Health Care Cost Transparency Board meeting

June 3, 2025

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Health Care Cost Transparency Board
Agenda

Wednesday, June 3, 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 • Calendar Update • Update on Extending Meeting Times	1	Mich'l Needham, Chief Policy Officer Ross Valore, Board & Commissions Director Health Care Authority
2:05–2:10 (5 min)	Review of the March & April Meeting Minutes - VOTE: Approval of March & April Meeting Minutes	2	Mich'l Needham, Chief Policy Officer Health Care Authority
2:10–2:25 (15 min)	Public comment	3	Mich'l Needham, Chief Policy Officer Health Care Authority
2:25–2:40 (15 min)	Legislative session wrap-up	4	Evan Klein, Policy Director Health Care Authority
2:40–3:05 (25 min)	ASI Follow-up - VOTE: Approval of ASI Strategy and Recommendation	5	Joe Dielman, IMHE Harrison Fontaine, HCA Staff
3:05–3:55 (50 min)	Potential Policy Lever for Hospital Spending Topic: Hospital Global Budgets	6	Robert Murray, President, Global Health Payment LLC
3:55–4:00	Wrap Up and Adjourn Next meeting: July 22, 2-4 PM		Mich'l Needham, Chief Policy Officer Health Care Authority

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.

Washington State Health Care Authority

Health Care Cost Transparency Board Meeting Minutes

April 24, 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
Jane Beyer
Eileen Cody

Members present via Zoom

Lois Cook
Kenneth Gardner
Margaret Stanley
Greg Marchand
Ingrid Ulrey
Carol Wilmes

Members absent

Bianca Frogner
Kim Wallace
Jodi Joyce
Mark Siegel

Call to order

Mich'l Needham, Interim Chair of the Health Care Cost Transparency Board (Cost Board) and Chief Policy Officer, HCA, called the meeting of Cost 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, HCA, provided an update on attribution. HCA staff are currently reviewing different methodologies and the comments received about attribution. Ross said that staff will bring the topic back to the Cost Board when this process is further along.

Ross conducted the roll call. Initially, there weren't enough members present to allow a quorum. Two members joined the meeting via Zoom after roll call, resulting in a quorum. Board members and the public could attend either in person or virtually via Zoom.

Approval of meeting minutes

The vote to approval the minutes from the March 5, 2025 meeting will occur at the June 3, 2025 meeting due to the lack of a quorum at the time of this agenda item.

- Tab 2: Health Care Cost Transparency Board Meeting Minutes, March 5, 2025

Public comment

Ross Valore called for comments from the public. The Washington State Hospital Association sent written comment which is in Tab 3 of the meeting packet. Four members of the public provided comments during the meeting.

- Katerina LaMarche, Policy Director, Washington State Hospital Association, commented on the strategies to address hospital cost growth presented in the meeting packet. She requested a deeper analysis to better determine the problems and strategies to address cost growth as related to hospitals.
- Fran Marasow, President of Professional Medical Corporation, a medical supply company which primarily provides incontinence and neurological supplies for Medicaid patients, expressed concerns about HCA's plans to contract with a value-based plan in another state. Fran stated that there is a local supplier community ready and willing to work with the HCA to accomplish their goals of cost containment and better care through a value-based approach.
- Graham Smith, Vice President of Business Development at Soundview Medical Supply, a company focused on the senior care resident community, stated that he hopes the HCA will be transparent in discussions with local suppliers and stakeholders regarding a move to value-based contracting with vendors in other states. He added that local suppliers have expert product knowledge and expressed concern about adopting a one-size-fits-all approach that won't serve patients well.
- Laura Berry, Owner Soundview Medical Supply, also expressed concern about the HCA's plans to move to a value-based program for supplies. She said that the state might not experience financial savings and risks jeopardizing the health of enrollees by moving to a lower quality product.

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

- Tab 3: External Email from Eric Lewis, Chief Financial Office, Washington State Hospital Association and Stakeholder Advisory Committee member

Legislative session update

Evan Klein, Special Assistant for Policy and Legislative Affairs, HCA, provided a brief update on bills of interest for cost transparency currently discussed by the legislature or awaiting the Governor's signature.

- House Bill (HB) 1382 is a piece of HCA request legislation to modernize the all payers claims database (APCD). The bill will enable HCA to function as the lead organization for Washington state's APCD, if there are no successful third-party bidders to run the program. It also expands the type of data that can be shared from the APCD to include information on contract terms and fixed reimbursement arrangements.

- Senate Bill (SB) 5083 and its companion bill HB 1123 are about ensuring access to primary care, behavioral health, and affordable hospital services. The bill establishes reference pricing related to HCA's Public Employees Benefits Board (PEBB) Program and the School Employees Benefits Board (SEBB) Program. This is expected to improve access and affordability.
- SB 5084 concerns health carrier reporting and will increase the alignment between the Office of Insurance Commissioner (OIC) and HCA primary care reporting requirements.
- SB 5579 prohibits health carriers, facilities, and providers from making any public statements of any potential or planned contract terminations unless it satisfies a legal obligation.
- HB 1432 is focused on improving access to appropriate mental health and substance use disorder services. The bill applies to commercial health plans including PEBB and SEBB. It adds language from the strong federal mental health parity statute into state law.

Evan will provide a more extensive summary of legislative action and bills impacting the Cost Board's work at the Cost Board's June 3, 2025, meeting after the legislative session has concluded.

Hospital expenditures: current data, policy options, and discussion

Harrison Fontaine, Senior Health Policy Analyst, HCA, provided a high-level summary of reports previously presented to the Cost Board. He focused on what the cost driver analysis, benchmark report, and other analyses tell us about the contribution of hospital spending to total expenditures in Washington State.

Hospital spending is a top contributor to growth or medical expense, especially in the commercial market. **Michael Bailit**, Bailit Health, presented seven strategies to address hospital cost growth, reviewing a menu of policy options for the Cost Board's consideration as the body evolves to recommend policy.

- **Jane Beyer** asked where the non-claims payments are going and how they relate to hospitals. This is information that can help the Cost Board understand trends across the other categories as well. Harrison said that staff would follow up with this information at the next Cost Board meeting.
- **Margaret Stanley** asked how strategy 7 (prospectively review and approve hospital revenue and/or price growth) compares to Washington's history with hospital rate setting and asked staff to compare rate setting success and failures to strategies 5–7. She stated that strategy 7, as well as 5 (establish a hospital price growth cap) and 6 (set a hospital price cap — aka reference-based pricing), seem most promising.
- **Michael** said that lots of states used to have rate setting commissions. Vermont didn't set rates but did review and approve budgets and revenue growth and prices in relation to revenue growth.
- Jane stated that Washington used a methodology that was more like fee-for-service rate setting vs. the approach Maryland uses, which is building a global budget with incentives and structures to promote more investment in primary care. She suggested it would make sense to consider Maryland in the analysis, as it has been using this approach for 11 years and has had more success than anyone else.

Ross Valore asked which strategy or policy lever the Cost Board might like to select to work on for the next 12 to 18 months. He asked what information would be most helpful to the Cost Board members to be able to choose a strategy over the next three meetings.

- **Jane Beyer** stated that the Cost Board should be looking at options that can address both claims and non-claims expenditures. In Rhode Island, the insurance commissioner has the authority to review and approve large group rates which Washington doesn't. Taking on strategy 5 would require looking at whether OIC should receive authority for prior approval.
- **Greg Marchand** agreed that strategies should address claims and non-claims expenditures. He also said that the ability to leverage current legislation would make it easier to execute a strategy. He feels strongly that it should be based on something global vs. service-by-service.
- **Ingrid Ulrey** voiced appreciation for the shift to policy focus and moving beyond transparency. She suggested building on the recent incremental legislative successes and momentum that can lead to

meaningful impact. Reference-based pricing in the individual market and then the PEBB market are building blocks toward impact. She recommended that the Cost Board take this approach rather than spending 12–18 months doing deep policy work and working up an elegant proposal that may not have legs.
- **Eileen Cody** said that we'll need to pass something with enforcement.
- **Lois Cook** said most members seem to be thinking of strategies 4, 5, 6 and maybe 7, so targeting those makes sense. Strategies 1–3 don't seem strong enough because there's no easily identifiable enforcement mechanism.

Ross said that staff would develop a comparison table based on evaluation of the levers Michael described and the thoughts and questions, such as enforcement, members have shared today. Staff will bring this to the June Cost Board meeting.

- Tab 5:
  - Hospital cost growth in Washington State
  - Strategies to address hospital cost growth

Analytic Support Initiative (ASI)

Joe Dieleman, Institute for Health Metrics and Evaluation, University of Washington presented an interactive data visualization, followed by a brief update on a proposed analysis of how avoidable ED and hospital admissions contribute to hospital expenditures. Joe said that he would send a password to Cost Board members for early access before the visualization is publicly available.

- Tab 6: Analytic Support Initiative

Advisory committee reflections report out

This agenda item will move to a future meeting due to lack of time at today's meeting.

- Tab 7: Summary of feedback: Committee member experience

Wrap up and adjourn

The meeting adjourned at 4 p.m.

The next Cost Board meeting is on June 3, 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 May 22, 2025. The start time is 2 p.m.

Tab 3

From: Dorothy F Teeter
To: HCA HCCT Board
Cc: Dorothy F Teeter
Subject: Thoughts post meeting today
Date: Thursday, May 22, 2025 4:22:59 PM

External Email

Good afternoon,

A few thoughts regarding today's very informative and thought provoking meeting.

I am concerned that the focus on hospital cost only misses a chance for WA state to be a true leader in health care reform. Many of the cost drivers do not relate directly to a facility (in patient hospital, out patient clinic) but rather to the variation in clinical decisions and referrals that are made for the population of the State of WA. For example, one practice might recommend surgery, another might recommend physical therapy for a particular orthopedic condition. One might require folks trying to manage asthma to come in for repeat visits, another might encourage self care and virtual care. One ER might readily admit all patients who can justifiably be admitted for care, another might recommend out patient follow up. Different health systems have different labor agreements which result in different costs. These are just some simple examples of the system variation issues that drive cost of care.

If we don't take a more global look at root causes of variation in cost, access, quality and health outcomes for clinical and demographic population, then I fear we will fall prey to the historically unsuccessful and (by now, unoriginal) approaches to managing costs and health outcomes. We have an opportunity to delve into the systemic health issues and the systemic care delivery issues that can drive up costs unnecessarily. We have an opportunity to innovate, by asking the people who live in our state and our clinicians to give us their ideas and their pain points. The challenge is whether we can find the fortitude to stick with it for awhile and not just hit on hospital costs because they seem to cost a lot. (That is not to say that hospital costs should be ignored..but the approach to look at that in isolation seems short sighted and destined to create resistance instead of collaboration.)

Thanks for the opportunity to respond,

Dorothy Teeter

From: Bond Huberman
To: HCA HCCT Board
Subject: 2025 Healthcare cost example in Edmonds, Washington
Date: Tuesday, May 6, 2025 11:22:45 AM
Attachments: image.png

External Email

I don't know if this is the right way to submit this information - but I would like to highlight what Virginia Mason Franciscan is charging for an **in-network** office visit to see an allergist in Edmonds, WA: **$565 for the office visit (presumably facility fee?). And $864 for the physician. See screenshot below from my insurer's portal.**

Note, those costs don't include the approximately $800 I already spent on my monthly premium to Aetna.

Aetna of course kicked in ~$360 in theoretical dollars with their "discounts." That leaves me with around $1,000 to pay. To see an allergist.

I spent approximately one hour at this appointment. I did not receive life-saving nor emergent nor particularly exceptional care.

How can a medical facility justify this price for roughly an hour of non-emergent services provided?

Happy to send additional documentation if it helps serves your work.

My contact information:
Bond Huberman
713.299.0940
Edmonds, WA resident

Go to

Details for 2 services

OFFICE VISIT

Service Date: Apr 29, 2025

Amount billed	Plan discount	Plan's share	Your share
$565.00	$33.57	$0.00	**$531.43**

PERCUT ALLERGY SKIN TESTS

CPT Code: 95004 | Service Date: Apr 29, 2025

Amount billed	Plan discount	Plan's share	Your share
$864.00	$338.96	$0.00	**$525.04**

Explanation of Benefits (EOB) Statement

EOB statements may contain multiple claims. Claims may also appear on multiple EOB statements if they've been reprocessed.

The EOB Statement for this claim will be ready on May 24, 2025.

Washington State Hospital Association

Washington Hospital Finances

Financial Vulnerability and the Impacts to Health Care Access

May 23, 2025

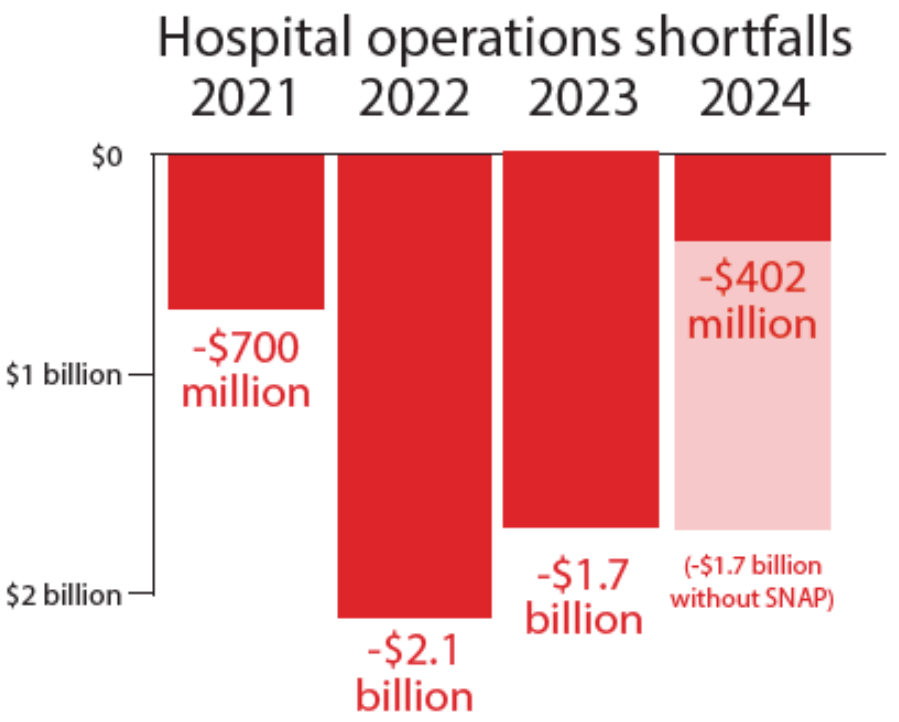
Washington State Hospital Association

Price-Capping Policies: A Threat to Access and Sustainability

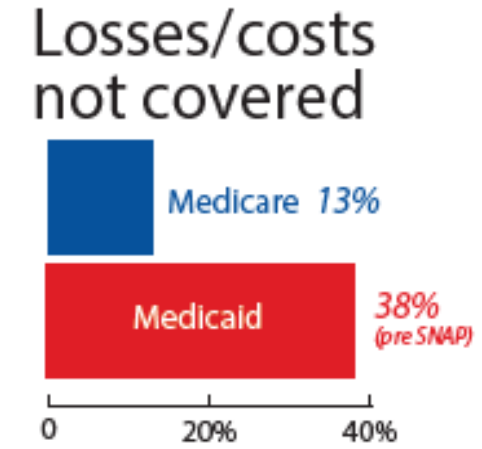
- **Proposed HCCTB policy strategies cap hospital "prices" or cut reimbursement hospitals receive from carriers.**
  - Capping hospital prices doesn't mitigate input costs for hospitals – what it costs to provide health care services – which have grown significantly since 2020.
- **WA hospital prices are average when compared nationally.***
- **WA hospital operating margins are *below* average when compared nationally.***
- **WA hospitals are financially vulnerable with low or negative operating margins.**
  - Hospitals can't absorb cuts with low or negative operating margins. They will be forced to reduce services, close, or consolidate. Losses have already forced cuts and closures, which will be further exacerbated by new cuts and taxes at the state and federal levels.
- **The proposed policies might curb health care prices but at the expense of access**. Affordability is only meaningful if there is access to care.

*Consistent with the RAND study cited by HCCTB's consultants

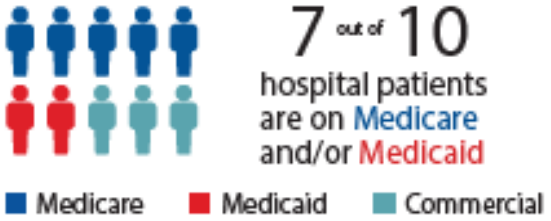
Hospital Finances: Losses from 2021 - 2024



Source: WSHA Hospital/Health System Financial Surveys, 2021-2024, representing 97% of licensed beds



Source: 2023 Medicare Cost Reports

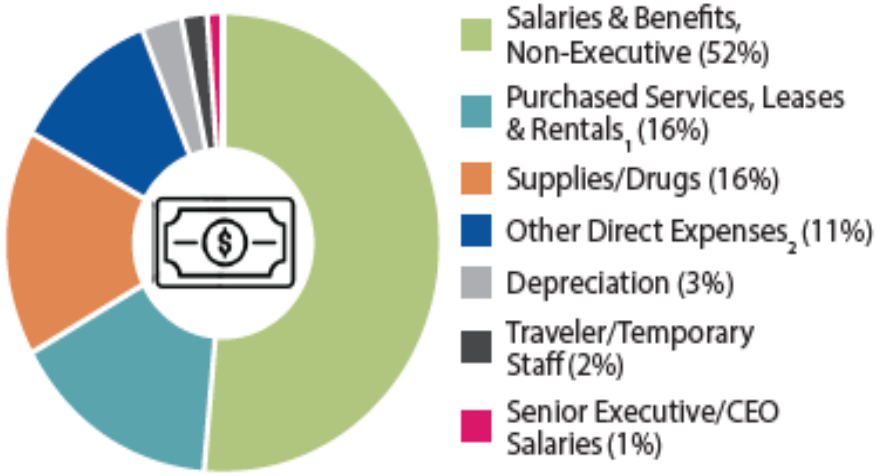


Source: 2024 WA State Discharge Dataset; payer mix by billed charges

Hospital Expenses: Labor/Supplies Driving Major Increases

What are Washington hospital expenses?

Washington hospitals employ 130,000 workers



Source: *WSHA 2024 financial survey, representing 97% of licensed beds. 2023 DOH End of Year and Hospital Compensation Reports used to disaggregate salaries into executive and non-executive and inform the proportion of spending on Purchased Services, Leases & Rentals.*

1: Purchased Services, Leases & Rentals Includes: *Electricity, fuel, gas, water, disposable service, telephone, purchased medical services contracted for patient care (such as radiology, anesthesia, emergency room, and laboratory), repairs & maintenance, management services, rental & leases, insurance, licenses & taxes, interest.*

2: Other Direct Expenses Includes: *Staff recruitment, training cost, dues & subscriptions, travel, amortization of intangible assets, provision for bad debt, blood supplies, information technology - licensing and maintenance, laundry services, internal laboratory services.*

Growth in expenses: 2021-2024

Growth in length of stay: 2019-2024

Did you know?

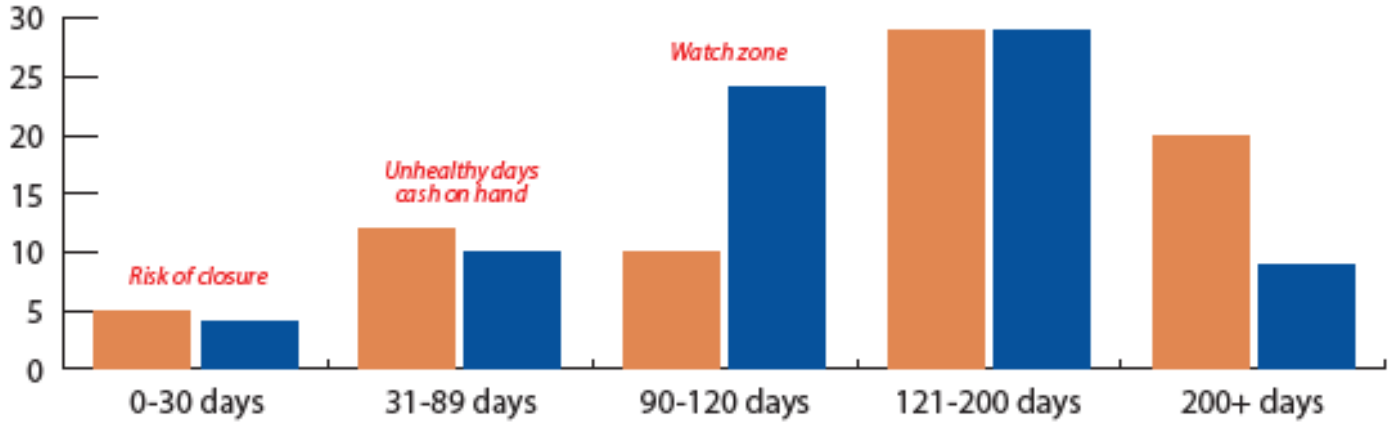
90% of Washington hospitals are non-profit or publicly owned

Growth in expenses source: *WSHA Hospital/Health System Financial Surveys, 2021–2024.*
Growth in length of stay source: *WA State Discharge Dataset for all acute care hospitals, excluding psychiatric, long-term care and swing bed claims.*

Hospital Reserves Have Declined: Days Cash on Hand

Washington hospitals'/health systems' days cash on hand decreasing[1]

For a healthy bond rating, hospitals should have at least 200 days cash on hand



Source: *WSHA financial survey, Jan. 1-Dec. 31, 2019; Jan. 1-Dec. 31, 2024. Hospital financial information represents 96% of total licensed beds.*

1: Days cash on hand is important, as it measures a hospital's ability to operate in an emergency or economic downturn. Hospitals, just like individuals, need at least 3-6 months of reserves to help ensure operations continue 24/7/365. Lenders require a minimum number of days cash (typically 60) in debt covenants and may requirement repayment of debt if cash falls below minimums, which can lead to bankruptcy.

