5526 created the public option, known as Cascade Select which was the first ever public option program in the nation. Public option plans are intended to offer a high quality, affordable option for Washingtonians.

Public option plans utilized the standard benefit design of all Cascade Care QHPs which is designed by the Exchange. As a result, public option plans, offered exclusively through *Washington Healthplanfinder* since 2021, provide the same predictable benefits as all other Cascade Care plans. However, plan provided by public option carriers are required to meet higher quality standards and State-defined reimbursement rates for providers such as hospitals and doctors.

Through competitive procurement for plan years 2023 and 2024, HCA selectively contracted with three Exchange carriers to offer high-quality, affordable public option plans. This competitive selection aims to both promote healthy competition on the Exchange and lower premiums for Washingtonians. A summary of the goals of the public option, related legislative requirements, and how those requirements achieve the desired goals is detailed in Table 1 below.

Table 1: Public option policy goals and requirements

Public option goal	Legislative requirements to achieve the goal	How the legislation advances the goal
Affordability	Provider reimbursement requirement: ESSB 5526 requires the following reimbursement targets for providers: • The total amount the qualified health plan reimburses providers and facilities for all covered benefits in the statewide aggregate, excluding pharmacy benefits, may not exceed 160% of the total amount Medicare	• State-defined provider reimbursement requirements ensure that health care costs are controlled by creating an upper aggregated cap. By controlling health care costs, public option plans are more

Public option goal	Legislative requirements to achieve the goal	How the legislation advances the goal
	would have reimbursed for the same or similar services. • For services provided by rural hospitals certified by the Centers for Medicare and Medicaid Services as critical access hospitals or sole community hospitals, the rates may not be less than 101% of allowable costs as defined by the Centers for Medicare and Medicaid Services. • Reimbursement for primary care services may not be less than 135% of the amount that would have been reimbursed under the Medicare program for the same or similar services. Requirement for state procurement: ESSB 5526 required HCA to procure and contract for public option plans offered on the Exchange. This is in alignment with its role procuring and administering Apple Health, Public Employees Benefits, and School Employees Benefits programs.	affordable for Exchange consumers. • Plans competitively procured by the State leverages stronger purchasing power to ensure access to affordable health plans for consumers.
Statewide access	Hospital participation requirement: E2SSB 5377 requires that hospitals (except those owned and operated by a health maintenance organization) must contract with at least one public option plan to provide in-network services to enrollees beginning plan year 2023.	• Participation requirements for hospital systems ensure that all Washingtonians in every country have access to hospitals and affordable public option plans.
Quality & equity	Quality and value requirements: ESSB 5526 requires public option quality and value metrics and ongoing monitoring including adoption of recommendations by the Dr. Robert Bree Collaborative, adoption of recommendations by the Health Technology Clinical Committee, and reporting on health improvement activities, primary care expenditures, and other quality measures.	• Quality and value measurements ensure access to affordable, quality health plans for Washingtonians.

In addition to affordability requirements and the goal to reach statewide availability, public option plans are intended to incentivize high-quality care with an emphasis on primary care. As public option plans are QHPs, these plans must meet Exchange plan design standards in addition to their added quality and value requirements.[6 & 7] This section describes the design and quality requirements of public option plans, including:

[6] All QHPs are required to meet design and quality standards to be certified and offered on *WashingtonHealthplanfinder*.

[7] All plans offered in the Exchange must be certified by the Exchange Board as QHPs. To participate in the Exchange's QHP certification process, a carrier must submit plans and supporting documentation annually as specified for 19 criteria, summarized in Appendix X. Each criterion is reviewed and approved by OIC, the

- Certification requirements for all QHPs, including quality requirements.
- Benefit design requirements of Cascade Care plans, including public option plans.
- Quality and value contractual requirements specifically for public option plans.

The standard benefit design applicable to all Cascade Care plans sets the framework for how consumers enrolled in public option plans access health care, including how much they spend at their providers' office on deductibles, co-pays and other out-of-pocket costs. This is a critical element of Cascade Care's affordability goals because high-cost sharing is a primary barrier to Washingtonians accessing health care. Ultimately, public option plans are intended to be the highest-quality health plans on the Exchange with affordable out-of-pocket costs when consumers seek care.

Description of Cascade Care plan design requirements, principles, and approach

In accordance with the law, carriers must offer Cascade Care plans in each county in the carrier offers coverage with limits on the number of non-Cascade Care plans that the carrier can offer in a county. This is to ensure that Cascade Care plans are available to every *Washington Healthplanfinder* consumer and limits overcrowding of the marketplace.

The Exchange creates the standard benefit design, which is utilized by all Cascade Care plans including public option plans, based on national models with the following guiding principles:

- Lower deductibles and access to services before the deductible.
- Prioritize copays where possible to provide predictability for consumers when seeking services.
- Limit premium impacts.
- Maximize tax credits with silver plan design for lower-income individuals receiving subsidies to help them pay for care.

Cascade Care plans, including public option plans, also support easier access to high-clinical value care because visits to primary care providers and mental health care providers not subject to the deductible, therefore the deductible does not need to be paid or satisfied by consumers when visiting these providers.[8] This makes getting necessary care easier, which may enable individuals to more effectively manage their conditions and prevent an avoidable costly emergency department visit or surgery.

Public option quality and value contractual and ongoing monitoring requirements

Public option plans have additional quality, value, and provider reimbursement standards. To ensure quality, Engrossed Substitute Senate Bill 5526 requires participating public option carriers to align certain quality review processes with the clinical criteria published by the HCA, including recommendations by the Dr. Robert Bree Collaborative, and the Health Technology Clinical Committee. Additionally, Cascade Select carriers are expected to engage with HCA for ongoing monitoring including reporting on health improvement activities, primary care

Exchange, or both. QHP certification requires that carriers report quality and health performance data to fulfill the Exchange's regulatory responsibility to oversee the clinical quality and patient experience in QHPs. The Exchange Quality Program's core components include quality measure reporting, quality improvement activities, and data collection and quality measure reporting stratified by race and ethnicity. See Appendix X for a summary of QHP Quality Program components.

[8] These services are set at a copay.

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expenditures, Quality Rating System,[9] and the Washington State Common Measure Set.[10]

HCA conducts annual validation and ongoing monitoring processes with public option carriers. This ensures carriers that are awarded contracts for the public option plans fulfill the expectations to complete annual review of their plan offerings, including alignment with the clinical criteria published by HCA.

The public option program is still in its early stages, with data available for only the first plan year (2021) for most quality reporting.[11] For the years data are available, carriers are successfully meeting public option's quality and value requirements. Carrier requirements and results for plan years 2021 and 2022, where available, are described in Appendix X.

Public Option Analysis and Evaluation

Public option plans have had a significant overall positive impact on Washingtonian individual health plan consumers. To fully evaluate the public option and reach this conclusion, the Board examined:

- Cost-sharing for consumers, including deductibles.
- Plan design of Cascade Care plan which includes the public option, including cost-sharing scenarios.
- Consumer access challenges and opportunities.
- Public option affordability, including premiums and factors affecting affordability.
- Public option enrollment.

Analysis of Cascade Care plan cost-sharing and impact on consumers

Benefit design sets consumer cost sharing, which is an integral part of access to coverage and care. Unlike non-Cascade plans (or non-standard plans), which are designed by carriers and can vary in deductibles and copays, Cascade Care plans, including public option plans, have the same benefits regardless of the carrier.

Analysis of cost sharing demonstrates that:

- The introduction of Cascade Care plans to the Exchange marketplace decreased deductibles across all Exchange plans.
- Public option deductibles are an average of $1,000 less than non-Cascade deductibles.
- Enrollees in public option plans are likely to pay less out-of-pocket when receiving services of high clinical value such as primary care, or for a series of related health care services such as having a baby or managing a chronic health condition.

Analysis of Cascade Care's deductibles and impact on consumers

[9] QRS measures are required for all plans offered on Washington Healthplanfinder. Participating Cascade Select carriers are required to report on QRS measures for their Cascade Select plan enrollment and, for administrative measures only, to report on these metrics by region, sex, and age group, and, to the extent the carrier is in possession of the data, by race, ethnicity, and language.

[10] Like Medicaid, PEB, and SEB carriers, Cascade Select carriers must report on a subset of the Washington State Common Measure Set. The Common Measure set provides the foundation for health care accountability and measuring performance. The development and ongoing evolution and implementation of a set of measures is mandated under House Bill 2572 (2013-14).**https://www.hca.wa.gov/about-hca/who-we-are/washington-state-common-measure-set**

[11] Carriers' reporting deliverables are spread over the plan year, therefore the full complement of carriers' quality reporting data for plan year 2022 are not yet available.

Prior to offering Cascade Care plans, only one plan on *Washington Healthplanfinder* had a deductible of less than $1,000. The introduction of Cascade Care plans on the Exchange in 2021 significantly reduced the average Exchange deductible at the Silver and Gold levels. Additionally, the average non-Cascade Silver plan deductibles decreased by $700. Upon the launch of Cascade Care plans, carriers offered several new lower-deductible plans, such as Molina's $0 medical deducible Silver plan, and Kaiser Permanente Washington's Virtual Plus plans that offered $0 cost share virtual visits. Figure 1 and Tables 2 through 6 denote the impact of Cascade Care plans' introduction to the market.

Figure 1: Impact of Cascade Plans on Exchange consumers' deductibles[12]

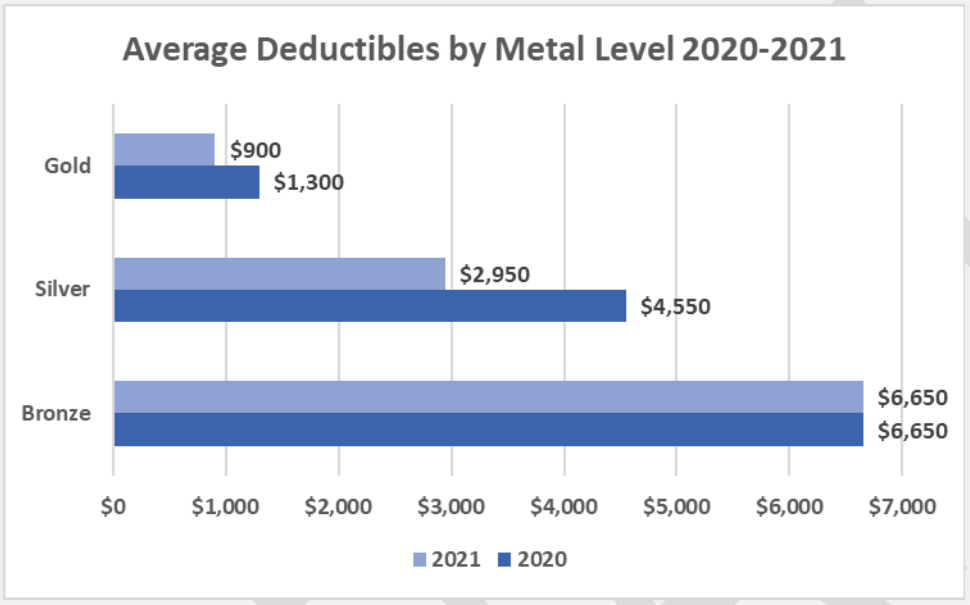

Table 2: 2020 average and median deductibles by metal level (pre-Cascade Care)

Metal	Range	Average	Median
Bronze	$5,000-$8,150	$6,650	$6,650
Silver	$2,000-$7,500	$4,550	$4,000
Gold	$0-$2,900	$1,300	$1,200

Table 3: 2021 average and median deductibles by metal level, non-Cascade QHPs compared to public option plans

Metal	Range	Average Non-Cascade	Median Non-Cascade	Public Option
Bronze	$3,000-$8,550	$7,050	$6,800	$6,000
Silver	$800-$6,900	$3,850	$3,250	$2,000
Gold	$0-$2,925	$1,450	$1,500	$500

[12] 2021 averages include Cascade plans.

Table 4: 2022 average and median deductibles by metal level, non-Cascade QHPs compared to public option plans

Metal	Range	Average Non-Cascade	Median Non-Cascade	Public Option
Bronze	$3,000-$8,700	$7,100	$7,500	$6,000
Silver	$800-$6,900	$3,900	$3,350	$2,000
Gold	$0-$2,500	$1,500	$1,500	$500

Table 5: 2023 average and median deductibles by metal level, non-Cascade QHPs compared to public option

Metal	Range	Average Non-Cascade	Median Non-Cascade	Public Option
Bronze	$3,800-$8,900	$7,300	$6,000	$6,000
Silver	$750-$7,550	$3,100	$2,900	$2,500
Gold	$0-$2,000	$1,500	$1,650	$600

Cascade plan design compared to non-Cascade plan design

In addition to plan deductibles, plan design broadly defines out of pocket expenses when seeking care, thereby reducing out-of-pocket expenses. An analysis comparing the 2022 benefit design of Cascade Care plans at each metal level to three non-Cascade plans at the same metal level shows that Cascade Care plans, comparatively, offer the following:

- Strong pre-deductible coverage.
- Limit financial barriers to services such as primary care, mental health visits, lab services and x-rays through lower co-pays and/or services before the deductible.
- Require more consumer responsibility for services that can be expensive and sometimes overused such as advanced imaging.
- Have room to improve in creating fewer financial barriers to prescription drugs.

Table 6 below shows the comparison between the 2022 benefit design for three non-Cascade plans at the Silver metal level and the 2022 Cascade Care plan benefit design at the Silver metal level. Nearly half of public option enrollees are enrolled in plans at this metal level.

Table 6: Benefits comparison chart of 2022 Cascade Silver plan to 2022 non-standard Silver plans

	Cascade Silver offered by all Exchange carriers	Molina Constant Care Silver 1	Coordinated Care Ambetter Balanced Care 4	Kaiser WA Flex Silver
Deductible	$2,000	M:$0 RX:$800	$6,900	$1,800
Coinsurance	30%	40%	0%	30%
MOOP	$7,800	$8,000	$6,900	$7,900
Emergency Room Services	$800, deductible applies	$750	0%	30%
All Inpatient Hospital Services (inc. MH/SUD)	$800, deductible applies (per day copay, limit of 5 copays per stay)	$1200 (per day copay, limit of 2 copays per stay)	0%	30%

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Primary Care Visit	$25	$30	$30	$20, deductible applies	Deductible waived for first 4 visits
Specialist Visit	$60	$60	$60	$45, deductible applies	
MH/SUD Outpatient Services – Office	$25	$30	$30	$20, deductible applies	
Imaging (CT/PET Scans, MRIs)	30%	$700	0%	30%	
Speech Therapy	$35	$60	0%	$45, deductible applies	
Occupational and Physical Therapy	$35	$60	0%	$45, deductible applies	
Laboratory Outpatient and Professional Services	$35	$45	0%	30%	
X-rays and Diagnostic Imaging	$60	$80	0%	30%	
Skilled Nursing Facility	$800, deductible applies (per day copay)	$1200 (per day copay)	0%	30%	
Outpatient Facility Fee	$600, deductible applies	$500	0%	30%	
Outpatient Surgery Physician/Surgical Services	$200, deductible applies	$75	0%	30%	
Generics	$20	$20	$15	$10	
Preferred Brand Drugs	$70	$60	$50	40%	
Non-Preferred Brand Drugs	$250, deductible applies	40%	0%	50%	
Specialty Drugs (i.e., high-cost)	$250, deductible applies	40%	0%	50%	

Silver plan comparison takeaways

- Cascade Silver plans offer strong coverage for primary care and specialty care because these benefits are not subject to deductible. For example, in the Kaiser Flex Silver plan, the consumer is responsible for meeting the deductible after four primary and specialty care visits.
- Cascade Care plans keep costs for office visits low so that consumers can better manage their health needs as opposed to relying on expensive emergency room care. Cascade Care silver plans offer strong coverage on lab and x-ray because these benefits are set at a copay and not subject to the deductible.
- However, compared to the other Silver plans, Cascade Care consumers are responsible for more costs of outpatient hospital care. For example, Cascade silver consumers must meet their deductible and pay an additional copayment for facility fees and surgery costs.
- Also, some Cascade Care consumers are responsible for more of the costs of emergency room services than consumers certain non-standard plans like Molina Constant Care Silver and KP WA Flex Sliver.
- Finally, cost sharing is higher in Cascade Care Silver plans for preferred brand drugs and generics than in some non-standard plans.

Cost scenario differences between Cascade Care and non-Cascade consumers receiving care

Consumers experience the full benefit of plan design when they utilize their coverage to manage and address illness or other health conditions. Tables 7 through 10 below illustrate examples of how consumers in Cascade Care plans may pay lower out-of-pocket costs compared to consumers in non-Cascade plans on the Exchange. These scenarios are for illustrative purposes only, as many factors can impact a patient's course of treatment and how they are billed for services.

Table 7: Consumer cost scenario for six-month outpatient treatment for uncomplicated depression (2023 plan designs)[13]

	KP WA Flex Bronze	Cascade Bronze
Deductible	$5,500	$6,000
Counseling Visits (25)	$2,196	*$1,250 (25 copays)*
Primary Care Visits for Medication Management (2)	$202 (2 copays)	*$100 (2 copays)*
Prescription for Generic Antidepressants 6-Months	*$150 (6 copays)*	*$192 (6 copays)*
Consumer Out-of-Pocket Costs	$2,548	$1,542

Table 8: Consumer cost scenario for having a baby (2023 plan designs)[14]

	Ambetter Balanced Care 4	Cascade Silver
Deductible	$7,550	$2,500
Obstetrics Visits (15)	$450	*$450*
Ultrasounds (2)	*$343*	*$130*
Bloodwork & Other Lab Tests	*$1,153*	*$160*
Generic Drugs	$5	$11
Preventive Services & Vaccines	$0	$0
Inpatient Hospital Care (2 days)	$6,054	$4,100
Consumer Out-of-Pocket Costs	$8,005	$4,851

Table 9: Consumer cost scenario for managing diabetes (2023 plan designs)

	LifeWise Essential Gold	Cascade Gold
Deductible	$1,000	$600 Medical/ $0 Pharmacy

[13] On KP WA Flex plan, 2 counseling visits are at $40 copay and 1 Primary Care Provider visit is at $40 copay, then subsequent visits subject to deductible. Visit cost estimates came from WA Health Compare using zip code 98122 used average cost of $92 for mental health therapy visit and average cost of $162 doctor office visit current patient.

[14] Italicized cost shares indicate benefits not subject to the deductible.

Primary Care Visits (5)	$150	$75
Lab Services (2 sets of diagnostic tests)	*$122*	$40
Generic Emergency Glucagon Kit	$10	$10
12 Months of Brand Name Insulin (state cap)	*$420*	$420
Blood Test Strips/Insulin Syringes	$509	*$638*
Consumer of Out-of- Pocket Costs	$1,211	$1,183

Table 10: Consumer cost scenario for simple fracture (2023 plan designs)

	Molina Constant Care 1	Cascade Silver
Deductible	$0 Medical/ $900 Drug	$2,500
Ambulance	$472	$375
Emergency Room Visit	$742	*$742*
2 Orthopedic Visits (Specialist)	$120	$130
X-Ray	$95	$65
Prescription for Ibuprofen for Pain	$5	$5
Crutches & Walking Boot	$124	*$248*
Evaluation and 4 Sessions of Physical Therapy	$300	$200
Consumer Out-of-Pocket Costs	$1,858	$1,765

Consumer access challenges and opportunities

Access to public option plans and providers

While Cascade Care plans are available in every county of the state, public option plans have not yet reached statewide availability. In 2023, public option plans are available in 34 counties of 39 counties, up from 25 counties in 2022 and 19 in 2021. This growth signals increased ability of carriers and health care providers to reach contractual agreements and build public option provider networks that meet the program's quality and affordability requirements.

Exchange carriers that offer public option plans have voiced intent to offer public option plans to consumers statewide. However, this will rely on carriers' ability to secure public option networks with providers that will agree to the program's reimbursement rates to achieve the state-defined aggregate affordability standards, which has proven challenging.

While carriers are not required to offer public option plans, the Legislature required that hospitals must contract

with at least one public option plan to provide in-network services to enrollees beginning plan year 2023.[15] However, carriers report that some difficulties with providers that appear to be unwilling to agree to participate in public option networks or agree to public option reimbursement rates. [16] With this anecdotal evidence, HCA, as the entity enforcing hospital participation requirements, continues to monitor the impact of the recent rulemaking on availability and accessibility for the public option.

Beyond plan availability, provider participation in the public option plans impacts public option enrollees. While all QHPs, including public option plans, must meet OIC network access requirements, public option provider networks differ from non-public option plans on the Exchange in that they appear to not be as extensive.[17] However, all QHPs, including public option plans, must meet OIC's network access requirements.

Additionally, consumers have reported confusion navigating the different networks, particularly as they switch from a carrier's non-public option plan to the same carrier's public option plan. Network data analysis is currently underway to better understand provider networks and the effects on public option enrollees, but this research is expected to take some time. The Exchange and HCA are working to collect the needed data to perform future analysis.

