Health Care Cost Transparency Board meeting

April 24, 2025

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Health Care Cost Transparency Board
Agenda

Wednesday, April 24, 2025
2–4 p.m.
Hybrid Zoom and in-person

Board Members		
☐ Mich'l Needham, Interim Chair	☐ Ken Gardner	☐ Ingrid Ulrey
☐ Jane Beyer	☐ Jodi Joyce	☐ Kim Wallace
☐ Eileen Cody	☐ Gregory Marchand	☐ Carol Wilmes
☐ Lois C. Cook	☐ Mark Siegel	☐
☐ Bianca Frogner	☐ Margaret Stanley	

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome and roll call • Agenda overview	1	Ross Valore, Director of Board and Commission Health Care Authority
2:05-2:10 (5 min)	Approval of the March meeting summary	2	Mich'l Needham, Chief Policy Officer Health Care Authority
2:10-2:20 (10 min)	Public comment	3	Ross Valore, Director of Board and Commission Health Care Authority
2:20-2:25 (5 min)	Legislative session update	4	Evan Klein, Special Assistant for Policy and Legislative Affairs Health Care Authority
2:25-3:25 (60 min)	Hospital expenditures: current data, policy options, and discussion	5	Harrison Fontaine, Senior Health Policy Analyst Health Care Authority Michael Bailit, President Bailit Health
3:25-3:40 (15 min)	Analytic Support Initiative: interactive data visualization and analytic strategy discussion	6	Joe Dieleman, Associate Professor Institute for Health Metrics and Evaluation
3:40-4:00 (20 min)	Advisory committee reflections report out	7	Eileen Cody, Chair Stakeholder Advisory Committee
4:00	Wrap Up and Adjourn Next meeting: June 3, 2-4	8	

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board Meeting Minutes

March 5, 2025

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

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

Members present

Mich'l Needham, Interim Chair
Kim Wallace
Carol Wilmes

Members present via Zoom

Lois Cook
Kenneth Gardner
Margaret Stanley
Bianca Frogner
Jane Beyer
Greg Marchand
Jodi Joyce
Ingrid Ulrey

Members absent

Eileen Cody
Mark Siegel

Call to order

Mich'l Needham, Interim Chair of the Cost Board and Chief Policy Officer, Health Care Authority, called the meeting of the Health Care Cost Transparency Board to order at 2:04 p.m. and reviewed the agenda.

Washington State Health Care Authority

Agenda items

Welcoming remarks

Ross Valore, Director, Board and Commissions, Health Care Authority, conducted the roll call. Enough members were present to allow a quorum. Board members and the public were able to attend either in person or virtually via Zoom.

The Cost Board welcomed a newly appointed member, Kenneth Gardener, who introduced himself. His biography is on **the Cost Board members webpage**.

Approval of meeting minutes

Margaret Stanley moved, and **Lois Cook** seconded a motion to approve the January 30, 2025 meeting minutes. Minutes were approved by unanimous vote.

- Tab 2: Health Care Cost Transparency Board Meeting Minutes, January 30, 2025

Public comment

Ross Valore, Director, Board and Commissions, Health Care Authority, called for comments from the public. One member of the public provided comments.

The Washington State Hospital Association (WSHA) provided written comment in advance which can be read in Tab 3 of the meeting packet. In addition, **Katerina LaMarche**, Policy Director at WSHA, made comments via Zoom addressing: the cost shift occurring from inpatient to outpatient which contributes to the cost increase for hospital outpatient services, the need to examine cost drivers at a more granular level, a request to update labels in graphs and tables such that "price" be changed to "price and intensity," and suggested that the Cost Board focus on how cost reductions should be accomplished given the financial challenges faced by Washington's hospitals.

- Tab 3: External Email from Katerina LaMarche to HCA HCCT Board which includes:
    - Background for Analysis Group Study on Washington State Hospital Nursing Expenses
    - Cost analysis cover sheet
    - A Comparative Study on Cost and Value of Nursing Care in Washington State

Full testimony can be found in **the recording for this meeting**.

Legislative session updates

Evan Klein, Special Assistant for Policy and Legislative Affairs, Health Care Authority, provided an update on bills of interest for cost transparency currently being discussed by the legislature. **Jane Beyer** mentioned House Bill (HB) 1432 as a relevant bill. HB 1432 focuses on expanding access to behavioral health and strengthening behavioral health parity structure. **Ingrid Ulrey** commented that going forward, the Cost Board should sharpen its direction to legislators via the annual legislative report, align with the organizations supporting legislation and members should mention the Cost Board in their testimony to continue heightening awareness of this entity.

- Tab 4: Bills of interest for cost transparency

Review of OnPoint's cost driver analysis

Ross Valore, Director, Board and Commissions, Health Care Authority, introduced OnPoint's work and the cost driver analysis. **Amanda Avalos**, Deputy for Enterprise Analytics, Research, and Reporting, Health Care Authority provided the context for OnPoint's cost driver analysis which will provide the Cost Board with information to inform policies and strategies to reduce costs. **Amy Kinner**, Director of Health Analytics, OnPoint, presented data on cost drivers, identification of top health care expenditures and expenditures related to behavioral

health. Ross led a discussion asking if the data highlights any policy implications and strategies for the Cost Board to consider. Some questions for follow-up were identified:

- What is the impact of behavioral health and pharmacy on total claims?
- Can we break out physician-administered medications from the inpatient and outpatient numbers to get a sense of how that may be increasing price?
  - Ross will reach out to Cost Board member **Greg Marchand** to get more detail on how Greg is able to generate this type of data for his organization.
- It would be helpful to understand the difference in per member per month cost between patients who have an engaged primary care relationship compared to those who don't.

- Tab 5: Cost Driver Analysis: review of claims experience

Analytic Support Initiative (ASI) presentation on cost growth trends

Joe Dieleman, Institute for Health Metrics and Evaluation, University of Washington presented the overview and objectives for the ASI project. His presentation focused on cost growth trends which show that service utilization is going down and price intensity is going up. Several areas were identified for follow-up:

- A motion was made and approved that confirmed the 2025 ASI strategy with a request to provide Cost Board members with the opportunity to provide feedback on the list of health conditions included in the upcoming analysis of preventable admissions and to include behavioral health diagnoses on the list.
- Several Cost Board members requested a summary of themes to connect the dots between all the research and analyses that have been presented to the Cost Board. This will provide the information needed to move forward with policy recommendations.
- **Mich'l Needham**, Interim Chair of the Cost Board and Chief Policy Officer, Health Care Authority, stated that the HCA Policy team will be presenting a draft workplan for the Cost Board's review at the next meeting.