Hospital/Health System Finances: A Challenge to Sustain Access

Year	Hospital/Health System Operating Margin (4-6% = healthy)	Operating Loss/Gain	Total Margin after Cash Investment Losses/Gains & Taxes
2019	2.2%	425M	4.1%
2020	-4.7%	-232M	0.4% (w/ Covid $)
2021	-1.3%	-742M	4.2% (w/ Covid $)
2022	-7.0%	-2.1B	-8.9%
2023	-5.0%	-1.7B	-0.6%
2024	-1.0%	-402M	1.6%

Source: 2019-2024 WSHA financial survey. Includes hospital, physician practices, clinics and other services hospitals/health systems operate.

Why Should You Believe Us?

- **The proof is in the outcomes**. The next slide shows multiple service closures in the last 5 years.

- **Hospitals and health systems are legally required to report accurate financial data** to various entities. There are major legal consequences for improper reporting.

- **The NASHP Hospital Cost Tool is flawed.** Many have used this tool to show that WA hospitals are actually profitable. The tool uses a flawed formula to calculate operating margins for hospitals using legitimate Medicare cost report data.
  - Example: The NASHP HCT shows Valley Medical Center with a ***28%*** operating margin in the most recent year available (2023). Valley just announced major service closures and layoffs. Organizations with 28% operating margins don't need to eliminate entire lines of service.

Impact of Financial Losses: Some Cuts and Closures Since 2020

Hospital	City/Cities	Units/Services Closed
Valley Medical Center	Newcastle, Renton, Kent, Auburn, Covington	Inpatient adult, inpatient pediatrics, primary care, maternal fetal medicine
Providence Sacred Heart Medical Center	Spokane	Children's inpatient psychiatric unit
Astria Health	Sunnyside, Prosser, Toppenish, Union Gap, Grandview, Zillah	Invasive or interventional cardiology services
Astria Health	Toppenish	Labor and delivery unit
Astria Health	Yakima	Astria Regional Medical Center (*hospital closed*)
MultiCare Covington Medical Center	Covington	Family birth center
St Michael Medical Center	Bremerton	Emergency department
Virginia Mason Medical Center	Seattle	Family birth center and women's clinic
Forks Community Hospital	Forks	Labor and delivery unit
Swedish	Ballard	Labor and delivery unit
Island Health	Anacortes	Sleep center

Washington State Hospital Association

New Budget Cuts and Taxes: Increased Strain

The new state and proposed federal budget impose new taxes and make significant cuts to Washington's already financially fragile hospitals, which will likely result in more service cuts and closures.

Budget savings for Washington state will cut health care access for state employees | Opinion

By **Darin Goss and Will Callicoat**

April 11, 2025 5:00 AM

Opinion

Washington state hospitals lose nearly $400 million in first nine months of 2024, Providence loses $66 million in Spokane area

Cuts to WA hospitals will hurt children statewide

Hospitals warn Legislature's budget plans would deal them a financial hit

Jacquelyn Jimenez Romero Washington State Standard

April 10, 2025, 10:51 a.m. PT

Health Care

Valley Medical Center to close clinics, cut jobs amid financial strain

State Budget: Estimated Annual Fiscal Impact of Cuts and Taxes to Hospitals

All amounts shown in $ millions					
	2025	**2026**	**2027**	**2028**	**2029**
SB 5083 PEBB/SEBB payment cut			$100	$100	$100
HB 2081 B&O - 0.5% surcharge		$60	$60	$60	$60
HB 2081 B&O – Professional tax rate increase	$4	$17	$17	$17	$17
SB 5814/HB 2083 Sales tax on services - IT services/custom software	$4-5	$15-20	$15-20	$15-20	$15-20
1% Medicaid MCO rate cut: Hospital impact*		$30-50	$30-50	$30-50	$30-50
HB 2051 Ancillary services for complex discharge		$5	$5	$5	$5
Total	**$8-9**	**$127-152**	**$227-252**	**$227-252**	**$227-252**

*Hospital impact unknown. Total funds impact is $90M per year in Medicaid cuts. WSHA estimates $30-50M in hospital cuts.

Regardless of who is making the cut or which program they are cutting, when hospitals have low or negative operating margins, a cut to payment means a cut to services.

Federal Budget: Estimated Impact of Cuts to Hospitals

Estimated losses/impacts annually from House Energy and Commerce Legislation (passed House):

- $460 million loss of FMAP at 10% to state.
- $40 million loss from freeze of state directed payment program inflation increases (Hospital Safety Net Assessment).
- $120 million loss in federal funding for Alien Emergency Medical program.
- $80 million in the following: cost sharing requirements (hospital charity care laws prevent Medicaid enrollees from paying;), long term care impacts, and implementation of work requirements and other eligibility requirements. (This may be a low estimate.)
- Increased uncompensated care from exchange and Medicaid enrollment decreases: unknown.

Regardless of who is making the cut or which program they are cutting, when hospitals have low or negative operating margins, a cut to payment means a cut to services.

Revise Focus: Reduce Hospital Prices by Targeting Hospital Cost Drivers

To preserve health care access, policies that target hospitals should:

- **Recognize that rising expenses for hospitals (labor, supplies, drugs) are real pressures that hospitals cannot control**
- **Recognize that WA hospitals are not inefficient – margins are low because costs are higher in WA**
  - Higher nursing expenses alone account for ~25% of the observed cost difference in operating expenses between WA hospitals and the national average.
  - WA nursing expenses per adjusted discharge are ~40% higher than the national average, even after adjusting for case mix.
  - WA nursing wages per hour are ~20% higher than the national average.
- **Address cost-drivers for hospitals.** Hospitals can't and don't want to reduce nursing wages. How else can policy impact major cost drivers?
  - Ensure patients who are ready to be discharged have access to post-acute care (complex discharge).
  - Decrease unnecessary administrative burden.
  - Improve population health and address health-related social needs.

Washington State Medical Association
Physician Driven, Patient Focused

May 29, 2025

Health Care Cost Transparency Board
Cherry Street Plaza
626 8th Avenue SE
Olympia, WA 98501

Dear Members of the Health Care Cost Transparency Board,

As you know, the Washington State Medical Association (WSMA) represents physicians across all specialties and practice settings statewide. We have been members of the Board's Advisory Committee since its inception, and we continue to support a cogent analysis of the reasons for ongoing increases in the cost of health care in our state. I am writing to reiterate our ongoing concerns about the mounting challenges facing physician groups, including tax burdens that contribute to the rising cost of care.

The final state operating budget agreement reached by legislators this year that relies on Business & Occupation (B&O) tax increases through HB 2081 serves as a recent and troubling example of the difficult external pressures that are now threatening the viability of independent medical practices in Washington.

For background, non-hospital physicians and health care providers were subject to a B&O tax increase in 2019 that had the effect of raising rates from 1.5% to 1.75%. Coupled with the base rate increase in HB 2081, the cumulative effect will be increasing B&O rates on these groups by 40% since 2019. Additionally, Section 201 of HB 2081 imposes a .5% surcharge on businesses that gross over $250 million annually, which will impact a number of physician organizations.

Over the last four years, the WSMA and its members have come before this Board in public comment, formal presentations, and written correspondence to consistently stress the *existential* challenges facing independent physician practices—an essential, lower cost setting where many healthcare services are delivered, including primary care, chronic disease management, outpatient surgery, mental and behavioral health, and many more services that keep people healthier and out of higher cost settings.

We urge the Board to consider a more comprehensive and curious approach to understanding the root causes of rising health care costs. It is not enough to merely establish that costs are rising—we all know and feel that. But too often, the discussion stops there, with no examination of what is *driving* those increases.

Seattle Office
1215 Fourth Avenue, Suite 1901
Seattle, WA 98161
o / 206.441.9762 *fax* / 206.441.5863
email / wsma@wsma.org

Olympia Office
1800 Cooper Point Road SW
Building 7, Suite A
Olympia, WA 98502
o / 206.441.9762 *fax* / 206.441.5863

We continue to witness a troubling disconnect between the state's stated goal of controlling health care costs and policy decisions that directly undermine that goal. The recent increase in the B&O tax on physician practices—on top of prior increases—is one such example. Physician practices, unlike many other businesses, cannot adjust their pricing in response to increased taxation or rising operational costs, as they are locked into reimbursement rates determined by government programs and commercial insurers. These rates are not only stagnant but in many cases declining, with federal Medicare payments falling by 33% (adjusted for inflation) over the past 25 years and Medicaid rates for specialty services in Washington among the lowest in the country. We also cannot ignore the looming impact of federal cuts to the Medicaid program, which are sure to compromise the ability of physician practices to remain operational and residents in our state to receive timely health care services.

Meanwhile, inflation has significantly increased the cost of operating a medical practice—from labor and rent to medical supplies and malpractice insurance. Simultaneously, as we have shared in presentations to this Board, administrative burden placed on practices by both insurers and regulators continues to grow, contributing not only to costs but also to provider burnout and early retirements, further stressing our workforce.

As these pressures mount, the unfortunate but predictable result is the consolidation of independent practices into larger health systems. For some practices, the only other option may be to close.

On May 29, the American Medical Association (AMA) issued a press release announcing the latest *Policy Research Perspective*, which presents an analysis of current physician practice arrangements. The findings reveal a continuing trend: more physicians are transitioning to practices owned by hospitals and private equity groups. This shift is largely driven by the growing financial and administrative challenges of operating independent practices. Physicians cited inadequate reimbursement rates, high operational costs, and burdensome regulatory and administrative requirements as persistent and significant factors influencing this move. The full press release is available on the AMA Press Center: More physicians move to practices owned by hospitals, private equity.

The Health Care Cost Transparency Board has a unique opportunity and responsibility to look beyond surface-level data and engage with the complex realities behind rising costs. We urge the Board to seriously consider:

- Rising taxes and fixed reimbursement models;
- Increased administrative waste that does not add value to patient care;
- Inflationary pressures on staffing and operational costs;
- Declining federal and state payment rates, especially in Medicaid and Medicare.

We hope the Board will approach this work with renewed urgency and a more holistic lens. We are partners in the effort to identify, and control health care cost drivers; the sustainability of independent practices—and the broader goal of an accessible, affordable health care system—depends on it.

Sincerely,

John Bramhall, MD, PhD
President
Washington State Medical Association

Tab 4

Cost Board Legislative update

Evan Klein
Special Assistant for
Policy And Legislative Affairs

Washington State Health Care Authority

2025 session

- Adjourned April 27, 2025 (sine die)
- Long session with biennial budget
- Selected highlights with Agency Request Legislation and affordability related bills

Washington State Health Care Authority

2025 Legislative priorities

- Maintaining coverage and ensuring access
- Strengthening behavioral health, substance use disorder (SUD), and housing supports
- Improving health outcomes through enhanced rates and benefits
- Critical staffing support
- Health and Human Services (HHS) Enterprise Coalition projects and IT investments

2025 session by the numbers

Washington State Health Care Authority

HCA Agency Request Legislation

Washington State Health Care Authority

HCA request: access and affordability

- E2SSB 5083 – **PEBB/SEBB affordability**
- Beginning January 1, 2027, caps PEBB/SEBB reimbursement for licensed hospitals in Washington.
  - In-network acute care hospitals: 200% of Medicare payments amounts
  - In-network children's hospitals: at 150-190% of Medicaid ratio of cost-to-charges (RCC)
  - Out-of-network rates for acute care and children's hospitals capped at lower levels
- Establishes reimbursement floors at 150% of Medicare for Primary Care and Behavioral Health Services

HCA request: modernizing the APCD

- HB 1382 – **Modernizes the Washington State All Payer Claims Database (WA-APCD)**
- Removes references to "proprietary financial information" in statutes implementing the WA-APCD, effective July 1, 2026.
- Allows HCA to act as the lead organization for the WA-APCD effective immediately.
- Expands the goals of the WA-APCD as they relate to providers, hospitals, carriers, and certain statewide associations; also allows data disclosures in accordance with those goals.
- Requires HCA to update the Legislature on health care price transparency programs by December 31, 2025.

A few related policy bills

Washington State Health Care Authority

Health carrier reporting

- SB 5084 – **Primary Care Spend Reporting**
- Allows OIC to require health carriers to annually report primary care expenditures in previous calendar years, or anticipated expenditures for upcoming calendar years
- OIC to determine reporting requirements
  - Consider the definitions and targets set by the Cost Board

Health care registry

- **E2SHB 1686 – Creating a health care entity registry**
- Requires the Department of Health (DOH), in consultation with others, including HCA, to develop a plan and recommendations to the Legislature on how to create an interactive registry of the health care landscape in Washington
  - Intent is to understand the business structure and funding sources of health care entities operating in Washington
  - Covers licensed and unlicensed facilities, providers, provider groups, systems, carriers, and benefit managers

Price transparency

- SSB 5493 – **Hospital price transparency**
- By July 1, 2027, hospitals must publish all data and comply with all federal rules and regulations on standard charges and shoppable services.
- Beginning July 1, 2027, at least once a year hospitals must submit the most recent machine-readable file containing:
  - A list of all standard charges for all hospital items or services
  - The most recent consumer-friendly list of standard charges for a limited set of shoppable services to DOH

Public Statements During Negotiations

- SSB 5579 – **Prohibiting health carriers, facilities, and providers from making any public statements about terminations**
- Prohibits health carriers and health care providers from making public statements regarding a possible contract termination until 45 days before the termination, except when the disclosure is to satisfy a legal obligation.
- OIC must develop a standard template for providing such notices.

State health plan

- SSB 5568 – **Updating and modernizing the Washington state health plan.**
- Requires the Office of Financial Management (OFM), in coordination with relevant public and private stakeholders, to update the state health plan by developing a statewide health resources strategy.
  - OFM must consider the principals of health equity
  - OFM can access APCD
  - Including data from OIC, DSHS, and the Health Benefit Exchange
- OFM report
  - Preliminary report due July 1, 2026
  - Completed health resources strategy report to the Governor's Office and Legislature by December 31, 2027
  - Report updates starting January 1, 2033, and every 4 years after

Failed bills

- 1881 – Keep Our Care Act (KOCA) / mergers and acquisitions
- 5387 – Corporate practice of medicine
- 5395 - Prior authorization/health
- 1589 – Relationships between carriers and providers

Questions

Evan Klein
Special Assistant,
Legislative & Policy Affairs
evan.klein@hca.wa.gov

Shawn O'Neill
Legislative Relations Manager
shawn.oneill@hca.wa.gov

Washington State Health Care Authority

Tab 5

Washington State Health Care Authority

Analytic Support Initiative: brief context

Harrison Fontaine
Senior Health Policy Analyst

Washington State Health Care Authority

Data streams overview

- **Data sources**: foundation for analyses (**reports** and **interactive visualizations**) provided to the Cost Board
- Sources are *currently* each associated with one report
- Data visualizations for APCD[1] and DEX[2]

1. APCD: All payer claims database
2. DEX: Disease expenditure database
3. IHME: Institute for Health Metrics and Evaluation

Washington State Health Care Authority

Data sources: overview

Characteristic of data source	Data Call	APCD	DEX[1]
Aggregated: Summarized information in data source	X		
Granular: Claims-level data		X	
Granular Estimates: *estimates* from processed data			X
Comprehensive: Proportion of population captured	92% of total WA population	70% of total WA population	Estimates adjusted to be representative of WA population
Most recent data* *As of 5/1/2025	2022	2024	2022

- Data Call and APCD
  - Reported spending from claims or carrier/providers
  - HCA leads
- DEX
  - Estimated spending triangulated using APCD and other sources.
  - IHME leads

Washington State Health Care Authority

ASI reports: analytic focus and key findings

- ASI as part of overall analytic approach
  - Analytic capacity to parallel internal analytic capacity building
  - **Analytic focus**: Service category and condition-level cost driver analysis
    - Service category utilization by regional characteristics and conditions driving potentially avoidable expenditure
      - → Focus of today's presentation
- Prior findings: highlights
  - **Increasing price/intensity was the primary driver of increased spending across service categories**
  - Demographic shifts primarily affected Medicare spending, with other payers less influenced
  - Spending on behavioral health disorders (mental disorders and substance use disorders) increased at a faster rate than other health conditions

Analytic Support Initiative

WA Health Care Cost Transparency Board

HCA & Institute for Health Metrics and Evaluation

June 3, 2025

ASI

Analytical Support Initiative Overview

Condensed objective:

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

Philanthropic funding for July 2023-July 2025

Timeline:

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

Today's discussion

Key questions:

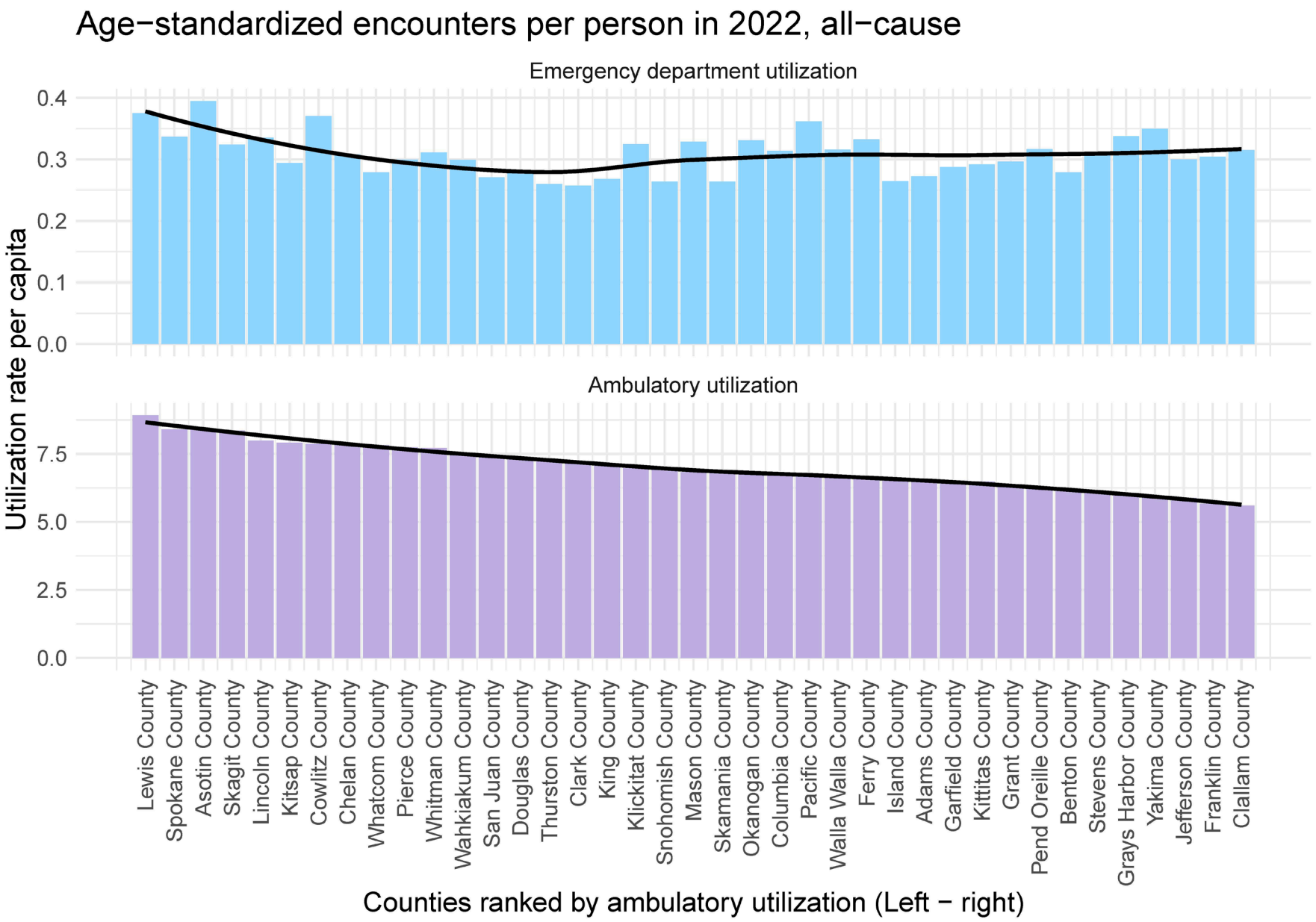
1) How does the relationship between missing utilization of outpatient services and preventable admissions interact with rurality and wealth?
2) What is the spending burden associated with top contributors to potentially preventable admissions ?