Public option affordability

Aggregated carrier results of public option reimbursement requirements

The 2019 legislation intended the public option to provide high quality, affordable health plans on the Exchange for the individual market. The following are reimbursement requirements for providers participating in public option:

- The total amount the qualified health plan reimburses providers and facilities for all covered benefits in the statewide aggregate, excluding pharmacy benefits, may not exceed 160% of the total amount Medicare would have reimbursed for the same or similar services.
- For services provided by rural hospitals certified by the Centers for Medicare and Medicaid Services as critical access hospitals or sole community hospitals, the rates may not be less than 101% of allowable costs as defined by the Centers for Medicare and Medicaid Services.
- Reimbursement for primary care services may not be less than 135% of the amount that would have been reimbursed under the Medicare program for the same or similar services.

With the program in its infancy, and data for the first plan year has only recently been made available, the review of the public option reimbursement target is in the early stages. Data from initial and ongoing monitoring reports that public option carriers with claims data adequate for analysis in the aggregate slightly exceeded the statewide

[15] Except those owned and operated by a health maintenance organization.
[16] Public Option Legislative Report 2022.
[17] Based on preliminary research conducted by HCA and HBE.

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reimbursement target of 160 percent of Medicare in 2021 (Figure 3, Exhibit 2).[18 & 19]

Figure 3 Public Option Aggregated Reimbursement Target Review [20]

Exhibit 2
Cascade Care Public Option - Results of Reimbursement Target Review
Affordability Requirement Performance Summary
Claims Incurred from January 1, 2021 through December 31, 2021

ALL CARRIERS — Member months: 26,622

Affordability Requirement	Metric Results: Requirement	Performance	Results
A) Aggregate Percent of Medicare Reimbursement[1]	< 160%	164%	FAIL
B) Physician Primary Care Percent of Medicare Reimbursement	> 135%	139%	PASS
C) Critical Access and Sole Community Hospital Reimbursement	> 101%	160%	PASS
Summary of Affordability Requirements[2]	FAIL		

Notes
1. Inpatient hospital claims experience and percent of Medicare reimbursement rates adversely affected by several large outlier claims in late 2021.
2. Of five 2021 carriers, two carriers meet all three affordability requirements and one carrier has insufficient experience for evaluation.

Initial affordability analyses, which only includes data from the first year of public option (plan year 2021), suggests that the reimbursement targets may not be low enough, or that the aggregated cap may create negotiating difficulties for carriers, to significantly reduce premiums across public option plans.[21] However, the public option shows promise in accomplishing more affordable premiums relative to other plans on the Exchange.

Analysis of 2021-2023 public option premiums

This analysis of public option premiums shows:

- While public option plan premiums were initially higher than non-Cascade plan premiums on the Exchange, public option premiums have consistently trended downward at all metal levels.
- Public option plans are the most affordable QHP in many Washington counties (25 out of the 34 counties where public option plans are available).[22]
- HCA's competitive and selective public option procurement in 2023 (compared to a process for the 2021-2022 plan years that allowed all interested carriers to offer the public option) was a driver of 2023 advancements in affordability, statewide availability, and healthy market competition.
    - Public option plans are the lowest-cost Silver premium offering on the Exchange in 25 counties in 2023, up from 13 counties in 2022.
    - The average public option premium rate in plan year 2023 decreased by 3 percent compared to average rate increases of more than 8 percent for non-public option health plans on the Exchange.

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[18] For ongoing monitoring of compliance with these requirements, HCA's actuarial consultant, Milliman, collects and assesses paid claims data twice yearly as provided by public option carriers. The percent of Medicare reimbursement is produced by dividing the total carrier allowed amount by the amount Medicare would have allowed for the same services. In the final analysis for all quarters in 2021, one carrier still had reimbursement targets in excess of 160 percent of Medicare. Two of the four carriers with claims data had aggregate statewide reimbursement targets below 160 percent of Medicare. **If outlier medical claims for a carrier whose reimbursements exceeded the target were removed, the average across all carriers would have met the 160 percent reimbursement target.**

[19] "Cascade Select Public Option," Dec. 1, 2022: https://www.hca.wa.gov/assets/program/cascade-select-leg-report-20221216.pdf

[20] Ibid.

[21] Ibid.

[22] Public option premiums for a 40-year-old nonsmoker are the lowest-premium silver QHPs in 25 counties in 2023.

Additionally, average public option plan premiums across all metal levels were lower than non-Cascade Care premiums for the first time in plan year 2023. These advances are promising indicators that a comprehensive set of benefits can be offered at a lower premium, particularly when paired with requirements that address underlying cost drivers of premium rates. Figures 4 through 7 below denote premium comparisons of public option plans and non-public option plans for plan years 2021-2023.

Figure 4: Average plan rates by metal level public option versus non-Cascade Plans on the Exchange 2021-2023 for a 40-year-old nonsmoker.

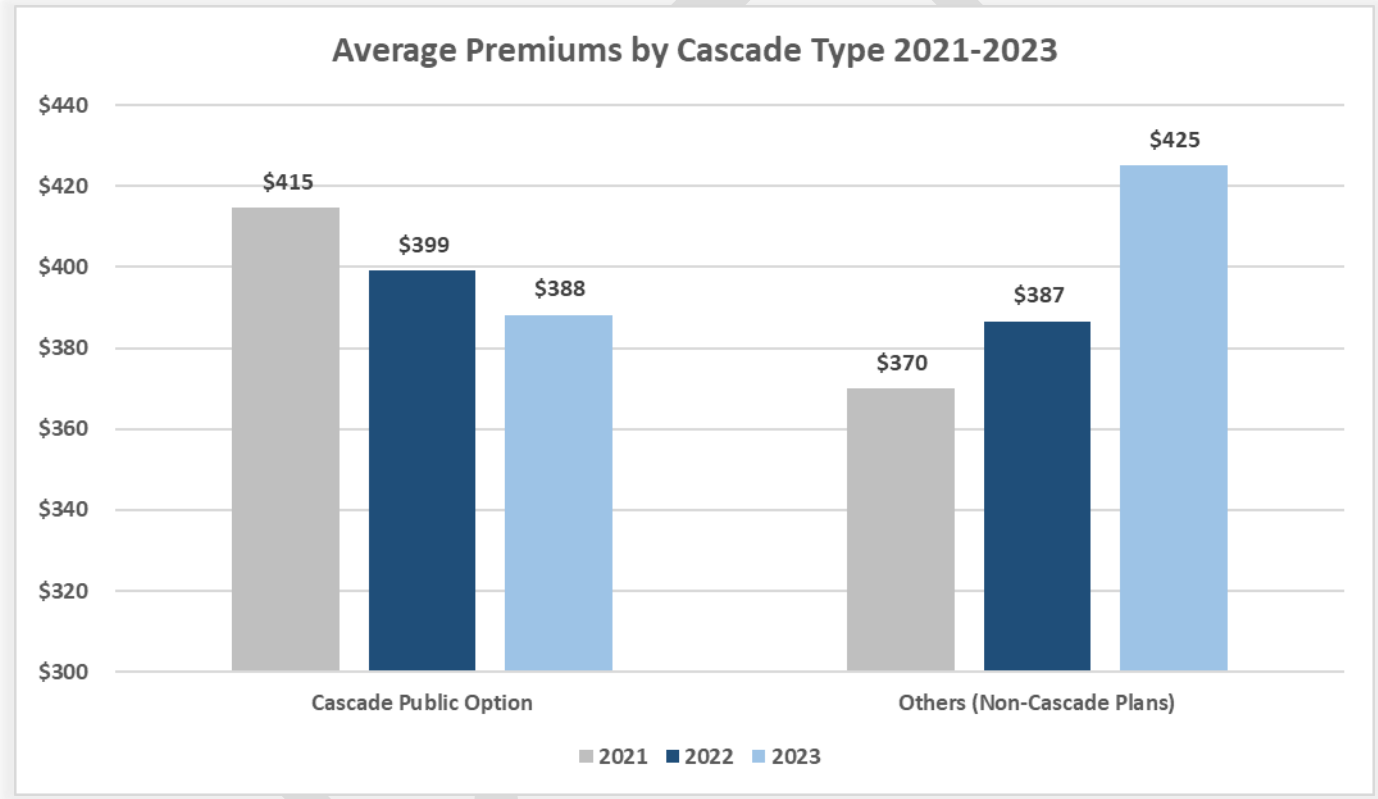


Figure 5: Average plan rates for Bronze public option versus non-Cascade Plans on the Exchange 2021-2023 for a 40-year-old nonsmoker

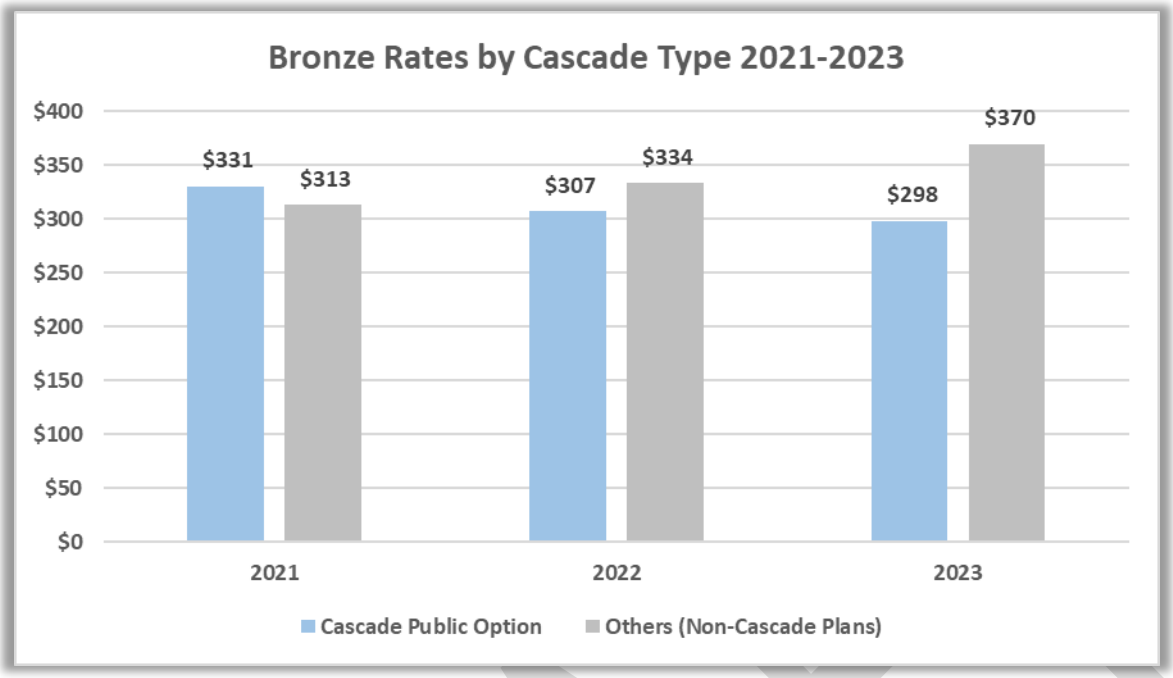


Figure 6: Average plan rates for Silver public option versus non-Cascade plans on the Exchange 2021-2023 for a 40-year-old nonsmoker

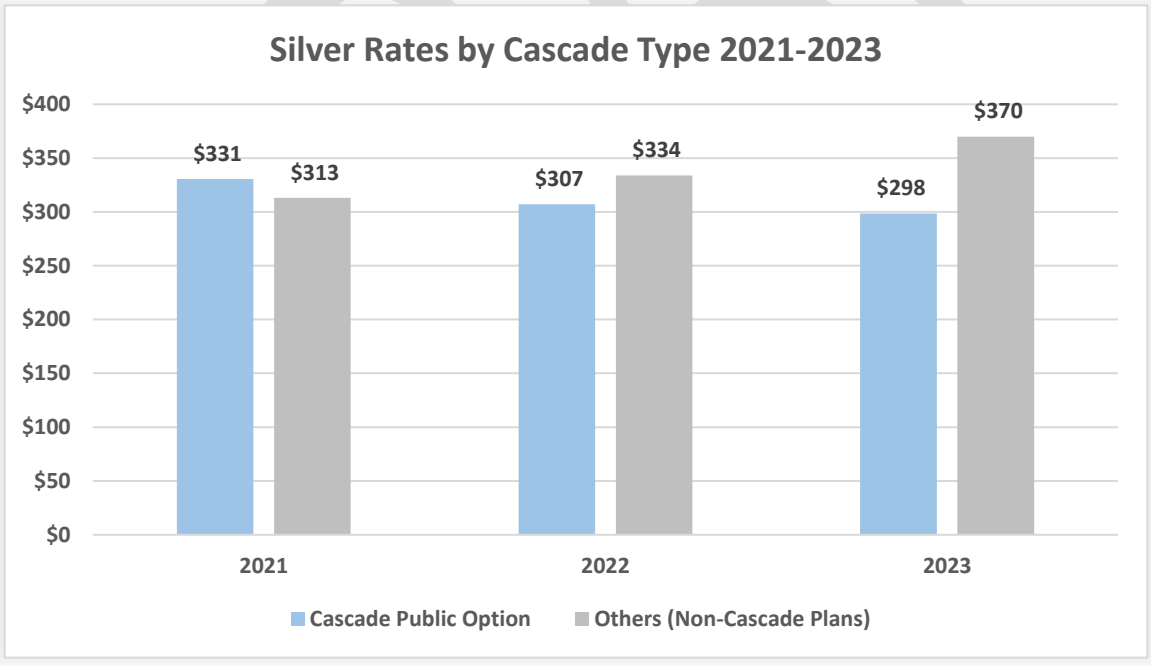
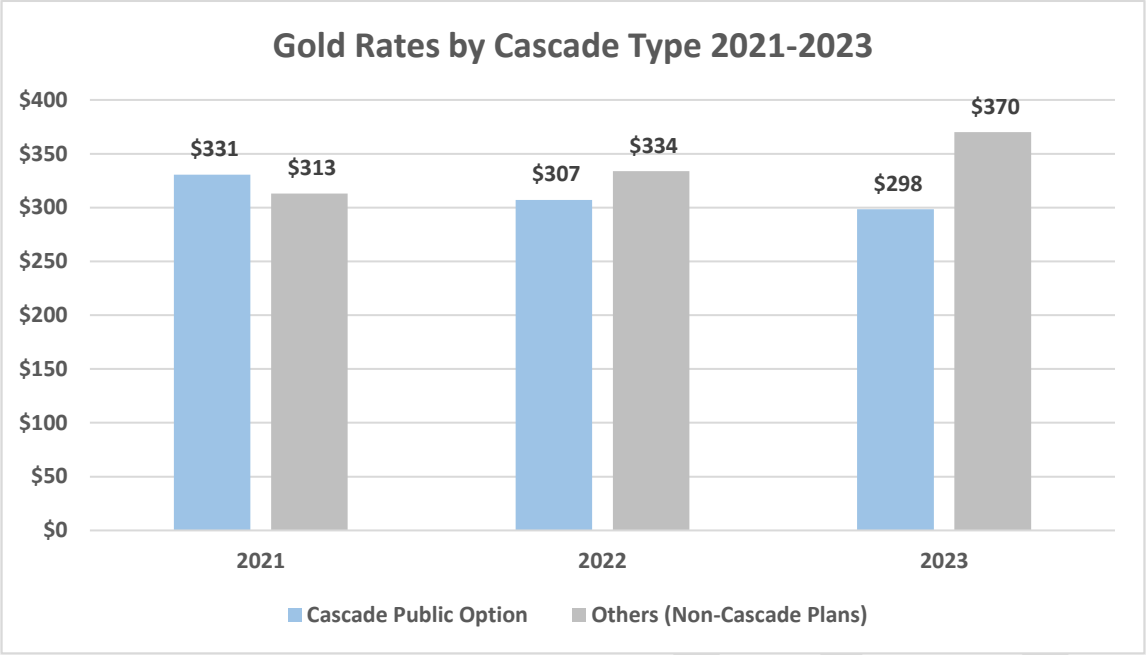


Figure 7: Average plan rates for Gold public option versus non-Cascade plans on the Exchange 2021-2023 for a 40-year-old nonsmoker



Between 2021 and 2023, public option premiums decreased by 6 percent. This is compared to 15 percent premium increases in non-Cascade Care plans on the Exchange during that same time period, as illustrated by Table 11 below. Additionally, before subsidies, public option plans are the lowest-premium silver qualified health plans in 25 counties in 2023 (Table 12 and Figure 8).

Table 11: Rate percentage change for public option versus non-Cascade plans 2021-2023 for a 40-year-old nonsmoker, all metal levels

	Rate Change % 2021-2022	Rate Change % 2022-2023	Rate Change % 2021-2023
Cascade Public Option	-4%	-3%	-6%
Others (Non-Cascade Plans)	4%	10%	15%

Table 12: Number of counties where public option is the lowest cost QHP by metal level, 2021-2023

	Bronze	Silver	Gold
2021	1	1	3
2022	14	13	8
2023	24	25	1

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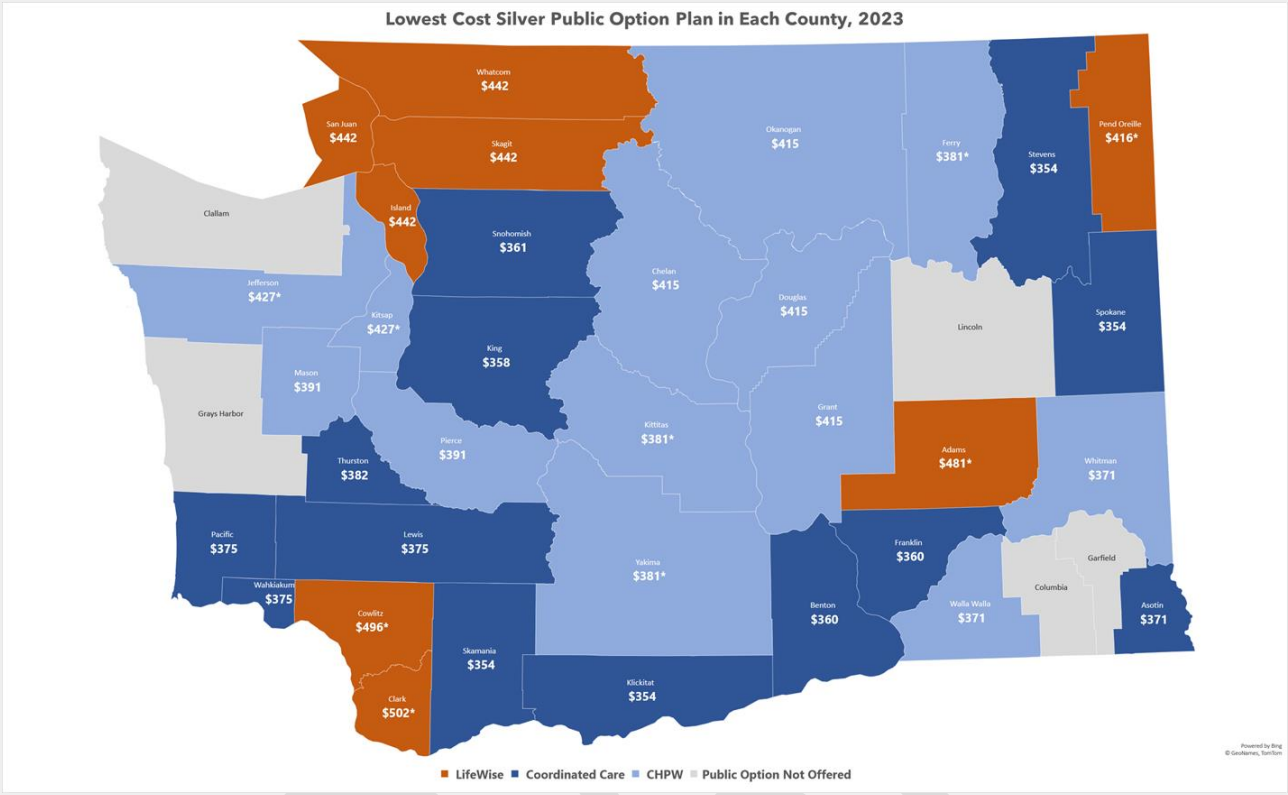
Figure 8: 2023 lowest cost public option Silver plan premium and carrier by county, 40-year-old nonsmoker[23]



Other market factors affecting consumer premiums

Washington's public option launched only recently in 2021 and has grown during a time of significant time of change in the health coverage and health care landscape. Of note, the COVID-19 pandemic and related interventions changed consumer access to health insurance and financial assistance in Washington state. Additionally, in 2021, the passage of ESSB 5377 established state-funded premium assistance for low-income Exchange consumers enrolled in Cascade Care plans, including public option plans.

Effects of the pandemic on access and affordability

In response to the COVID-19 pandemic, the Exchange opened a Public Health Emergency (PHE) Special Enrollment Period (SEP) for consumers on February 15 extending to August 15, 2021. The American Rescue Plan (ARPA), which offered enhanced premiums subsidies to pay for individual market coverage, passed in March 2021. Within two months, Washington's Exchange was among the first in the country to implement the new savings available under ARPA, including extra help to those reporting unemployment income.