- Tab 6: Analytic Support Initiative

Follow-up on National Academy for State Health Policy's Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency

Ross Valore, Director, Board and Commissions, Health Care Authority, presented on current Washington State facility oversight legislation, including a bill calling for a provider registry matched up against the requirements of the National Academy for State Health Policy's (NASHP) Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency. He noted that Washington does not currently regulate some of the facility types identified in transaction and transparency legislation and would not have information necessary to identify who should be reporting or how they should be reporting information. A provider registry would be a foundational step towards transparency.

- Tab 7: Business/Market Oversight Follow-up Status Report

Wrap up and adjourn

The meeting adjourned at 4 p.m.

The next Cost Board meeting is on April 24, 2025. The start time is 2 p.m.

A joint meeting of the Health Care Stakeholders Advisory Committee and Advisory Committee on Data Issues will take place on March 27, 2025. The start time is 2 p.m.

Tab 3

Washington State
Hospital Association

April 14, 2025

Dear Health Care Cost Transparency Board (Board),

We greatly appreciate the Board's reconsideration and potential update to the attribution methodology. At the January Board meeting, we understood that the Board requested the Data Advisory Committee review the pros and cons of the current attribution methodology, which assigns per capita patient spending to a provider entity. The Board asked the committee for a recommendation about whether attribution is the right approach and how the Board can best partner with providers and carriers to make this data as accurate and useful as possible.

Attribution is a technical issue, and we believe it is imperative that the Data Advisory Committee has the opportunity to review the methodology and provide recommendations before the Board takes any action.

We support the overall goal of patient attribution. It allows comparisons of spending on a per person basis, which can be informative, as long as the groups being compared are large enough to have an equivalent mix of ages and underlying diseases.

While attribution may be a worthy goal, the specific methods used for attribution are important. Patient attribution is a point of consistent disagreement between provider entities and carriers. Incorrect attribution can have significant implications in capitated contracts, quality measurement, and the Board's benchmarking effort. The ability to validate patient attribution and associated cost data and ensure its accuracy is critical to achieve provider support to implement cost control efforts.

Disclosure of carrier attribution methodology. The Board has recommended a tiered methodology for its patient attribution, but it is not clear how the carriers interpret the recommendations. Better reporting from the carriers on their attribution would help identify if there are issues in interpretation. For example, it would be helpful if the carriers were required to report on the number of unique members in each attribution tier. It is also unclear if carriers are required to record the specific attribution decision for each provider. As a result, if a provider entity inquired about attribution, there is no guarantee they would be able to get any details on this process. Without understanding the attribution methods, the provider entity may not have any ability to validate the resulting cost data.

Standardization of tier 3 methodology. Additionally, there are not sufficient instructions to the carriers on how to handle patients in tier 3, where patients are assigned to providers based on utilization patterns. We think the Board needs to specify a standard approach which can be used across all carriers. Currently it is unclear how carriers distribute medical expenses across provider entities if one person receives primary care services with multiple entities during a calendar year. This makes validation nearly impossible.

Improvements to the Board's data call requirements. We offer again the following recommendations, which are substantially the same as those provided in our August 21, 2024 letter. We think these would enhance the value of provider-specific reports for both the Board and the provider entities.

1. Require carriers to report the individual primary care providers attributed to large provider entities, and the patients assigned to those individual primary care providers by product type and attribution tier.
2. Provide First-Look reports to the provider entity prior to the carrier data validation process being complete in order for HCA/HCCTB to address provider entity concerns with the data directly with each carrier.
3. Allow 30 days for provider entities to validate the data and send issues to HCCTB staff for review and follow up with carriers.

999 Third Avenue, Suite 1400 | Seattle, WA 98104-4041 | PHONE: (206) 281-7211 | FAX: (206) 283-6122 | www.wsha.org

4. Separately report the total medical expenditure data and non-claims data by carrier by product type, as well as PMPMs, in the provider entity reports. This would make validation easier for the provider entity and help differentiate between medical and non-claims related payment.
5. Require carriers to differentiate what portion of total medical expenditure is attributable to services not provided by the attributed provider entity.
6. Include age and sex adjustments by TIN and NPI included in the provider entity rollup.
7. Ensure no 2017-2019 data is used for comparison purposes with post-Covid utilization/expenditure years.

Setting a reasonable benchmark. While it is important to get the attribution correct to compare groups against the benchmark, it is also critical to set a reasonable and achievable benchmark. In 2021, the Board set the current health care cost growth benchmark at 3.2%, which is set to reduce to 2.8% by next year. The benchmarks were established using a combination of historical medical wage and potential gross state product (PGSP). While looking at methodology issues, we encourage the Board to reconsider the benchmark methodology.

Setting a benchmark was intended to encourage providers and payers to keep costs at or below the benchmark, but the current benchmark is untenable based on the criteria used to create it. Median wage was selected as a link to consumer affordability, and PGSP as a reflection of business cost and inflation. PGSP and median wage index do not account for the price inputs of the health care sector, including health care wage inflation and inflation in health care supplies. The original assumptions were based on periods of relatively low and stable inflation rates. During the discussions, HCA's consultant indicated that the current benchmark includes only a 2% rate of inflation[1]. Yet, during the past several years, inflation in goods and services which hospitals use has far exceeded 2%. As we have repeatedly pointed out, at least 60% of hospital expenses are attributed to labor, and statewide hospital labor expenses have increased 35% since 2021. Expecting providers to keep costs at or below a benchmark that does not reflect economic realities is simply not reasonable.

If the Board is unwilling to reconsider the benchmark methodology, we request that the Board at least formally review whether the benchmark rates need to be adjusted. When the Board originally discussed adjusting the benchmark in 2023, the HCA consultant maintained there was no immediate need because inflation's impact on health care spending is lagged. They maintained that health plan payment rates are set in advance for the upcoming year or multiple years, and therefore the unusually high rates of inflation would not impact plan spending until 2023. We believe it is now time to revisit this issue. Hospital contracts have been renegotiated since 2021, when the benchmark rates were developed. The impact of inflation is real, and it is critical for the Board to at least recognize this and provide a temporary allowance when assessing performance against the 2023 benchmark.

We ask the Board to consider changes to improve provider attribution and data reporting as well as the benchmark methodology so that the effort to improve affordability is realistic and achievable for hospitals.