Approach:

1) Aggregate analysis
2) Health condition specific analysis

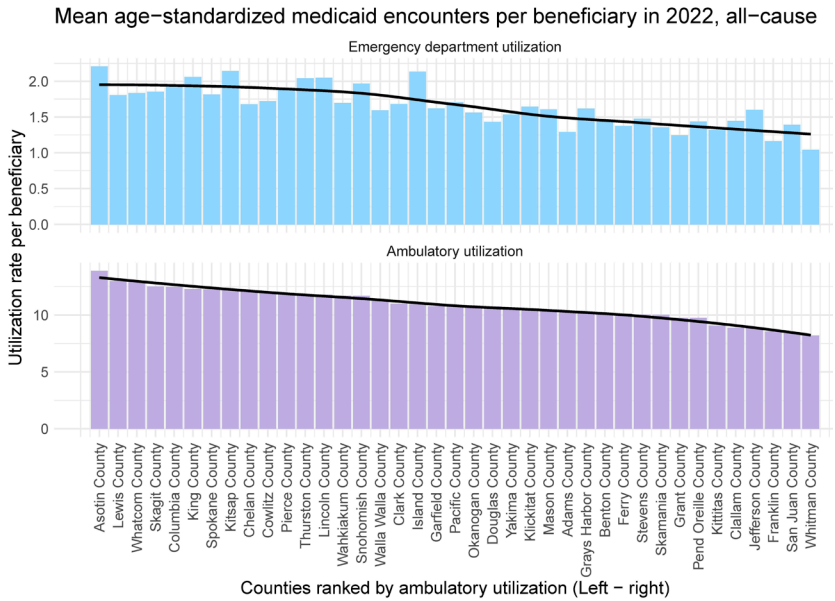
AGGREGATE ANALYSES

There is not a clear tradeoff between ambulatory and ED services

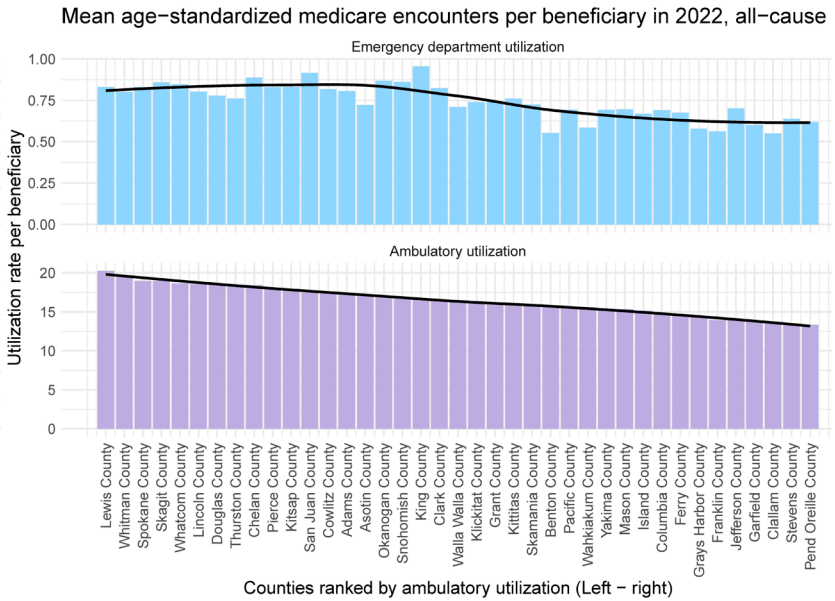


When disaggregating by payer, there is a weak *positive* relationship

Medicaid



Medicare



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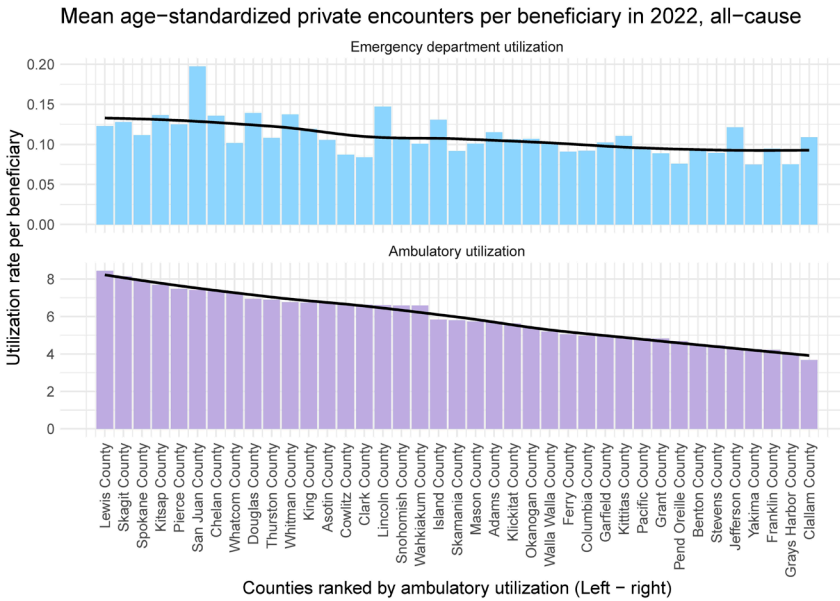
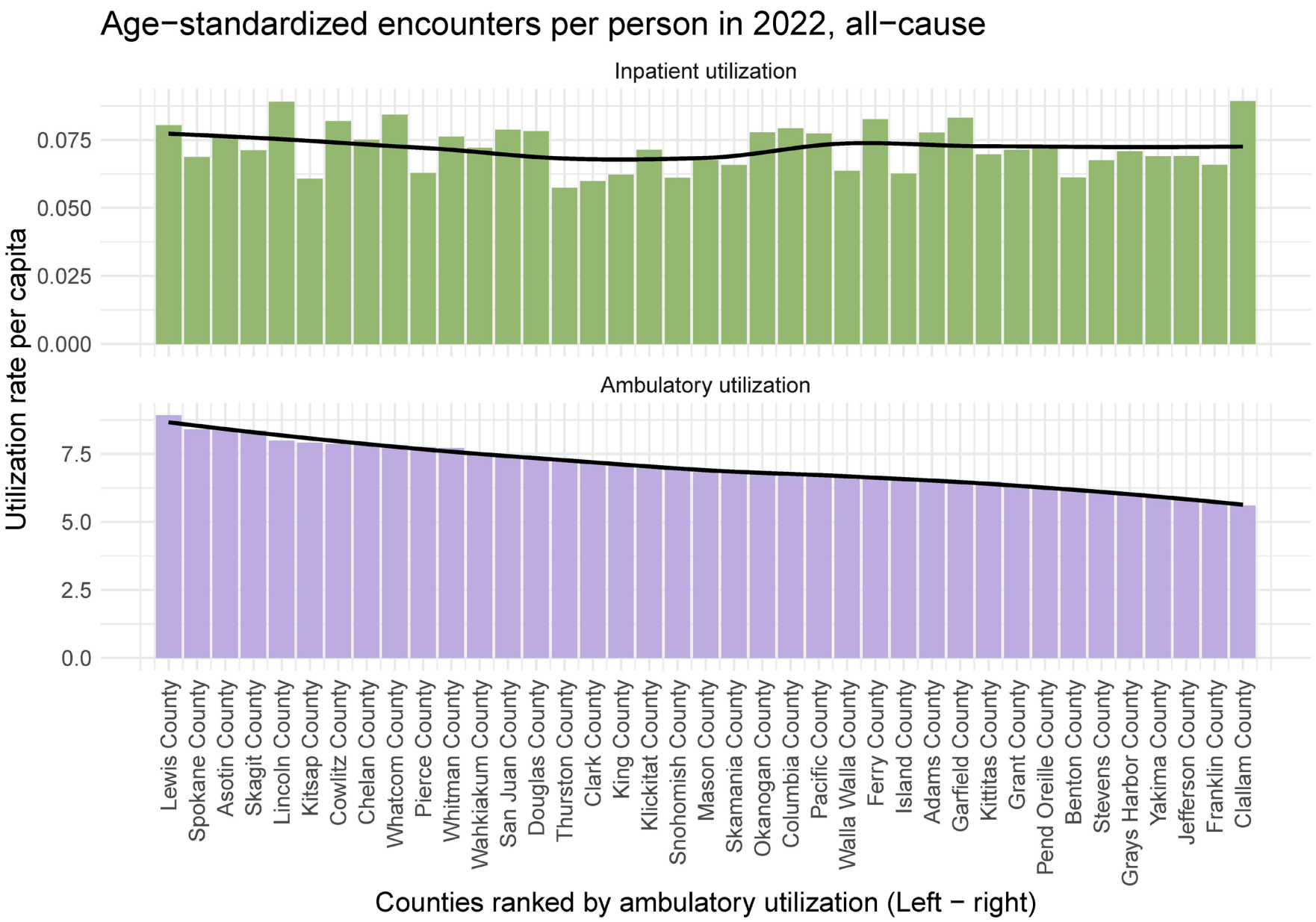


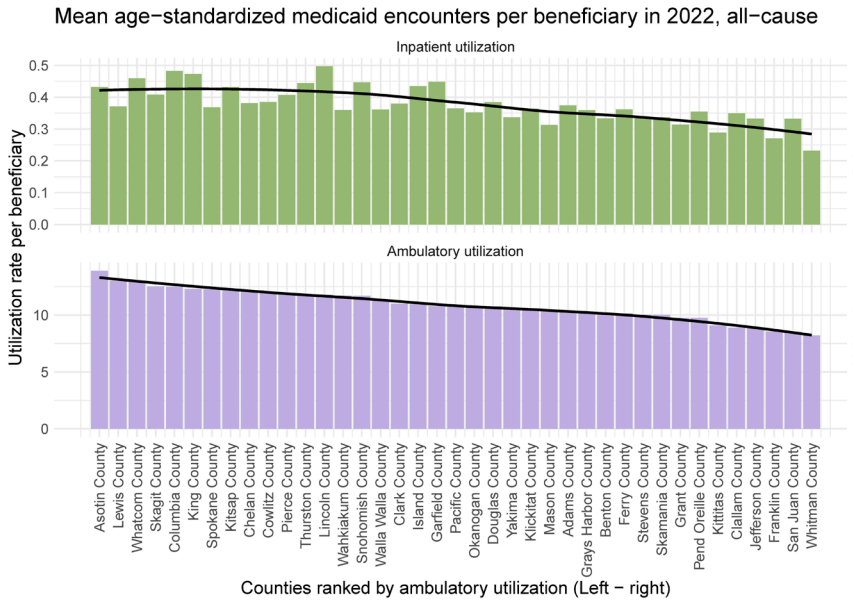
Utilization rates per beneficiary

There is not a clear tradeoff between ambulatory and inpatient services

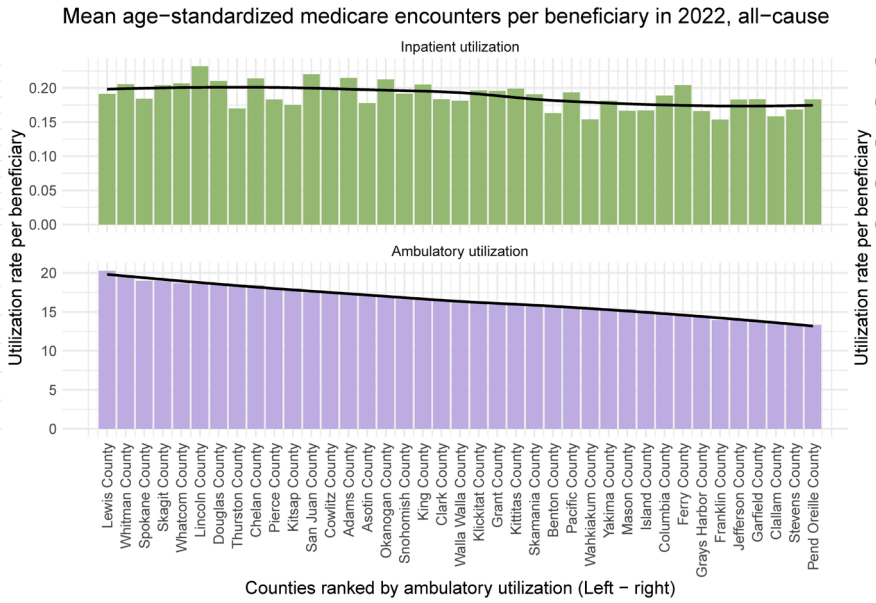


Including at the payer level

Medicaid



Medicare



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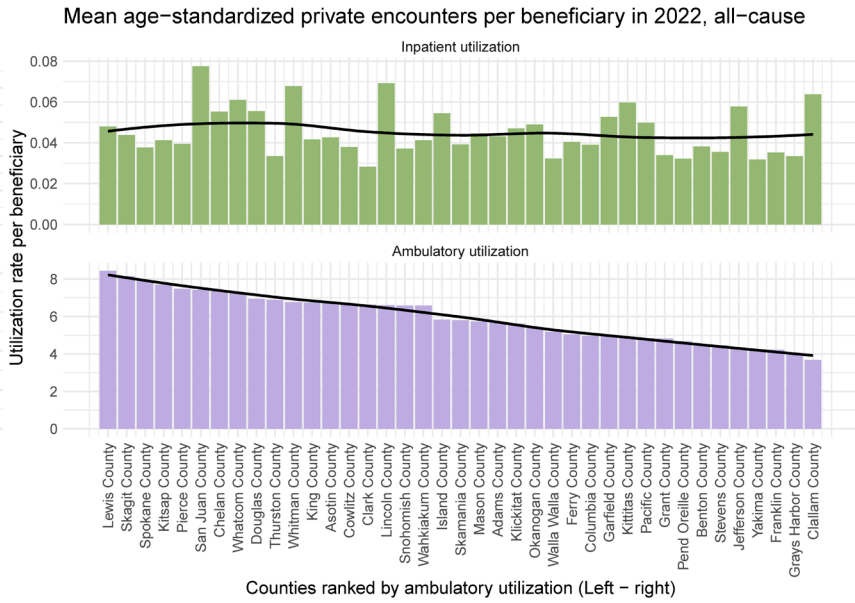
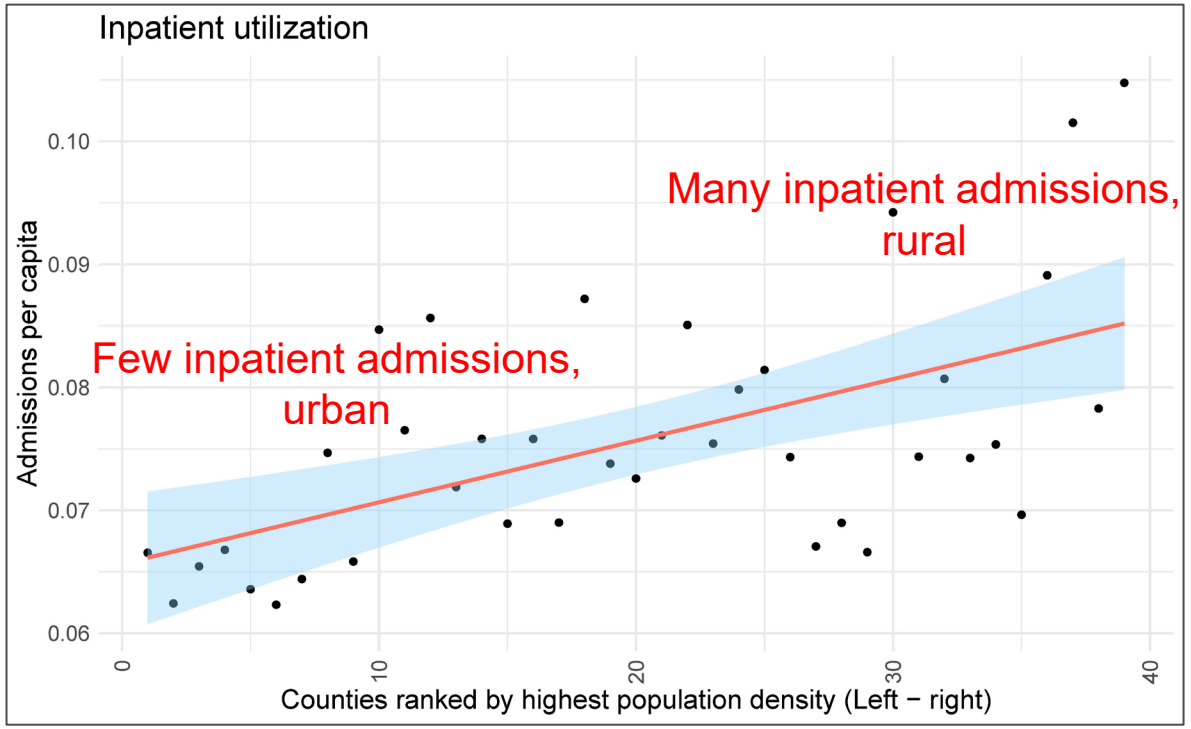
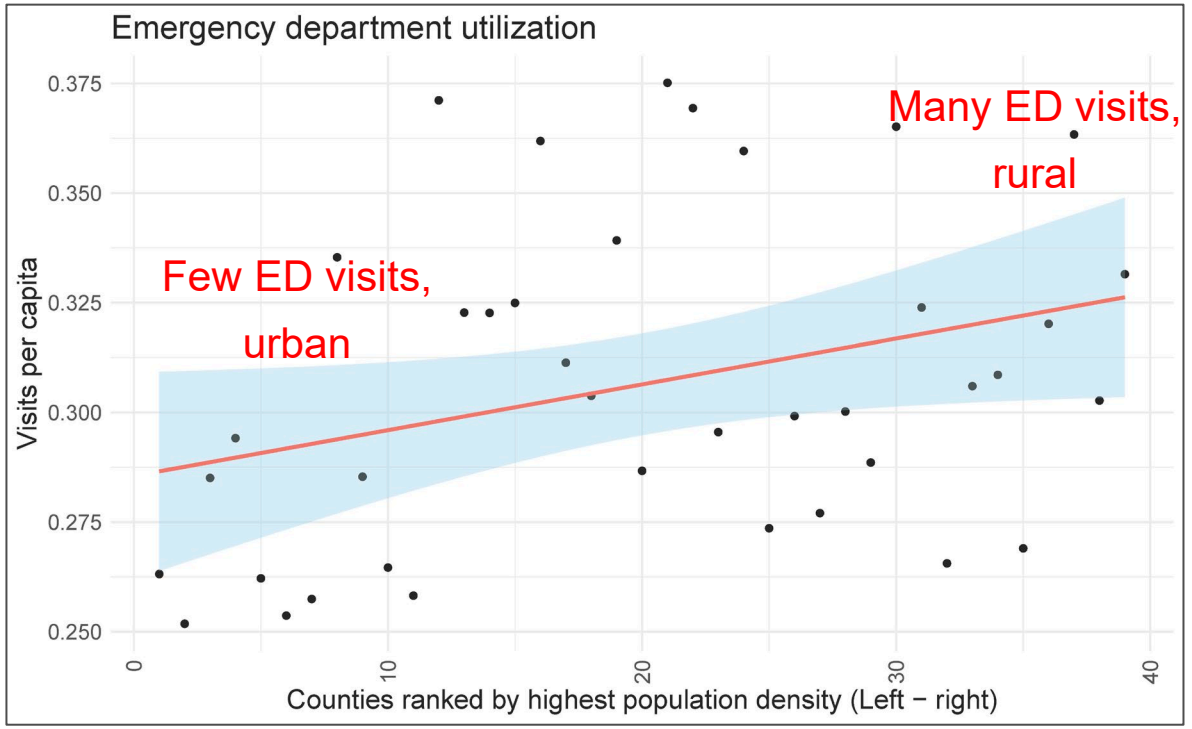


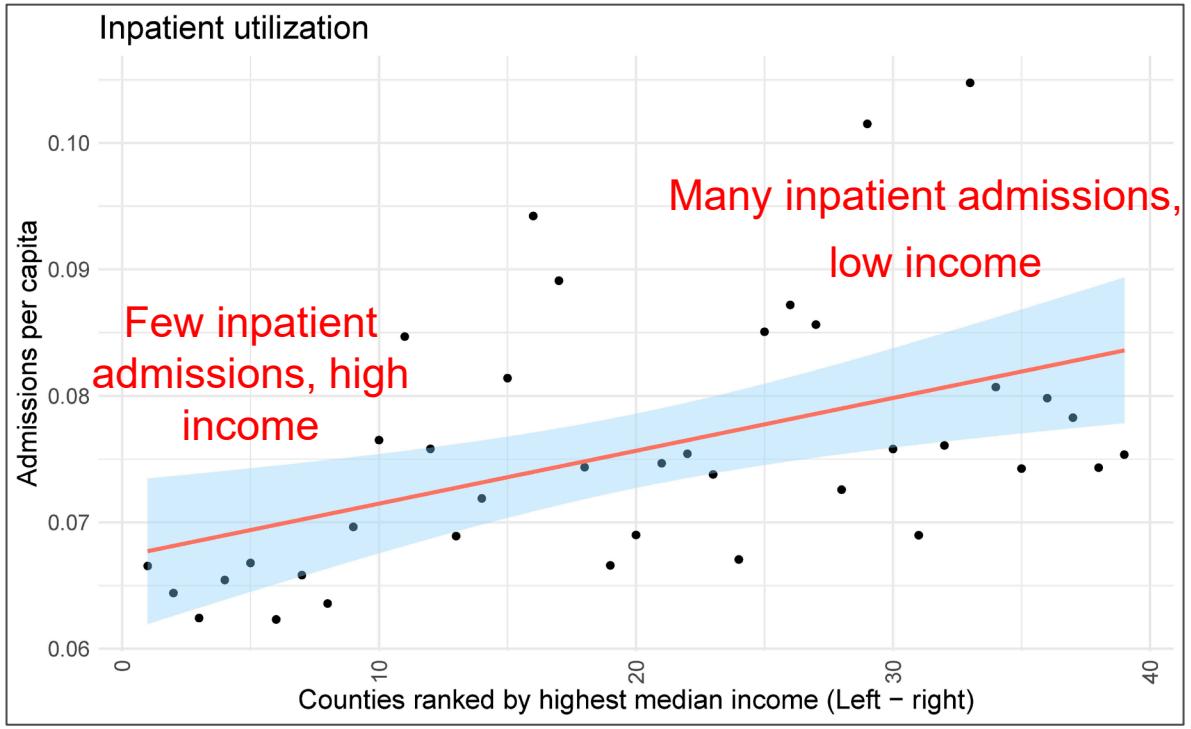
Utilization rates per beneficiary

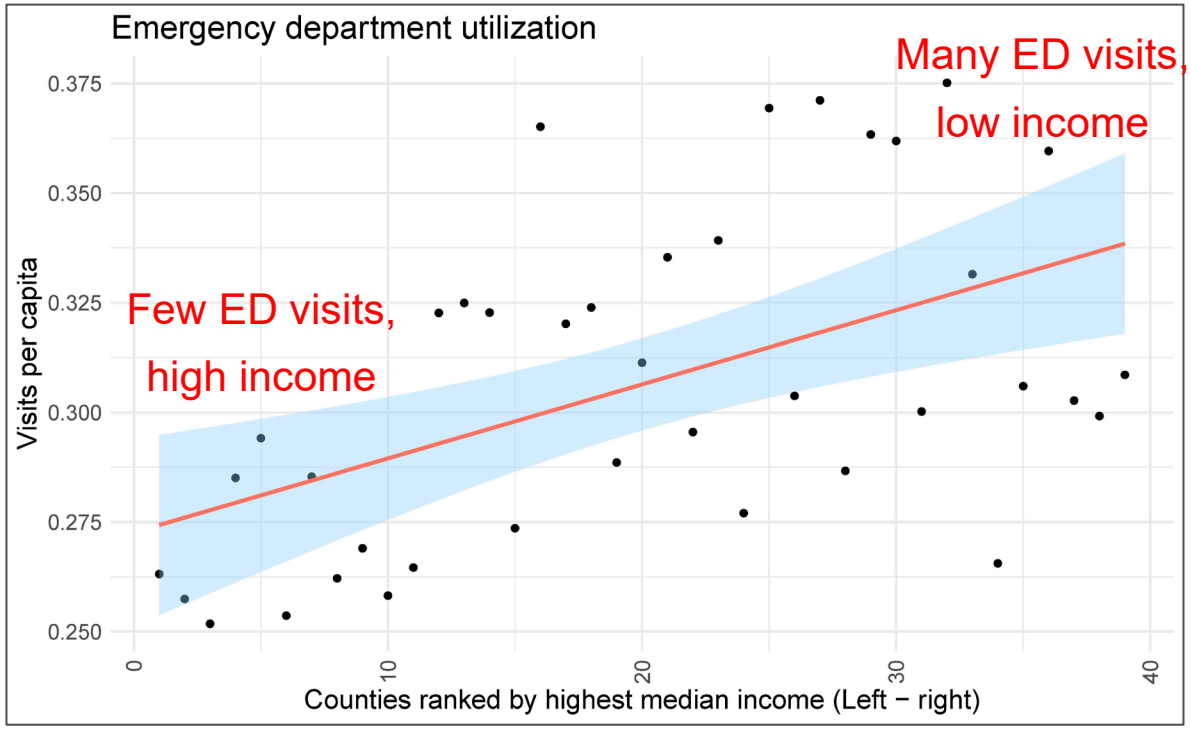
And there is a clear relationship that rural counties rely more on inpatient care and maybe a little more ED care