From May to August 2021, 28,000 new consumers signed up for Exchange coverage. Approximately 500 consumers also enrolled in public option plans during this time. As of August 15, 2021, 78 percent of Exchange consumers were receiving subsidies, up from 61 percent pre-ARPA. Additionally, nearly half of all QHP consumers paid less than $100 per month for coverage. Subsidized QHP consumers over 400 percent FPL (23,000 enrollees)

[23]*Asterisk next to premium amount on map indicates where public option plan is not lowest cost silver qualified health plan in county.

previously not eligible for subsidies, also paid nearly $200 less per month for premiums. The additional subsidization through ARPA resulted in important gains in affordability for consumers.

During the PHE, individuals covered by Medicaid remained continuously covered under Medicaid because Medicaid redeterminations were paused, where.[24] Washington's uninsurance decreased to a record low of 5.3 percent in 2021, driven by the enhanced ARPA subsidies and continuous Medicaid coverage.[25] However, some of the gains in coverage and affordability are at risk now that federal requirements for Medicaid redeterminations restarted in 2023, and the enhanced federal subsidies are only available through the end of 2025.

Cascade Care Savings

A $50 million annual state-funded premium subsidy, called Cascade Care Savings, was established by the Washington State Legislature in 2021 and made available to consumers starting January 2023.[26] Cascade Care Savings is available to Washingtonians making up to 250 percent FPL who are not eligible for existing state and federal coverage programs such as Washington Apple Health or Medicare. To receive Cascade Care Savings, consumers must enroll in a Cascade Care Gold or Silver plan, which includes public option plans.

Cascade Care Savings maximizes all available federal tax credits and helps consumers who do not qualify for federal subsidies. The state premium subsidies, in tandem with federal subsidies, provide an unprecedented opportunity for uninsured, low-income Washington residents to get coverage. The exact amount of savings received is displayed to consumers in *Washington Healthplanfinder* and based on where the consumer lives, age and income.

To date, more than 50,000 consumers are receiving Cascade Care Savings to lower their monthly premiums. About 75 percent of consumers enrolled in Silver and Gold Cascade Care plans—including public option plans—are receiving state-funded premium assistance and pay less than $100 for their monthly premiums. Of these consumers, 25 percent have a $0 monthly premium.

Table 13: Cascade Care Savings recipient enrollee count by net premium, Spring 2023[27]

Net Premium	CCS Enrollees
$0	10,656
$1-50	10,969
$51-100	8,995
$101+	11,138
Grand Total	41,758

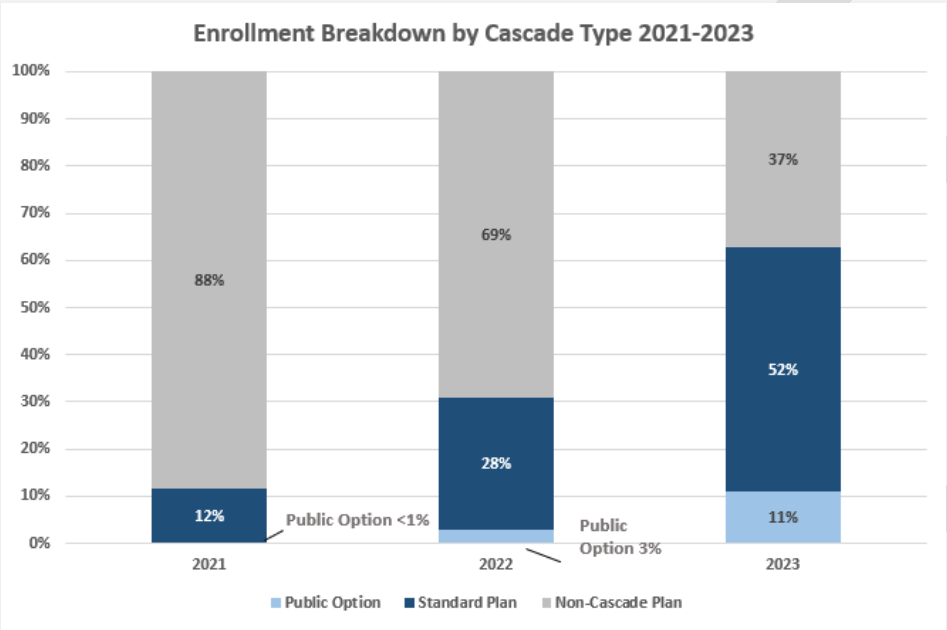
Impact of premium affordability on exchange consumers

[24] A Medicaid redetermination is where individuals must show proof of their eligibility for Medicaid to remain covered.
[25] See Appendix X for a comparison of WA and US uninsured rates between 2010-2021.
[26] In 2022, the Exchange applied for and received approval for a first-in-kind Section 1332 State Innovation Waiver to provide access to QHP and QDP through Washington Healthplanfinder to people who were previously ineligible to purchase coverage due to their immigration status. During the 2023 legislative session, the Legislature appropriated an additional $5 million in annual state-funded premium assistance for consumers who are ineligible for federal premium tax credits but otherwise meet Cascade Care Savings eligibility criteria for coverage starting in plan year 2024.
[27] Citation and reference for enrollment report.

Consumer enrollment in public option plans

Since the launch of Cascade Care three years ago, most Exchange consumers have shifted their enrollment to Cascade Care plans, including public option plans. As of March 2023, two-thirds of Exchange enrollees are in Cascade Care plans, including the public option. Public option plans currently represent more than 10 percent of Exchange enrollment, with nearly 25,000 enrollees. Figure 9 below illustrates the market shift to Cascade Care plans.

Figure 9: Market shift to Cascade Care plans by percentage of total exchange enrollment 2021-2023



Primary drivers of enrollment in public option plans include the following:

- Public option plans are the lowest-cost premium plan for many consumers.
- New enrollees are more likely to enroll in public option plans as they actively shop for a plan as opposed to renewing enrollees who auto-renew into the same health plan.
- Annual plan mapping results in renewing enrollees into public option plans.[28]

Public option enrollee demographics

Public option enrollees are consistently slightly younger than non-public option Exchange enrollees. In 2021 and 2023, public option enrollees were more likely to be lower income enrollees than non-public option enrollees, though there was no difference in income levels between the two groups in 2022. This suggests additional years of enrollment are needed to establish a clear trend. Figure 9 and Figure 10 illustrate differences in FPL distribution between public option and non-public option enrollees in plan year 2022 and plan year 2023 respectively.

Figure 9: Differences in FPL distribution between public option and non-public option enrollees in 2022

[28] Annual plan mapping is a process that includes the Exchange and health plan carriers moving renewing enrollees into different plans and most often occurs when consumers' existing plans are no longer available in the next plan year.

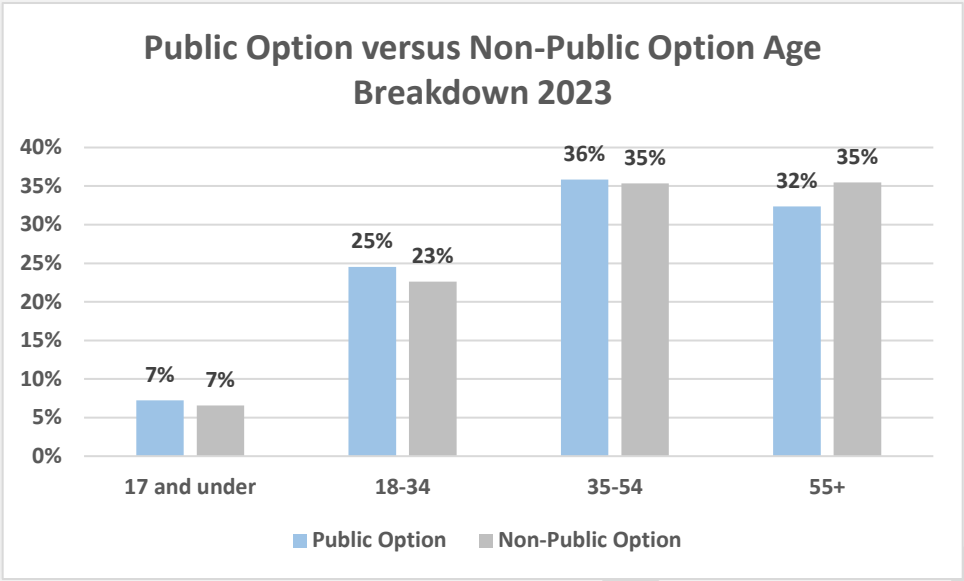
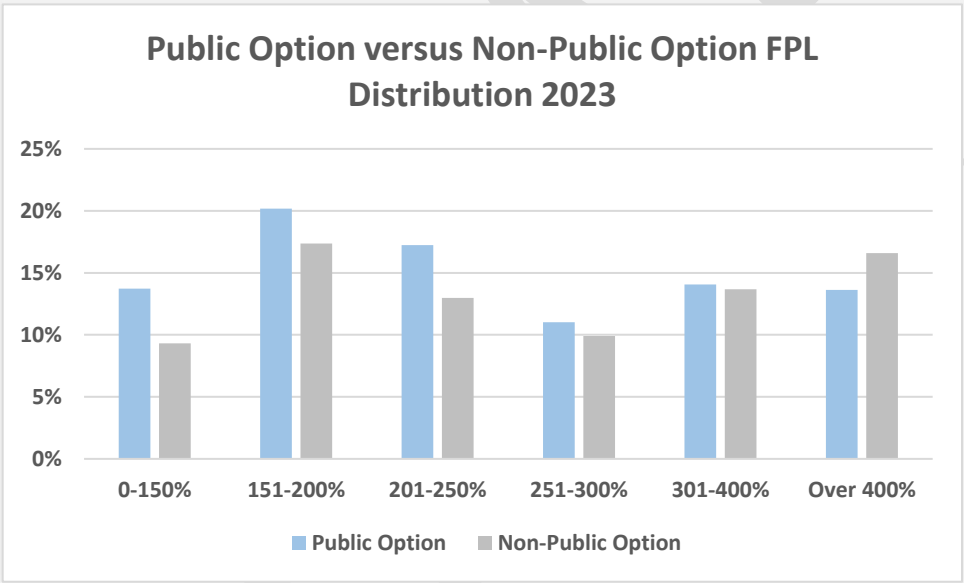


Figure 10: Differences in FPL distribution between public option and non-public option enrollees in 2023



Consumer shifting to higher benefit plans

With the introduction of premium affordability measures, paired with public option plan premiums being lower than other plan types, Exchange enrollees are selecting plans with more comprehensive benefits. All Exchange health plans come in four metal levels—Bronze, Silver, Gold and Platinum. The difference between the metal levels is the percentage of care covered, e.g., Bronze plans cover 60 percent of the costs of care, and Gold plans cover 80 percent. Each year since 2021, marketplace composition has shifted from Bronze metal level enrollment to Silver and Gold metal level enrollment.

The introduction of both enhanced federal subsidies in 2021 and state premium assistance in 2023 made it possible for many consumers to purchase more comprehensive plans. Public option enrollees are even more likely than their non-public option counterparts to enroll in a Silver or Gold plan; a trend observed even before state

premium assistance became available in 2023. Figures 11, 12, and 13 illustrate the comparison of public option to non-public option QHP meal level selection from 2021, 2022, and 2023 respectively.

Figure 11: Public option to non-public option QHP metal level selection trends in 2021

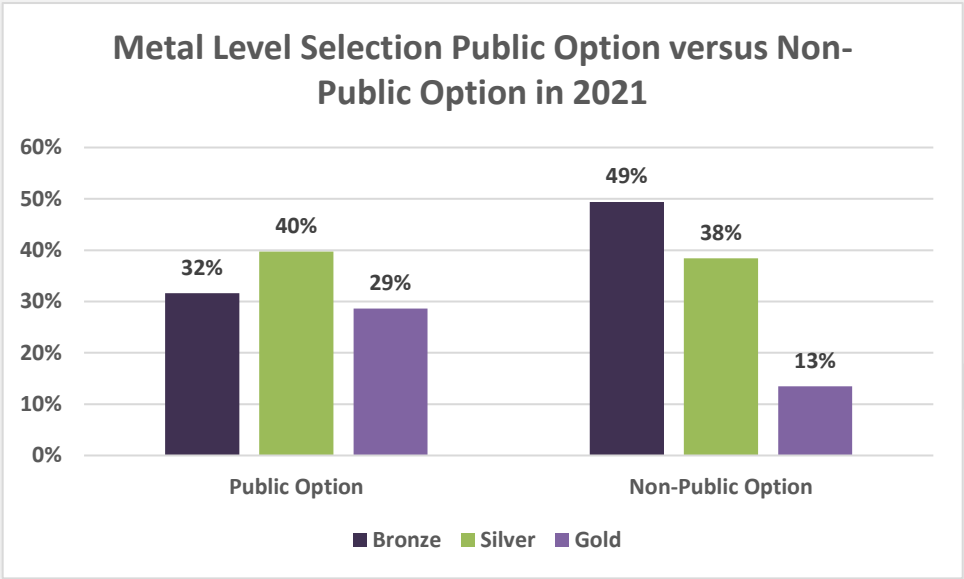


Figure 12: Public option to non-public option QHP metal level selection trends in 2022

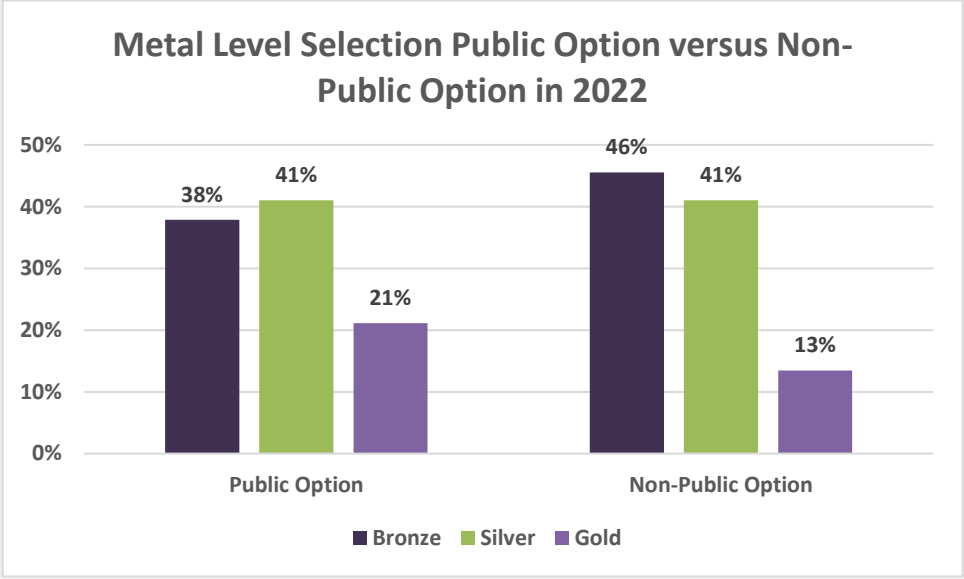
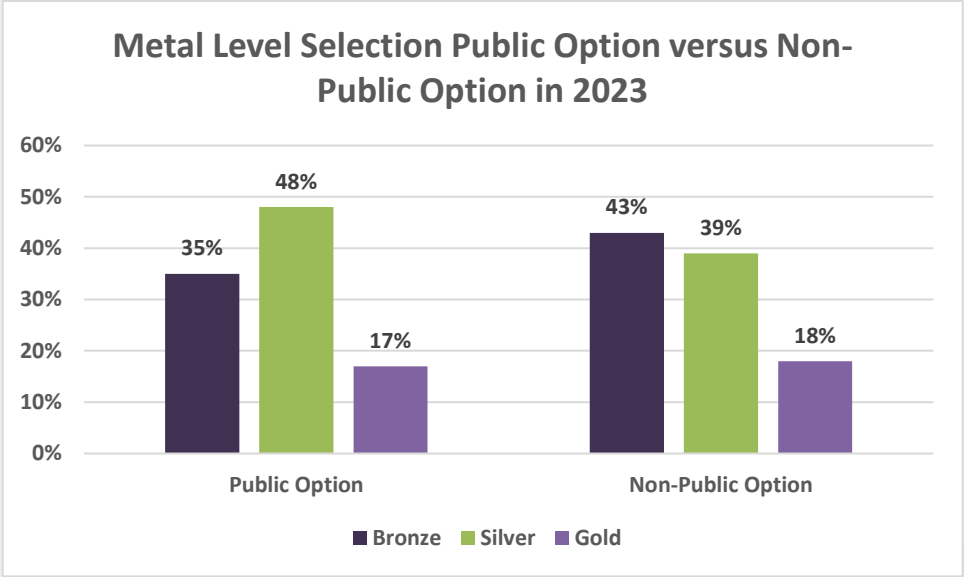


Figure 13: Public option to non-public option QHP metal level selection trends in 2023



Conclusion

Cascade Care and the state's first-in-the-nation public option plans present a unique opportunity to increase the availability of and access to quality, affordable health coverage on the Exchange marketplace. Addressing barriers and risks to consumer access relies on maintaining and strengthening public option tools to achieve meaningfully lower premiums, provider participation in public option statewide, and high-quality, meaningful plan choice.

The public option shows promise in increasing access to high-quality, affordable health coverage for all *Washington Healthplanfinder* consumers. Public option premiums are currently the most affordable QHPs in many Washington counties, increasing consumer access to health insurance coverage. Additionally, the public option's high-value benefit design allows enrollees to pay less out of pocket when using their benefits to access care.

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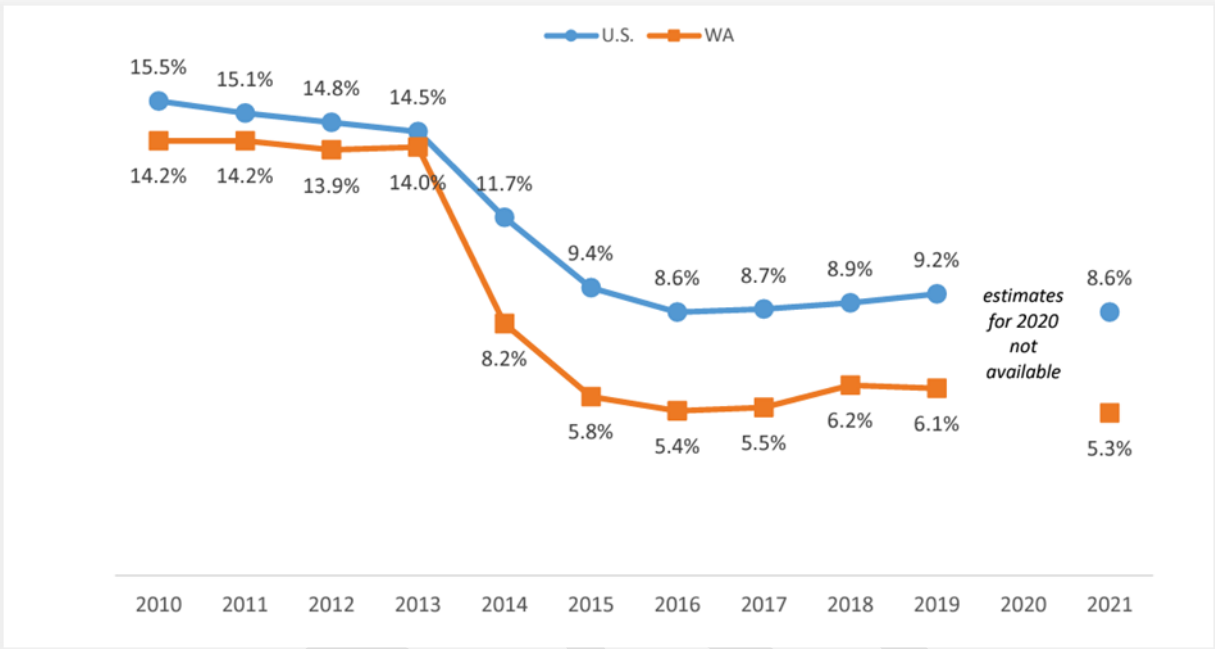
Appendix X: Comparison of WA and US uninsured %, 2010-2021



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Appendix X: health plan types offered on Washington Healthplanfinder

2023 Health Plans Offered on *Washington Healthplanfinder*				
			Cascade Care Plans	
		Non-Cascade plans	Cascade plans	Cascade Select plans
Meets all QHP requirements	Requirements for all QHPs in 2023: • All plans must meet all requirements under RCW 43.71.065. • Carriers must offer gold and silver Cascade Care health plans to participate in *Washington Healthplanfinder*. • Carriers offering a non-Cascade bronze plan on *Washington Healthplanfinder* must also offer one bronze Cascade Care health plan on *Washington Healthplanfinder* in any county where it offers a bronze plan. • Carriers offering Cascade Care health plans may offer up to two non-Cascade gold plans, two non-Cascade bronze plans, one non-Cascade silver health plan, one non-Cascade platinum health plan, and one non-Cascade catastrophic health plan in each county where the carrier offers a qualified health plan.	X	X	X
Eligible for tax credits		X	X	X
Eligible for Cascade Care Savings state premium subsidy for residents earning up to 250% FPL.			X	X
Includes standard health plan benefit design set by the Exchange.			X	X
Includes quality, value, and provider reimbursement requirements set by the Legislature and Health Care Authority.				X
Hospital participation requirements set by the Legislature.				X
Procured through the Health Care Authority.				X

Appendix X: QHP certification criteria

The following chart summarizes the nineteen criteria applied in the certification process of a QHP. Each criterion is reviewed and approved by OIC, the Exchange, or both.

