

MARKET ASSESSMENT:

A Snapshot of U.S. Health Care Costs,
Health System Trends, and Washington State
Public Purchasing Health Care Strategies

July 14, 2016

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EXECUTIVE SUMMARY

The U.S. health care market has changed rapidly since the passage of the Affordable Care Act (ACA) in 2010, with the most substantial changes occurring over the last two years. In 2014, after five consecutive years of historically low growth, health care spending in the United States grew more than 5 percent, reaching \$3.0 trillion. Health care spending was driven by health insurance expansion (both private insurance and Medicaid) under the Affordable Care Act, and growth in benefit spending on prescription drugs (specialty drugs), physician and clinical services, and hospital care. Under Medicaid, total spending increased by about 8 percent in FY 2014, rising to \$498 billion in 2014, due to increased utilization of medical and dental services and prescription drugs by newly enrolled individuals.

At the same time, national prescription drug spending rose exponentially, outpacing the rate of general inflation as well as growth of medical costs. There are many reasons cited for prescription drug cost growth, including the structure of drug pricing, lack of transparency around pricing, and the increasing number of high-cost specialty drugs.

Projections suggest that health care spending will continue to grow at an average rate of 5.8 percent per year as a result of health insurance coverage expansion, stronger economic growth, and the aging of the population.

In response to rising health care costs, health care stakeholders—purchasers (public and private employers), health plans, and providers—have shifted their business strategies to adjust to market changes and lower health care costs. Led by Medicare, purchasers—including states, which are often the largest health care purchaser in their markets—are moving away from traditional fee-for-service payment arrangements and implementing new payment models that reward high quality. Consolidation by health plans and delivery systems hit a record high in 2014, in response to new value-based payment approaches.

Washington State has taken steps to reform our own state purchasing, for Medicaid and public employees. HCA recently developed a Value-based Road Map that describes how HCA will move 90 percent of state-financed health care into value-based payment arrangements by 2021. Under value-based payment arrangements, providers and health plans will be held accountable for achieving better health, better care, and lower costs.

PURPOSE AND PROCESS

PURPOSE

The purpose of this report is to provide context and insights from the health care industry to support ongoing budget and forecasting efforts of policy decision-makers and health care stakeholders in Washington State.

This report presents a summary of major health care cost and market trends, the direct and indirect effects on state budgets, and Washington's strategies for improving cost and quality performance in its public purchasing programs, Apple Health (Medicaid) and Public Employees Benefits Board (PEBB).

This report is divided into the following sections:

- Overview of U.S. health care trends
- Prescription drug trends and drivers
- Public programs and the transition to value-based payment
- Provider and health plan consolidation
- Washington State's value-based purchasing strategy to manage increases in health care costs while achieving better health and better care

The Washington State Health Care Authority (HCA) will produce market assessment reports semi-annually, at least ninety days prior to each budget forecast. This is the first semi-annual report.

PROCESS

HCA closely monitors key information channels and news sources to identify and track relevant trends in the health care market that can inform purchasing strategies. Analysts at HCA compile market information from published sources, as well as state and national experts, and track emerging research. Internal and external subject matter experts also provide input to assure relevance and accuracy.

OVERVIEW OF U.S. HEALTH CARE COST TRENDS

Every year, the Office of the Actuary in the Centers for Medicare & Medicaid Services (CMS) publishes historical (1960-2014)¹ and projected (2015-2024)² data on health care spending within

¹ Office of the Actuary (2015, December 3). National Health Expenditure Data: Historical. Centers for Medicare & Medicaid Services. Retrieved on June 29, 2016 from: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

² Office of the Actuary (2015, July 30). National Health Expenditure Data: Projected. Centers for Medicare & Medicaid Services. Retrieved on June 29, 2016 from: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>

the National Health Expenditure Accounts (NHEA). This data tracks health care spending by source of funds and expenditures by type of service.

The following section and graphs come from the latest information published by CMS.

- After five consecutive years of historically low growth (between 2.9 and 4 percent), U.S. health care spending grew 5.3 percent in 2014 (most recent data available), reaching \$3.0 trillion or \$9,523 per person. Health care spending accounted for 17.5 percent of the nation's gross domestic product (GDP), up from 17.3 percent in 2013.