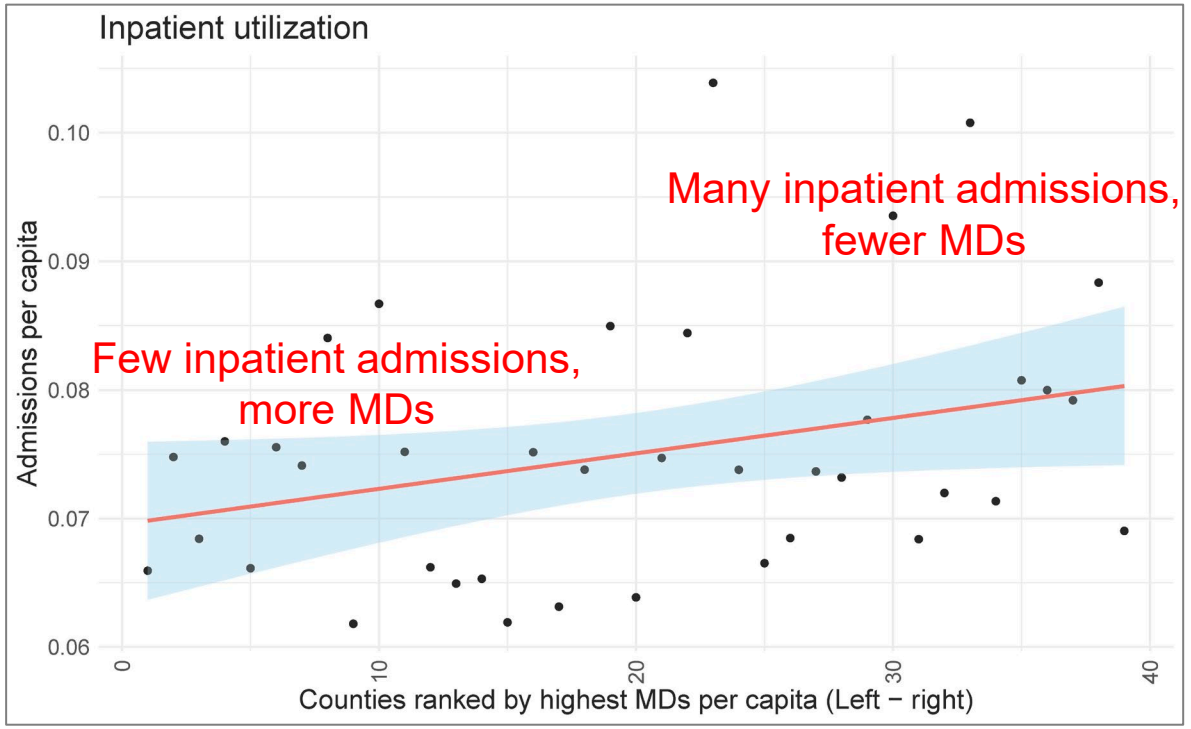


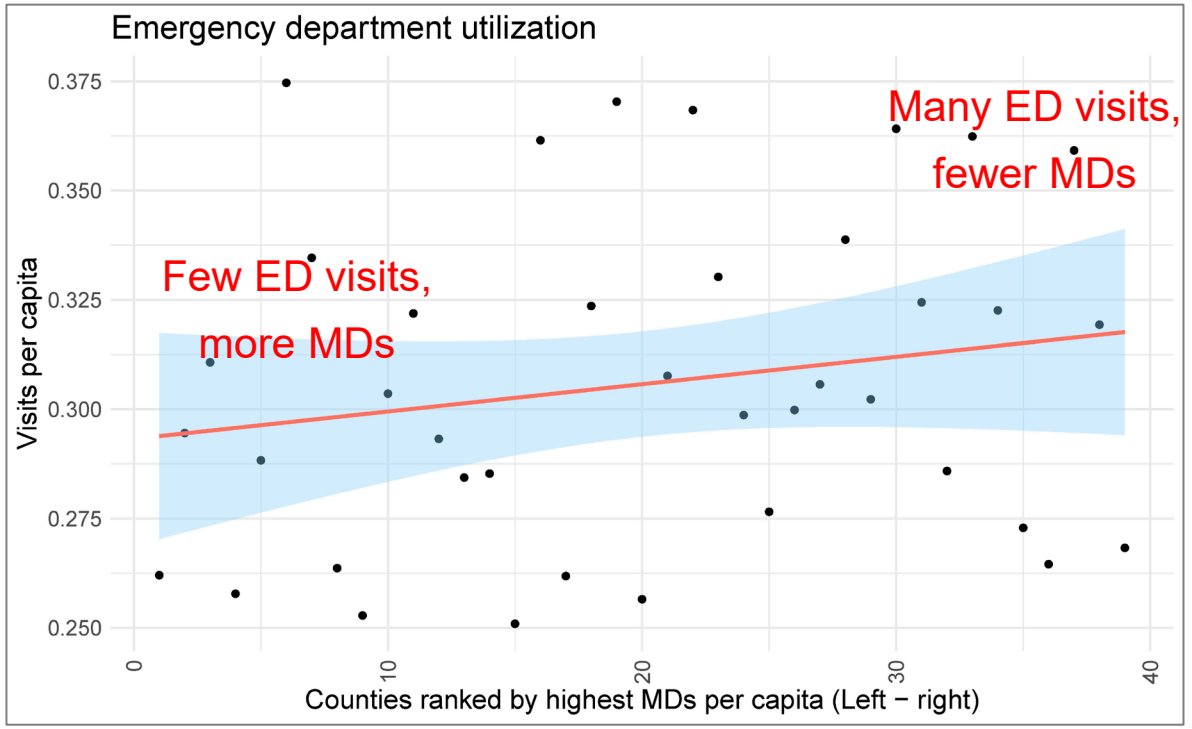
There is a clear relationship that lower income counties rely more on inpatient care and ED care





And there is a weak relationship that counties with fewer doctors rely more on inpatient care and ED care





Health condition specific analyses

Picking health conditions to focus on:

1. Focus on health conditions where inpatient admissions are potentially avoidable

+

2. Have input data

+

3. Focus on health conditions that are significant drivers of health care spending in Washington

External inputs:

- CMS Potentially Avoidable Hospitalizations (PAH)
- AHRQ Ambulatory Care Sensitive Conditions (ACSC)
- Behavioral health conditions

Picking health conditions to focus on

Table 1.

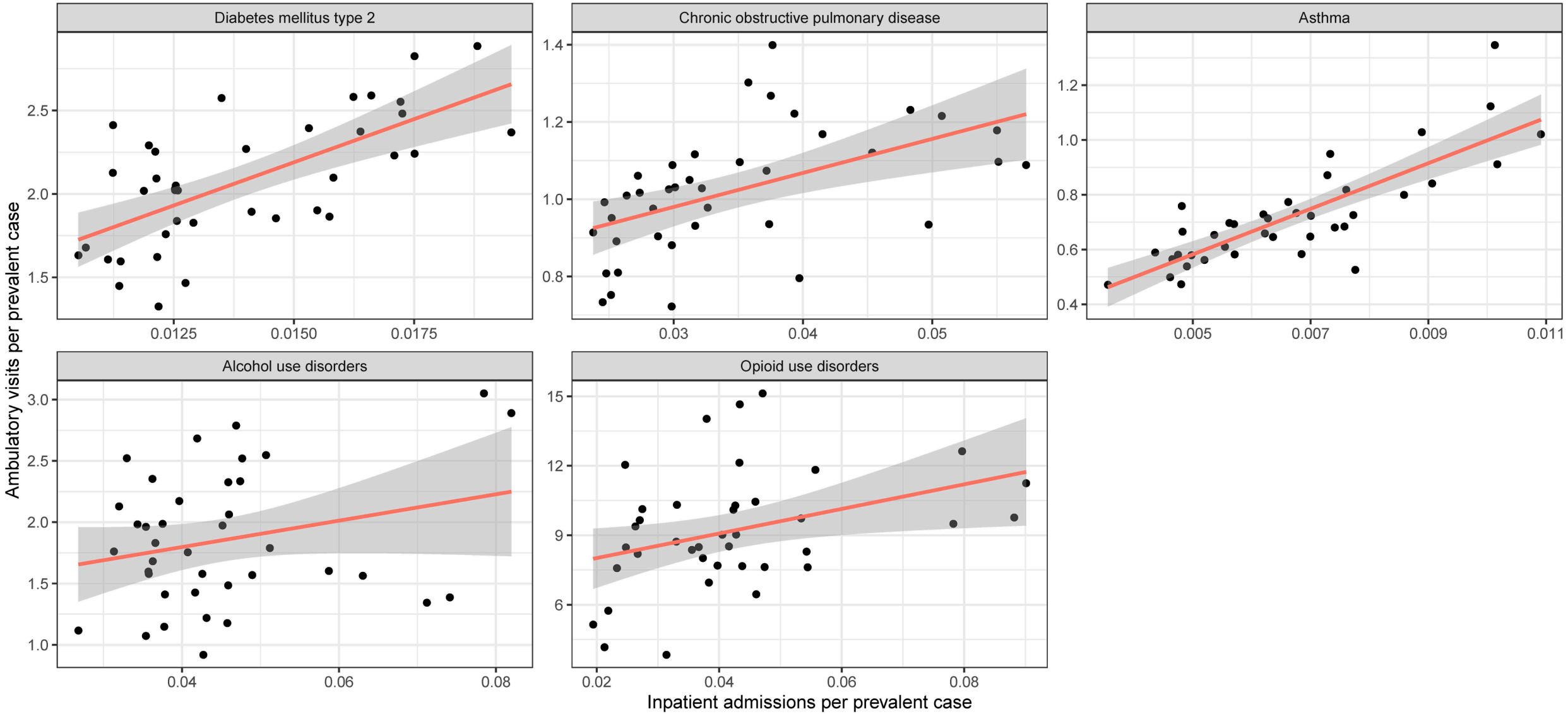
Health condition	WA total spending in 2022	WA total IP spending in 2022	WA total ED spending in 2022
Type 2 diabetes	$3,000M	$250M	$66M
Chronic obstructive pulmonary disease (COPD)	$600M	$150M	$28M
Asthma	$510M	$50M	$21M
Alcohol use disorders	$470M	$220M	$17M
Opioid use disorders	$400M	$62M	$4.1M

Collectively these conditions account for 8.3% of total spending, and 5.6% of IP and 8% of ED spending on health care in WA in 2022.

External inputs:

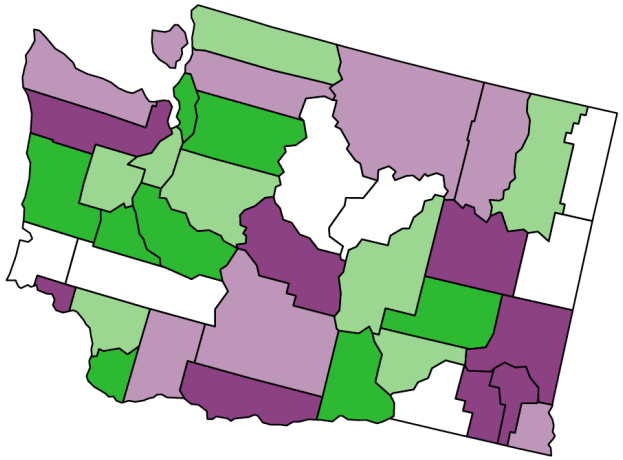
- CMS Potentially Avoidable Hospitalizations (PAH)
- AHRQ Ambulatory Care Sensitive Conditions (ACSC)
- Behavioral health conditions

Even when adjusting for disease prevalence, counties that use more ambulatory services also use more inpatient services



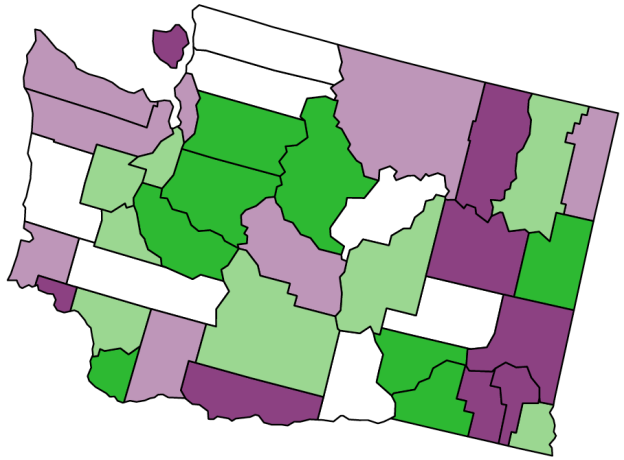
Potentially preventable inpatient admissions per case (2019), age-standardized

Diabetes mellitus type 2



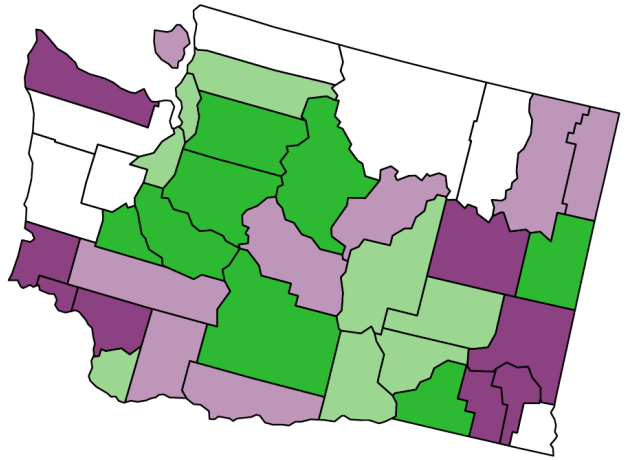
0.012 – 0.014 | 0.014 – 0.016 | 0.016 – 0.018 | 0.018 – 0.019 | 0.019 – 0.027

Chronic obstructive pulmonary disease



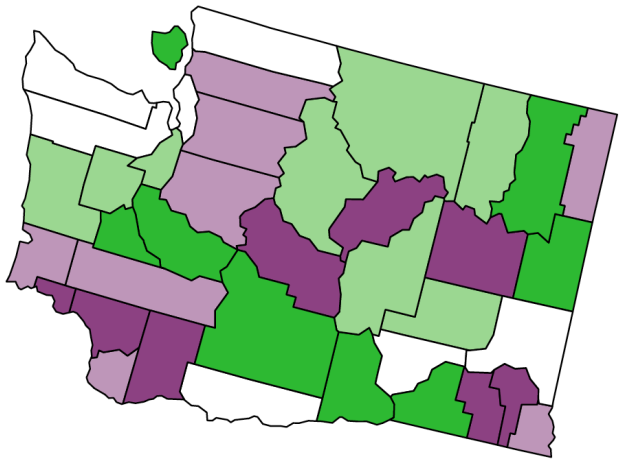
0.026 – 0.031 | 0.031 – 0.035 | 0.035 – 0.042 | 0.042 – 0.063 | 0.063 – 0.118

Asthma



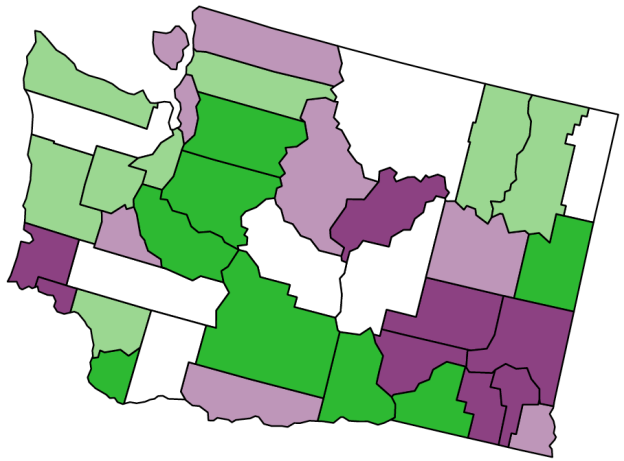
0.004 – 0.005 | 0.005 – 0.006 | 0.006 – 0.007 | 0.007 – 0.008 | 0.008 – 0.011

Alcohol use disorders



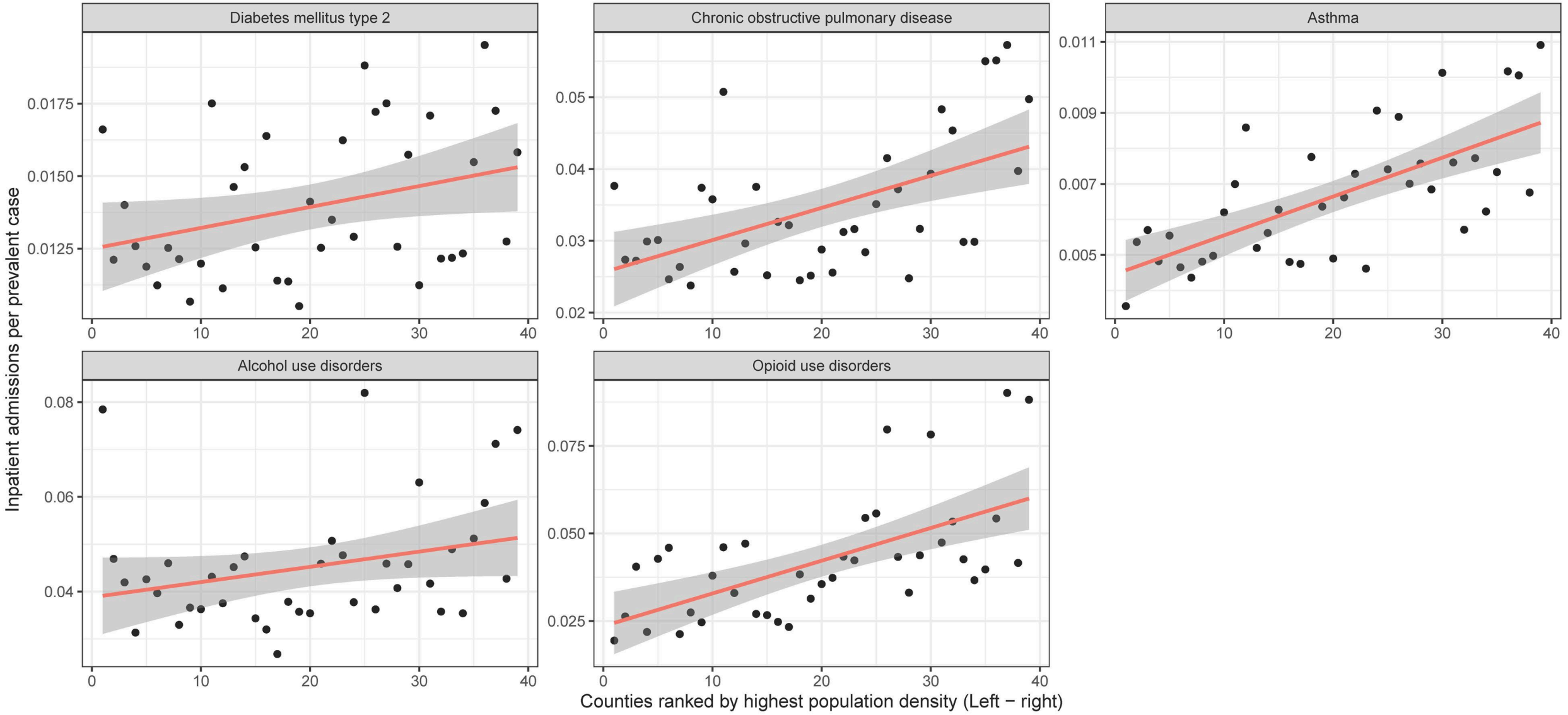
0.027 – 0.034 | 0.034 – 0.039 | 0.039 – 0.043 | 0.043 – 0.048 | 0.048 – 0.082