Exchange Plan Certification Criteria

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Number	Criteria Level	Criteria	OIC or Exchange Review	Initial Certification Criteria	Recertification Criteria
1	Issuer	Issuer must be in good standing	OIC	Yes	Yes
2	Issuer	Issuer must pay user fees, if QHPs assessed	Exchange	Yes	Yes
3	Issuer	Issuer must comply withthe risk adjustment program	OIC	Yes	Yes
4	Issuer	Issuer must comply with market rules on offering plans, including participation in State Premium Assistance Program*	OIC/ Exchange*	Yes	Yes
5	Issuer	Issuer must comply with non-discrimination rules	OIC	Yes	Yes
6	Issuer	Issuer must be accreditedby an entity that HHS recognizes for accreditation of health plans	Exchange	Yes	Yes
7	Product	QHP must meet marketing requirements	Exchange	Yes	Yes
8	Product	QHP must meet networkaccess requirements, including ECPs	OIC	Yes	Yes
9	Product	Issuer must submit provider directory data	Exchange	Yes	Yes
10	Product	Issuer must implement a quality improvement strategy	Exchange	Yes	Yes

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11	Product	Issuer must submit health plan data to be used in standard format for presenting health benefit plan options	Exchange	Yes	Yes
12	Product	Issuer must report qualityand health performance data	Exchange	No	Yes
13	Product	Issuer must use the Exchange enrollment application	Exchange	Yes	Yes
14	Product	Issuer may only contract with a hospital with morethan 50 beds if the hospital utilizes a patient safety evaluation system	OIC	Yes	Yes
15	Product	Services provided under aQHP through a direct primary care medical home must be integrated with the QHP issuer	OIC	Yes	Yes
16	Plan	A QHP must comply withbenefit design standards(e.g., cost-sharing limits, "metal level," EHB, standard plan design*)	OIC/Exchange*	Yes	Yes
17	Plan	Issuer must submit a QHP's service area andrates for a plan year	OIC	Yes	Yes
18	Plan	Issuer must post justifications for QHP premium increases	OIC	No	Yes
19	Plan	Issuer must submit QHP benefit and rate data for public disclosure	Exchange/OIC	Yes	Yes

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Appendix X: QHP quality program

QHP certification requires that carriers report quality and health performance data. This is the vehicle of the Exchange's Quality Program where the Exchange leverages opportunities to receive additional reporting from carriers. The Exchange has a regulatory responsibility to oversee the clinical quality and patient experience in QHPs offered to consumers. The Exchange Quality Program's core components include quality measure reporting, quality improvement activities, and data collection and quality measure reporting stratified by race and ethnicity.

- **Quality Rating System (QRS)**
  - Health plans submit data to CMS on 39 quality measures (mix of administrative or medical record and survey data).
  - CMS creates quality star rating displayed to consumers shopping on Healthplanfinder.
  - Exchange also receives QRS measure data directly from carriers and uses data to inform quality program focus areas.
- **Quality Improvement Strategy (QIS) program**
  - HBE/carriers pick from among federal focus areas (e.g., health disparities, hospital readmissions), develop activities to improve quality in those areas, include a consumer- or provider-directed financial incentive for improvement, and report on progress.
    - Market incentives for providers through bonus payments and patients through gift cards.
  - Carriers submit annual progress reports using an HBE-specific form.
- **Additional quality requirements**
  - HBE uses the quality certification criteria to engage with carriers on quality initiatives beyond federally-required QRS and QIS such as:
    - Race/ethnicity data collection.
    - Quality measure stratification by race and ethnicity and urban/rural areas.
    - Meeting performance targets for quality measure improvement.
    - Requiring carriers to implement a Bree primary care strategy.
    - Reporting on primary care spend as a proportion of total spend.
    - Reporting of claims data to WA Health Alliance for custom quality reporting.

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Appendix X: public option quality & value requirements

To ensure that public option plans are quality health plans for Washington consumers, Senate Bill 5526, requires participating public option carriers to align certain quality review processes with the clinical criteria published by the HCA, such as recommendations by the Dr. Robert Bree Collaborative (Bree Collaborative), and the Health Technology Clinical Committee (HTCC). Additionally, Cascade Select carriers are expected to engage with HCA for ongoing monitoring including reporting on health improvement activities, primary care expenditures, Quality Rating System (QRS),[29] and the Washington State Common Measure Set.[30]

HCA conducts annual and ongoing validation and renewal processes with public option carriers. This ensures carriers that are awarded contracts for public option fulfill the expectations for their plan offerings, including alignment with the clinical criteria published by HCA.

The program is still in its early stages with data only being available for the first plan year (2021) for most quality reporting.[31] Carriers' full reporting results for plan year 2021, the first year Cascade Select was offered, are described in this report.[32] However, results for Bree and HTCC reporting are available for both plan years 2021 and 2022 and are described in those respective sections below.

Bree Collaborative

The Bree Collaborative is a statewide public-private consortium established in 2011 by the Legislature "to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State."[33] Annually, the Bree Collaborative identifies up to three areas where there is substantial variation in practice patterns and/or high utilization trends that do not produce better care outcomes.

Recommendations from the Bree Collaborative help HCA guide state purchasing for programs like Apple Health, Public Employee Benefits (PEB), and School Employee Benefits (SEB). Carriers participating in or bidding for Cascade Select contracts must also align with Bree recommendations selected by HCA for reporting and evaluation.

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[29] QRS measures are required for all plans offered on Washington Healthplanfinder. Participating Cascade Select Carriers are required to report on QRS measures for their Cascade Select plan enrollment and, for administrative measures only, to report on these metrics by region, sex, and age group, and, to the extent the Carrier is in possession of the data, by race, ethnicity, and language.

[30] Like Medicaid, PEB, and SEB carriers, Cascade Select carriers must report on a subset of the Washington State Common Measure Set. The Common Measure set provides the foundation for health care accountability and measuring performance. The development and ongoing evolution and implementation of a set of measures is mandated under House Bill 2572 (2013-14).**https://www.hca.wa.gov/about-hca/who-we-are/washington-state-common-measure-set**

[31] Carriers' reporting deliverables are spread over the plan year, therefore the full complement of carriers' quality reporting data for plan year 2022 are not yet available.

[32] Two of the five contracted carriers' enrollment was less than 500 in plan years 2021 and 2022. These carriers were not required to report on Bree, Common Measures, HTCC, primary care expenditures, or QRS due to the respective carriers' reporting sample size. However, these carriers were required to report on health improvement activities and aggregate provider reimbursement rates.

[33] RCW 70.250.

During the procurement process, public option bidders are required to describe actions and steps their organization has taken to implement the mandatory Bree topics, as well as any planned activities for the next plan year. Bidders must also submit details regarding progress implementing these recommendations.

Carriers must first complete a baseline report to determine their current alignment with Bree recommendations. Each subsequent report measures against the performance goals carriers select to work towards each plan year.

2021 and 2022 reporting results

Participating carriers' reporting data on Bree recommendations are available for both plan years 2021 and 2022. All carriers required to report[34] met Bree reporting requirements.

Carriers reported on progress and implementation of Bree recommendations on the selected mandatory topics. Of the current Bree recommendations, the following topics were selected to align with other statewide initiatives and priorities for plan years 2021 and 2022:

- Avoidable readmissions
- Behavioral health integration
- Low back pain
- Opioid use disorder
- Total knee and hip replacement.

Health Technology Clinical Committee (HTCC)

This committee was established by law to make coverage determinations for selected health technologies based on available scientific evidence.[35] HTCC is composed of community health care practitioners and is supported by HTA.[36] HTA develops scientific, evidence-based reports on selected medical devices, procedures, and tests, and HTCC uses the reports to determine the conditions for coverage.

The director of HCA selects technologies for review by HTCC in consultation with other agencies and the committee itself. The determinations of HTCC are followed by state purchased health care programs including Apple Health, the Uniform Medicare Plan (UMP), and the Department of Labor and Industries. HTCC decisions are also incorporated into the ongoing Cascade Select reporting requirements of carriers currently participating, as well as for carriers bidding for contracts during procurement years.

During the procurement process, bidders must complete and submit the HTCC Decisions Matrix, a reporting tool designed by HCA. This matrix establishes baseline levels of bidders' alignment with existing HTCC decisions and is utilized to continue to track progress in subsequent reports required of carriers.

In the procurement for plan year 2023, bidders were required to provide information based on current alignment and any expected changes for the upcoming plan year. Bidders were scored on the content and submission of their respective HTCC Decisions Matrix. During the contracting term, the successful bidders will continue to submit reports for tracking against the initial submission to ensure progress and success.

Participating carriers are required to report annually on alignment of their coverage criteria with HTCC

[34] Not including two low-enrollment carriers.
[35] RCW 70.14.090.
[36] HTA supports HTCC which makes coverage decisions that apply to state purchased health care programs.

decisions. Carriers must first complete a baseline report to determine their current alignment with HTCC Decisions. For HTTC Decisions where carriers are fully aligned, each subsequent report is intended to monitor carriers' alignment with HTCC. In areas where carriers are not fully aligned, carriers are required to describe their progress and plans to reach full alignment.

For plan year 2023, carriers are required to be aligned with at least 50 percent of HTTC decisions and submit a plan for increasing alignment with additional HTCC decisions in subsequent years. HCA will evaluate these reports (clinical and program teams, including value-based purchasing). If not fully aligned, carriers will be required to describe where their policies are or are not aligned, as well as whether those policies are beyond the scope of HTCC. Additionally, if not aligned, HCA (clinical and/or program teams) will provide verbal or written feedback, which may include the development of an improvement plan, to ensure carriers are supported and equipped to meet quality reporting requirements.

2021 and 2022 reporting results

Participating carriers' reporting data on HTCC are available for both plan years 2021 and 2022. All carriers required to report[37] met HTCC reporting requirements. These carriers reported on a range of over 70 HTCC decisions. Some HTCC topics include:

- Breast MRI
- Glucose monitoring
- Non-invasive cardiac imaging
- Vitamin D screening and testing.

Additional Cascade Select-specific quality measures

Certain quality reporting metrics required of bidding and participating Cascade Select carriers are not required of other qualified health plans on the Exchange. Cascade Select carriers must also annually report on the Washington State Common Measure Set, Health Improvement Activities, and primary care expenditures.

Washington State Common Measure Set

The Washington State Common Measure Set (WSCMS) was created by the Performance Measures Coordinating Committee (PMCC) as directed by legislation in 2014 and is intended to minimize variation in how the health care delivery system is measured and monitored.[38] The PMCC provides oversight of the WSCMS and meets quarterly to continue to evaluate and update the measure set, as needed. The WSCMS is used by HCA to promote quality improvement efforts in Medicaid, PEB, SEB, and Cascade Select. The WSCMS captures carriers' quality performance in areas such as primary care and prevention, behavioral health, and effective management of chronic illness.

Washington State Common Measure Set 2021 reporting results

Carriers' reporting deliverables are spread over the plan year and all carriers met the requirements for reporting of the WSCMS for 2021 plan year.[39] Carriers' WSCMS reporting results for plan year 2022 will be

[37] Not including two low-enrollment carriers.

[38] Engrossed Second Substitute House Bill 2572 Chapter 223, Laws of 2014. https://lawfilesext.leg.wa.gov/biennium/2013-14/Pdf/Bills/Session%20Laws/House/2572-S2.SL.pdf?q=20220405155431

[39] Not including the two low-enrollment carriers for plan years 2021 and 2022.

available in plan year 2023, at which point HCA can evaluate carriers' quality reporting over two full plan years.

Carriers awarded Cascade Select contracts for plan year 2021 reported on a subset of the WSCMS. The selected measures from the WSCMS are relevant to the individual market, allow efficiency in carrier reporting, and align with measures in state purchasing contracts. Some of the measures Cascade Select carriers reported on include:

- Asthma medication ratio
- Follow-up after emergency department visit for mental illness
- Patient experience with primary care: how well providers communicate with patients
- Statin therapy for patients with cardiovascular disease
- Use of spirometry testing in the assessment and diagnosis of chronic obstructive pulmonary disease (COPD)

Carriers were also required to report on two measures by race/ethnicity. These measures included:[40]

- Antidepressant medication management (both acute phase treatment and continuation phase treatment)
- Breast cancer screening

Health Improvement Activities

Participating Cascade Select carriers must annually report on health improvement activities selected by HCA to reduce barriers to maintaining and improving health. These requirements include, but are not limited to:

- Standards for utilization management to reduce administrative burden and increase transparency and clinical effectiveness
- Population health management
- High-value, proven care
- Health equity
- Primary care
- Care Coordination and chronic disease management
- Wellness and prevention
- Prevention of wasteful and harmful care
- Patient engagement

Health Improvement Activities 2021 reporting results

Carriers' reporting deliverables are spread over the plan year and all carriers met the requirements for health improvement activities reporting for plan year 2021.[41] Carriers' health improvement activities reporting results for plan year 2022 will be available in plan year 2023, at which point HCA can evaluate carriers' quality reporting over two full plan years.

Contracted carriers were required to submit a health improvement activities report including descriptions on

[40] Carriers not in possession of race, ethnicity, and language data for their Qualified Health Plan (QHP) population were required to submit and implement a plan to collect this data for their population enrolled in a procured QHP.

[41] All five contracted carriers for plan year 2021 were required to report on health improvement activities.

utilizing and/or implementing the following:

- Utilization review selection criteria and process, and which national accreditation standard(s) were achieved
- Complex case and chronic condition management
- Population health management strategies, including closure of care gaps and promotion of preventive services
- Web-based or other tools utilized to encourage patient engagement, such as application to allow patients to schedule appointments, refill prescriptions, and other functions
- Shared Decision Making programs
- Approach to encourage provider use of certified Electronic Health Record (EHR) systems as defined by the Office of the National Coordinator and providers' contribution of clinical data from its EHR system to the state Clinical Data Repository (CDR) hosted by OneHealthPort
- Programs to support active participation of providers in at least one Accountable Community of Health (ACH), including various workgroups and committees
- Participation in Multi-Payer Primary Care Transformation Model, other state or national multi-payer efforts, and data sharing initiatives to reduce variation in care, improve value and reduce overall cost of care
- Behavioral Health/SUD services
- Pharmacy benefits/programs

Primary care expenditures

One of the goals of the Cascade Select program is to incentivize high-quality care with an emphasis on primary care. Improving primary care is the key to better care, smarter spending, and healthier people and communities.

There is no target percentage for primary care spend for Cascade Select plans. Rather, carriers annually report on primary care expenditures for partnering Cascade Select agencies to better understand the level of primary care expenditures and investments in the public option program and to inform future primary care strategies and activities.[42]

Carriers must submit primary care expenditures in aggregate for their Cascade Select plans.[43] This includes primary care payments data using both narrow and broad definitions of primary care, and both narrow and broad definitions of primary care services.[44]

Carriers also report on all payments made to Washington facilities and providers, regardless of where the member resides, during the reporting period.[45] This is reported in three components:

- All prescription drug costs paid through the Medical benefit

[42] HCA utilizes a similar template in its state-financed programs, including Medicaid, PEB, and SEB.
[43] Payments include total plan incurred and paid payments, including deductibles, coinsurance, or copays by patients. Carriers are asked to exclude secondary payer medical payments from all definitions in their reporting.
[44] The narrow and broad definitions for each are exclusive, e.g., the broad definition does not include or repeat the providers or services included in the narrow definition.
[45] Payments must be reported as dollars spent during the reporting period. Carriers must exclude from medical primary care payments, vision, dental, lab, imaging services and prescription drugs.

- All prescription or pharmacy costs paid through a Pharmacy Benefits Manager (PBM) or paid through the pharmacy benefit
- All other medical payments, including all payments described above excluding prescription drugs, e.g., hospitals or physician services.

Finally, carriers must describe their approach to calculating primary care related non-claims-based payments.[46] For example, data sources such as provider contracts, methods to attribute payments to primary care providers, and any barriers encountered.

2021 reporting results

Carriers' reporting deliverables are spread over the plan year and results for primary care expenditures reporting for plan year 2022 have not yet been evaluated. However, for plan year 2021, all carriers met the requirements for primary care expenditures reporting.[47] Carriers' primary care expenditure reporting results for plan year 2022 will be available in plan year 2023, at which point HCA can evaluate carriers' quality reporting over two full plan years.

Continued monitoring and evaluation of carriers' ongoing reporting

The program is still in its early stages, with data only being available for only the first plan year (2021) for most quality reporting. Carriers' full reporting results for plan year 2022 will be available near the end of plan year 2023, at which point HCA can evaluate carriers' quality reporting over two full plan years.

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[46] Total non-claims-based payments include all payments for: capitated or salaried arrangements with providers or practices not billed or captured through claims; risk-based reconciliation for arrangements with providers or practices not billed or captured through claims; payments to National Committee for Quality Assurance (NCQA) or equivalent Patient-Centered Primary Care Homes, Patient-Centered Medical Homes, or based upon that recognition or payments for participation in proprietary or other multi-payer medical home or specialty care practice initiatives; financial incentive payments to providers or practices earned in a value-based payment arrangement conditioned on the quality of services provided.

[47] Two carriers were not required to report on primary care expenditures due to low enrollment, however one of the low-enrollment carriers volunteered to submit primary care expenditures despite no requirement to do so.

Tab 7

Washington State Health Care Authority

Washington State Health Care Authority

Report to the Legislature

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Health Care Cost Transparency Board

Annual Report

Second Substitute House Bill 2457; Section 7(2); Chapter 340; Laws of 2020

Substitute Senate Bill 5589; Section 1(3); Chapter 155; Laws of 2022

August 1, 2023

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Executive summary

House Bill (HB) 2457 (2020) established the Health Care Cost Transparency Board (Board) under the Washington State Health Care Authority (HCA) because increasing health care costs have a significant impact throughout the state. Rising health care costs in Washington make health care unaffordable to working families across the state. About half of U.S. adults say they have difficulty affording health care costs. About four in ten adults reports that they have delayed or gone without medical care in the last year due to cost.[1] Substantial shares of adults 65 or older report difficulty paying for various aspects of health care.[2] Approximately, a quarter of adults say they or family member in their household have not filled a prescription, cut pills in half, or skipped doses of medicine in the last year because of the cost of prescription.[3] These costs also strain the budgets of businesses and government agencies which attempt to cover needed health care services.

The Board is responsible for analyzing total health care expenditures in Washington, identifying trends in health care cost growth, and establishing a health care cost growth benchmark to assist in Washington's efforts to better control increasing health care costs. The goal of the benchmark is to gain a better understanding of and respond to growing health care costs. As a part of its responsibilities, the Board also provides an annual report to the Legislature on developments over the past year.

The Board made significant progress in its work since the 2022 legislative report:

- Conducted cost driver analysis and began to identify potential additional focus areas. Some of the key findings from the initial analysis were:
    - All other markets except Medicare FFS experienced high growth in total expenditures.
    - For total spending by categories of care, inpatient services was the highest category of spending in 2018 and continued to be the highest in 2021, with outpatient services also rising.
    - There was greater overall growth in outpatient spending compared to inpatient.
    - For pharmacy spending, individuals had the same number of prescriptions, but prices increased by almost 25 percent.
    - Medical Per Member Per Month (PMPMs) across Washington counties ranged from $150 to $1,200.
    - Spending growth occurred across all age categories for both men and women.
- Continued to analyze Washington hospital cost and profit through a contract with independent consultants.
- Established the Advisory Committee on Primary Care to develop recommendations to increase primary care spending to 12 percent of total health care expenditures.

[1]KFF https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/

[2] *Ibid.*

[3] *Ibid.*

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- Continued the benchmark analysis including:
    - Collected data for the cost benchmark data call with a comprehensive initial report expected in fall 2023.
    - Engaged with a variety of stakeholders and consultants to gather additional data on costs affecting the benchmark.
    - Completed the 2023 data call technical manual and submission template for the second benchmark data call.

With the information collected from the benchmark and cost driver analyses, the Board can begin conversations with all stakeholders in Washington's health system to identify the best ways to curb health care spending and take meaningful action to increase health care affordability for all Washingtonians.