Sincerely,

Eric Lewis

Eric Lewis
Chief Financial Officer, Washington State Hospital Association
HCCTB Stakeholders Advisory Committee Member

[1] https://www.hca.wa.gov/assets/program/board-meeting-summary-20230215.pdf

Tab 4

Legislative update

Evan Klein, Special Assistant for Legislative and Policy Affairs

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Tab 5

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Hospital cost growth in Washington State

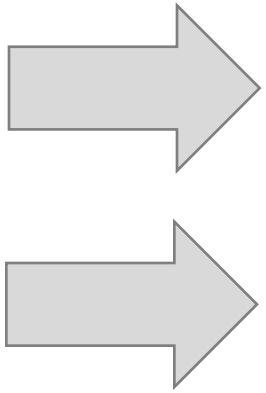
Harrison Fontaine, Senior Health Policy Analyst

Washington State Health Care Authority

Cost Board directives

Identify **trends** in health care cost growth

Analyze total **health care expenditures**



Provide **policy recommendations** to the Legislature to increase transparency and affordability

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Cost Board topic areas in review

Looking back at identified priorities in 2024-2025:

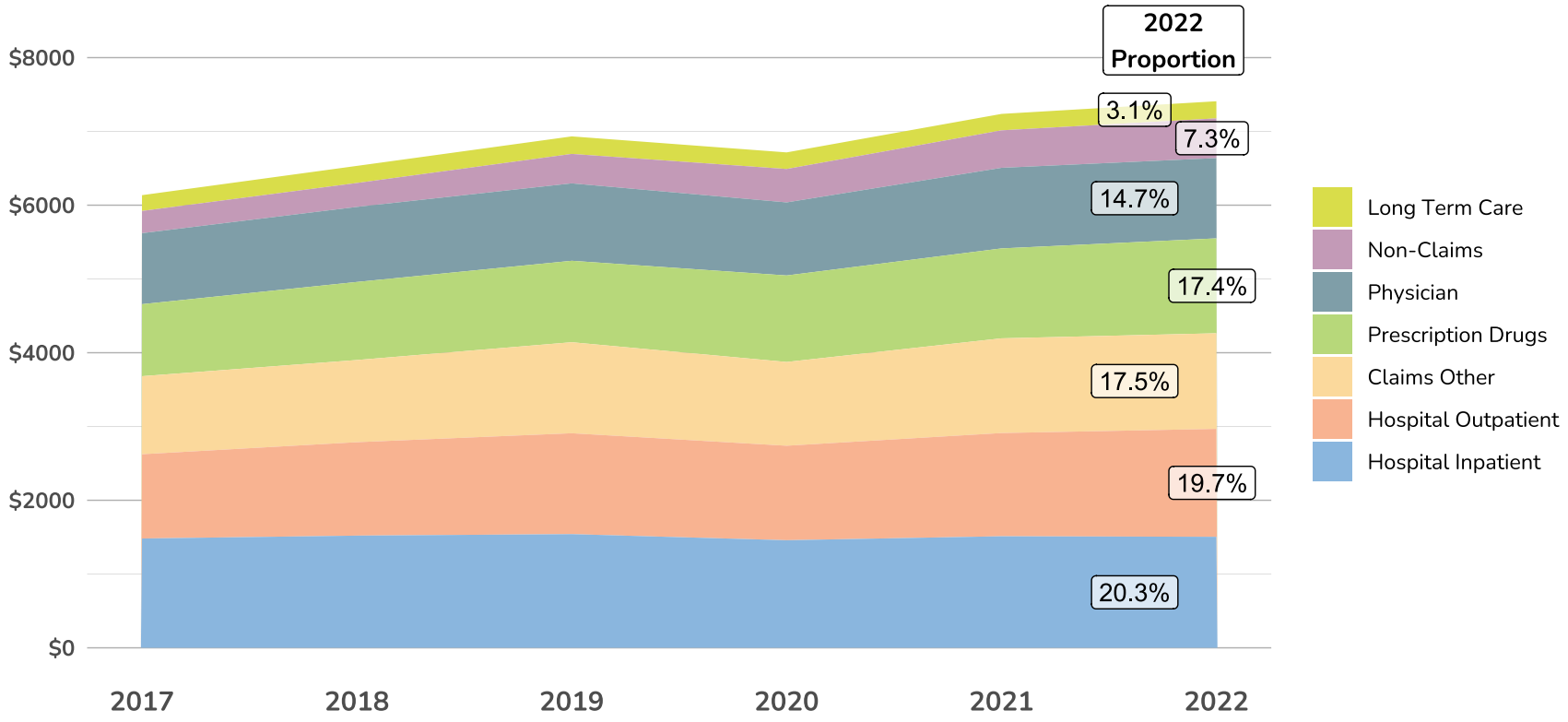
- ❑ Increasing utilization of primary care
  - ✓ Developed a primary care definition
  - ✓ Adopted actions and recommendations to increase primary care expenditure
- ❑ Increasing oversight of mergers and acquisitions
  - ❑ Restricting anticompetitive contracting clauses
  - ❑ Increasing billing & ownership transparency
  - ❑ Requiring reporting of ownership structures and legal affiliations
- ❑ Addressing Hospital Cost Growth
  - ❑ Requiring reporting of specific information for facility fees
  - ❑ Requiring billing & ownership transparency
  - ❑ Exploring reference-based pricing models

Overall spend, by service category

Top categories identified by:

- Total spending
- Spending growth

Total medical expense by category
All markets, per member per year



Source: WA Health Care Cost Transparency Board data calls

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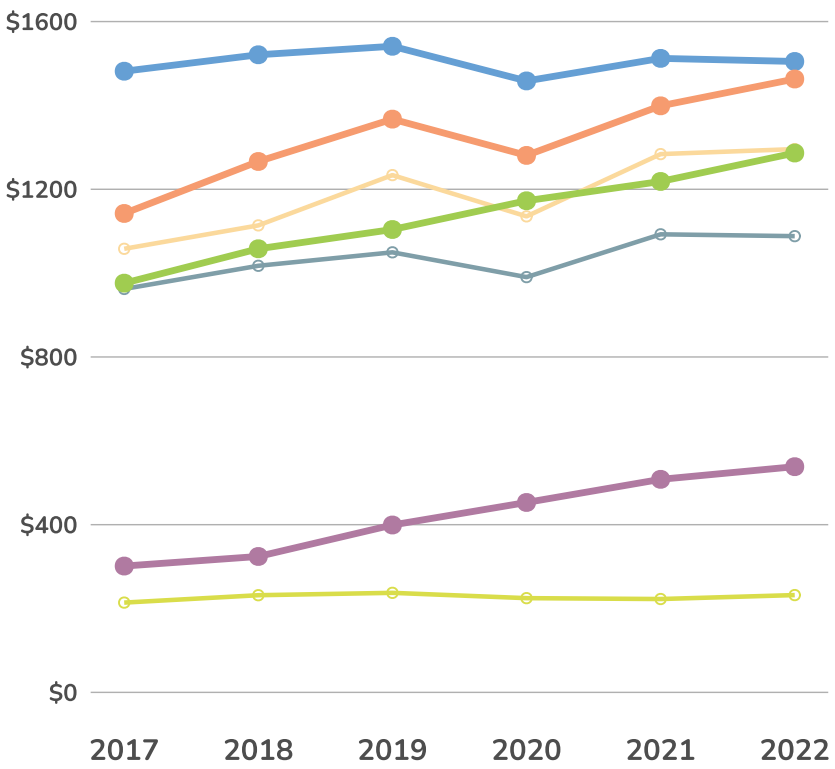
Overall spending growth, by service category