Opioid use disorders



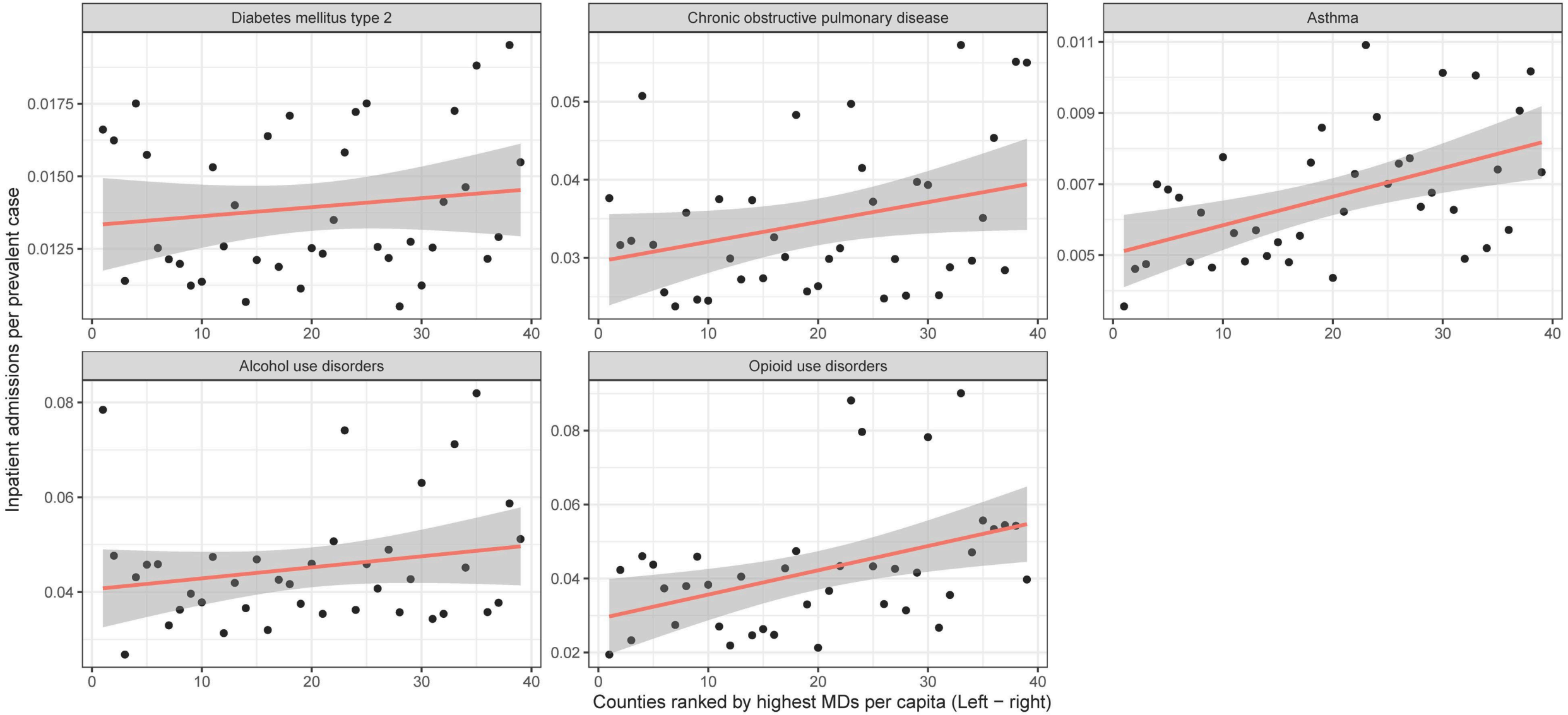
0.044 – 0.064 | 0.064 – 0.078 | 0.078 – 0.084 | 0.084 – 0.112 | 0.112 – 0.192

Counties with high population density have fewer potentially preventable inpatient admissions per case (2019), age-standardized



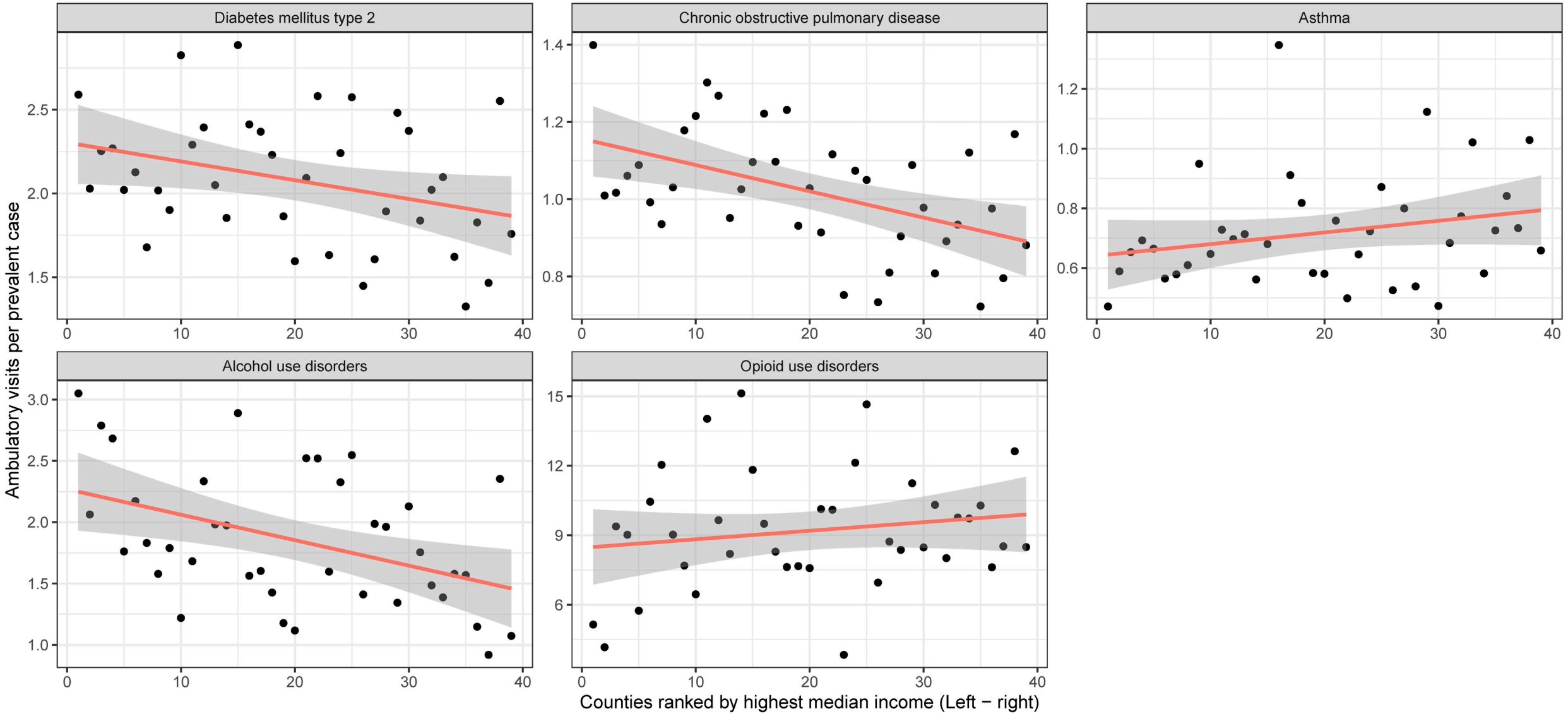
← More urban, less urban →

Counties with high doctor availability have fewer potentially preventable inpatient admissions per case (2019), age-standardized



← More MDs, fewer MDs →

And there is a clear relationship between income and ambulatory utilization



← More income, less income →

Take-aways

1. We don’t see that more outpatient visits are associated with fewer hospitalizations

2. For conditions that are ambulatory care sensitive:
   a) more inpatient admissions in rural counties, and
   b) more outpatient visits in wealthy counties

Thank you

ASI

ASI final steps

Review of ASI objectives

- **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

Final steps

- Vote on inclusion of ASI 2025 analytic findings (i.e., analysis from today's presentation) in the legislative report and relation to policy levers

Cost Board vote

Motion:

Accept the ASI 2025 analytic findings for inclusion in the 2025 Legislative Report and recommend continued evaluation of policies to address hospital expenditures.

Washington State Health Care Authority

Tab 6

Review of strategies to address hospital spending

Washington State Health Care Authority

Strategies to control cost growth

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 of benchmark values

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")

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

8. Establish hospital global budgets

Current policy actions targeting cost growth

PEBB/SEBB Reference Based Pricing
ESSB 5083

State Health Plan
SB 5568

Primary Care Expenditure Reporting by Carriers
SB 5084

Hospital Price Transparency
SSB 5493

Provider Registry
ESSB 1686

Washington State Health Care Authority

OON = Out of Network

Overview of an All-Payer Hospital Global Budget Payment Model

Presentation for the Washington State Health Care Cost Transparency Board

Robert Murray, FTAC Member, Former Executive Director of the Maryland All-Payer Hospital Rate Setting System

June 3, 2025

Agenda

- My Background
- Key Policy Goals and Current Healthcare Problems States Need to Address
- Description and General Characteristics of a Hospital Global Budget Rate Setting model
- Simplified Example of a Hospital Global Budget (HGB)
- Past Hospital Global Budget Model Applications
- Policy Objectives and Key Incentives of HGB Payment Model
- Advantages and Disadvantages of Hospital Global Budgets
- Modifications to address Model Weaknesses
- Governance and Oversight Considerations
- Conclusions, Q&A, Discussion and Potential Next Steps

My Background

- BA and MA in Economics and MBA from Stanford University
- Management Consultant for Amherst Associates, Ernst and Young
- Longest Serving Executive Director, Maryland Health Services Cost Review Commission (HSCRC) 1994-2011
- During my time with HSCRC implemented several new payment initiatives:
  - A P4P quality-based incentive system to improve hospital quality of care
  - A new and more equitable method for funding Hospital Uncompensated Care (UC Pools)
  - The Implementation of a Hospital Global Budget (HGB) model for 10 more isolated rural hospitals
- Since leaving the HSCRC – served as a Consultant to the World Bank and various States (Vermont, Oregon, Rhode Island, Massachusetts) on Payment Reform and published a number of articles on Regulated Payment Models for states

Key State Policy Goals in the Health Care Sector

- Maryland and other states in the 1970s, 1980s and 1990s implemented hospital rate setting systems in an attempt to accomplish the following key policy goals:
  - Constrain hospital Price and Spending growth and make health more affordable (i.e., "Cost Control")
  - Improve the Equity of the hospital payment system – both in terms of prices and allocation of resources
  - Improve the Access to Care within the State
  - Improve the Accountability of hospitals and payers for improving the "Value" of care provided
  - Improve the Financial Stability and Predictability of the system for hospitals to meet the above policy goals
- These are key Policy Goals that all Developed Countries around the World attempt to achieve as they structure their Health Care Policy and Regulatory Systems

These were "Mantras" of the Maryland Hospital Rate System and Guided all Policy-making

Key State Policy Goals in the Health Care Sector

Excessive Healthcare Price and Spending Growth is at the Center of State Health Policy Issues & Goals

#5 Issue: Stability and Financial Viability
Inequitable payments, FFS Payment, cuts in Medicaid and inability to pay for Uncompensated Care Undermine Hospital Financial Stability & Access

#1 Issue: Affordability
Insurance becoming Unaffordable for Commercially Insured Patients (Many Related Policy Issues – state budget & Tax polices, etc.)

#4 Issue: Accountability
Absence of State Oversight of Hospitals results in excess prices, spending, operating expenses, high levels of inefficiency & inadequate Community Benefits

#2 Issue: Equity:
Varying levels of Market Power across providers results in HUGE variations in payment levels across providers – which has Equity and Access Implications

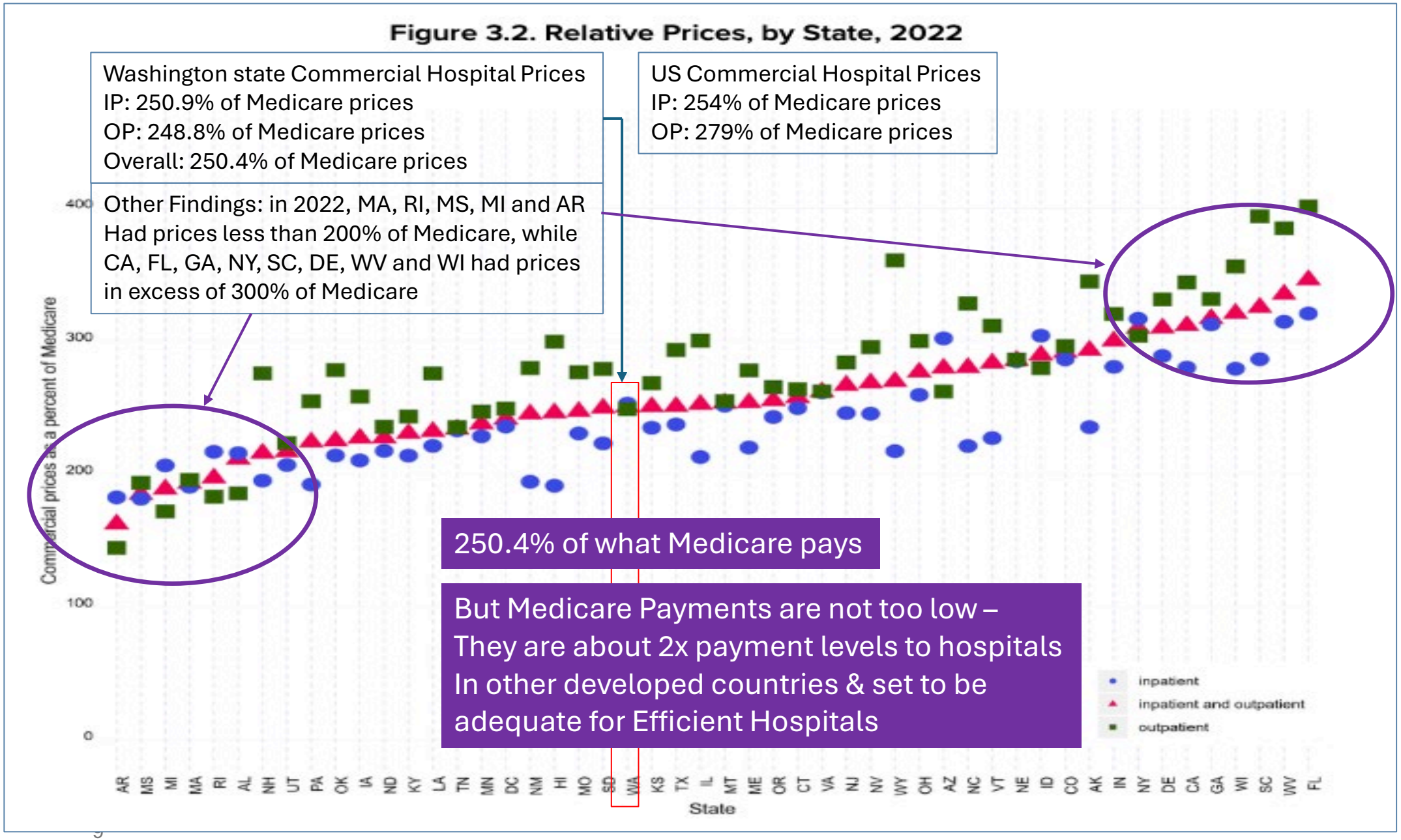
#3 Issue: Access to Care:
Excessive Cost primary barrier to Access to Care (unaffordable Insurance costs) but future cuts to state programs will create a crisis in Access across populations (Medicaid)

Key Policy Problems, Framed by State Policy Goals

- Hospital care is the largest category of healthcare spending and has been growing the fastest
- Unlike other Developed Countries, the US doesn't regulate hospital prices/spending in the Commercial Insurance Market
  - In the US, this is left to the "Market" to control
  - However, the Health Care Market exhibits several devastating "Market Failures" which undermine the ability of States to achieve their policy goals #1 Market failure in US: Uncompetitive Hospital markets
- Since the mid-1990s, hospitals (and other providers) have engaged in at least 2 rounds of mergers & acquisitions
- This consolidation increased Market Power vs. Insurers and which dramatically increased the payments hospitals get from insurers, from 113% of Medicare in 1997, to 170% in 2018 to over 250% in 2022 (1)
- Hospital (and other provider) concentration continues unabated by Commercial Insurers, Antitrust or other Policy Approaches

(1) Although Medicare payment levels are thought by providers to be inadequate, Medicare payment levels are believed to be adequate for "efficient" providers and are far in excess of hospital payment levels internationally (>2x higher)

Extremely High Hospital Prices in the US and in Washington



Source RAND Employer Survey 5.1

Key Policy Problems, Framed by State Policy Goals - Continued

- Variations in "Market Power" has also created HUGE Pricing Inequities across Hospitals and Geographies which creates inequities in financing and access to care issues
- High costs, along with public cuts (Medicaid) contribute to eroding Access to Care
- Due an absence of Oversight – hospitals are not accountable for cost, quality or access to care or community benefits they provide
- Some large Hospital Systems and "must-have" hospitals are highly profitable with huge "financial reserves" while smaller hospitals in rural and underserved urban areas are on the verge of closure
- Fee-for-Service (FFS) payment exacerbates many of the above-mentioned policy problems and contributes to the provision of unnecessary and low-value care (LVC)

A hospital rate Regulatory System can address these problems and achieve stated policy goals

The use of caps on Hospital Prices, is (as contemplated in SB 5083) is a good place to Start

If can be demonstrated, this approach saves the state money but does not undermine hospital financial viability, the State should consider a more comprehensive Spending Control Model

A broader regulatory structure (Flexible Hospital Global Budgets) governed by a Public-Utility style Commission – can create the regulatory infrastructure to avoid regulatory issues but be structured to 1) Control Costs; 2) improve Equity; 3) Expand Access; 4) Improve Accountability & 5) Improve Financial Viability and Achieve other Goals

Global Budget Applications in the Past

- Used widely in Canada and Europe – different iterations
  - France and Germany initially implemented Fixed Global Budgets but found these models too restrictive and moved to a more "Flexible" Budgeting model
- Maryland's original payment system employed a system of "Flexible" Hospital Global Budgets 1976-92
- Rochester and Finger Lakes Area hospitals (New York 1980s)
- Maryland 2009 (10 rural hospitals) and 2014-present (CMM), Vermont All-Payer ACO model & Pennsylvania Rural Health Model (CMMI) implemented Fixed Global budgets
- CMS/CMMI AHEAD Demonstration (2024-2033)
  - Currently, Maryland, Vermont, Hawaii, Connecticut, Rhode Island and several "down state" counties in New York have been approved to participate

Hospital Global Budgets General Characteristics – A Regulatory Model

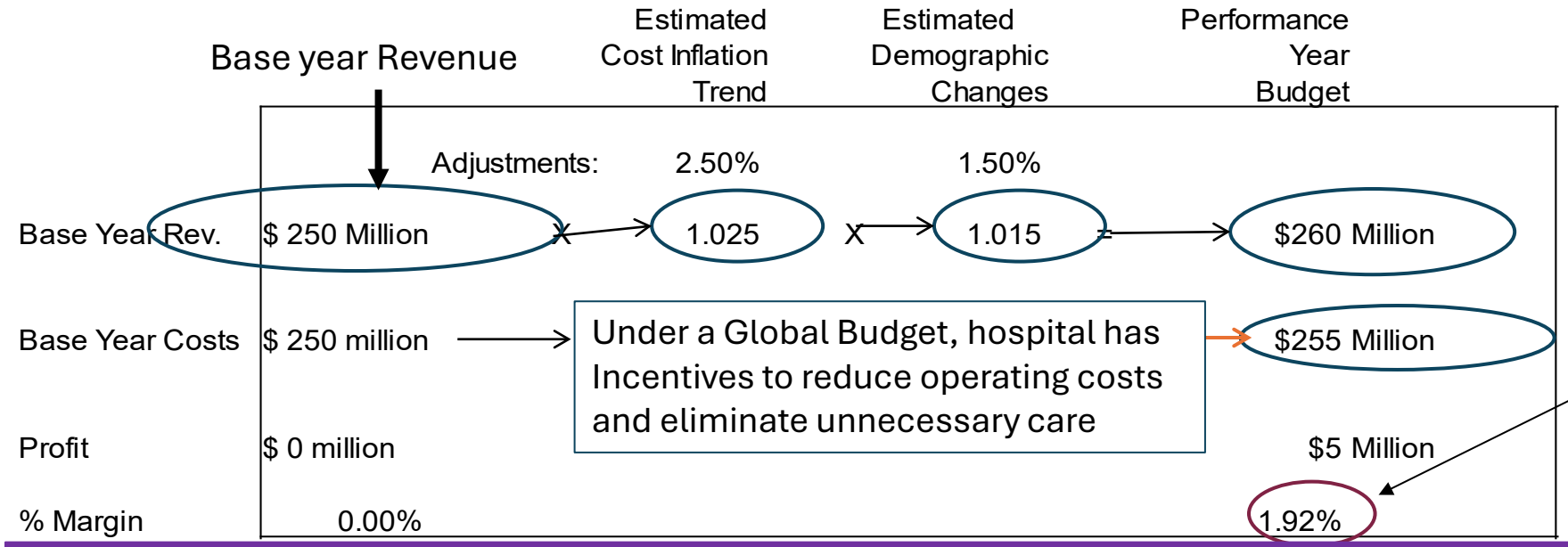
- Establishment of a fixed or semi-variable budget covering all hospital and potentially other services
- Initial budgets are based on hospital historical revenues in a recent Year < Eases Transition to HGBs
- HGBs established and enforced by a regulatory authority based on a Public Utility regulatory model
- The State has Legal Authority to control the growth of budgets to meet state affordability goals
- Best if HBG model applicable to all payers and all or most hospitals in a state
  - Medicare & Medicaid participation requires negotiation of Medicare Waiver with CMMI
  - Commercial/Self Funded payer participation must be mandated by state law
- HGBs generally cover all acute inpatient and outpatient hospital services, but may also include some physician services, post-acute and home health services
- HGBs are a more comprehensive cost containment model but still a "Lower Intensity" model: Regulating aggregate budgets - less complex than regulating individual service prices
- There are different HGB approaches: fixed budgets or semi-variable ("Flexible" Global Budgets)

Simplified Example of a "Fixed" Hospital Global Budget

- Washington County Hospital
  - Community hospital in a rural part of the State
  - Separated by distance and mountain ranges
  - Serves 148,000 population in Washington County
  - Limited "in-migration" from other parts of the State
  - Budget in Prior year = $250,000,000

This illustrates what is referred to as a "Fixed" Global Budget structure. Maryland and Rochester New York, implemented a more Flexible Global Budget model allowing additional payment for the Marginal Costs associated with new Volume

Updating the HGB from a Base Year
To future Performance Years



HGBs provide strong incentives for hospitals to control operating costs and unnecessary volume increases