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Background

Nationally, health care spending continues to increase. Over the past 20 years in Washington, health care costs have increased faster than inflation[4] and premiums have increased faster than wages.[5] The Board's primary objective is to set a target for future cost growth and collect Washington-specific data on total health care expenditures. The Board is also tasked with analyzing growth trends in the state and by insurance market, and in future years by health insurance carrier and large provider. The board will utilize benchmark data and cost driver analysis to make informed recommendations and develop statewide health care policy to lower spending and curb health care cost growth.

To better understand and respond to growing health care costs, the Board organized its work into four different data projects:

1. Cost growth benchmark
2. Performance against the benchmark
3. Cost driver analysis
4. Primary care spending

Table 1: Health Care Cost Transparency Board data projects overview (not including specific cost driver analyses, e.g., hospital cost analysis)

	Cost growth benchmark	Performance against benchmark	Cost driver analysis / cost experience	Primary care spend measurement
What it is	The goal for the growth of spending on health care year over year.	Assessment of cost growth against the benchmark.	Assessment of key drivers of cost growth.	Measurement of expenditure on primary care in relation to overall health care expenditure.

[4]From 2000 to 2020, annual growth in health care costs averaged 5.14 percent. Health care cost growth has slowed since 2010 but remains higher than inflation. Washington Office of Financial Management, "Change in Medical Costs."

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

	Cost growth benchmark	Performance against benchmark	Cost driver analysis / cost experience	Primary care spend measurement
What it represents	Reflects **affordability** for healthcare consumers and purchasers.	Reflects performance of payers and providers against the cost growth benchmark at an **aggregate** level.	Reflects a first-level drill down analysis of factors that are **contributing** to health care cost growth.	Reflects the emphasis on primary care and preventive care as measured through proportion of total health care expenditure spent on primary and preventive care activities.
Analytic basis	**Macro-economic indicators** such as median wage, potential gross state product (PGSP).	**Aggregate** expenditure data, direct from all payers (carriers). Includes claims-based and non-claims-based expenditures.	**Claims-based** payment data that Carriers submit to WA-APCD. Includes Individual claims data – enables stratification by geography, risk, etc.	WA-APCD **claims based** payments; plus, not-yet-developed measurement of non-claims payments.
Risk-adjustment consideration	Does not apply. Based on macro-economic indicators.	Age and sex adjustment is being used for analysis of performance against benchmark. Severity-of-illness-based risk adjustment is not applicable as data are submitted by payers at an aggregate level and not at a client level.	Risk-adjustment based on severity-of-illness may be applied to WA-APCD data to better assess the impact of cost drivers for certain analyses where the adjustment would be prudent. An example might be person-oriented measures.	Yet to be discussed and developed.

	Cost growth benchmark	Performance against benchmark	Cost driver analysis / cost experience	Primary care spend measurement
Other considerations		WA-APCD data do not include self-funded plan data and cannot be used for assessing provider performance against benchmark.	For purposes of cost-driver analyses, risk-adjustment methodology will need to be developed in collaboration with Data Advisory Committee and applied consistently to relevant analyses.	Risk adjustment typically focuses on all aspects of care for an individual. How to appropriately focus on a single category of care will need to be investigated.

Advisory committees to the Board

Since the last report in August 2023, the Board continued its work analyzing Washington health care expenditures and the Board's advisory committees have assisted with each of the board's data projects, including the Advisory Committee for Health Care Providers and Carriers and the Advisory Committee on Data Issues. The Advisory Committee for Health Care Providers and Carriers continues to provide expert advice from the provider and carrier perspective to support the development and analysis of the cost growth benchmark through the data call. The Advisory Committee on Data Issues is comprised of members across a broad range of stakeholders, such as the Washington Office of Financial Management, the Health Benefit Exchange, the Washington Health Alliance, and several health plans, among others. This committee provides expertise on many aspects of the benchmark data call, as well as the analysis of existing data sources to determine cost drivers.

The Board also established the Advisory Committee on Primary Care, as directed by SSB 5589 (2022), to focus on measurement of primary care spending and developing recommendations for increasing primary care spending while reducing total health care expenditures. The goal of this legislative assignment is to recommend steps to increase primary care expenditures to 12 percent of total health care expenditures by measuring and incentivizing reimbursement of primary care spending.

Cost growth benchmark

Washington one of nine states in the nation to adopt a cost growth benchmark. It is also a participant of the Peterson-Milbank Program for Sustainable Health Care Costs. The Board established the benchmark target in 2022 for the subsequent five years and will evaluate the benchmark annually moving forward. The cost growth benchmark represents a common goal for payers, purchasers, regulators, and consumers to increase health care affordability. It serves as a starting point from which to align health care spending to ensure that spending growth does not increase at a faster rate than the economy, state revenue, or wages.

Performance against the benchmark, also referred to as the data call, is assessed by measuring annual cost growth against each annual benchmark target. Benchmark performance data will reflect the performance of

payers and providers against the cost growth benchmark at an aggregate level, for each insurance market (e.g., commercial, Medicare, Medicaid). The benchmark data comes from aggregate expenditure data from all payers (carriers) and include claims-based and non-claims-based expenditures.

Cost drivers analysis

In addition to developing a cost growth benchmark, the Legislature directed the Board to analyze cost drivers in the health care delivery system. The cost driver analysis examines paid claims to assess where services have been provided, e.g., hospital inpatient, outpatient, pharmacy, etc. Unlike the work on the cost growth benchmark, cost driver analysis requires disaggregated data that is not currently captured as part of the data call.

To develop the cost driver analysis, the board contracted with OnPoint, the data vendor for the Washington State All Payer Claims Database (WA-APCD) for review of APCD data. OnPoint provided the board with the preliminary findings of its cost growth drivers study, or the cost driver analysis findings, in December 2022. The Board also worked with OnPoint to develop an interactive cost driver analysis dashboard using WA-APCD data that will be posted on the APCD website as it is completed.

The first-year cost driver analysis included a high-level review of:

- Trends in price and utilization
- Spend and trend by geography
- Spend and trend by demographics

In February 2023, the Board discussed options for a second cost driver analysis. Finalization of phase two analysis is still under development. OnPoint plans to present potential phase two analysis options to the Advisory Committee on Data Issues, and the board, in summer of 2023.

In 2022, the Board also hired Tom Nash and John Bartholomew, independent consultants, to perform an initial analysis of Washington hospital costs, price, and profit. This year, the Board continued its contract with Bartholomew-Nash & Associates to analyze Washington hospital costs and margins. The Board approved the framework for the secondary analysis in April 2023 with findings to be presented in July.

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Progress toward improving health care affordability

The Board achieved several significant milestones to assist with Washington's efforts to reduce health care cost growth and increase transparency. These include:

- Furthering the work related to performance against the benchmark such as:
    - Deciding how to account for inflation's possible effects on the benchmark.
    - Continuing to process submissions for the initial benchmark data call.
    - Preparing to issue the second benchmark data call.
- Completing the cost driver analysis for Washington and preparing for a second cost driver analysis to analyze health care price trends.
- Initiating specific analysis on health care drivers in Washington, such as hospital costs, and engaging with a variety of stakeholders and board consultants to gather additional data.
- Establishing the Advisory Committee on Primary Care to provide recommendations to the board on increasing primary care spending to 12 percent of total health care expenditures.

Ensuring flexibility within Washington's cost growth benchmark

The benchmark target is a specific rate that carriers' and providers' expenditure performance will be measured against. The goal of the benchmark is to influence a slower health care cost growth to ensure access to affordable health care. The Board's benchmark target covers a five-year period, granting providers and policymakers the ability to plan for future years when calculating total expenditures. In September 2021, the Board approved Washington's cost growth benchmark from 2022–2026 (see Figure 1, below). This benchmark is based on a hybrid of median wage and potential gross state product (PGSP) at a 70:30 ratio.[6]

In establishing the benchmark, the Board reviewed how other states created their benchmarks and considered many different factors that might influence their choice of benchmark. One of these factors included current economic indicators, such as wages and inflation. In designing Washington's benchmark methodology, the board examined rates of health care inflation in other states with cost growth benchmarks, as well as those states' benchmark methodologies.

Figure 1: Cost growth benchmark for Washington State

Years	Target

[6] Median wage was selected to link the measure to consumer affordability, and PGSP as a reflection of business cost and inflation.

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2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

Inflation and the benchmark

During February and March 2022, the Board reviewed the impacts of inflation on spending trends in 2019 and 2020, and in June 2022, invited the Washington State Hospital Association (WSHA) to present on cost challenges, including the impact of COVID-19 and increasing labor costs. While the Board recognized the significant impacts of the pandemic on the system, it also considered the impact of increasing cost to residents and the need for a cost growth target to support affordable access.

The Board consulted with Bailit Health on the impact of inflation on health care spending and the implications for Washington's cost growth benchmark. Bailit Health is a consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and employer purchasers and has worked with several other states in their cost growth benchmark efforts. Bailit Health has been involved with the Board since 2021 as part of a grant and participation in the Peterson-Milbank Program for Sustainable Health Costs.

Inflation's impact on health care spending lags compared to the prices of goods and services because rising prices in the general economy don't impact health prices immediately for several reasons:

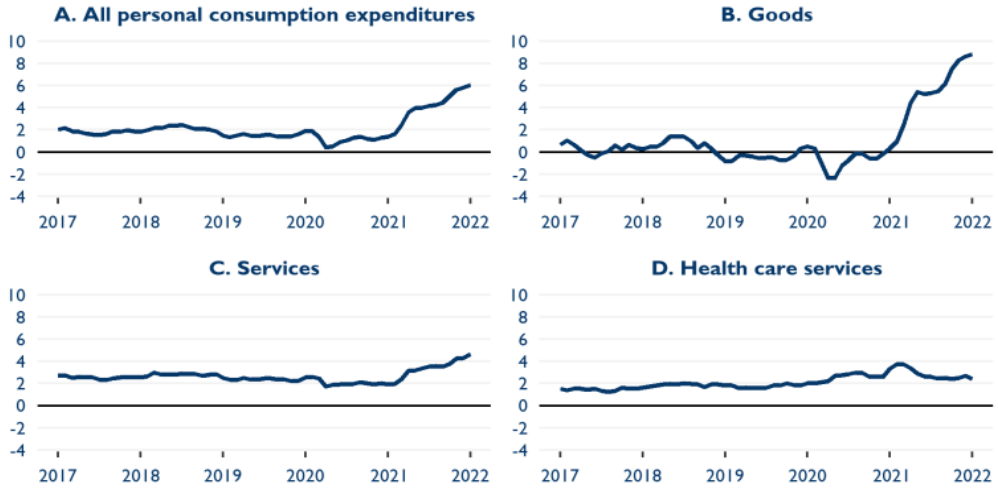
- Medicare prices for most services are updated annually based on projected growth in input costs.
- Commercial prices are often defined within multi-year contracts.
- Medicaid prices change infrequently and are not specifically linked to input costs.

During 2021, the price for goods increased significantly, the price for services increased somewhat, and the price for health care services remained relatively flat in comparison.[7] In 2022, the prices for medical care increased at a significantly slower rate than other goods and services. Another analysis by Altarum showed that health care inflation was relatively flat through the end of 2022, despite high and sustained inflation overall.[8]

[7] Source: Bureau of Economic Analysis, personal consumption expenditure prices indices.

[8] Inflation-Adjusted Health Care Spending is Falling for the First Time in Half a Century | Altarum. 2023.

Figure 2: Inflation by product type, January 2017–January 2022



Year-over-year percent change. Source: Inflation's Impact on Health Care Spending and Implications for the Cost Growth Benchmark, Bailit Health. 2023. Bureau of Economic Analysis, personal consumption expenditures price indices.

All five Peterson-Milbank cost growth target states have based target values on economic indicators that are affected by inflation. For example, the cost growth benchmark established by the Board in Washington looks at median wages and income, which are indirectly impacted by inflation. Additionally, household income tends to grow when inflation grows. As a result, these methodologies were developed under the assumption that inflation would increase at low levels.

Arguments for adjusting for inflation:

- States could lose support from providers and insurers who feel the benchmark value was set using inputs that are completely different from actual experience,
- The benchmark could be viewed as unrealistic and unfair, potentially leading to lost credibility with some as a meaningful state policy and a rejection of the benchmark as a basis for contract negotiations, such as between carriers and providers.

Arguments against adjustment for inflation:

- The benchmark value purposely utilizes a methodology intended to provide long-term stability.
- It is unlikely that the benchmark value or performance against the benchmark would be adjusted if providers were posting record profits or if deflation occurred.
- Any adjustment could open the door to future calls for benchmark changes. Benchmarks matter because payers routinely invoke cost growth benchmark values at the negotiating table.

Key policy considerations:

- How the state should balance protecting consumers who face slower income growth and a potential recession while acknowledging impacts on provider organizations and insurers from increased costs.
- The precedent that might be set if the state chooses to modify benchmark values.
- The basis on which any modification should be made, and for what duration.

Several states have developed their own responses to the rise in inflation. Massachusetts adjusted their 2023 target up by 0.5 percent, and Rhode Island adjusted their 2023 through 2025 targets up by 2.7, 1.8, and .2 percentage points, respectively. However, Oregon, and Connecticut made no adjustment to the benchmark. After considering this information, the Board voted for the benchmark to remain unchanged and to account for additional inflation, if needed, when there is additional data.

Table 2: States' responses to the rise in inflation

State	Decision / status of stakeholder body discussions
Connecticut	Committee held initial discussions in October. Committee recommended no adjustment.
Delaware	Discussed by Economic and Financial Advisory Council in January. No decision yet.
Massachusetts	Adjusted 2023 target up by .5 percentage points
New Jersey	Not yet discussed.
Oregon	Advisory Committee recommended no adjustment and delaying application of accountability provisions by one year.
Rhode Island	Adjusted 2023-25 targets by 2.7, 1.8, and .2 percentage points, respectively.

Source: Inflation's Impact on Health Care Spending and Implications for the Cost Growth Benchmark, Bailit Health. 2023.

Reporting on benchmark performance

The Board anticipates reporting on the benchmark performance in fall of 2023 for the data call that was issued in 2022, with the baseline experience for 2017, 2018, and 2019 calendar years. Like other states, Washington has been challenged with the start-up process, helping carriers/data submitters to submit, establishing data validation and review processes, and resubmission processes. Care and attention have been built in as well as with a third-party validation process, which should ensure quality baseline data and a smoother process in future years.

Updates to the benchmark data call and technical manual

The board completed updates to the 2023 benchmark data call. Changes to the 2023 data call include:

- Inclusion of calendar years 2020, 2021, and 2022 in next submission.
- The performance against the benchmark will be calculated using 2021 and 2022.

There will also be a few updates to reference categories to clarify submission data. These updates include:

- An additional insurance category for Federal Employee Health Benefits (FEHB).

- Implementation of a new method to associate non-claims-based spending to providers without age/sex stratification.

The Board has incorporated these changes into the technical manual for submitters. Like the first benchmark call, training will be provided to submitters through a webinar.

Publishing results of the cost driver analysis

While the benchmark uses payer-collected aggregate data to identify trends, the cost driver analysis examines granular claims and encounter data to analyze cost. However, there is a relationship between the cost growth benchmark and the cost driver analysis. The benchmark identifies trends, while the cost driver analysis helps determine where the cost is showing up and potentially what is driving those trends. The cost driver analysis also helps identify opportunities for reducing cost growth and informs policy decisions.

The Board chose and utilized the WA-APCD as the primary data source for the cost driver analysis, after assessing the limitations and benefits of available data sources. The Board examined other states' areas of focus, such as Connecticut, which focused on trends in price and utilization. This approach allowed Connecticut to decipher whether increasing costs were due to increased utilization or increased payment per unit of service (price).

In addition to utilization and price, the Board focused on the importance of better understanding how Washington's geographic environment impacts cost and access to care. The Advisory Committee for Health Care Providers and Carriers and the Advisory Committee on Data Issues provided feedback to the Board on possible consequences of transparency and cost reduction efforts and recommended areas for monitoring.

Based on the research and information reviewed, the following areas of focus were identified for cost driver analysis:

- Trends in price and utilization
- Spend and trend by geography
- Spend and trend by health condition
- Spend and trend by demographics

These metrics will develop robust data and reporting on cost drivers. These metrics will also create a solid foundation for future areas of focus and recommendations to the Legislature.

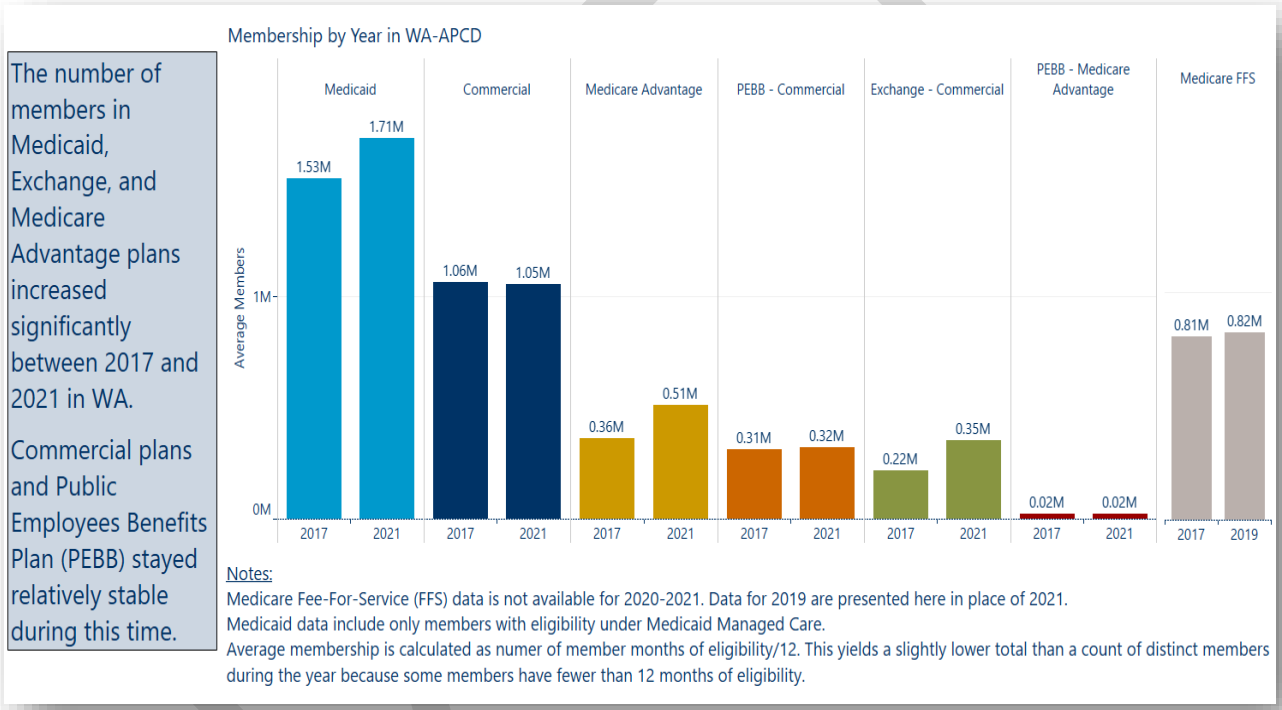
In December 2022, the cost diver analysis was complete and the results available. The analysis utilized five years of data from the WA-APCD, from 2017 through 2021, to align with the initial cost-benchmarking period. This data set represents approximately 4 million individuals across Medicaid managed care, Medicare (fee-for-service, or FFS, data only for 2019[9]), commercial, commercial Medicare Advantage (MA), commercial

[9]Due to lags in publication of Medicare data, data from 2020 and 2021 was not available for inclusion in this initial analysis.

and MA Public Employees Benefits Board (PEBB), and the commercial Health Benefit Exchange (HBE) markets out of the state population of approximately seven and a half million.[10]

Between 2017 and 2021, enrollment (as measured in the WA-APCD) increased from 3.5 to 4 million. As a result of individual changes between insurance types during the year, e.g., from Medicaid to employer coverage, there is only partial data for the full 12 months for every enrollee. Additionally, enrollees moved in and out of state, further contributing to inexact enrollment figures. Between 2017 and 2019, enrollment in Medicaid increased from 1.5 to 1.7 million. Nationwide, MA plans became more popular, in part due to increased marketing. There was also a significant increase in Exchange enrollees, from .22 million to .35 million. Commercial plans and PEBB plans stayed relatively stable during this time. See Figure 4 below for enrollment details.

Figure 31: WA-APCD enrollment by market, 2017 and 2021



Source: Cost Driver Analysis Results. December 2022.

The cost driver analysis detailed the changes in Washington's health care cost landscape. The insured population has grown and there have been shifts between markets, such as increases in Medicaid, Exchange, and MA enrollees, driving changes in spending. Both total and per capita expenditures have increased. Professional spending growth also occurred in most specialties and other provider categories, like physician

[10] Source: United States Census Bureau. Washington's population in 2021 was 7.739 million.

assistants (PAs) and nurse practitioners (NPs). There are some differences in how inpatient, outpatient, and pharmacy spending growth has occurred due to pricing and utilization (See Table 4) and variation by geography, age, and gender (Figures 11 through 13), detailed in later sections of this report.