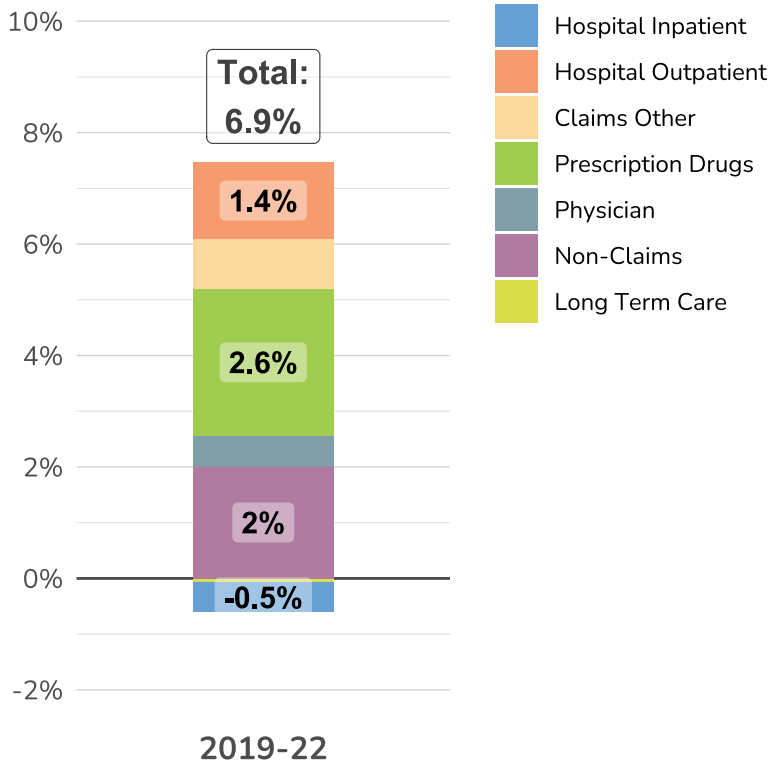
Top contributors by **total** spending or by **growth**:

- Hospital inpatient
- Hospital outpatient
- Prescription drugs
  - Focus of PDAB
- Non-claims
  - Expected from payment reform (e.g., bundled payments)

Total medical expense by category
All markets, per member per year



Contribution to Growth
Ordered by 2022 PMPM



Source: WA Health Care Cost Transparency Board data calls

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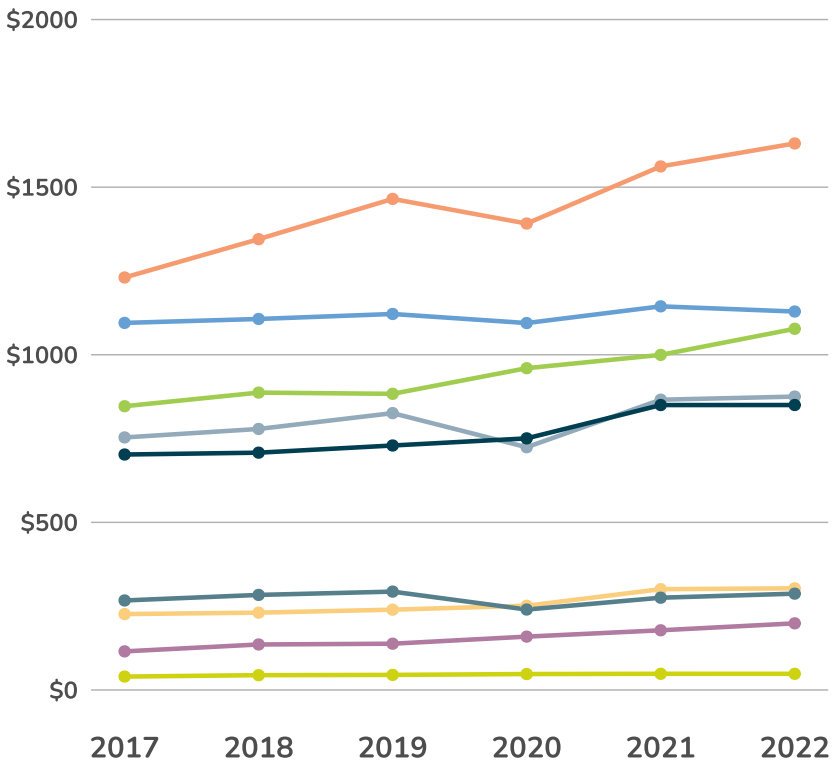
Commercial spending growth, by service category

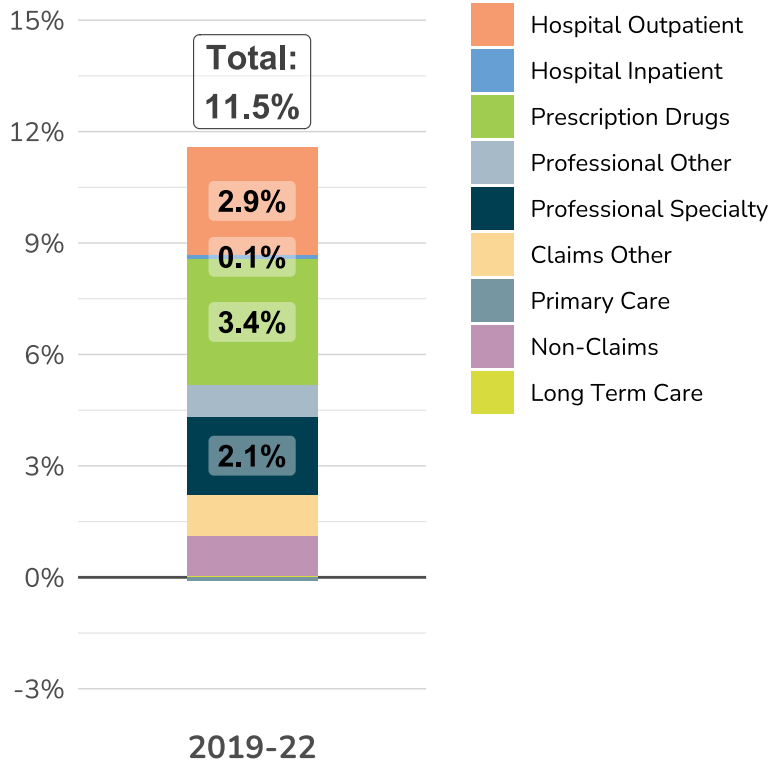
Top contributors by **total** spending or by **growth:**