If the hospital can control its cost growth and reduce unnecessary utilization, it can improve its profitability

Note: the Mechanics of "Flexible Hospital Global Budgets" Works a bit differently and is less severe

Hospital Global Budgets can Achieve the Following Policy Goals:

- Constrain both price and total hospital spending (both price & volume) growth
- Remove or reduce FFS incentives hospitals currently face that promote increased and unnecessary volume of care
  - Reducing the incentive to provide unneeded care will reduce the need for pre-authorization/denial of care
- Encourage investments in initiatives by using savings generated by reducing unnecessary use/cost and redeploying them to invest in/improve Population Health
- Provide financial predictability & stability for hospitals, (especially small/rural facilities)
  - Facilitate transition of small/rural hospitals to reduced service capacity
- Improve overall payment equity (reduce high prices and raise low prices)
- Support other Value Based Care initiatives such as ACOs
- Be modified to include Quality Incentive programs, funding of Uncompensated Care & Graduate Medical Education
- Implement other Complementary programs (Help address Staffing Shortages)
- Be the basis of a future and broader Population-Based payment system

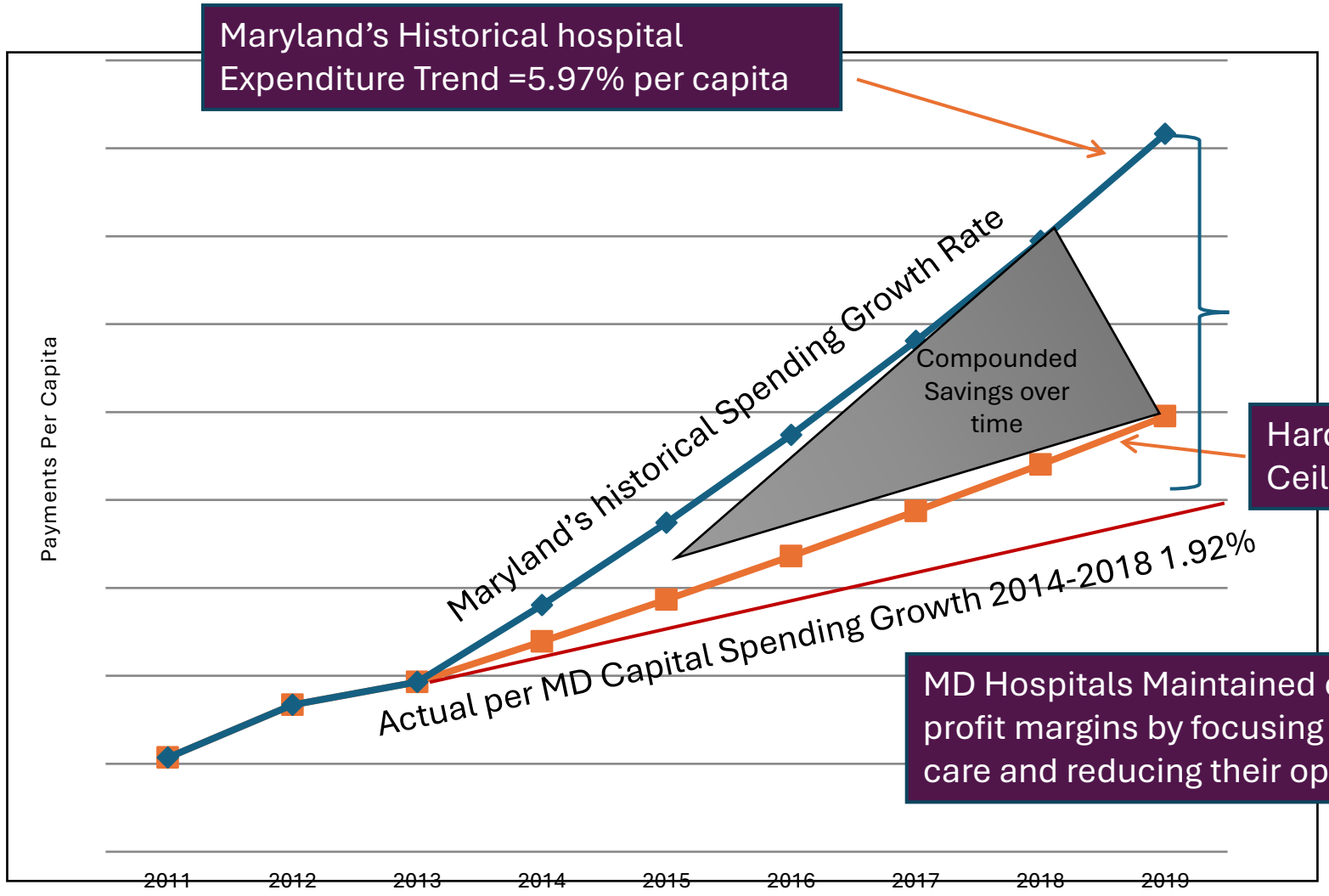
Weaknesses of Global Budgets include:

- Inequities and conflicting financial incentives if some payer categories and hospitals are not participating in the Global Budget Model
- Fixed budgets may also have too strong a set of incentives to reduce service provision: e.g., to shed patients/services or stint on care
  - Resulting in increased wait times for elective and ED care (experience in Europe and Maryland)
  - And shifts of care from acute hospitals to non-hospital and "unregulated" ASCs, imaging etc.
- Shifting of services away from the hospital may result in "double payment" for care (once under the HGB and once when care shifts)
- Fixed budgets are less responsive to shifts in volume (payer induced or other shifts) or service augmentation needs by communities/AMCs
- Fixed budgets also present a hospital with significant financial risk which may result in insolvencies for smaller hospitals
- As with all rate models, subject to "regulatory failure" particularly if model is too complex and "regulatory capture" by powerful provider interests

Absolute Requirements of a Regulated HGB Model

- HGB Model requires broad participation by hospitals and payer categories
- Must be overseen and operated by a State Regulatory Agency (enforcing participation & budget compliance) Past and current "voluntary" payment models have not been effective
- Compliance with established Budgets/Performance targets should be mandated by state law and regulation with significant fining authority for "non-compliance"
- Regulatory Commission should have broad powers of data collection and the legal authority to initially establish and annually update hospital rates/budgets
- Regulatory Commission should be governed by a board (volunteers appointed by the Governor) and staffed by a highly trained and sufficiently paid professional staff
- A Public Utility model of rate oversight and regulation has been effective in the past and can help avoid key pitfalls of "regulatory failure" and "regulatory capture"

Key Objective of HGBs: Meet State Affordability Goals

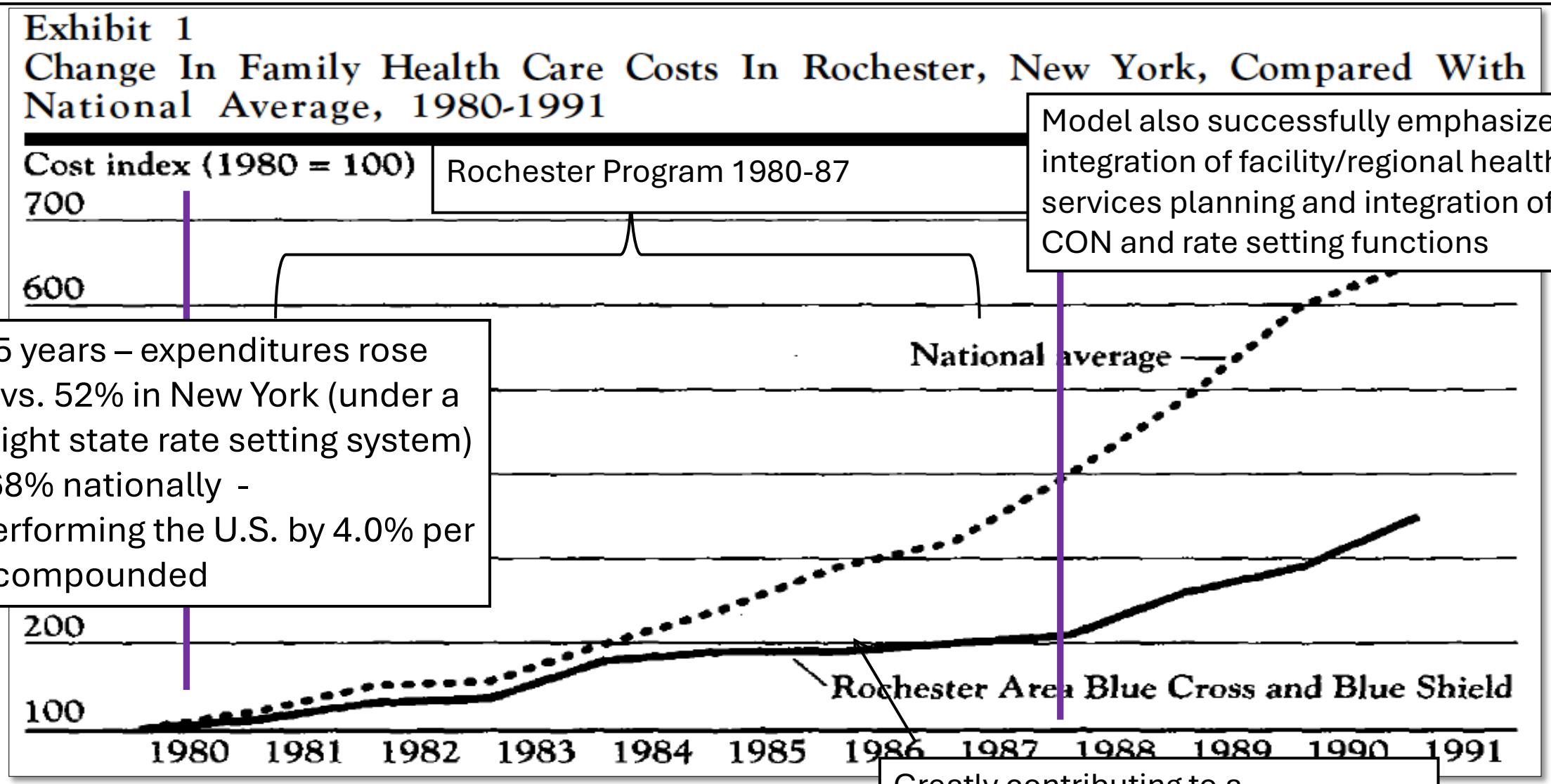


Hard Expenditure All Payer Ceiling = 3.58% per capita

MD Hospitals Maintained or increased their profit margins by focusing on reducing unnecessary care and reducing their operating costs

HGB models can help reduce the use of marginal/unnecessary services, improve hospital pricing equity, promote improved quality of care, improve hospital financial stability and equitably fund hospital uncompensated care

Global Budget Experience from Rochester NY



Rochester Program 1980-87

Model also successfully emphasized the integration of facility/regional health services planning and integration of CON and rate setting functions

First 5 years – expenditures rose 46% vs. 52% in New York (under a very tight state rate setting system) and 68% nationally - outperforming the U.S. by 4.0% per year compounded

Greatly contributing to a stabilization of commercial insurance premiums in the region

Hall and Griner et al. Health Affairs 1993

Global Budget Experience from Rochester NY

Table 1.—Cumulative Operating Profit (Loss) of Hospitals in Various Regions of New York State, 1980 Through 1984

Region	Operating Profit/(Loss), Millions of Dollars
New York City	(693.7)
Northern metropolitan (downstate)	(150.1)
Nassau/Suffolk	(180.7)
Abany	(41.7)
Utica	(33.7)
Syracuse	(77.7)
Rochester	11.9
Buffalo	(122.3)

Table 2.—Hospital Admissions to General Hospitals in New England, New York State, and Rochester, NY

Year	Admissions/1000		
	New England	New York State	Rochester
1979	148	149	135
1980	149	149	133
1981	147	150	132
1982	146	149	126
1983	146	148	124
1984	141	148	124
Net change, 1979-1984	−7	−1	−11

Profitability and cash flow of Rochester hospitals was significantly better than other New York hospitals 1980-84

System also experienced larger drops in use rates than other nearby areas (NY and NE)

Block JAMA 1987

Weaknesses of FFS Payment

- Fee-for-Service (FFS) payment systems have an unfortunate weakness – they provide incentives for hospitals to produce unnecessary services
- This is because under FFS payment, hospitals are paid 100 cents on the dollar for each new service
- However, hospitals have both Fixed and Variable Costs
  - Fixed costs are covered in their base payments and are funded as long as volumes remain steady or increase
  - Variable costs vary by service, but are generally 50-60% of average costs
- The excess of marginal (variable) revenue (100 cents on the $) earned by new hospitals for each new service they provide in EXCESS of their marginal costs to produce this new service (50 cents on the $), adds to hospitals' profit margins
- It is this excess of Marginal Revenue earned over Marginal Cost of Production – that induces Hositals to generate large amounts of unnecessary and low-value services
- Thus, under FFS payment hospital, are over-rewarded for providing/promoting the use of more services – resulting in substantial over provision of care Excess/ unnecessary care = $600-900bill./year in the USA
- Hospital Global budgets can correct this distortion

HGBs – Two Versions: 1) Fixed Budgets

- First pioneered in Europe and Canada & used currently in Maryland
- Hospital receive a set, pre-determined amount of revenue regardless of patient volume
- Very strong incentives to manage care, restrict volumes and shift services out of hospital
- Budgets adjusted for patient demographic changes and annual approved inflation update
- Fixed budgets protected Maryland hospitals from revenue drops during the Pandemic
- However, evidence from Europe and Canada shows that Fixed Budgets also increased wait times for elective services and emergency room treatments
- Under Fixed Budgets, Maryland met its waiver tests but saw significant shifting of services to non-hospital providers < Causing double payment
- Academic Medical Centers complained about the rigidity of Fixed Budgets which constrained their ability to fund new drugs and technology

HGBs – Two Versions: 2) Flexible Budgets

- Flexible budget concept based on Rochester and Finger Lake Hospital Demos in 1980s and early Maryland rate setting system 1976-1992
- Flexible budgets are a "middle ground" approach – less severe than 100% fixed budgets but still corrects the flawed incentives of FFS payment that encourages over-use
- Flexible budgets provide additional revenue for hospitals as volumes increase – to cover their marginal or variable costs of production
  - Flexible budgets also provide hospitals with funding to cover fixed costs if volume decline
- Areas where implemented – (Rochester and Early Maryland system) performed well on both cost per case and cost per capita growth
- Flexible Budgets also allowed for adequate funding for new technology and provided sufficient increases in global budgets for increased service use
- Flexible Budgets didn't encourage shifts of services to non-hospital providers or care
- Also believe that Flexible Budgets are more "pro-competitive" – allowing hospitals to compete more on the basis of service delivery and quality - to attract patients

Incentives Under Different "Bases of Payment"

Payments: 100% Variable 0% Fixed | Middle Ground | Payments: 0%Variable 100% Fixed

FFS Payment

- Hospital is paid 100 cents on the dollar for each new service, even though cost to produce the service (i.e., variable costs) are 50-60 cents
- Excess of marginal revenue earned under FFS over hospital marginal cost results in increased profits with volume increases (and vice versa)

FFS Incentives are the primary driver of excess low value & unnecessary care – leading to need for pre-authorization and denials policies of Commercial Payers & MA

Flexible Global Budget

- Hospital receives revenue for volume growth, but only for variable cost of new volumes
- Provides a predictable revenue source, and strong incentives to reduces LVC
- But reduces incentive to decrease volume to increase profits (Care Stinting) and eliminates current FFS incentives to "chase volumes" or provide unnecessary care or Low Value Care

Fixed Global Budget

- Hospitals do not receive additional revenue for volume growth
- May encourage stinting of care as hospital earns substantial rewards if volumes decline
- May encourage hospitals to shift care to non-hospital providers – resulting in "double payment"

Flexible Global Budgets

Flexible Global Budgets is a "Middle Ground" Policy intervention that:

1) Corrects the flawed incentives of FFS payment which induces hospitals to provide a lot of unnecessary and low-value care

2) Thus, provides incentives to reduce unnecessary or Low Value Care

Note: if they do reduce unnecessary care – they generate surpluses (profits) under their Global budgets

3) Provides incentives for hospitals to focus on improving their operating efficiency and lowering their input costs

Note: if they do reduce unnecessary care – they generate surpluses (profits) under their Global budgets

4) Does not incentivize hospitals to stint on care or look to shift care out of the hospital to non-hospital providers (which results in double payment)

5) Budgets can still be regulated (updated by rate agency) year over year to achieve the cost-containment goal of the state over time

6) Can be augmented by the addition of other programs such as a financing system for Uncompensated care, a quality improvement system, a capital improvement policy,

Key Steps in Global Budget Model Development

- Develop the Rate Base for hospitals

  Best to use actual Historical Volumes/Revenues to set Base Year Budgets

- Define the Services and Populations subject to the Global Budget
- Determine Adjustments to the Rate Base

  Ability to add funding for hospital Uncompensated Care & "Seed" Funding to promote better care management and primary care

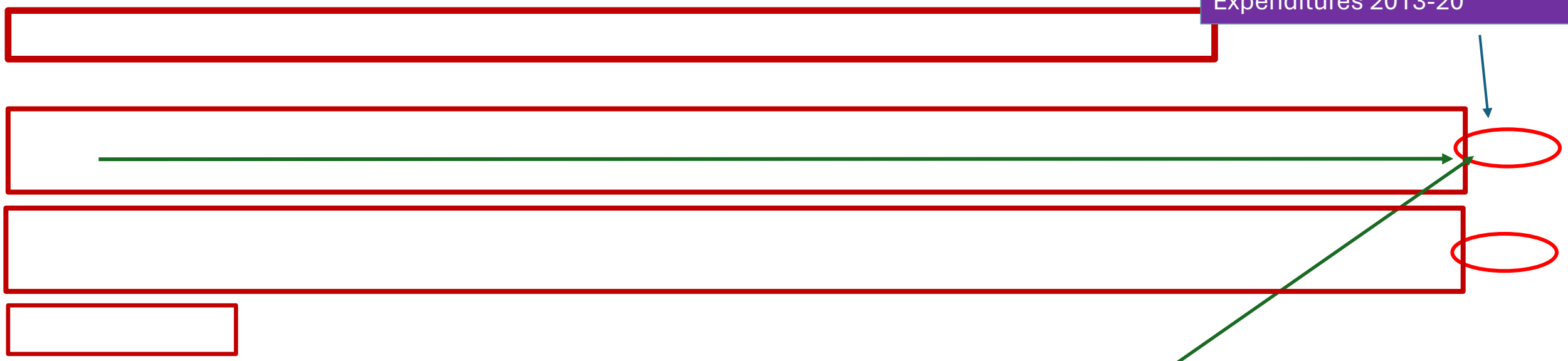
- Choose between a Fixed HGB model and a "Flexible" HGB using a Volume Adjustment
- Determine how hospitals are paid for the services they deliver

  Two basic Options – but advocate simplicity

- Develop a Formula-based "prospective" method of Updating Budgets annually
  - As shown, Update must account for Hospital Input Cost inflation and Service Area Demographic changes
  - States may wish to "Tier" their annual budget updates to improve pricing & budget equity (i.e., limit high priced hospitals' updates and enhance low priced hospitals' updates)
- Regulatory Agency/Commission must exercise its legal authority to mandate compliance with approved Global Budget and approved annual updates to Global Budgets

This is a government mandated, and state regulated model – not a voluntary model

Modeling of a Flexible HGB Model for Washington – Base



Actual Washington Hospital Expenditures 2013-20

HGB Model can Produce Hospital Price/Volume increases of 2.5% or less

Key Points:

(1) Actual Washington CAGR 2013 – 2020 for hospital expenditures = 2.93%

(2) Washington CAGR 2013 – 2020 for non-hospital expenditures = 4.20%

(3) Modeled Per capita (all-payer) hospital expenditure growth = 2.5% per year under Flexible HGB model

(4) Flexible HGB model will not induce shifts to non-hospital sector as is the case in Maryland currently

(5) 2.5% growth is well below Washington Gross State Product (total incomes) growth and below Spending target of 2.8%

(6) Washington projected hospital savings from implementing an All Payer Flexible HGB model 7 years 2014-20 = $1.7 bil.