The primary factors that contributed to the acceleration of health care spending growth in 2014 were:

- Faster growth in private health insurance spending, from \$949.2 billion in 2013 to \$991 billion in 2014 (a 4.4 percent increase). This growth was driven in part by expansion of health insurance coverage under the Affordable Care Act, which contributed to faster growth in benefit spending on prescription drugs, physician and clinical services, and hospital care.
- Increases in Medicaid spending—from \$446.7 billion in 2013 to \$495.8 billion in 2014 (an 11 percent increase)—largely due to expanded eligibility under the Affordable Care Act (ACA) and enhanced payments to primary care providers.

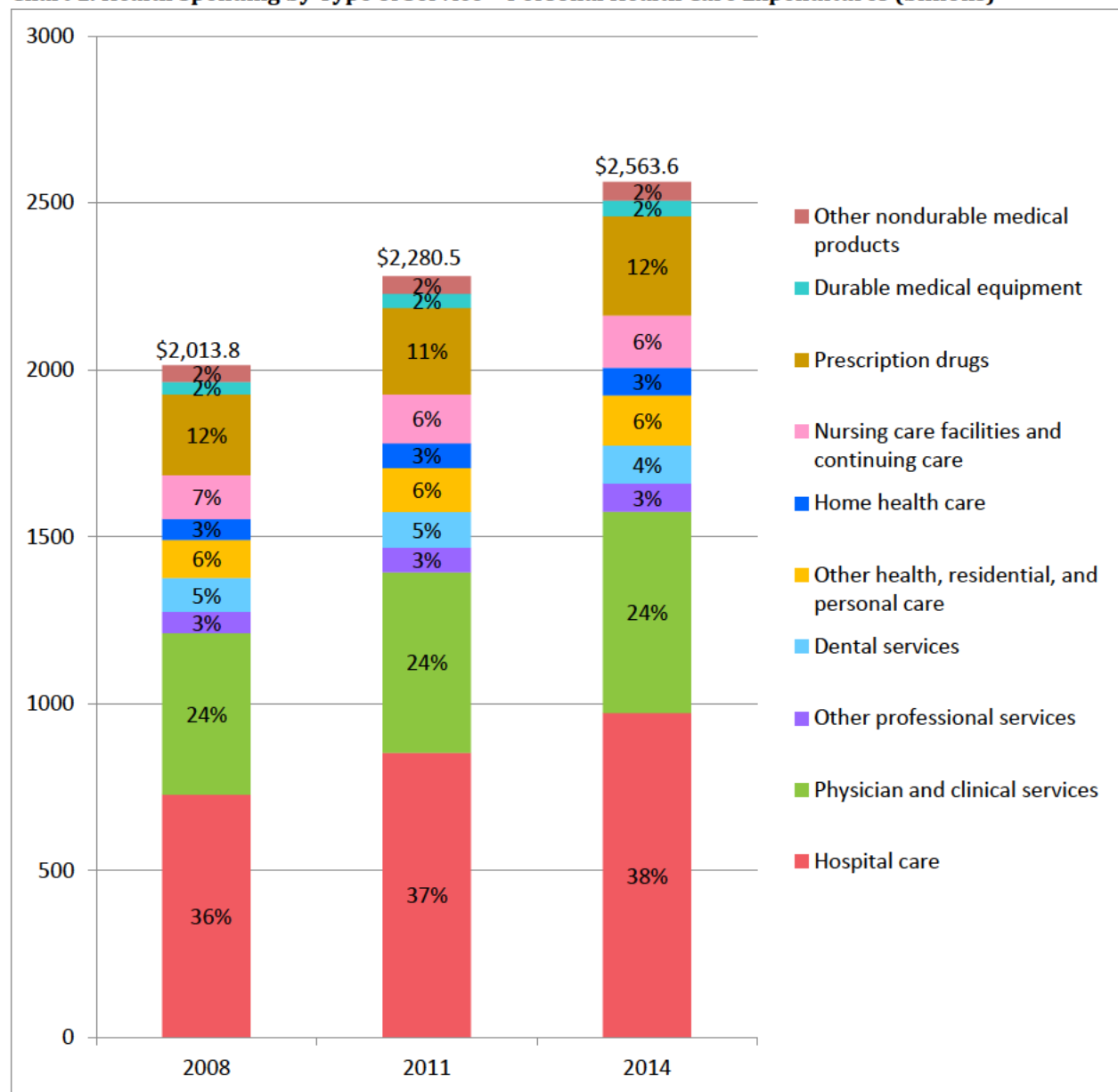
ACTUAL HEALTH CARE SPENDING (2008—2014)