- Hospital outpatient
- Hospital inpatient
- Prescription drugs
  - Focus of PDAB
- Professional specialty

Total medical expense by category
Commercial market, per member per year



Contribution to Growth
Ordered by 2022 PMPM



Source: WA Health Care Cost Transparency Board data calls

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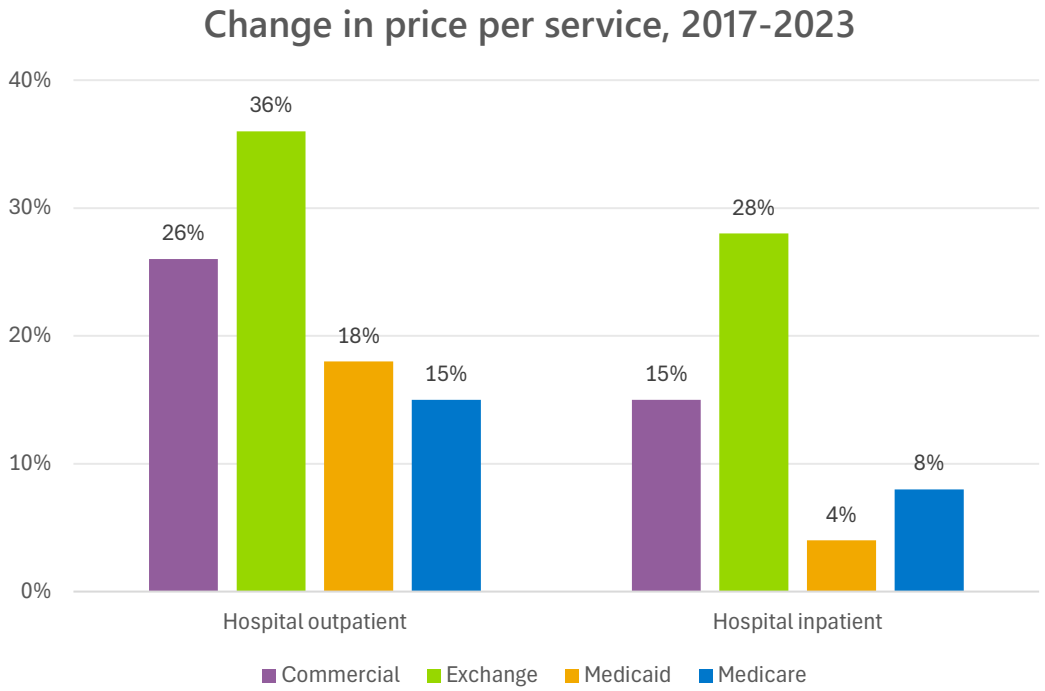
Washington hospital spending in context

Analysis conducted for the Cost Board shows that for hospitals in Washington State:

- **Price and cost are higher** than for peer hospitals.[1]
- **Commercial reimbursement was 250 percent what Medicare would pay**.[2]
- **Price per service increased** across all markets from 2017-2023. Increases were highest in commercial and exchange markets. [3]



Source: OnPoint's WA Cost Driver Analysis Using APCD Data

Sources:
1. Washington Hospital Financial Analysis
2. RAND Report Round 5 Washington State Analysis
3. OnPoint's WA Cost Driver Analysis Using APCD Data

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Key takeaways

- Two independent analyses conducted for the Cost Board show growth in overall expenditures and costs in key service categories.
- Hospital spending was consistently identified as a top contributor to growth or total medical expense
  - Other cost drivers were identified but are explained or addressed by other ongoing efforts
- Top cost drivers were mostly consistent across markets
  - Per legislative charge, the focus of analysis and policy action is the commercial market
- Hospital expenditures, especially within the commercial market, in Washington State are high and rising
- These analyses and the policy actions available to the Cost Board should inform policy recommendations and in-depth analyses

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Strategies to address hospital cost growth

Michael Bailit, President
Bailit Health

Washington State Health Care Authority

Agenda

1. Moving from transparency to policy
2. State strategies to address hospital prices
3. Discussion

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Moving from transparency to policy

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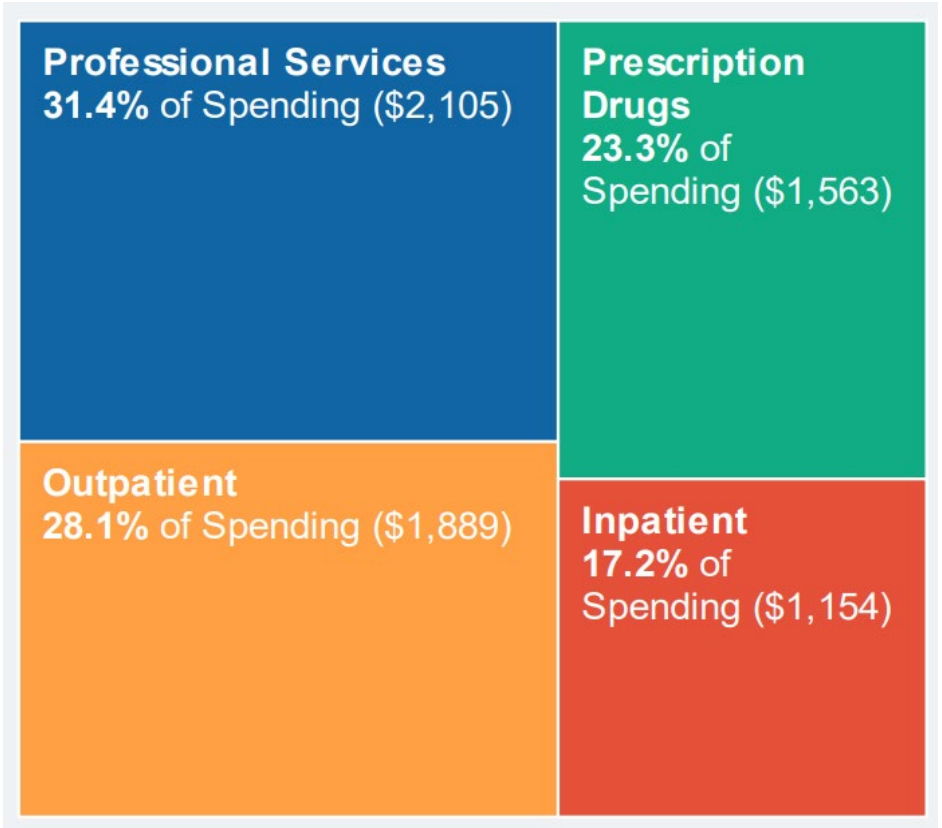
The evolution of cost growth benchmark programs

- The initial focus of state cost growth benchmark programs: improving health care cost transparency.
- However, **transparency alone has proven insufficient to generate sustained change.**
- States are moving beyond transparency to develop policies that address the drivers of spending and spending growth, particularly with respect to hospital prices and spending.

