Advisory Committee of Health Care Providers and Carriers meeting summary

June 2, 2022
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 is available on the Health Care Cost Transparency Board webpage.

Members present

Bill Ely
Bob Crittenden
Dorothy Teeter
Jodi Joyce
Louise Kaplan
Mika Sinanan
Mike Marsh
Natalia Martinez-Kohler
Ross Laursen
Stacy Kessel
Todd Lovshin
Vicki Lowe
Wes Waters

Members absent

Mark Barnhart
Megan McIntyre
Paul Fishman

Agenda items

Welcome, call to order, approval of April meeting minutes

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 9:02 a.m. Minutes from April were approved.

Topics we will discuss today

Ms. Gellermann shared the list of topics, including reviewing Board presentations on hospital costs in Colorado, and an update on the provider reporting list for the 2022 Benchmark Data Call. Ms. Gellermann informed the committee that Dr. Zerzan was unable to attend, and that the discussion of primary care would be rescheduled.

Hospital Costs, Price, and Profit Analysis: The Colorado Story and input for Washington's analysis

John Bartholomew and Tom Nath
PowerPoint presentation

John Bartholomew shared a presentation on hospital costs in Colorado. The committee was informed that after viewing the presentation, the Board approved an analysis of Washington hospital costs based on the same methodology. This will be presented at a future Board meeting.
Mr. Bartholomew described the Colorado issue that prompted the analysis as an unexpected increase in insurance and hospital costs of over 50% more than the national average between 2009 and 2018. In 2014 Colorado legislature established the Colorado Commission on Affordable Health Care to understand why commercial health care costs were rising so fast. One of the main findings of the Commission still in use is that hospital financial analysis is needed at the state level.
Mr. Bartholomew explained the methodology of the report. Using Medicare Cost Report data submitted by the hospitals, metrics were created on Net Patient Revenue, Hospital-Only Operating Cost, and Net Income by diving data by adjusted discharges. The results were used to identify trends across hospital types, including health systems, independents, for-profit, not-for-profit, rural, urban, and by y bed size,
Mr. Bartholomew presented summary slides from a report published in August 2021 (and available on-line) with the resultant rankings and findings. These included Colorado's ranking nationally on the metrics listed above, an aggregate income statement for all Colorado hospitals specifying two types of profit (patient services net income and other non-patient income), scatter plots charts identifying results. He also shared a chart of operating margins related to Covid, and a presentation on Consumer Benefit, both requested by the Colorado commission.
Relative to Washington, Mr. Bartholomew shared that in 2021, the state was ranked 7th in high cost per patient, and 14% higher than the national median on price per patient.
Committee members engaged in a lengthy discussion of the presentation and the sources of data used in the port, including:

- *Could the per-discharge population be more expensive if a system has an efficient ambulatory process that filters out more expensive in-patient interactions?* Mr. Bartholomew shared that he used a formula addressing the ratio of out-patient volume and in-patient discharges. He described the formula as in common use, and available for review in his appendix.
- *Is the analysis population based, in other words looking at managed care-based populations?* Mr. Bartholomew responded that the analysis was based on information submitted by hospitals in the Medicare Cost reports.
- *Is the additional federal money provided to Colorado hospitals described in the report similarly paid in Washington (e.g., the provider tax model)?* Mr. Bartholomew said he was aware of some similarities, and that he was learning about the differences. At this point, he was aware of a difference in size of the payments (Washington payments totals were lower than Colorado).
- *Adjusted discharge figures elsewhere are based on an adjusted case mix that considers the acuity level of discharges?* Mr. Nash responded that he was familiar with this type of adjustment as "equivalent discharges", and that that national case mix information was not currently available to use for national comparisons. As a result, the analysis used the more common adjusted discharge which can be determined from the Medicare Cost reports.
- *Did you conduct a per capita analysis in addition to the adjusted discharge analysis?* Mr. Bartholomew responded hospital admissions over population as a denominator created a metric that caused a lower score for states with a high admission per capita (e.g., less healthy states), and that he believed this result did not inform the purpose of the cost analysis, which is to compare relative performance between hospitals in to derive insights about what is driving cost. He shared a list to the August 2021 report.

- *Are the dollar values for charity care based on the hospital price list, or what would have been paid at Medicaid rates?* Mr. Nash reported that it was the actual cost incurred by the hospital for providing the services.
- *Was there any inclusion of the delta between cost incurred and payments made (e.g., the break*-even rate for the service)? Mr. Nash reported the results on the Charity slide were strictly charity, with no payments incurred.
- *Does this report take as a given that cost-shifting is occurring in Colorado (specifically commercial market subsidy of Medicaid rates), or conclude as a result of this analysis that is it not occurring?* Mr. Bartholomew responded that the initial argument in Colorado was that big hospitals shared that commercial pricing was a result of under-funding for Medicaid. The Colorado department had previously issued a report in January 2020, the "cost-shift myth" concluding that commercial increases far exceeded Medicaid under-payment even after Medicaid expansion. When asked if he believed this conclusion should be confined to Colorado, Mr. Bartholomew responded that he was aware of several reports and independent research that does not support the concept of const-shifting. Links to the Colorado report and one other were provided to the committee.