The markets analyzed included:

- Commercial (limited data from self-insured plans)
- Medicaid (managed care only)
- Medicare FFS data (only available through 2019)
- MA (covered by commercial plans)
- PEB (commercial and MA)
- Washington HBE (commercial)
- Dual-eligibles[11] (not broken out separately due to missing FFS data beyond 2019)

Categories of service for the cost driver analysis were aligned with the benchmarking initiative including:

- Hospital inpatient
- Hospital outpatient
- A narrow definition of primary care providers
- Non-primary care specialty providers
- Other providers like PAs and NPs, etc., long-term care, retail pharmacy, and all other spending (ambulances, durable medical equipment, etc.)

There were several limitations to the parameters of the analysis, including:

- WA-ACPD does not contain Alternative Payment Model (APM) data.
- No data on self-insured plans.
- Medicaid FFS data has a longer delay in entry to the APCD.
- Long-term care data for Medicaid was not reported in the APCD.

Key findings

Changes in total expenditures

All other markets except Medicare FFS experienced high growth in total expenditures. Medicare FFS, which was broken out separately from Medicare, remained stable. For total spending by categories of care, inpatient was the highest category of spending in 2018 and continued to be the highest in 2021, with outpatient also rising. There was greater overall growth in outpatient spending compared to inpatient. The percentage of overall spending on inpatient care decreased relative to other spending, as did specialist, long-

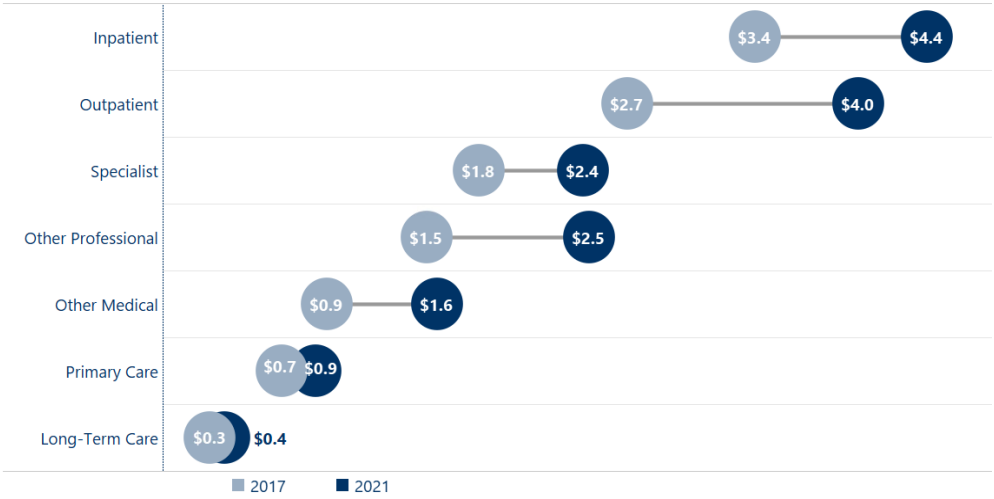
[11] A dual-eligible individual has both Medicare coverage and Medicaid coverage. This includes physical and behavioral health care coverage.

term care, and primary care. Pharmacy claims increased from 4.6 to 6 percent. Pharmacy costs continue to be a key area of investigation for the Board and future analyses will include collaboration with other efforts underway by the HCA, such as the work being initiated with the Pharmacy Affordability Board.

Figure 4: Growth in medical claims expenditures, 2017 and 2021

Spending for all medical categories increased between 2017 and 2021. The most significant increases were in outpatient spending ($2.7 billion to $4.4 billion), inpatient spending ($3.4 billion to $4.0 billion), and other professional ($1.5 billion to $2.5 billion).

In 2021, total inpatient spending ($4.4 billion) remained greater than outpatient spending ($4.0 billion), but **outpatient spending has been growing at a more rapid pace.**



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

Spending in billions of dollars. Source: Cost Driver Analysis Results. December 2022.

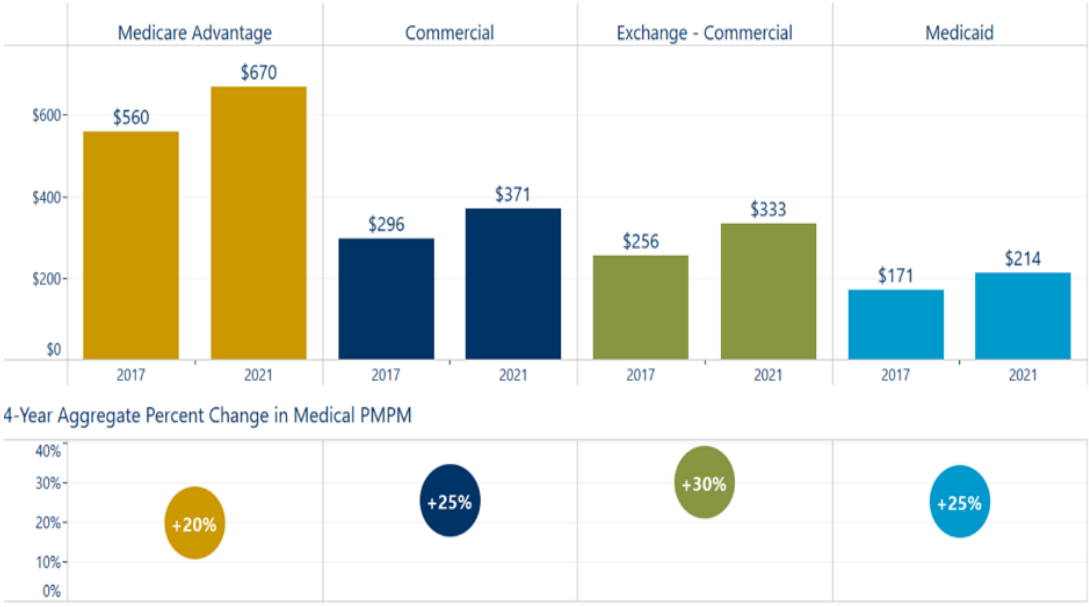
Changes in PMPM expenditures

For this analysis, the PMPM calculation was derived by dividing total expenditures by member months in a group. PMPMs increased from $271 to $340 between 2017 and 2021. The aggregate growth was $69 per month, $800 per year, per person. There was an aggregate change of 25 percent over time – mostly focused in 2021. This includes commercial, Medicaid, MA (as a combined rate across all markets) and does not include Medicare FFS. Different markets experienced different growth rates, for medical spending only. MA has the highest PMPMs due to enrollees' higher health needs compared to commercial patients. There was growth across all payers, but slightly lower in MA.

The cost driver analysis also examined pharmacy spending by market. Pharmacy PMPMs showed the same aggregate percent increase of 25 percent over five years with an increase of $21 per month. Spending was slightly higher under the HBE. All markets increased between 21 and 29 percent.

For PMPM spending by category, most spending was on inpatient and outpatient services. Other professional services and other medical services, while lower than inpatient and outpatient, still saw significant growth. The data and analysis revealed that inpatient and outpatient spending constituted the bulk of costs for both purchasers and consumers when compared to other spending categories.

Figure 5: Total medical PMPM spending by market, 2017 and 2021



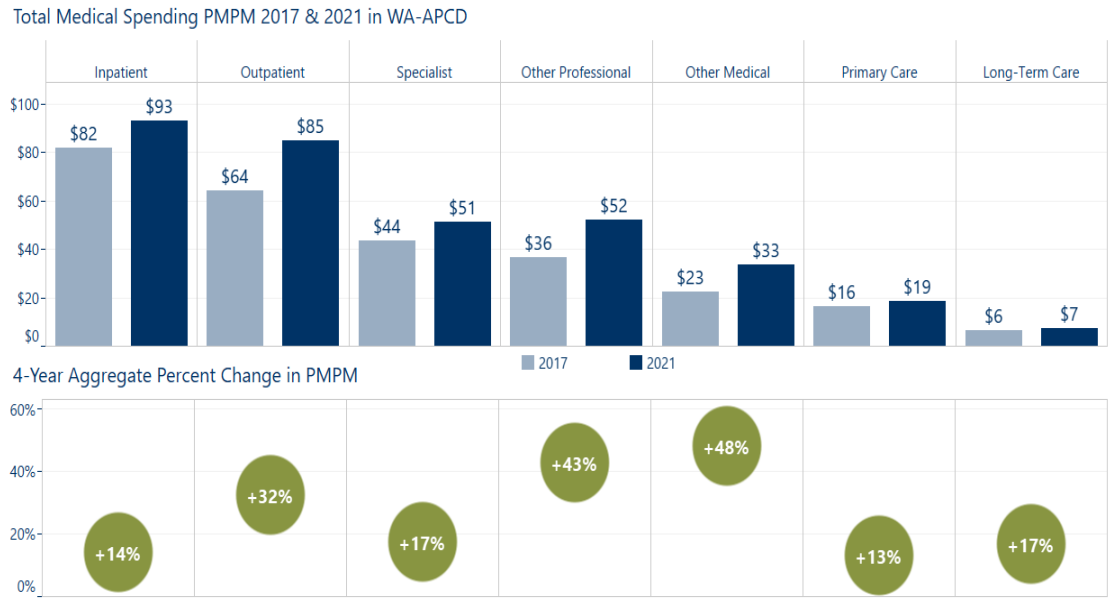
There was a wide range of medical PMPM costs by payer in 2021, from $670 PMPM for Medicare Advantage members to $214 PMPM for Medicaid members.

PMPM spending growth for medical services ranged from 20% for Medicare Advantage to 30% for Exchange plans between 2017 and 2021.

Note that Medicaid PMPM totals include only Medicaid Managed Care claims submitted to the WA-APCD. Medicaid Fee-For-Service expenditures and non-claims spending are not included in this analysis.

Source: Cost Driver Analysis Results. December 2022.

Figure 6: PMPM by category of medical service, all markets, 2017 and 2021



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.

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

Source: Cost Driver Analysis Results. December 2022.

Rates of growth across markets

The cost driver analysis also specifically examined inpatient, outpatient, and total pharmacy PMPM spending growth across markets. These three were selected due to their high impact on cost for insurance purchasers, such as Washingtonian individual health plan purchasers and employers. For inpatient spending by market, spending for MA was much higher than other plans. Outpatient spending showed a growth for MA of almost 50 percent. Individual market outpatient spending was also high, with 47 percent growth. Commercial outpatient growth remained steady, while Medicaid outpatient growth remained low. Outpatient PMPM growth was driven by a utilization increase of 32 percent despite no pricing increases.

For pharmacy spending, individuals had the same number of prescriptions, but prices increased by almost 25 percent. The spending increase was more for pharmacy than for outpatient services. Price spending increased for inpatient PMPM in the average allowed amount per service, however, there was a decrease in utilization, likely due in part to higher costs for services. Of the cost drivers analyzed, pharmacy costs, followed by outpatient services, represent the highest costs for consumers and purchasers at the commercial population level.

Consumers, employers, and other health care purchasers are experiencing higher costs, reflected by higher premiums and greater cost-sharing for needed services.[12] In Washington, average premiums for plans have increased 39 percent since 2014[13] and some Washingtonians have been forced to forego health care services such as pharmacy prescriptions and inpatient services.[14]

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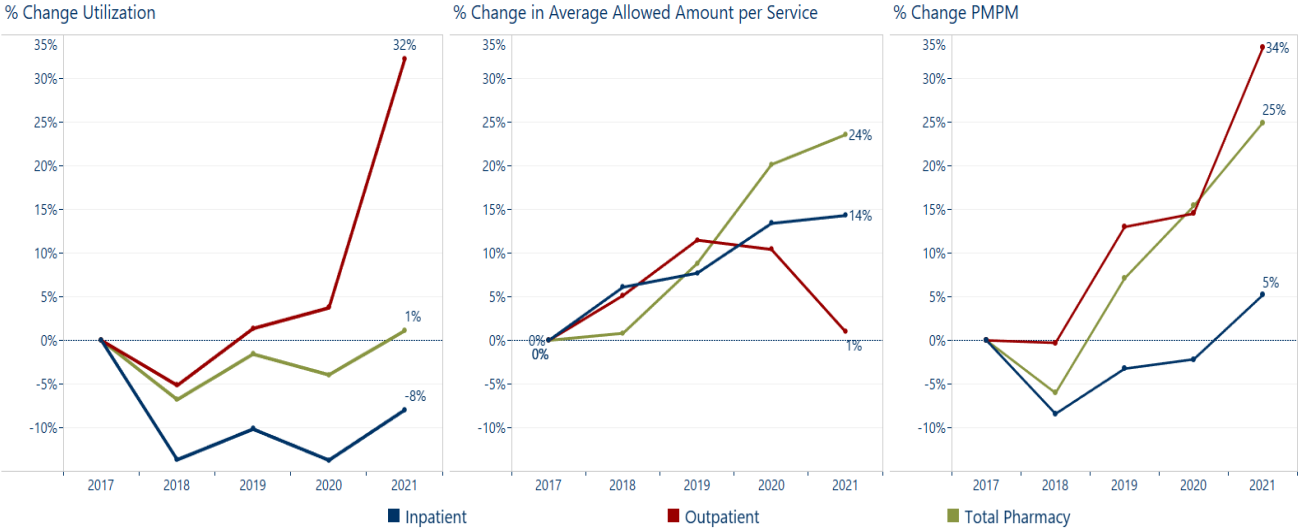
[12]An estimated 5 to 6 percent of Washington residents remain uninsured, an issue which disproportionately affects communities of color. Source: OFM (2021), https://ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/healthcoverage/COVID-19_impact_on_uninsured.pdf

[13]KFF Marketplace Average Benchmark Premiums, www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premium.

[14]Altarum's Consumer Healthcare Experience State Survey (CHESS). 2022.

Figure 7: Changes in commercial cost drivers, 2017–2021



In the commercial population, outpatient spending PMPM grew by 34% between 2017 and 2021 (see graph on far right). This was driven by a 32% increase in outpatient services per 1,000 members during that time, while the average allowed amount per service grew by only 1%.

The pattern for pharmacy was much different. Pharmacy spending PMPM increased by 25% between 2017 and 2021, but this was primarily driven by an increased average allowed amount per service (24% increase), while pharmacy use per 1,000 members increased by only 1%.

Inpatient spending PMPM grew by 5% between 2017 and 2021. Allowed amounts per inpatient discharges increased by 14%, while inpatient discharges per 1,000 members decreased by 8%.

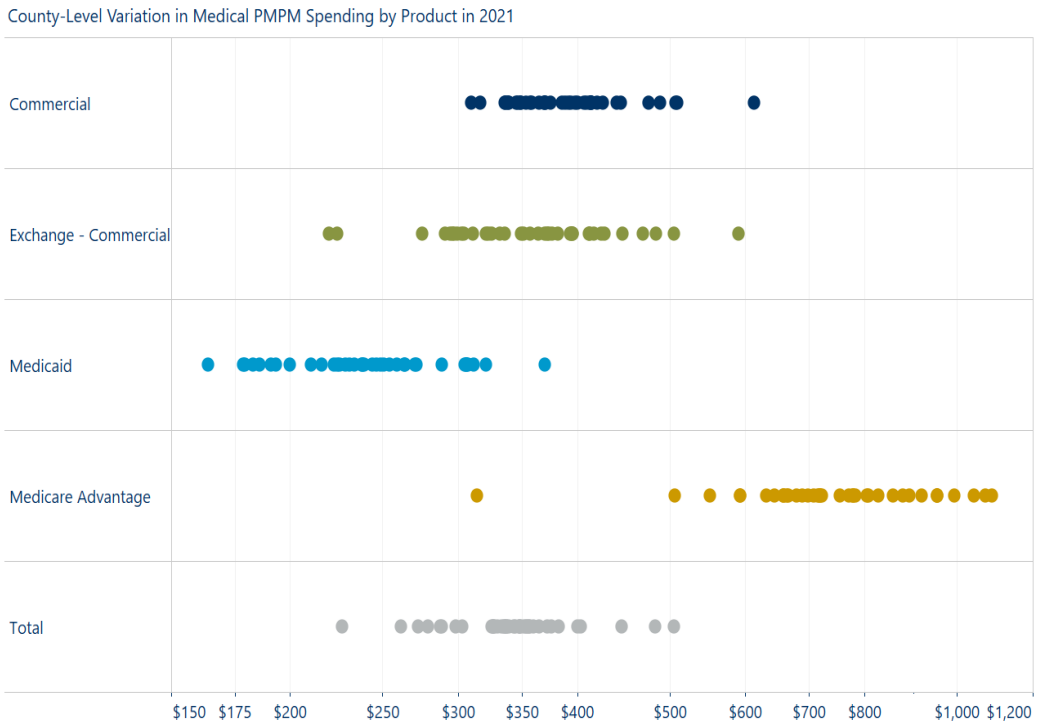
Source: Cost Driver Analysis Results. December 2022.

Regional differences in spending

Medical PMPMs across Washington counties ranged from $150 to $1,200. This analysis showed a wide range of geographic variation for Medicaid and MA. In addition to other regional differences, PMPM spending by Accountable Community of Health (ACH) regions showed a significant increase in spending growth for the southwest ACH region and significant variation between individual regions. These variations could be due to outlier patients, or differences in care delivery.[15]

[15] ACHs are independent, regional organizations. They work with their communities on specific health care and social needs-related projects and activities. Health care is measured in the region and is not reflective of the ACH as an entity.

Figure 8: County-level variation in medical PMPM spending by market in 2021



Each mark in the figure represents a county-level medical PMPM value within the state of Washington.

There is significant variation in medical PMPM spending by Washington county for each insurance product.

Note that data have not been adjusted to account for differences in age, gender, or other risk factors between counties.

Source: Cost Driver Analysis Results. December 2022.

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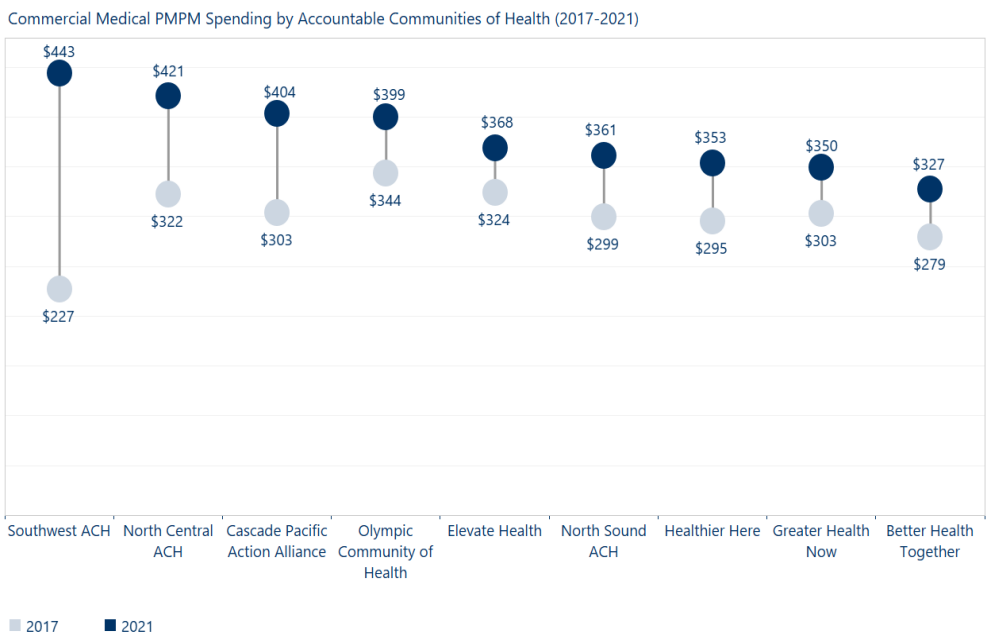
Figure 9: Commercial medical PMPM spending by accountable community of health regions, 2017 and 2021

There is significant variation in medical PMPM spending by region in Washington. For the commercially insured population, in 2021, medical PMPM spending ranged from $443 in the Southwest Accountable Communities of Health (ACH) to $327 PMPM in the Better Health Together ACH.

Regional spending may vary due to pricing as well as the age, gender, and other population risk factors.

Spending growth varied by ACH. For example, commercial spending almost doubled between 2017 and 2021 in the SW Regional Alliance Area.