Why focus on hospital spending?

- Hospital spending is the largest component of commercial spending.
- Hospital outpatient spending has been growing over time.
  - It now exceeds inpatient spending.
  - The gap is widening as more care shifts to the outpatient setting.

Share of Per Capita Spending in 2022



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Source: Health Care Cost Institute. 2022 Health Care Cost and Utilization Report. April 2024.

Why focus on hospital spending?

- From 2018–2022, high and fast-growing **hospital prices were the #1 driver of commercial market spending** in the U.S.
- Most Peterson-Milbank states have identified hospital spending and, particularly, hospital prices, as a primary contributor to commercial market spending growth.

Note: By "**prices**," we don't mean what hospitals charge, but rather the payments they receive. Most of these payments are at contractually defined levels. Thus, when we say "price," we really mean "**payment per service unit**."

Source: Health Care Cost Institute. 2022 Health Care Cost and Utilization Report. April 2024.

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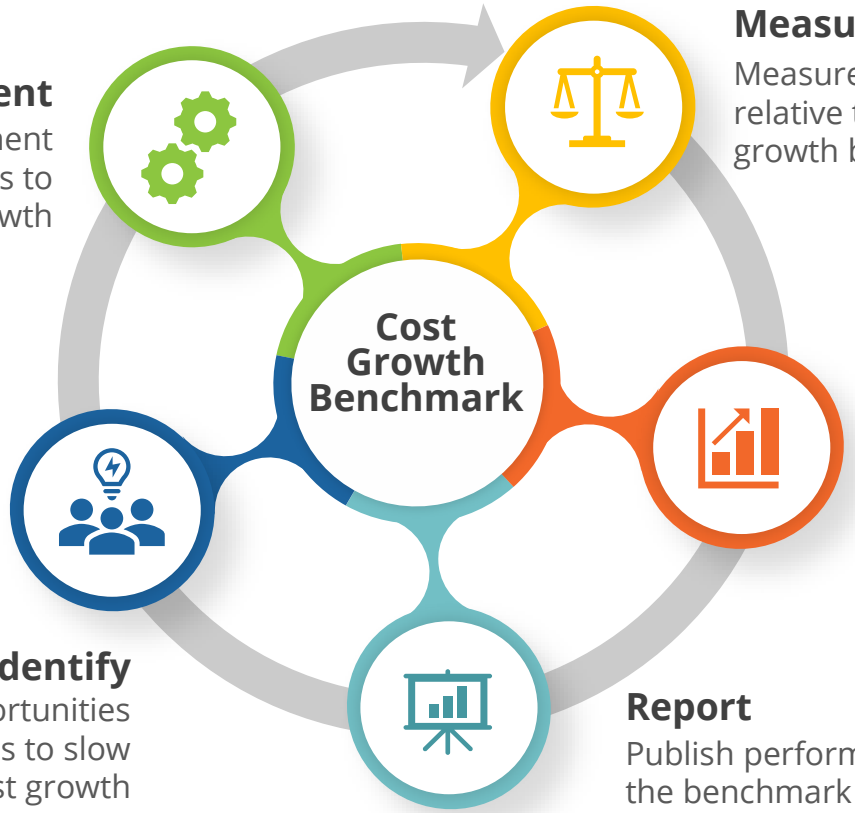
Cost growth benchmarks do not sufficiently address hospital price growth

- Cost growth benchmarks **do not hold hospitals accountable** for their specific contributions to spending growth.
  - Total medical expense accountability is assessed for a population of patients based on an attributed primary care relationship.
  - A significant percentage of hospital services are delivered to patients who have not been attributed to the hospital's employed or contractually affiliated PCPs
- Cost growth against the benchmark measurement does not assess the role of price and utilization.

Cost growth benchmark programs need to be complemented by policy action



Measure
Measure performance relative to the cost growth benchmark

Analyze
Analyze spending to understand cost trends and cost growth drivers

Report
Publish performance against the benchmark and analysis of cost growth drivers

Identify
Identify opportunities and strategies to slow cost growth

Implement
Implement strategies to slow cost growth

- Cost growth benchmarks alone **do not result in meaningful action** to constrain cost growth.
- Cost growth benchmarks programs were designed to serve as a **catalyst** for other affordability policy actions.

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State strategies to address hospital prices

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Overview of potential strategies