Overall Summary

- The Hospital Sector in the US is characterized by PROFOUND Market Failure – due to poor market functioning (US Hospital markets do not function in a Competitive way!)
- In response to Payer and managed care domination in the 1980s and 1990s, Hospitals have undergone at least 2 rounds of massive consolidation – increased their Market Pricing Power
- With unconstrained pricing power, hospitals have experienced huge annual increases in revenues
- Lack of constraint of hospital revenues, takes pressure off hospitals to control their operating costs (The Medicare Payment Assessment Commission "MedPAC")
- Hospital input and operating costs 1995-Present have increased dramatically in the US
- Private Payers and other Policy action (Antitrust and other) have not made hospitals accountable for their costs, quality, access to care, community benefits and spending strategies
- Lack of oversight over their prices and spending is at the center of state Policy concerns and should be the primary health policy Goal for States
- Price caps followed by a more comprehensive rate model (Flexible Hospital Global Budgets) can create a price and spending control model and address most other policy issues
- Final thought: Advocate implementing as simple and straightforward a regulatory system as possible

States MUST focus on developing price & spending Control Models as #1 Priority – before even considering Insurance Expansions, Universal Coverage, or any other Key Policy Initiative

Next Steps

- Suggested reading: 1) Overview of the Hospital Pricing and Spending problem in the U.S. https://sourceonhealthcare.org/profile/americans-always-do-the-right-thing-when-will-the-u-s-finally-control-runaway-hospital-price-growth/?portfolioCats=1165%2C1167%2C1166 and 2) The RAND Employer Survey on Hospital prices and price growth Round 5.1 https://www.rand.org/health-care/projects/hospital-pricing/round5.html

- Pass and sign into law SB 5083 price caps for SEBB and PEBB

- Monitor the impacts of SB 5083 and make modifications as needed

- Consider using experience setting price caps for SEBB and PEBB and extending them to all out-of-network (OON) Hospital services

- Consider regulatory governance structures and what worked and didn't work previously (consider past history in Washington with regulatory commissions)

- Draft legislation for a Public Utility Governance Structure to oversee price & spending growth and meet other policy goals in the state – with a focus on implementing Flexible Hospital Global Budgets

- Consider applying to the CMMI for All-Payer Authority, but a model developed by Washington State

Closing statements and adjournment

Washington State Health Care Authority

Appendix: Analytic Support Initiative

Data sources: comparing characteristics

Characteristic of data source	Data Call	APCD	DEX[1]
Medicare spending: Medicare spending in data source *Note: APCD Medicare FFS and Part D data was available only through 2022	X	X*	X
Long term care spending: Long term care spending in data source *Note: some Medicaid long term care spending is not captured	X*	X*	X
Non-Claims: Includes non-claims payments, including incentives, direct payments	X		
Other related costs: Net Cost of Private Health Insurance	X		
Self-insured data: Submission from self-insured health carriers. *Note: self-insured carriers' submissions are voluntary to the APCD	X		X
Disease burden: Prevalence of diseases *Note: chronic conditions of those receiving care, using definitions from Chronic Conditions Data Warehouse (CCW)		X*	X
Demographics: Populations changes and characteristics (e.g., age, race, ethnicity, etc.) *Note: some data elements incomplete	X*	X*	X
Price/intensity: Price charged for service		X	X
Utilization: Volume of services utilized		X	X
Condition: Clinical condition of those seeking care		X	X
Location: Basis of geographic association		service and residency location	residency location

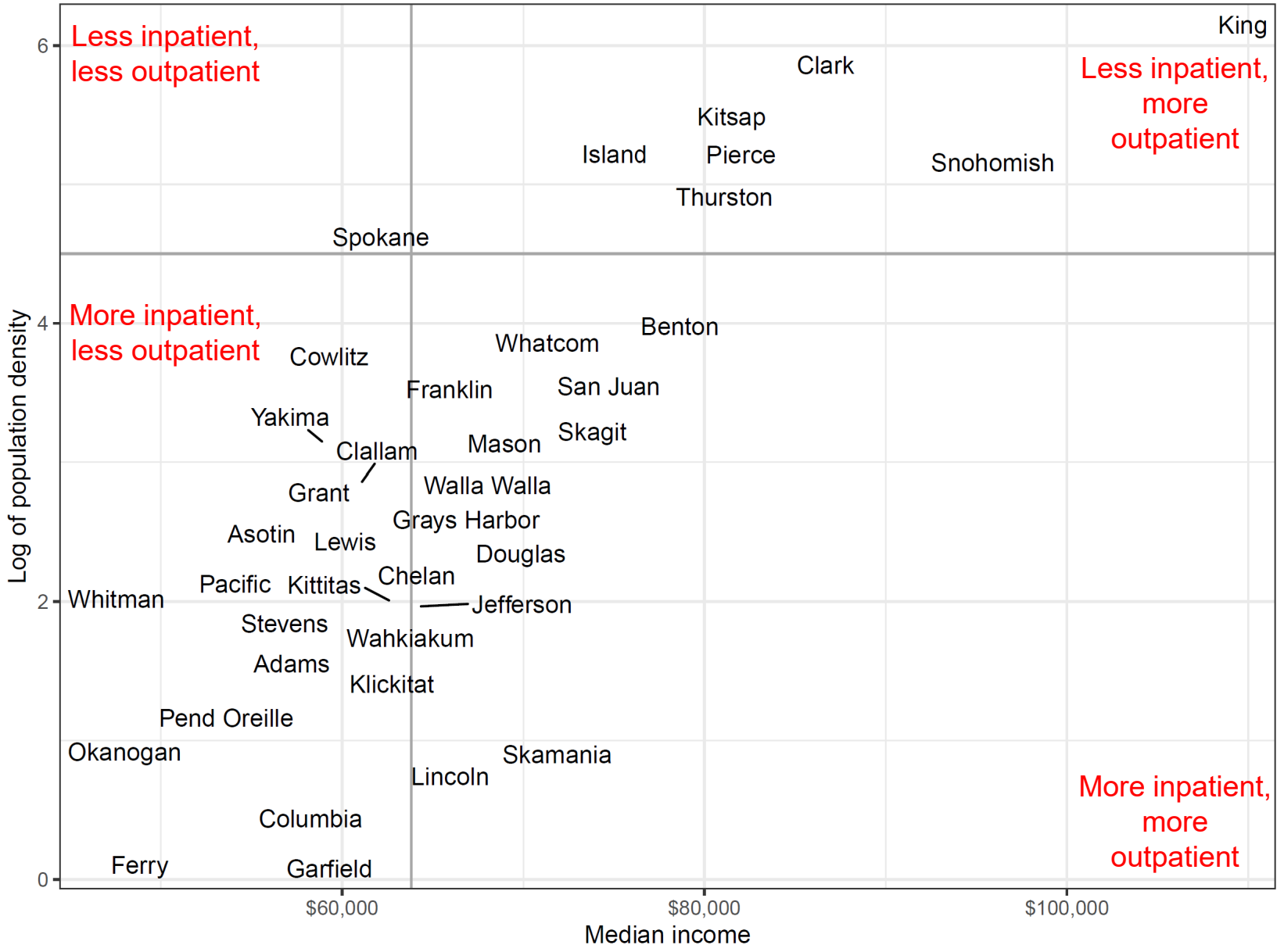
1: For each characteristic DEX reports *estimates,* including confidence intervals

Health Care Authority

Data Reports: comparing components

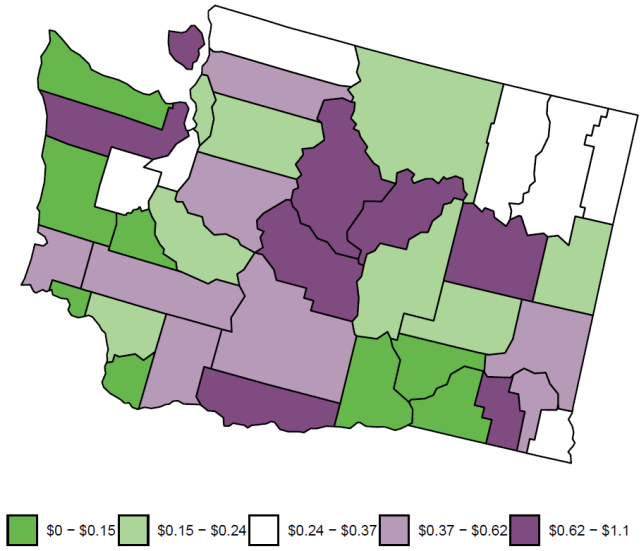
Component of report	Performance against the benchmark (HCA)	Main cost driver analysis (OnPoint)	Analytic Support Initiative (IHME)
Utilization: Volume of services utilized		X	X
Price: Price charged for service		X	X
Service category: High-level service categories (Inpatient, Outpatient, Rx, etc.) ***Services categorized differently**	X	X	X*
Condition: Clinical condition of those seeking care		X	X
Demographics: Populations changes and characteristics (e.g., age, race, ethnicity, etc.)			X
Disease burden: Prevalence of diseases			X
Geographic: Regional or geographic factors			X
Non-claims payments: supplemental payments, bundled payments, performance incentives, etc.	X		
Business Practice: Affiliations/Mergers/Acquisitions and other business practices	X		

Which counties are wealthy and urban vs poorer and rural



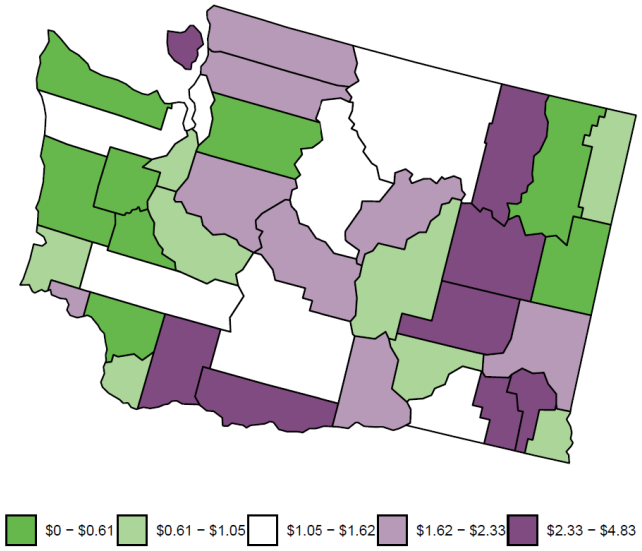
Excess spending per case on potentially avoidable hospitalizations, out-of-pocket only

Diabetes mellitus type 2



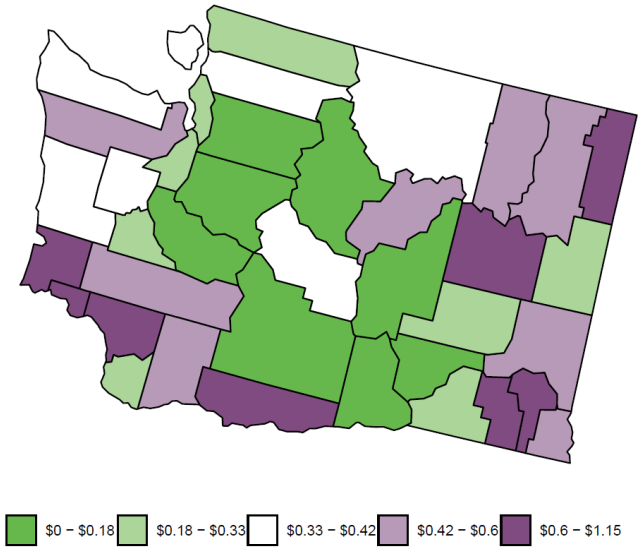
$0 – $0.15 | $0.15 – $0.24 | $0.24 – $0.37 | $0.37 – $0.62 | $0.62 – $1.1

Chronic obstructive pulmonary disease



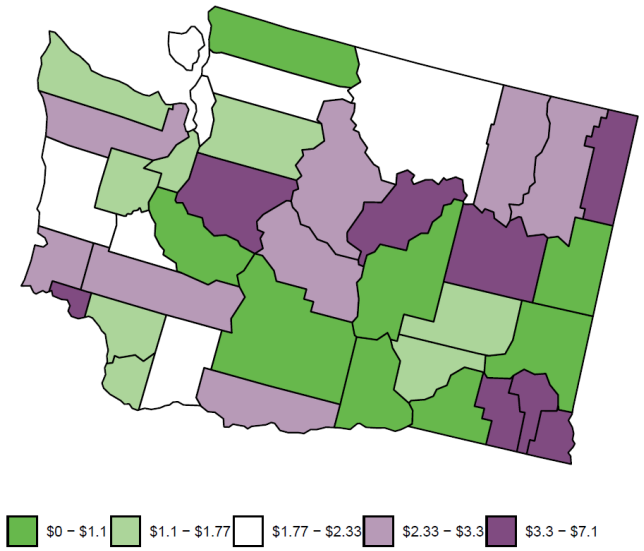
$0 – $0.61 | $0.61 – $1.05 | $1.05 – $1.62 | $1.62 – $2.33 | $2.33 – $4.83

Asthma



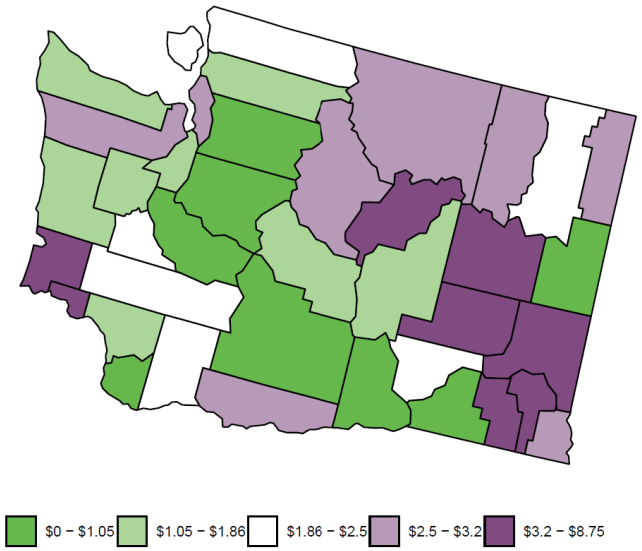
$0 – $0.18 | $0.18 – $0.33 | $0.33 – $0.42 | $0.42 – $0.6 | $0.6 – $1.15

Alcohol use disorders



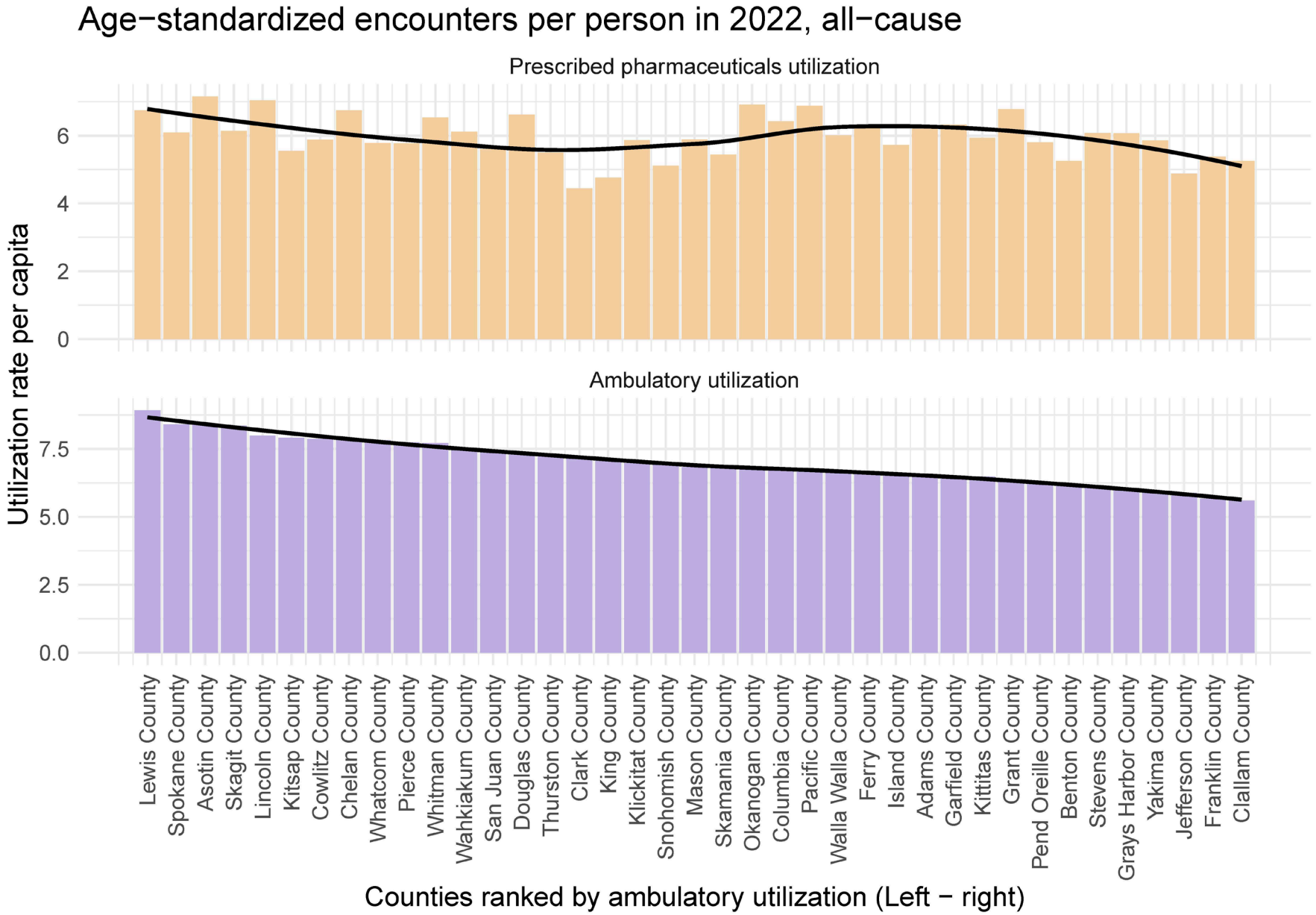
$0 – $1.1 | $1.1 – $1.77 | $1.77 – $2.33 | $2.33 – $3.3 | $3.3 – $7.1

Opioid use disorders

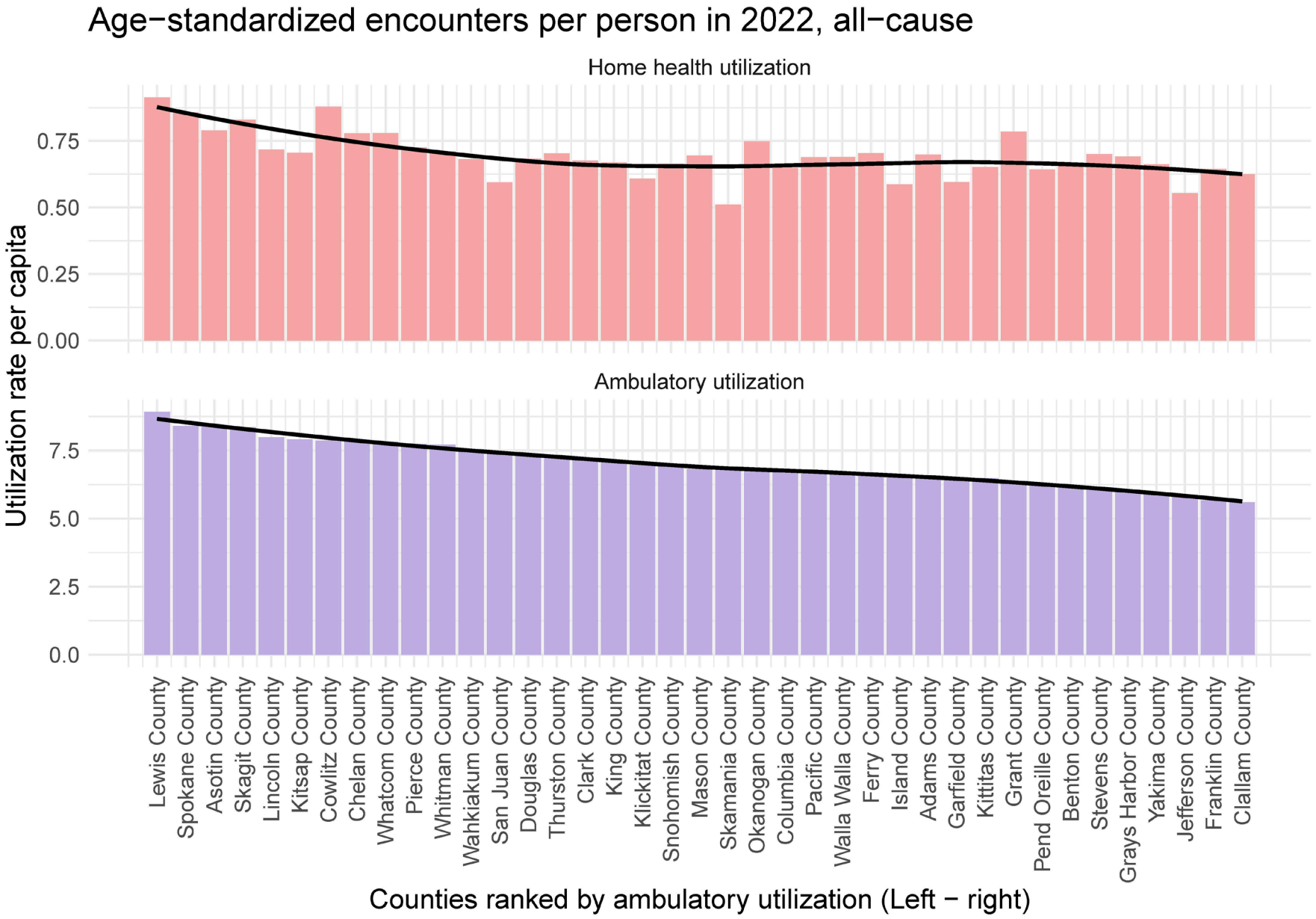


$0 – $1.05 | $1.05 – $1.86 | $1.86 – $2.5 | $2.5 – $3.2 | $3.2 – $8.75

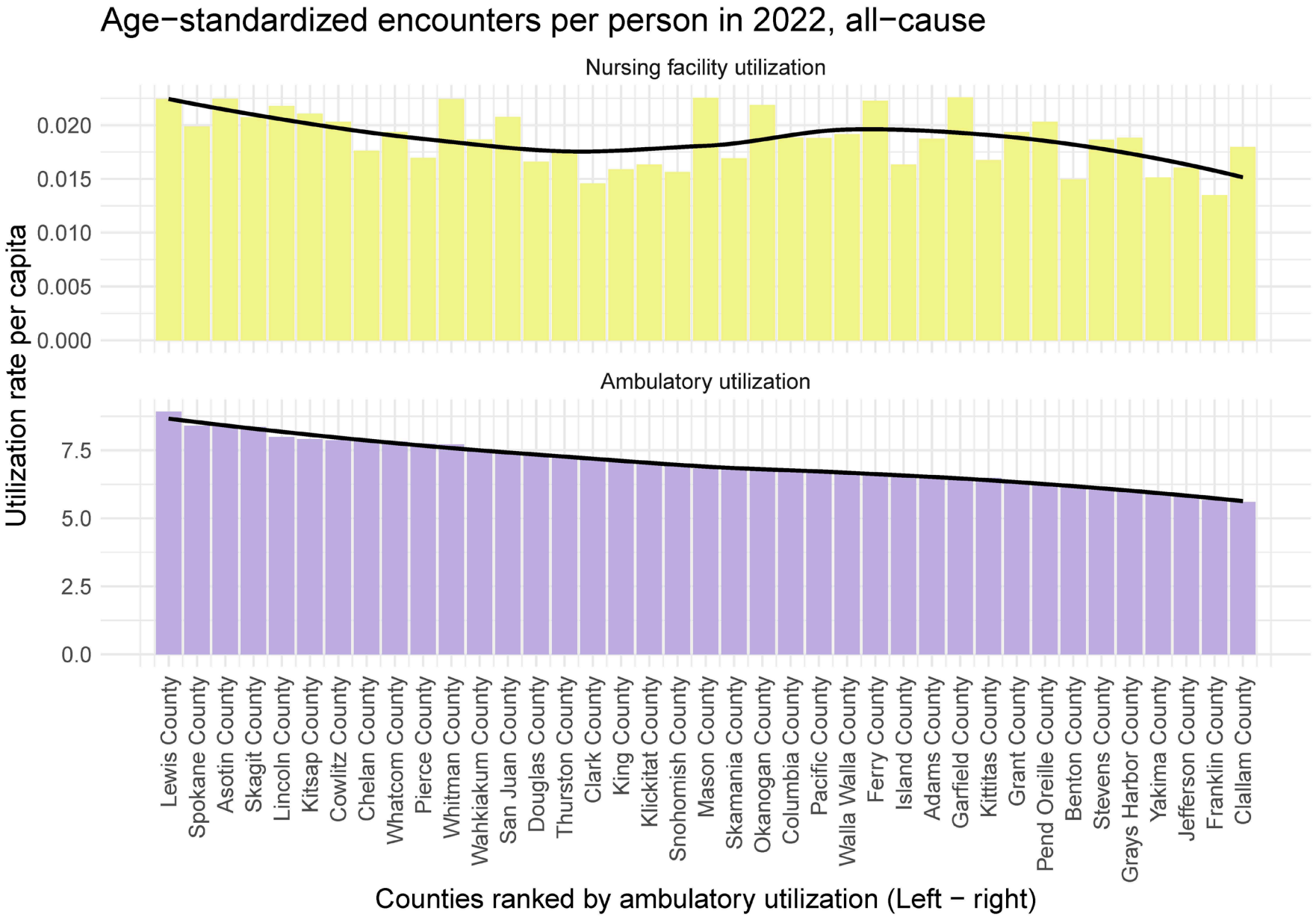
There is not a clear tradeoff between ambulatory and pharmaceutical services