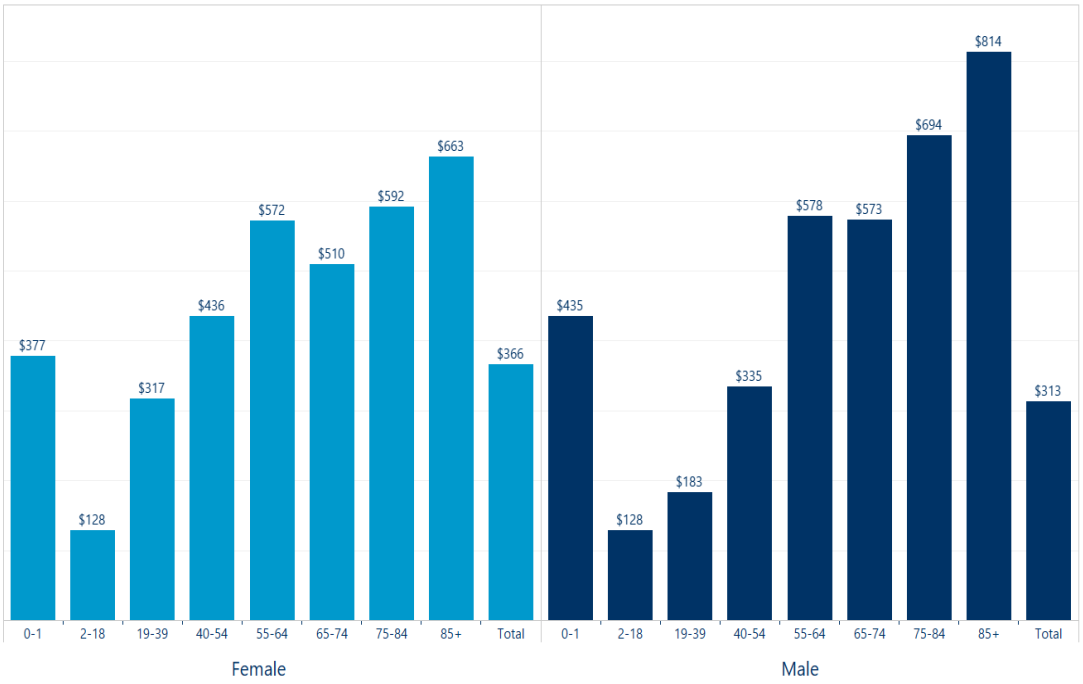
Source: Cost Driver Analysis Results. December 2022.

Spending variation by age and gender

Washingtonian's health care spending increased in every age category.[16] Spending growth occurred across the age categories for both men and women. There was higher spending for men in every category and higher spending in comparison for infants as well.

[16] This analysis did not include individuals over 65, as most are covered under Medicare.

Figure 10: Age and gender categories (PMPMs), 2021



PMPM medical spending increased roughly with age because of increased health issues in the older population.

There are a few exceptions to this trend. Children under the age of 2 had higher PMPM spending than other children.

Additionally, adults in the 65-74 age category tended to have lower PMPM spending than adults age 55- 64. This is likely due to higher prices for services in the commercial market compared to the Medicare Advantage market.

Source: Cost Driver Analysis Results. December 2022.

Moving forward with the cost driver analysis

Future cost driver analyses will continue evaluating subsequent years' data to monitor and examine the various markets for changes in health care costs in Washington including:

- Trends in price and utilization
- Spend and trend by geography
- Spend and trend by health condition
- Spend and trend by demographics

The Board is also currently evaluating its resources to determine if it might also include future in-depth cost-driver analysis on specific topics. These additional topics would supplement the other strategic in-depth topical analysis the Board is currently working on, such as hospital cost analysis.

Other cost driver analyses

To build on and complement OnPoint's cost driver analyses, the Board has engaged in further analysis that is targeted at specific cost drivers that constitute the top areas of health care spending. Hospital costs remain a high-priority area of investigation for the Board and the Board has continued its work with Bartholomew-Nash & Associates to examine Washington hospital costs, including workforce trends and administrative

costs. These additional areas provide key information to develop cost growth mitigation strategies, including those that reduce the total cost of care.

Hospital costs

Phase one hospital cost analysis by Bartholomew-Nash & Associates

Bartholomew-Nash & Associates have worked with the board since 2022 to examine hospital costs in Washington. Bartholomew-Nash & Associates developed the Colorado-specific hospital costs analysis. In June 2022, Bartholomew-Nash & Associates detailed and released the Washington hospital costs, price, and profit analysis.[17] The research was based on Medicare Cost Reports, submitted annually to the federal government by hospitals as a condition of participation in Medicare. These reports contain information about facilities and cost data, including utilization, charges by cost center in total and for Medicare, and financial statement data.

The first stage of analysis revealed that the price of services versus total costs of patient care in Washington hospitals is above the national average.[18] Additionally, hospital-only operating expense per patient is much higher in Washington compared to the national average. After reviewing the results of the initial study, the Board has engaged in a second phase of hospital cost analysis from Bartholomew-Nash & Associates.

Phase two hospital cost and margin analysis

In April 2023, the Board approved plans with Bartholomew-Nash & Associates for a phase two analysis of Washington hospital costs, price, and profit analysis. The second level analysis will include two types of methodology enhancements and additional financial review, consisting of:

- Calculated adjustments to the first level analysis of costs
- Creation of additional groupings beyond bed size, to allow for comparisons to the national database
- Washington hospital margin analysis

To inform the next phase of analysis, Bartholomew-Nash & Associates formed a workgroup to review the assumptions to address methodology enhancements for second level hospital financial analysis with a collection of Washington subject member experts. Workgroup members included representatives from WSHA, HealthTrends, University of Washington (UW) Medicine, HCA leadership, Tom Nash, and John Bartholomew. The workgroup held a series of meetings and conversations in early 2023 and finalized the recommendations for phase two analysis.

Adjustments to the cost data will include an adjustment to hospital-only operating expense by removing Council for Community and Economic Research (C2ER) as a cost-of-living adjustment. The analysis will utilize the labor wage index information from CMS wage index files and from the Medicare Cost Report at the hospital level. The labor wage index will be applied to the salary amount of costs of each hospital, with remaining costs applying the C2ER statistic.

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[17]Washington Hospital Costs, Price, and Profit Analysis. John Bartholomew & Tom Nash Bartholomew-Nash & Associates. 2022.
[18]Ibid.

The second analysis will contain additional groupings beyond bed size to create more informed peer groupings for hospital comparisons, both within Washington, and nationally, using data from the Medicare Cost Report. In addition to bed size, the secondary analysis will utilize one or a combination of the following measures to further refine the ability to compare "like" hospitals:

- **Teaching intensity measure**: A physician-resident-to-bed ratio measure which identifies the level of teaching at a hospital grouped into percentage ranges.
- **Service intensity measure**: A measure which calculates intensive care costs as a percentage of total costs and captures the degree to which a hospital offers intensive care services, grouped into percentage ranges.
- **Medicare case mix index**: A measure reported in the Medicare final rule public use files which is an index that captures the level of acuity at a hospital, grouped into ranges.

Finally, the second level analysis will review the payer mix measure. The payer mix measure is a ratio of hospital charges from Medicare and Medicaid, divided by total charges, and grouped into percentages. The second level analysis is estimated to be completed before the end of 2023.

WSHA hospital cost analysis

In July 2022, Jonathan Bennett, Vice President of Data and Analytic Services for WSHA and Bruce Deal, Economic Expert for WSHA, presented their analysis of Washington State hospitals and hospital costs. WSHA sought to provide a supplementary analysis to Bartholomew-Nash & Associates' hospital cost analyses.

Two-thirds of patient days in the hospital are provided by 19 larger hospitals in Washington.[19] The Washington state hospital system is comprised of five large systems and several smaller ones. Compared to national standards, Washington hospital admissions, utilization, and length of stay are very low.[20]

Table 3: Washington hospitals by size

Size Category (Available Beds)	Hospital Count	% of Hospital Patient Days
Large (250+ beds)	19	67%
Mid-Sized (99-249 beds)	22	25%
Small (22-98 beds)	21	6%
Very small (CAH)	39	2%
Total	**101**	**100%**

[19]A larger hospital is one with over 250 beds in the hospital.

[20]Bennett, Jonathan, WSHA and Deal, Bruce, WSHA. Washington State Hospitals: A Primer on Washington Hospital Costs. July 2022.

Source: A Primer on Washington State Hospitals. WSHA. 2022. Note: CAH refers to Critical Access Hospital.

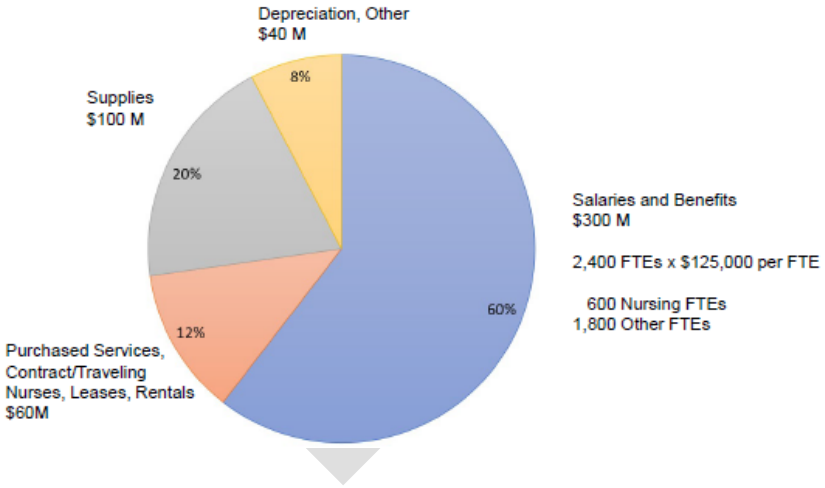
Table 4: Washington hospitals by system affiliation

	System Name	Number of Hospitals
5 Largest Systems	Providence/Swedish, MultiCare, Virginia Mason Franciscan Health, UW Medicine, PeaceHealth	40
	Smaller Multi-Hospital Systems	15
	Independent PPS Hospitals	10
	Independent CAH Hospitals	32
	Other (LTAC, Psych, etc)	4
	Total	101

Source: A Primer on Washington State Hospitals. WSHA. 2022. Note: LTAC refers to long-term acute care hospitals and Psych refers to psychiatric hospital.

The costs of running a hospital were also outlined, including employee costs, supply costs, purchased services (including travelling nurses) and facility/equipment costs. For example, a 300-bed hospital with over 50 departments would cost approximately $500 million annually. Salaries and benefits would represent about 60 percent of total costs, with an average of $125,000 per full-time-employee (FTE) in salary and benefits.

Figure 11: Hospital cost example



Source: WA DOH Hospital Financial Reports

Workforce trends

In August 2022, Dr. Bianca Frogner, Board Member and Director of the Center for Health Workforce Studies for UW, relayed her findings on workforce trends in Washington to the Board. Dr. Frogner provided details on the:

- Health workforce and its connection to health care spending.
- Effects of the COVID-19 pandemic on the health care workforce.
- National health care workforce shortage and support strategies.

Health care labor and wage rates have generally grown at a smooth rate, but the contribution of labor to health care spending is not well understood, especially at the state level. Dr. Frogner also presented research on:

- Various sectors within the health care industry and how much employment they represent.
- Occupations within the health care industry.
- Average education in each sector.
- Racial and ethnic distribution.

At the peak of the pandemic, in April 2020, 1.4 million health care jobs were lost in the United States. Various researchers and analyses tracked the turnover of among health care workers during the pandemic and looked at turnover rates per COVID phase by sector, occupation, race/ethnicity, and gender/parenthood. COVID has had the largest effect on long-term care employment. Additionally, since the start of the pandemic, wage rates have increased nationally and continue to increase at a faster rate in Washington.

Figure 12: Relative number of health care employees by segment, January 2020–July 2022

(January 2020=1.00)

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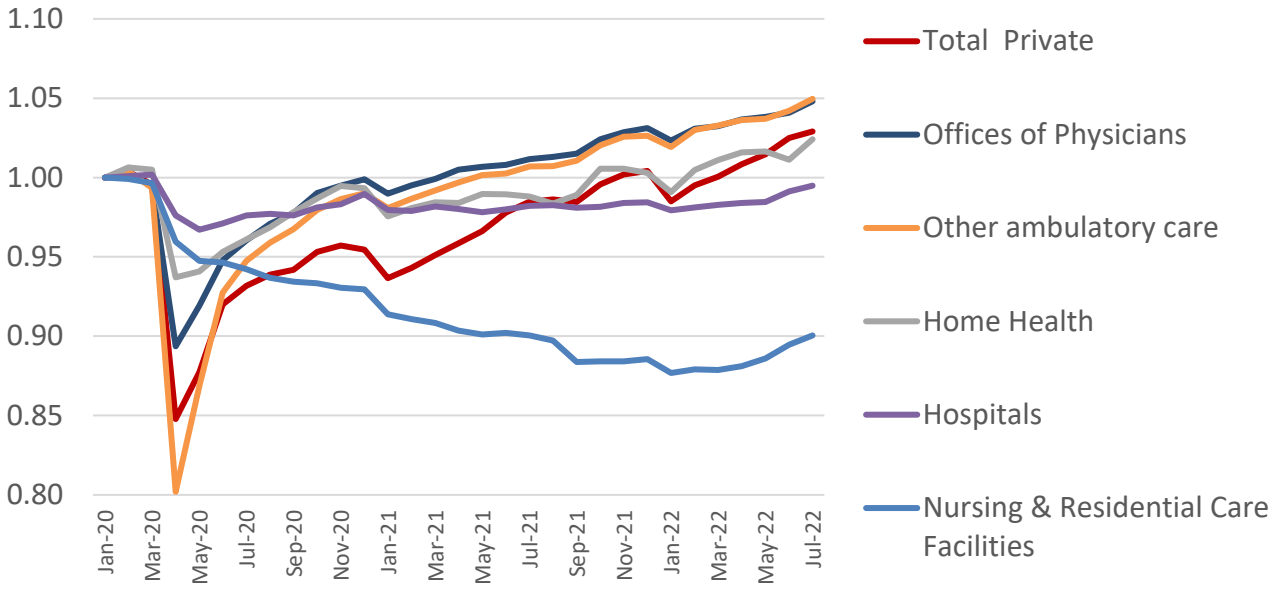


Source: Influence of health workforce trends on health spending growth, Calculations by Bianca Frogner, 2022. https://www.bls.gov/news.release/empsit.t17.htm.

Currently, there is a low health care labor supply.[21] There are several reasons for this, including lack of availability to work due to COVID and caregiving responsibilities, or unwillingness to work due to safety concerns or burnout. There is also a lack of qualified applicants because training is unavailable, slow, and expensive to complete. The availability of health care workers has fluctuated significantly over the pandemic and has not yet returned to pre-pandemic levels. As the economy recovers, competition will arise from other industries and within the health care sector. Labor shortages will continue to hamper access to care, and the board will continue to monitor the impact of workforce trends on health care costs.

Administrative costs

At the October 2022 board meeting, Dr. Mika Sinanan, M.D., Ph.D., Medical Director for Contracting and Value-Based Specialty Care, University of Washington Medicine, and Jeb Shepard, director of policy for the Washington State Medical Association (WSMA), gave a joint presentation to the board on administrative costs using data from WSMA, the American Medical Association (AMA) and Health Affairs. In their presentation, WSMA cited a study from the Annals of Internal Medicine that determined physicians spend only 27 percent of their total time with patients compared to 49 percent spent completing administrative work, e.g., work with electronic health records (EHRs).[22] The same study found that on average, clinicians,

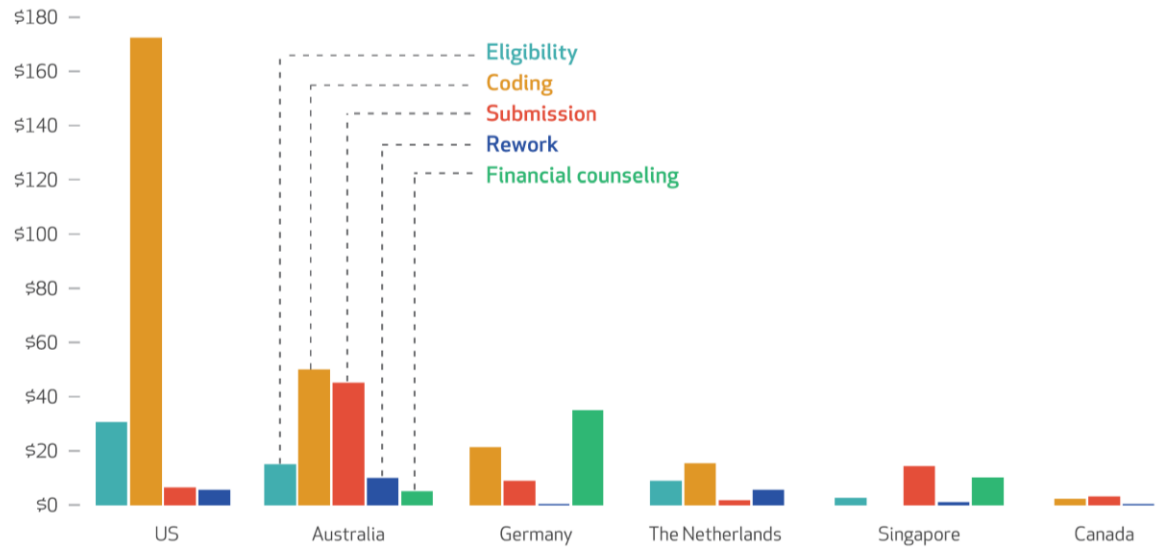
[21] Influence of health workforce trends on health spending growth. Frogner, Bianca K. University of Washington Center for Health Workforce Studies. August 2022.

[22] The Cost of Administrative Burden. WSMA. 2022. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties | Annals of Internal Medicine (acpjournals.org)

spend one to two hours of personal time each day doing additional clerical work, e.g., responding to patient emails, etc., which has contributed to burnout, both before and during the pandemic.

WSMA reviewed several examples of administrative burdens in the health care system, including insurance approvals, PA requests, coding and billing, and practice management. These burdens can result in negative consequences associated with administrative costs, including a more complicated coding system, variable contractual agreements, and non-standard authorization processes. Time spent on administrative work has resulted in less time spent with patients, reduced access to care, poorer clinical outcomes, and increased practice and treatment costs.[23] Data from a 2022 Health Affairs study that compared billing and insurance-related costs across six countries found that coding costs were significantly higher in the U.S. compared to the other countries.[24] The same cross-national analysis found that administrative costs consumed 25 to 31 percent of total health care spending in the U.S. The Board will continue to monitor administrative costs and their impact on total health care cost growth.

Figure 13: Billing and insurance-related costs in six countries, by activity category, derived from a time-driven activity-based costing study, 2018–2020



Cost per bill, purchasing power parity adjusted. Source: The Cost of Administrative Burden, WSHA, October 2022

Advisory committee on primary care

Background

Primary care is a fundamental component of the health care system. Primary care promotes healthier outcomes through preventive care and addresses a range of issues, including short and long-term health problems. Over time, expectations of primary care service delivery have increased, while practitioners remain

[23]The Cost of Administrative Burden. WSMA. 2022.

[24] https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00241

understaffed and underpaid in relation to other areas of medicine. This has led to multiple issues with primary care delivery, including sharp reductions in workforce, limited access to care, and inequitable care delivery.[25] Strong evidence supports the value of investing in primary care to deliver higher quality outcomes and lower total health care costs.[26]

Nationally, primary care spending remains low compared to other medical expenditures.[27] Washington primary care spending is also low, but current reporting could be refined to account for additional data. While Washington tracks claims-based spending, the state does not have a category of non-claims-based claims designated for primary care spending, unlike Oregon and Rhode Island.[28]. Non-claims-based payments are generally understood to mean payments made for services other than standard FFS claims. Non-claims-based spending can encompass a variety of payments, including capitated payments, sub-capitated payments, bundled payments, quality incentive payments, shared savings/risk arrangement payments, and infrastructure payments.

With the passage of SSB 5589 in 2022, the Legislature directed the board to build on previous efforts to define and measure primary care spending, and to consider work from the Office of Financial Management (OFM), the Dr. Robert Bree Collaborative (Bree Collaborative), other states, and the HCA in its recommendations. Washington became one of 19 states with statutory or regulatory actions to measure primary care spending and one of 11 states publishing annual reports on primary care spending. However, there is no standard definition of primary care in use at a national level or a universal method for measuring primary care expenditures, making it difficult to directly compare between different states.

In October 2022, the Board established the Advisory Committee on Primary Care (to begin developing recommendations to define and measure primary care spending. Under the Legislation, the Board is responsible for:

- Defining primary care.
- Detailing how to achieve Washington's target to increase primary care expenditures to 12 percent of total health care expenditures.
- Effectively measuring primary care, including identifying any barriers to access and use of data, and how to overcome them.

In December 2022, the Board released an **initial legislative report** on primary care spending. The report detailed the establishment of the primary care committee and the committee's initial progress reviewing

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[25]National Academies of Sciences, Engineering, and Medicine 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

[26] Mark Friedberg, Peter S. Hussey, and Eric C. Schneider, "Primary Care: A Critical Review of the Evidence on Quality and Costs of Health Care" Health Affairs 29, no. 5 (2010): 766-772.

[27] Centers for Medicare and Medicaid Services, Office of the Actuary, All Payments.

[28] Washington State Office of Financial Management, Forecasting and Research, **Primary Care Expenditures, Summary of current primary care expenditures and investment in Washington,** Report to the Legislature, December 2019.

existing primary care work in Washington. The report also previewed the committee's work to create a high-level definition of primary care, based on an amalgamation of the National Academy of Engineering and Medicine (NASEM) and the Bree Collaborative's definitions of primary care.