One committee member commented that Washington state was a very different environment (including that it is in the main a totally non-profit state) and expressed concerned that the Colorado results could create a false impression about Washington hospitals. Specifically, he pointed out that Washington margins were significantly lower, Washington Medicare contracts averaged about 175% which is significantly lower than other state reimbursements. This member suggested that the Board's report not focus on the disparity between for-profit and not-for-profit entities as potentially confusing, and that quality should be considered as an important element, especially in hospital with low discharge per thousand which likely experience higher acuity. Finally, he pointed out that the hospital system is in a period of historic crisis stemming from the Covid pandemic, staff shortages and wage rate inflation of over 20% year over year.

One committee member suggested that talking to hospital CEOs about the credibility of the adjusted discharge formula would be an important follow-up. This was supported by other committee members.

One committee member suggested that the Board needed to understand the context of hospital cost in relationship to total health care expenditures, pointing out that less than 1% of the population at any one time. She also stated it was important to understand where WA hospital costs stand related to other states. She also emphasized the importance of workforce issues. Ms. Gellermann asked if workforce was a separate topic than labor cost, and she said yes, this should be a separate topic. The member emphasized that all these topics were important to supporting sound policy recommendations.

One committee member pointed out the impact of behavioral health issues, much of which is provided by hospitals, and the lack of adequate discharge locations extending hospital stays.

Committee members also suggested that education on how to consider and evaluate hospital data are important.

One committee member stated that hospital reimbursement methodology would not be significant to the cost discussion, with the exception of how Covid and the staffing environment has shifted the cost and profit landscape. He also suggested that site of service and care patterns were important to understand.

Input for Washington's analysis

Ms. Gellermann then asked committee members for feedback on what aspects of hospital cost would be important for the Board to have information about when considering the future Washington report including what the Board needs to know, and who should be invited to present or assist in presenting? She reported that the Board was committed to an independent analysis conducted by Mr. Bartholomew and Mr. Nash, an explanation of the recently issued Rand report, a specific report on workforce and labor by Board member Dr. Bianca Frogner, and a presentation from the Washington State Hospital Association to the Board.

Once committee suggested information about the WA hospital landscape (e.g., for-profit vs. non-profit), labor and workforce issues, and the impact of Covid-19 and resulting anomalies in 2019 and 2020 data.
One committee member suggested that it would be important to consider differences between for-profit vs. non-profit hospitals and information about the impact of non-profits with for-profit subsidiaries. One specific topic would be to learn how funds received by non-profits are used and how they organize themselves.

Update on provider reporting list

Ross McCool, Operations Research Specialist, HCA
PowerPoint presentation

Mr. McCool presented the committee with a draft list of provider entities that would be subject to attribution by carriers for purposes of the benchmark report. He explained that the list contained the large provider entities in Washington that would by virtue of size and composition be able to impact the total cost of care. He also shared the rationale for rolling up providers to a parent entity.
He shared the initial list (presented to the Board and both committees), and the follow up survey done by HCA staff inquiring into the existence of total cost of care contracts. Some entities were added based on survey results. Finally, he shared the post-survey draft list and requested any feedback or comments. Based on the schedule for the 2022 benchmark data call, he requested feedback be provided by June 17, 2022.
One Committee member asked how proprietary the information is and questioned the inclusion of Eastside Health Network as a contracting entity for several providers. The call was interrupted for technical difficulties, and Ms. Gellermann directed Mr. McCool to follow up individually with that committee member.
Ms. Gellermann reminded committee members that no public reporting on carriers and providers would be done in the first benchmark report.
No additional comments were shared in the meeting.

Public Comment

There was no public comment

Future Meetings: virtual vs. hybrid

Ms. Gellermann shared that Governor Inslee's amended Public Health emergency order now permitted hybrid meetings. She also shared HCA Director Sue Birch's request that meetings continue virtually only, based on concern for public health and acknowledging that virtual meetings had been successful. She invited the committee to discuss and vote on Director Birch's recommendation to continue meetings virtually only for the future.
A motion was made to continue virtually only for the foreseeable future and adopted unanimously.

Primary Care Project overview and discussion:

Judy Zerzan, Chief Medical Director, HCA

This portion of the meeting was cancelled. It will be rescheduled for a future meeting.

Adjourn

Meeting adjourned at 3:49 p.m.

Next meeting

Wednesday, August 3, 2022
*Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.
**Zoom meeting is dependent on public health emergency.*