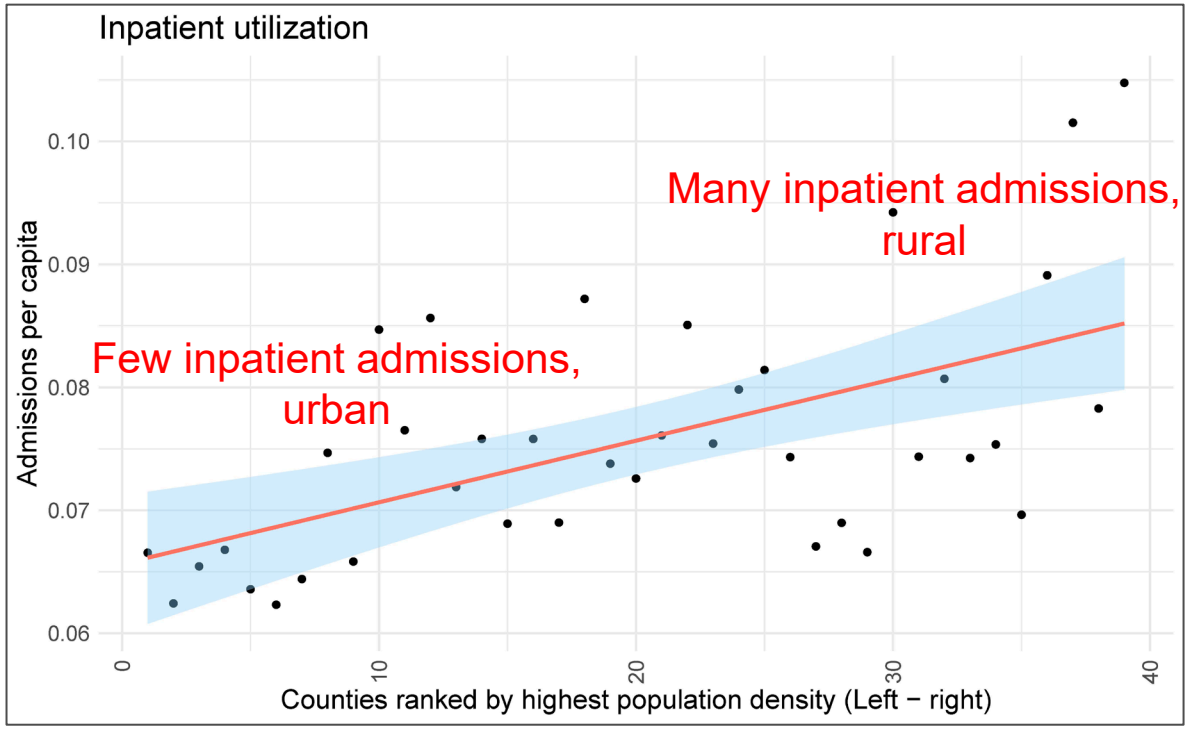
There is not a clear tradeoff between ambulatory and home health services

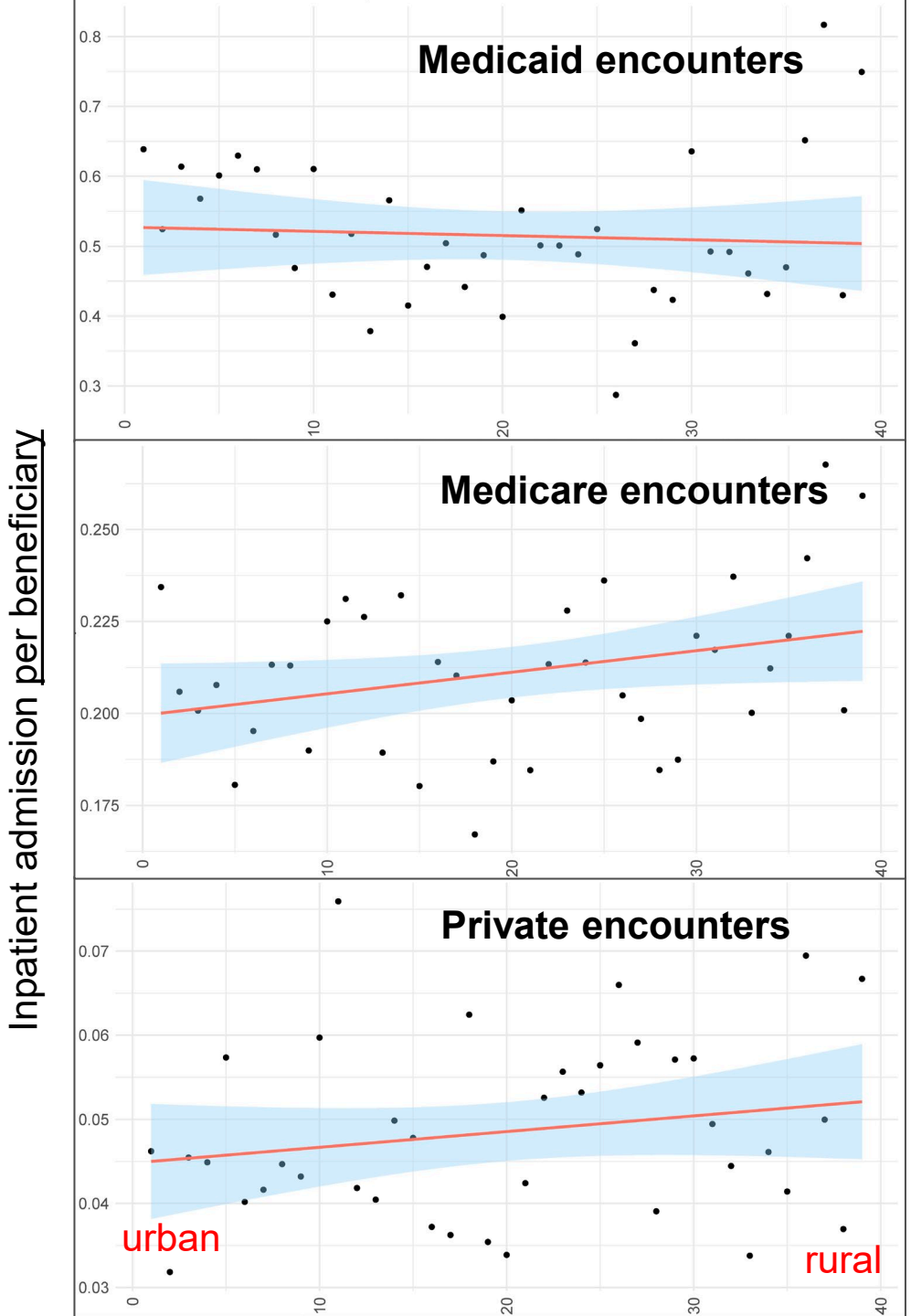


There is not a clear tradeoff between ambulatory and nursing facility services

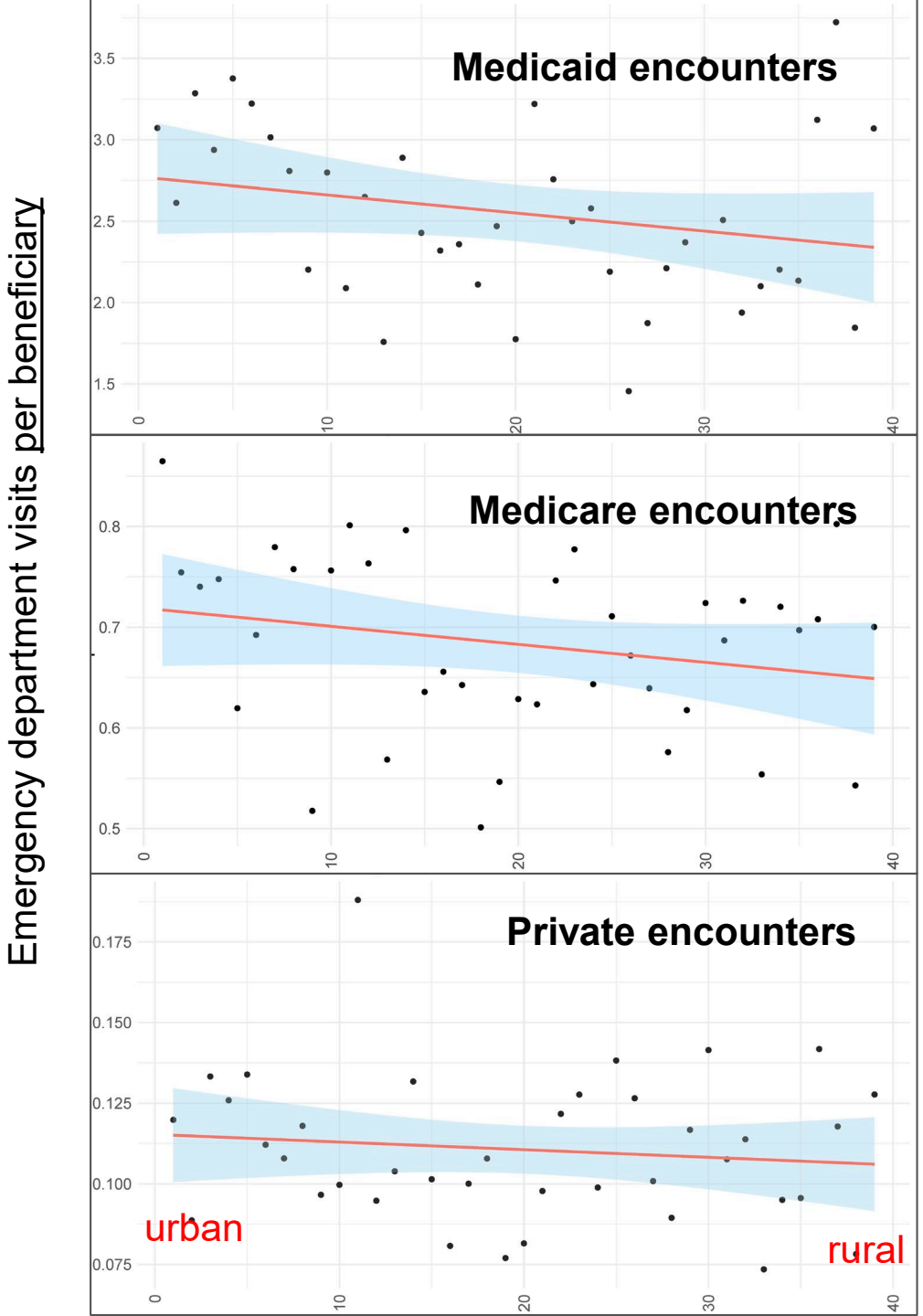


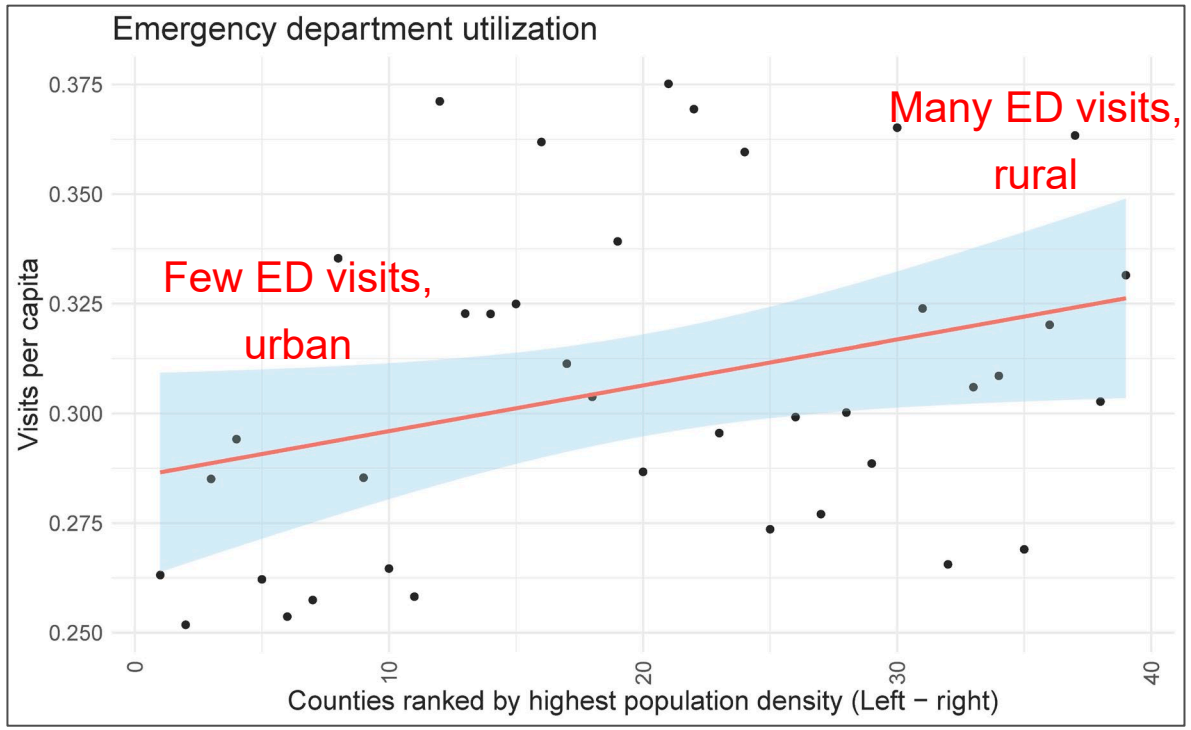
Inpatient patterns change by insurance



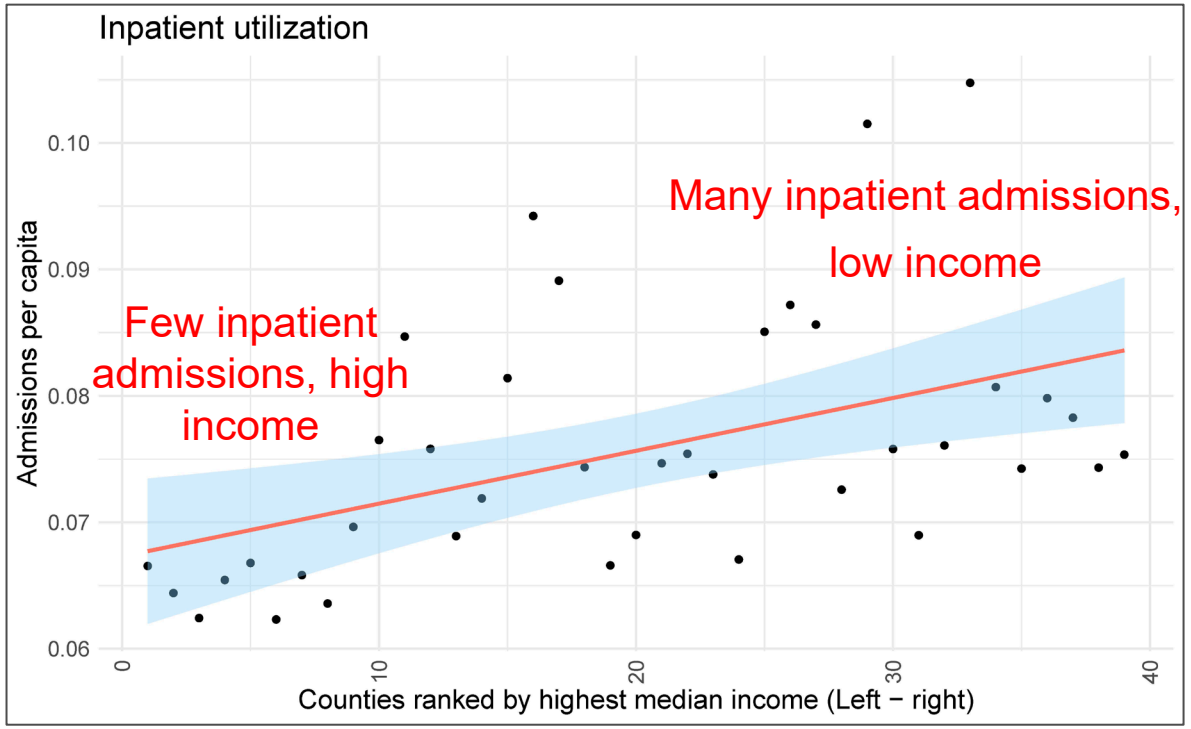


ED patterns change by insurance

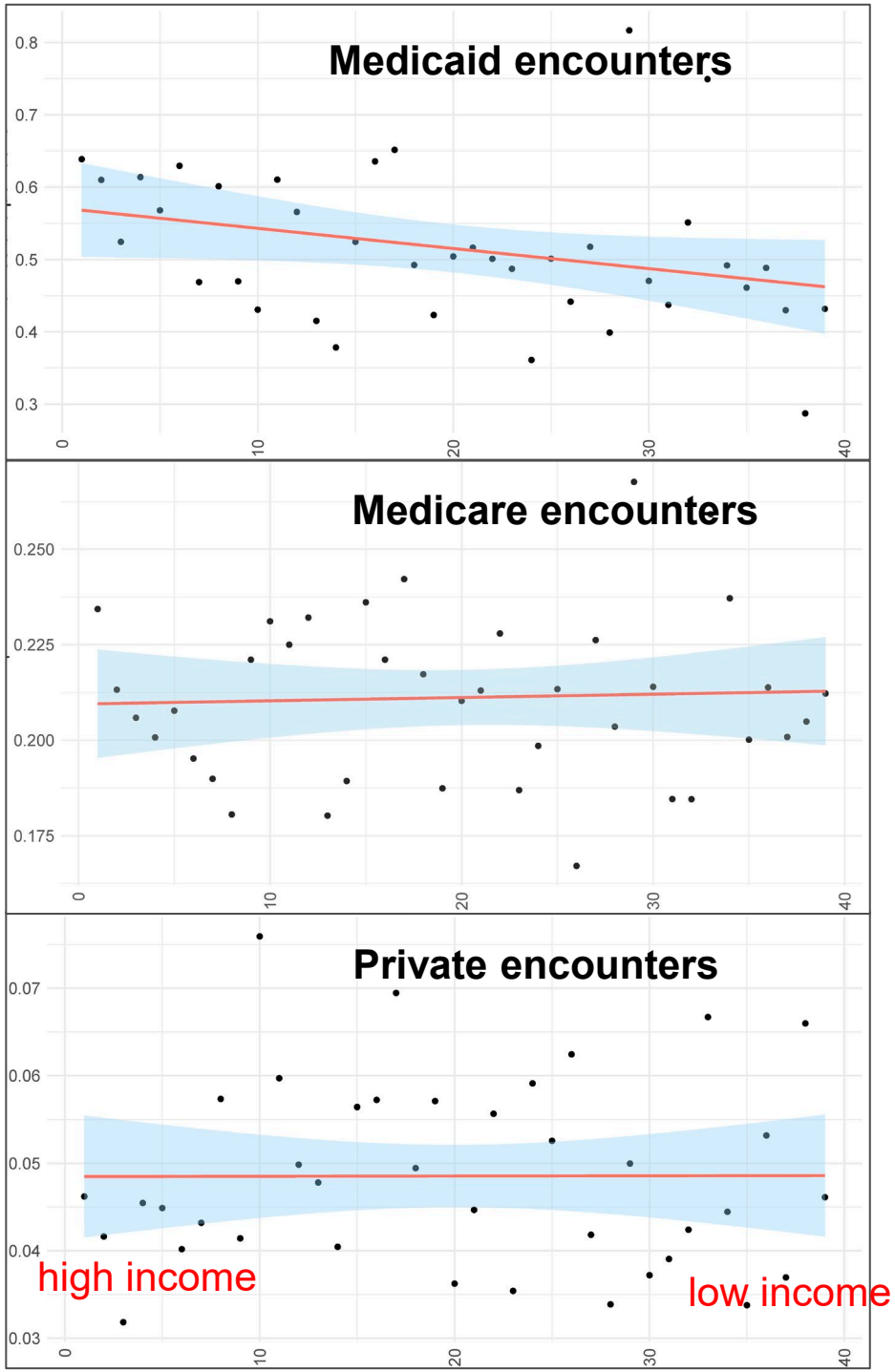




Inpatient patterns change by insurance



Inpatient admission per beneficiary



ED patterns change by insurance