Tied to cost growth benchmark values

1. Publish data on hospital prices and price growth, and "name names."

2. Create a complementary hospital price growth benchmark.

3. Tie the terms of hospital CON and CMIR approvals to the cost growth benchmark value.

Independent but complementary

4. Take direct action on specific hospital pricing policy issues, e.g., facility fees, OON fees.

5. Establish a hospital price growth cap.

6. Set a hospital price cap (aka "reference-based pricing").

Could be independent of or tied to cost growth benchmarks

7. Prospectively review and approve hospital revenue and/or price growth.

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OON = Out of Network

1. Publish data on hospital prices and price growth — and name names

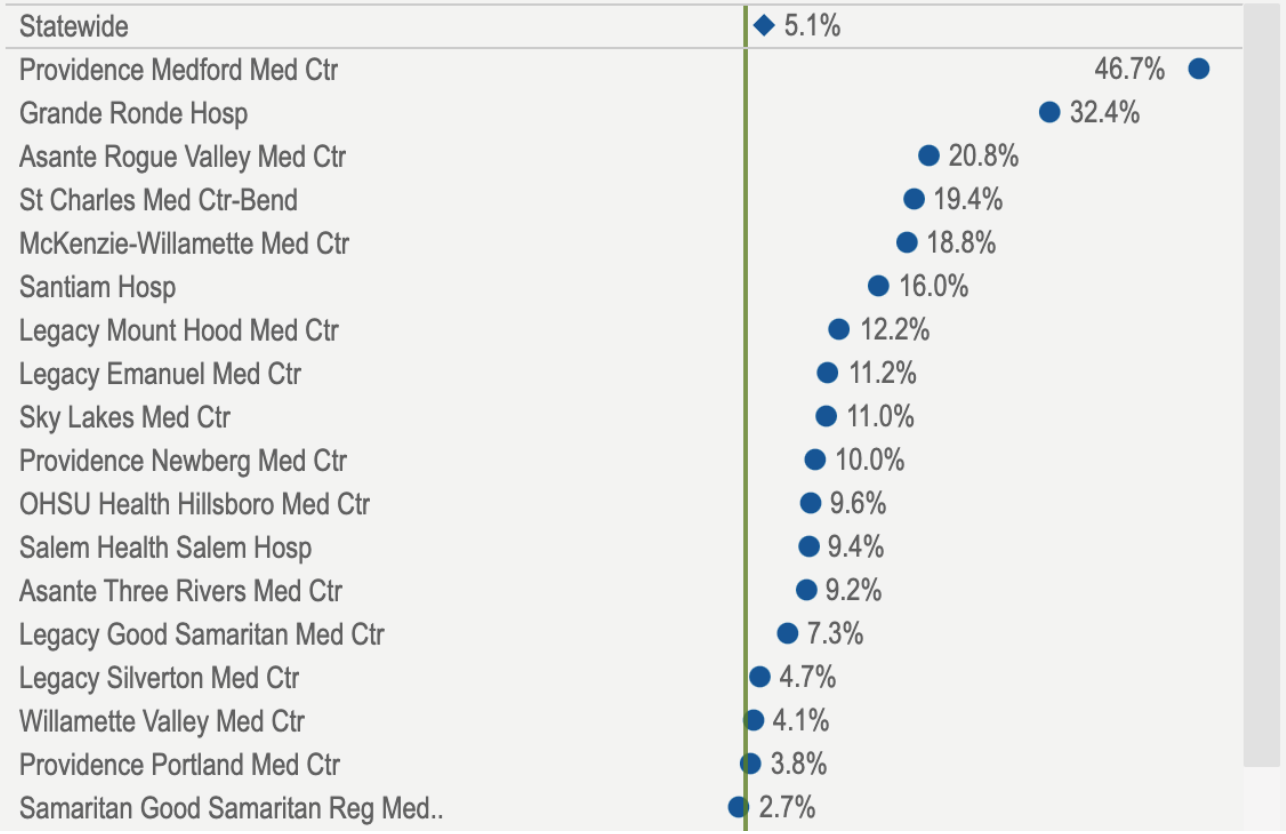
- For this strategy, states leverage commercial claims data from their all-payer claims databases (or other claims database alternatives).
  - The state can report prices at a point in time and/or report the percentage change in prices over time.
  - The state must ensure that the comparison is valid and accounts for differences in service mix.
- **Likely impact:** Transparency can raise awareness and motivate more impactful policy interventions.
- **Select state models:** Massachusetts and Oregon.

Example: Oregon hospital payment report

Outpatient surgical procedures: appendectomy

Percent change in median commercial payment from 2021 to 2022 (unadjusted)

Another way to look at change is relative change, or percent change from the previous year. The green line at 3.4% is the cross-payer sustainable health care cost growth target. Hospitals to the right of the green line had payment growth exceeding this target. The percent change values are unadjusted for inflation. Hospitals in the chart that do not have percent change data points performed the procedure at least 10 times in either 2022 or 2021, but not both years. Hover over a data point to display more information.



Source: Oregon Health Authority. Oregon Hospital Payment Report. July 2024.

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2. Create a complementary hospital price growth benchmark

- Many states can pursue this without additional legislation if the overall statutory charge is to promote affordability.
  - Application can vary by hospital; states pursuing this strategy must be mindful of potential impacts on hospital financial stability.
  - The price growth benchmarks could vary by hospital to reduce underlying disparities in payment.
- **Likely impact:** Would help states meet cost growth benchmarks.
- **Select state models:** Not currently implemented. Several states are in the exploration phase; two states have committed to implement.

3. Tie the terms of hospital CON and CMIR approvals to the cost growth benchmark value

- States can tie transaction and facility investment approval terms to their cost growth benchmark values. These include:
  - **Certificate of need assessments**: state regulatory mechanisms for approving major capital expenditures.
  - **Cost and market impact reviews**: prospective assessments of the cost and market implications of proposed mergers, acquisitions, contracting affiliations, and other market changes involving health care providers.
- **Likely impact:** Linking market expansion approval to the benchmark can improve hospital accountability for cost growth.
- **Select state models:** Massachusetts, Connecticut, and Oregon.

Examples: Connecticut and Oregon

Connecticut

- The Office of Health Strategy (OHS), where the cost growth benchmark program resides, also administers the CON program.
- OHS may review proposed health care transactions, including initiation or termination of services and changes in ownership.
- In 2024, OHS allowed Yale New Haven Health System to acquire Prospect CT's three Connecticut hospitals conditioned on the system constraining commercial price growth to within 0.5% of the benchmark for the first five years.

Oregon

- The Oregon Health Care Authority, which administers the cost growth benchmark program, also administers its Health Care Market Oversight (HCMO) program.
- The HCMO program complements the cost growth benchmark by evaluating how mergers and acquisitions may impact future health care costs, including the state's ability to meet its cost growth benchmark.

4. Take direct action on narrower hospital pricing policy issues

- For example:
  - Implement caps on OON prices, altering the negotiating dynamic between hospitals and health insurance plans for both OON and in-network prices.
    - **Select state model:** California
  - Implement site-neutral payments, mandating the same price for a certain ambulatory services irrespective of service delivery location.
    - **Select state models:** Colorado, Connecticut, and Indiana
  - Ban anti-competitive contracting, stopping dominant health care systems and hospitals from demanding favorable terms in contracts with insurance plans.
    - **Select state model:** Nevada
- While impactful, these strategies are likely to have less financial impact than more systemic approaches.

5. Establish a hospital price growth cap

- Hospital price growth caps limit how much provider prices can grow each year; these caps can be tied to economic indicators.
  - This strategy can be pursued on its own or paired with a hospital price cap.
- **Likely impact:** Price growth caps directly influence the growth in hospital prices and can be highly effective.
- **Select state models:** California, Rhode Island, and Vermont.

Example: Rhode Island Affordability Standards

- Rhode Island's Affordability Standards limit the average annual price increase rates for both inpatient and outpatient hospital services within each insurer-provider contract.
  - This is enforced through health insurer rate review.
- These caps may have been an important factor in the state meeting the benchmark every year through 2022.
  - The caps resulted in a 5.8% net decrease in quarterly total health care spending per commercially insured enrollee compared to a control group, per a 2019 *Health Affairs* evaluation.

Source: Aaron Baum et al., "Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers," Health Affairs 38, no. 2 (Feb. 2019): 237–45.

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6. Set a hospital price cap ("reference-based pricing")

- Price caps directly limit provider prices, usually as a percentage of Medicare rates.
  - The Washington public option program utilizes hospital price caps.
  - Washington has proposed 2025 legislation to expand hospital price caps for public employee health plans.
- **Likely impact**: This strategy has the potential to have a significant impact by directly constraining hospital prices.
- **Select state models:** Montana and Oregon (state employee health plans only).