Objective 1: defining primary care

In February 2023, the board approved the Advisory Committee on Primary Care's recommended definition of primary care. The definition was later amended by the Advisory Committee on Primary Care after additional stakeholdering with WSHA and other members of the public. The final definition of primary care is:

> "Team-based care led by an accountable primary care clinician that serves as a person's source of primary contact with the larger healthcare system. Primary care includes a comprehensive array of equitable, evidence-informed services to support patients in working toward their goals of physical, mental, and social health and the general wellbeing of each person, through illness prevention, and minimizing disease burden, through a continuous relationship over time. This array of services is coordinated by the accountable primary care clinician but may exist in multiple care settings or be delivered in a variety of modes."

Recommendation for a claims-based measurement methodology

The Board also recently approved and adopted the Advisory Committee on Primary Care's recommendations regarding a claims-based measurement approach to primary care providers, facilities, and services. Providers were grouped into narrow and broad categories (see tables 5 and 6) for measurement and modeled closely on the providers selected by OFM in their 2019 primary care expenditures report. The committee's list of primary care facilities was developed with significant input from researchers at UW Medicine (see Figure 16). Finally, to select the list of service codes, committee members reviewed information compiled by the California Health Care Foundation, which consolidated code-level primary care service definitions from across 11 states (including Washington), as well as two health care organizations, Milliman and the New England States Consortium Systems Organization (NESCSO). The full list of approved primary care service codes can be found in Appendix A of this report.

Table 5: Primary care service providers – narrow

Primary Care Provider Types and Relevant Subtypes - Narrow	

• Advanced Practice Registered Nurse
  ○ Nurse practitioner
  ○ Nurse midwife
• Family medicine
  ○ Adolescent medicine
  ○ Adult medicine
  ○ Geriatric medicine
• General practice
• Internal medicine
  ○ Internal medicine/pediatrics
  ○ Geriatric medicine
	• Naturopath
	• Pediatrics
	  ○ Adolescent medicine
	• Physician assistant
	• Prevention medicine, Preventive/Occupational environmental medicine

Table 6: Primary care service providers – broad

Primary Care Provider Types and Relevant Subtypes - Broad	

• Advanced Practice Registered Nurse
  ○ Nurse practitioner
  ○ Nurse midwife
  ○ Psychiatric mental health
• Counselors
  ○ Addiction (substance use disorder)
  ○ Mental Health
  ○ Etc.
• Family medicine
  ○ Addiction Medicine
  ○ Adolescent medicine
  ○ Adult medicine
  ○ Bariatric Medicine
  ○ Geriatric medicine
  ○ Hospice and Palliative Care
  ○ Etc.
• General practice
• Internal Medicine
  ○ Pediatrics
  ○ Addiction Medicine
  ○ Bariatric Medicine
  ○ Geriatric
	• Marriage and Family Therapist
	• Naturopath
	• OBGYN
	• Physician Assistant
	  ○ Psychiatric Mental Health
	• Psychologist
	  ○ Addiction (substance use disorder)
	  ○ Clinical
	  ○ Adult Development and Aging
	  ○ Etc.
	• Prevention medicine, preventive/occupational environmental
	• Registered Nurse
	• Social Worker
	  ○ Clinical
	  ○ School

Note: The broad definition includes all provider types and subtypes from the narrow definition

Table 7: Primary care facilities

Primary Care Facilities	
• Ambulatory Health Clinic/Center • Community Health Clinic/Center • Critical Access Hospitals (CAHs) with Method II Billing • Federally Qualified Health Center (FQHC) • Indian Health Services Facility • Long-term Care Facility	• Multi-specialty Clinic/Center • Primary Care Clinic (including on-site at hospitals) • Rural Health Clinic (RHC) • School-based Health Center • Urgent Care Clinic with IPCP • Virtual Care

Recommending a non-claims-based measurement methodology

In May 2023, the Primary Care Committee heard joint presentations from Oregon and Bailit Health on non-claims-based measurement methodologies. At the time of this report, the committee has initiated discussions of possible non-claims-based approaches in Washington at its June and July meetings.

Objective 2: Detailing how to achieve Washington's target to increase primary care expenditures to 12 percent of total health care expenditures

In April 2023, the committee began a discussion of policies to achieve the 12 percent primary care expenditure target. The committee used a four-domain framework to begin exploration of different types of policies that could support the expenditure target goal. The four domains (direct investment, capacity growth, patient behavior, and reduced expenditure on other services) are shown in Figure 14.

Figure 14: Four-component primary care policy framework

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A key observation that emerged from the committee's discussion was that while direct investment is critically important, it is insufficient to achieve the primary care expenditure target and the goal of ensuring access to and appropriate utilization of high-quality primary care services for the population. With that concept in mind, the committee developed a preliminary list of policies across three of the domains that committee

members were interested in exploring further. Reduced expenditures on other services as a means of achieving the 12 percent expenditure target was not discussed as ideally this will occur naturally because of other policies to support primary care. The preliminary list was informed by strategies implemented in other states, strategy recommendations at the national level, and committee member ideas. The initial list of polices, ordered by level of committee support, included the following:

1. Direct Investment - Increase primary care reimbursement.
2. Capacity Growth - Payer focus on reducing administrative burden/costs for providers.
3. Capacity Growth - Forgiveness for non-compete clause penalties incurred by primary care clinicians who leave a position to work elsewhere in Washington State.
4. Patient Behavior - Encourage employers to support/incentivize/encourage patients in selecting a PCP.
5. Capacity Growth - State funded expansion of loan forgiveness opportunity.
6. Capacity Growth - Work with education system to bolster pipeline of healthcare professionals.
7. Direct Investment - Increasing Medicaid reimbursement for primary care services
8. Capacity Growth - Multipayer collaboration to develop and implement payment models that offer greater financial flexibility and incentives while growing access and improving quality.
9. Capacity Growth - Provide options for practice teams to have a fully capitated system.
10. Direct Investment - Increase fee-for-service for remote patient monitoring services and chronic care management.
11. Direct Investment - Increase fee-for-service reimbursement for care team members such as clinical pharmacists, care coordinators / Community Health Workers, registered nurses, etc.

In addition to the aforementioned policies, the committee also discussed data and information technology policies that would be important for supporting effective delivery of primary care, maximizing capacity, improving patient behavior through patient navigation and care coordination, and overall delivery system monitoring. The preliminary list of policies the committee members expressed interest in was informed by recommendation at the national policy level, opportunities related to existing efforts in Washington, and ideas from committee members. The initial list of polices, ordered by level of committee support, included the following:

1. Invest in and support HCA's EHR-as-a-Service initiative which will provide access to certified EHR for BH, small, and rural providers.
2. Invest in and support HCA's Electronic Consent Management (ECM) initiative to support exchange of health information.
3. Maximize utility of One Health Portal through investment and other policy initiatives.
4. Maximize comprehensiveness/utility of APCD by encouraging self-funded plans to contribute data.
5. Support Master Patient Index by promoting use of a uniform patient identifier.
6. Expand the reach of the Clinical Data Repository through investment and other policy initiatives.

The committee will continue to explore policy options and refine policy recommendations that support achieving the 12 percent expenditure target over the course of the remaining committee meetings in 2023.

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Objective 3: Effectively measuring primary care, including identifying any barriers to access and use of data and how to overcome

Work is currently underway with HCA's data team to develop a data strategy that addresses primary care data collection challenges. The data strategy will also clarify who is responsible for measuring and reporting on primary care data. This work will continue throughout the remainder of 2023.

Next steps

Committee work to-date has largely focused on development of a primary care definition and initial exploration of policies that will support achieving the 12% primary care expenditure target. Next steps for the committee include the following:

- Finalize primary care definition encompassing claims/nonclaims-based measurement methodology recommendations,
- Develop a suite of policy recommendations to achieve the 12% expenditure target and related strategies to incentivize achievement of the target and present these options to the Board for potential adoption of recommendations, and
- Identify and recommend strategies to remediate challenges in measuring primary care expenditures.

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Conclusion

The Board's continued efforts on its data projects—the benchmark, performance against the benchmark (the data call), cost driver analysis, and primary care spending—will support more comprehensive health care cost reporting and creation of effective recommendations for the Legislature. Thorough research and understanding of increasing health care costs will facilitate and enhance efforts to improve affordability. The Board's evidence-based approach to health care cost data will provide a common understanding of spending trends for consumers, purchasers, and regulators to help make health care more affordable in Washington.

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Additional information

For additional information on the board and it's committees, including membership rosters, meeting materials and schedules, and the benchmark data call specifications, **visit the website**.

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Appendix A

Primary Care Services – Codes

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Tab 8

Washington State Health Care Authority

HCCTB Advisory Committee on Primary Care – Recommendations for Approval

June 21, 2023

Definition, data, and policy Committee charges

HCCTB Advisory Committee on Primary Care Charges

- **Primary Care Definition**
  - Recommend a definition of primary care
  - Recommend measurement methodologies to assess claims-based spending
  - Recommend measurement methodologies to assess 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
  - Report annual progress needed for primary care expenditures to reach 12 percent of total health care expenditures
  - Track accountability for annual primary care expenditure targets

- **Policies to Increase and Sustain Primary Care**
  - Recommend methods to incentivize achievement of the 12 percent target
  - Recommend specific practices and methods of reimbursement to achieve and sustain primary care expenditure targets

Primary Care Definition

HCCTB Advisory Committee on Primary Care charges

- Primary Care Definition
  - Recommend a definition of primary care
  - Recommend measurement methodologies to assess claims-based spending
  - Recommend measurement methodologies to assess 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
  - Report annual progress needed for primary care expenditures to reach 12 percent of total health care expenditures
  - Track accountability for annual primary care expenditure targets

- Policies to Increase and Sustain Primary Care
  - Recommend methods to incentivize achievement of the 12 percent target
  - Recommend specific practices and methods of reimbursement to achieve and sustain primary care expenditure targets

What Counts as Primary Care?

WHO

Is the **provider** considered a primary care provider?

WHAT

Is the **service** considered a primary care service?

WHERE

Is the **facility** considered a primary care facility?

Yes + **Yes** + **Yes** =

Primary care that counts toward the 12% target

General Definition of Primary Care

"Team-based care led by an accountable primary care clinician that serves as a person's source of primary contact with the larger healthcare system. Primary care includes a comprehensive array of equitable, evidence-informed services to support patients in working toward their goals of physical, mental, and social health and the general wellbeing of each person, through illness prevention, and minimizing disease burden, through a continuous relationship over time. This array of services is coordinated by the accountable primary care clinician but may exist in multiple care settings or be delivered in a variety of modes."

Broad vs. Narrow Definition

- Primary care can encompass a broad range of providers services.
- Some analyses conducted to measure primary care expenditures in the past have included both a broad and narrow definition of primary care.
  - The Office of Financial Management used this strategy with prior measurement of primary care expenditure in Washington.
- The Committee has worked to refine both a broad and narrow definition of primary care.
- The two definitions will be evaluated in the future to determine which would be used when measuring progress toward the 12% expenditure target.

Who provides primary care? (narrow definition)

- APRN/ARNP
  - Nurse practitioner
  - Nurse midwife
- Family Medicine
  - Adolescent medicine
  - Adult medicine
  - Geriatric medicine
- General practice
- Internal medicine
  - Internal medicine/pediatrics
  - Geriatric
- Licensed midwife
- Naturopath
- Pediatrics
  - Adolescent medicine
- Physician Assistant
- Preventive medicine, preventive/occupational environmental medicine

Who provides primary care? (broad definition)

- APRN/ARNP
  - Psychiatric mental health
  - Nurse practitioner
  - Nurse midwife
- Counselors
  - Addiction (SUD)
  - Mental health
  - Etc.
- General practice
- Family Medicine
  - Addiction medicine
  - Adolescent medicine
  - Adult medicine
  - Bariatric medicine
  - Geriatric medicine
  - Hospice and palliative care
  - Etc.
- Internal medicine
  - Addiction
  - Internal medicine pediatrics
  - Geriatric
  - Obesity
- Licensed midwife
- Marriage and family therapist
- Naturopath
- OBYGN
- Pediatrics
  - Adolescent medicine
- Physician Assistant
  - Psychiatric mental health
- Preventive medicine, preventive/occupational environmental medicine
- Psychologist
  - Addiction (SUD)
  - Clinical
  - Adult development and aging
  - Etc.
- Registered nurse
- Social Worker
  - Clinical
  - School

Where is primary care provided?

- Primary care clinic (including on-site at hospitals)
- Multi-specialty clinic/center
- Rural health clinic (RHC)
- Federally qualified health center (FQHC)
- Ambulatory health clinic/center
- Community health clinic/center
- Critical Access Hospital (CAH) with Method II billing
- Community health clinic/center
- School-based health center
- Indian health service facility
- Long-term care facility
- Urgent care clinic with PCP
- Virtual care

What services are included in primary care?

- The committee has reviewed an extensive list of procedure codes to determine which specific services should be included in the primary care definition.
  - The review included evaluating which codes other states and programs have used in their own primary care measurement efforts to better understand precedence and to align with standard definitions where possible.
- Additional data analysis may be conducted in the future to further refine the primary care code list.

Data to Support Primary Care

HCCTB Advisory Committee on Primary Care Charges

- Primary Care Definition
  - Recommend a definition of primary care
  - Recommend measurement methodologies to assess claims-based spending
  - Recommend measurement methodologies to assess 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
  - Report annual progress needed for primary care expenditures to reach 12 percent of total health care expenditures
  - Track accountability for annual primary care expenditure targets

- Policies to Increase and Sustain Primary Care
  - Recommend methods to incentivize achievement of the 12 percent target
  - Recommend specific practices and methods of reimbursement to achieve and sustain primary care expenditure targets

Data to support and measure primary care

The Committee reviewed general data strategies to support primary care and developed a ranked list of strategies aligned with members' preliminary interests.

Over the remainder of the year, the committee will be addressing the statutory charges related to data policy.

- Invest in and support HCA's EHR-as-a-Service initiative which will provide access to certified EHR for BH, small, and rural providers
- Invest in and support HCA's Electronic Consent Management (ECM) initiative to support exchange of health information.
- Maximize utility of One Health Portal through investment and other policy initiatives
- Maximize comprehensiveness/utility of APCD by encouraging self-funded plans to contribute data
- Support Master Patient Index by promoting use of a uniform identifier
- Expand reach of Clinical Data Repository through investment and other policy initiatives

Policies to Increase and Sustain Primary Care

HCCTB Advisory Committee on Primary Care Charges

- Primary Care Definition
  - Recommend a definition of primary care
  - Recommend measurement methodologies to assess claims-based spending
  - Recommend measurement methodologies to assess non-claims-based spending

- Data Focused to support primary care
  - Report on barriers to access and use of primary care data and how to overcome them
  - Report annual progress needed for primary care expenditures to reach 12 percent of total health care expenditures
  - Track accountability for annual primary care expenditure targets

- Policies to Increase and Sustain Primary Care
  - Recommend methods to incentivize achievement of the 12 percent target
  - Recommend specific practices and methods of reimbursement to achieve and sustain primary care expenditure targets

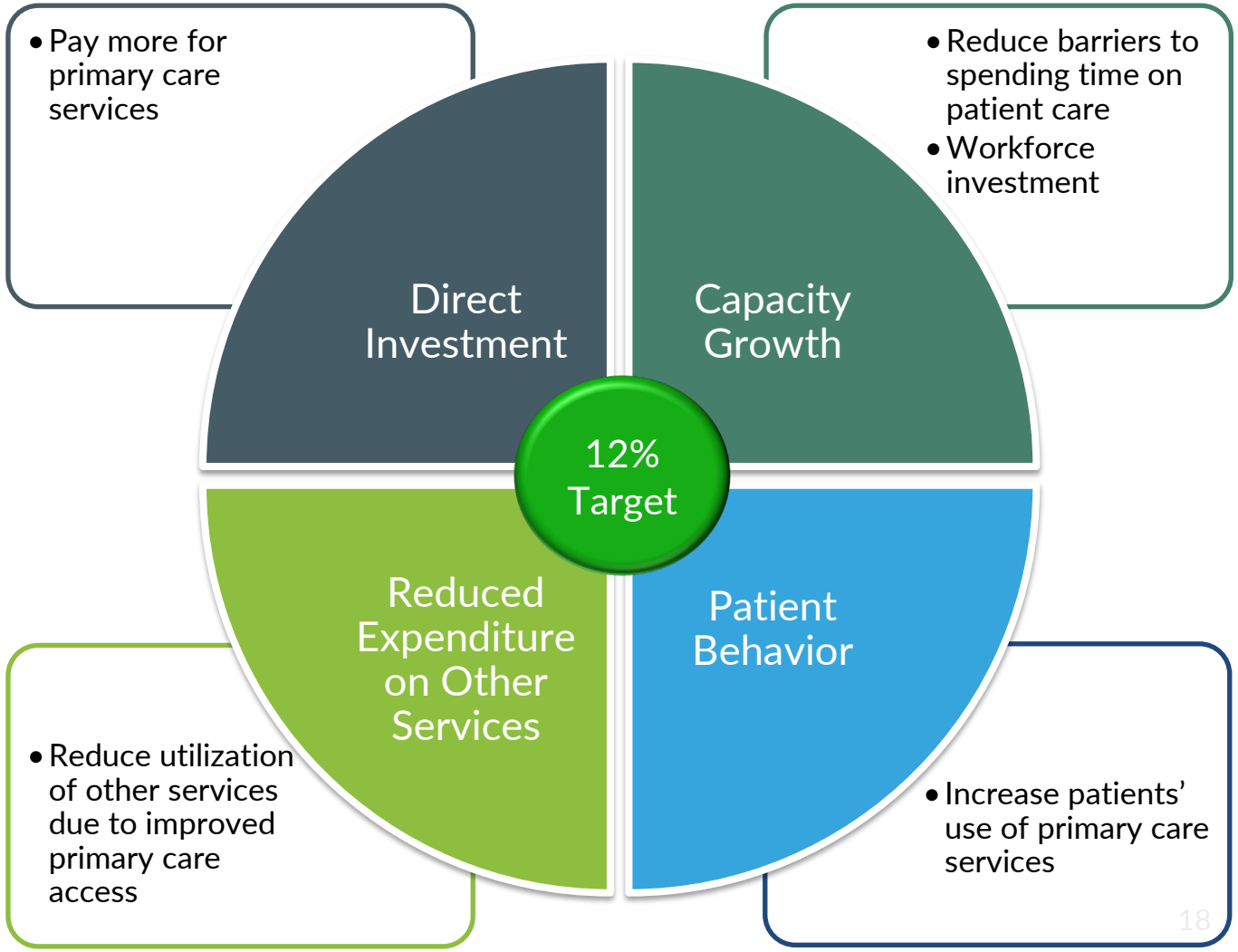
HCCTB Advisory Committee on Primary Care Charges

- To develop recommendations on how to achieve 12% target, have to understand the different drivers that influence the primary care to total spend ratio.
- Ultimate goal is to ensure access to high quality primary care, 12% is a lever to support this goal.
- Important to think through how expenditures support the ultimate goal and not just contribute to hitting 12% target.
  - How do you maximize the impact of additional investment in primary care?
- Committee used a four-domain framework to explore different strategies for advancing toward a 12% target in a manner that supports the ultimate goal of access and quality.

Policies to increase and sustain primary care – 12% in context

Four key domains that influence the primary care expenditure statistics:

- Direct investment
- Capacity Growth
- Patient Behavior
- Reduced Expenditure on Other Services



Policies to increase and sustain primary care – 12% in context

The strategies below, ordered by preference, had at least some support from committee members. Members will continue to work through the legislatively mandated bodies of work in future meetings.

1) Direct Investment - Increase primary care reimbursement.
2) Capacity Growth - Payer focus on reducing administrative burden/costs for providers.
3) Forgiveness for non compete clause penalties incurred by primary care clinicians who leave a position to work elsewhere in Washington State.
4) Patient Engagement - encourage employers to support/incentivize/encourage patients in selecting a PCP.
5) Capacity Growth - State funded expansion of loan forgiveness opportunity.
6) Capacity Growth - Work with education system to bolster pipeline of healthcare professionals.
7) Increasing Medicaid reimbursement for primary care services.
8) Capacity Growth - Multipayer collaboration to develop and implement payment models that offer greater financial flexibility and incentives while growing access and improving quality.
9) Provide options for practice teams to have a fully capitated system.
10) Increase FFS for remote patient monitoring services, chronic care management.
11) Increase FFS reimbursement for care team members such as clinical pharmacists, care coordinators / Community Health Workers, registered nurses, etc.

Next Steps

HCCTB Advisory Committee on Primary Care Next Steps

- June: Work through non-claims-based data collection policy and general data barriers and strategies to overcome them
- July: Review outcome of HCA Medicaid data analysis to finalize code set and total primary care definition; continue discussion of primary care expenditure advancing policies
- August: Continue July activities
- September through December: Develop measurement implementation plan

Questions/Discussion