7. Prospectively review and approve hospital revenue and/or price growth

- Some states have the authority to prospectively review hospital revenue and/or price growth.
  - This can take the form of a detailed prospective hospital budget review or a more limited review of revenue targets and aggregate prices.
  - States could decide to set a hospital-specific cap on revenue growth or a cap on price growth, which can also be tied to cost growth benchmark values.
- **Likely impact:** Direct regulation of prices or price growth will have the largest impact.
- **Select state models:** Delaware and Vermont.

Example: Delaware Diamond State Hospital Cost Review Board

- Delaware created its review board as a direct response to the state consistently exceeding its cost growth benchmark.
- The review board reviews and regulates hospital budgets to ensure compliance with the state's benchmark.
  - Starting in 2026, the board can require hospitals whose cost growth exceeds the benchmark to submit a performance improvement plan detailing action steps to curb cost growth.
  - The board can approve or modify budgets if a hospital fails to produce an acceptable plan or show sufficient improvement within 12 months.

Discussion

Washington State Health Care Authority

Discussion topics

- Among these strategies, which ones do you think offer the greatest promise in Washington?
- What are your key considerations for evaluating these strategies?
- What type of input on these strategies would you like from the advisory committees?

Tab 6

Analytic Support Initiative

WA Health Care Cost Transparency Board

April 24, 2025

HCA & Institute for Health Metrics and Evaluation

ASI

Agenda

1. Potentially preventable admissions

2. Tour of interactive visualization

Analytical Support Initiative Overview

Condensed objective:

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

Philanthropic funding for July 2023-July 2025

Timeline:

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

Reminder of next steps

Key questions:

1) How does the relationship between missing supply and preventable admissions interact with rurality and payer type?
2) Who is most impacted by preventable admissions and what is the associated spending burden?

Analytic strategy:

a. Quantify outpatient visits and/or prescriptions per prevalent case for key diseases for each county. Build composite index of access to care for each county.

b. Quantify ***inpatient admissions or ED visits for preventable diseases*** for each county. Build a composite index of preventable admissions for each county.

c. Assess relationship between (a), (b), rurality and payer.

d. Quantify spending on preventable admissions and ED visits by payer and county.

Two existing sources

1. CMS Potentially Avoidable Hospitalizations (PAH)

2. AHRQ Ambulatory Care Sensitive Conditions (ACSC)

MMRR
Medicare & Medicaid Research Review
2014: Volume 4, Number 1

A publication of the Centers for Medicare & Medicaid Services, Office of Information Products & Data Analytics

Medicare-Medicaid Eligible Beneficiaries and Potentially Avoidable Hospitalizations

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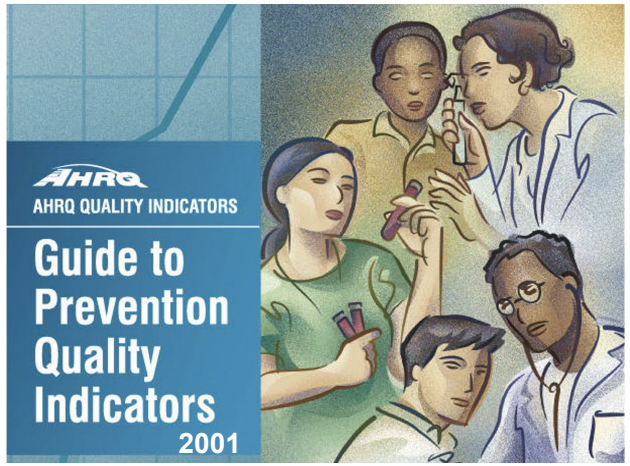

Two existing sources

CMS Potential Avoidable Hospitalizations

- **COPD**, chronic bronchitis, and **asthma**
- **Congestive heart failure**
- Constipation, fecal impaction, and obstipation
- Dehydration, volume depletion including acute renal failure and hyponatremia
- **Hypertension** and hypotension
- **Poor glycemic control**
- Seizures
- **Urinary tract infection**
- Weight loss and nutrition deficiencies

AHRQ Ambulatory Care Sensitive Conditions

- Bacterial pneumonia
- Dehydration
- Pediatric gastroenteritis
- **Urinary tract infection**
- Perforated appendix
- Low birth weight
- Angina without procedure
- **Congestive heart failure**
- **Hypertension**
- **Asthma**
- **Chronic obstructive pulmonary disease**
- **Diabetes**

Complementary analysis will focus on behavioral health conditions

- Requesting feedback from the Cost Board today and from the Advisory Committee on Data Issues on 5/22

2. Interactive visualization

Thank you

ASI

Tab 7

Summary of Feedback: Committee Member Experience

Eileen Cody, Chair of Advisory Committee of Health Care Stakeholders

Washington State Health Care Authority

Questions for committee members

- Are we making good use of your time?
- Are meeting packets helpful? How could they be improved?
- Do you get enough info about what the Cost Board is working on?
- Does the work of advisory committees further the mission of the Cost Board? How could this be improved?
- Does the work advisory committees are assigned utilize the expertise of committee members? How could this be improved?

Improvement area 1: advisory function

- Better utilize members' expertise to advise the Board
  - Input prior to Cost Board decisions
  - More focused topics/questions

Improvement area 2: meeting structure

- Separate advisory committee meetings unless topic requires a joint meeting

Improvement area 3: data

- Connect data presentations to Cost Board work plan and mission
  - Ad hoc presentations and reports can feel exploratory & disjointed

Improvement area 3: data continued…

- Consider committee recommendations to optimize data
  - Local data is more useful than benchmarks
  - Disaggregated data allows for better decisions
  - Advice on what data is missing
  - Consider data in context

Improvement area 4: administrative

- Keep committees up-to-date
  - Stakeholder charter updates
  - Timely committee packets
  - Email notification when Cost Board materials are posted

Improvement area 5: changing landscape

- Consider:
  - Proactive role as preventative services have been cut
  - How to incorporate consumer perspective without survey data
  - Partnership with Foundational Public Health Services Steering Committee to improve outcomes and bring down costs

Plans to address feedback

Structural	Topics & Agendas	Data
Work plan to anchor Cost Board & advisory committee work	Align topics between Cost Board and advisory committees	Anchor data presentations to work plan
Separate Data & Stakeholder committees in 2026*	Narrower questions for advisory committees	Data crosswalk
Increase email communication between staff & committees	Consider changing landscape	Writing data stories
Meet due dates for posting materials on the website		

* Unless topic requires a joint meeting or "sandwich" meeting

Discussion

- Are committees meeting the Cost Board's needs?
- What feedback from committees is most useful?
- What other suggestions do you have?

Tab 8

Closing statements and adjournment

Washington State Health Care Authority