SPENDING BY TYPE OF SERVICE

Of the total NHEA spend, personal health care (PHC) expenditures comprise all medical goods and services provided to individuals to treat or prevent a specific disease or condition. These include hospital care; professional services; other health, residential, and personal care; home health care; nursing care facilities and continuing care retirement communities; and retail outlet sales of medical products which include pharmacy and durable medical equipment. PHC does not include administrative costs or public health activities, nor does it include investments in research, structures, or equipment. The total 2014 spend on PHC was \$2.56 trillion of the total \$3.0 trillion NHEA spend, with the remaining amount spent on administration, investments, and public health activities.

From 2008 to 2014, the biggest growth in PHC expenditures was in hospital care (33.5 percent), followed by professional services (23.5 percent). (See Chart 1 on the next page.) Additionally, there was rapid growth in spending on retail prescription drugs where spending rose from a rate of 2.4 percent in 2013 to 12.2 percent in 2014 (the highest rate since 2002); this was due in part to the introduction of new drug treatments, such as those for hepatitis C, as well as drugs used to treat cancer and multiple sclerosis.

Chart 1. Health Spending by Type of Service—Personal Health Care Expenditures (billions)

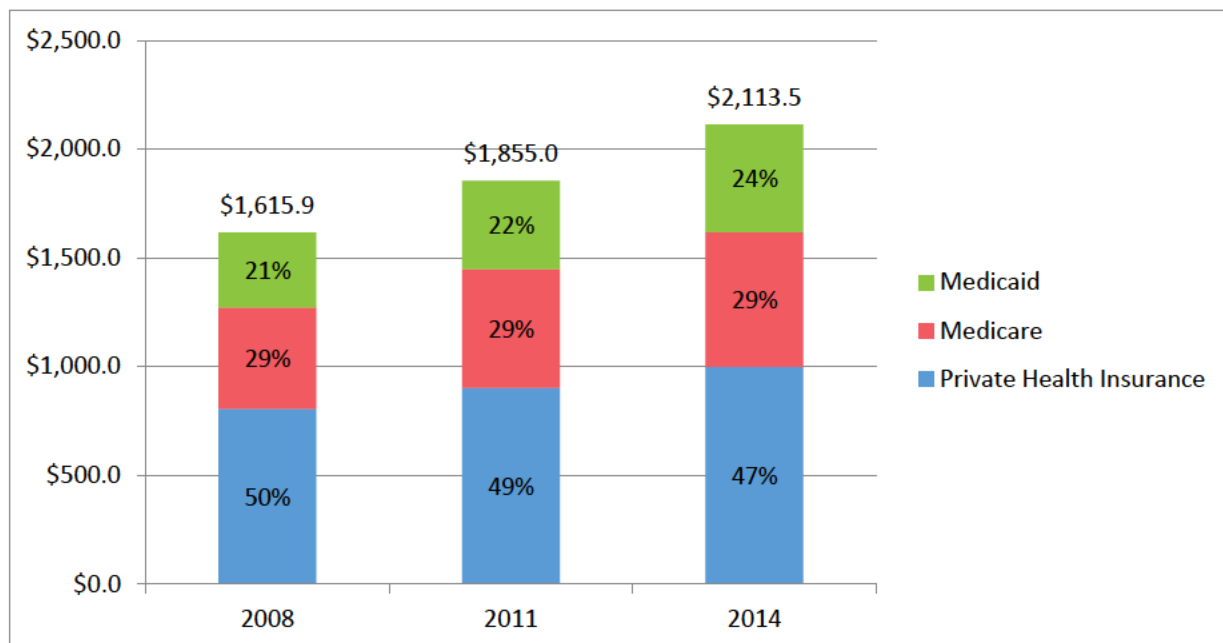


Source: CMS, National Health Expenditure Data, Historical (2014).

FUNDING SOURCES

In addition to reporting on expenditures, CMS provides a breakdown of the sources of funds used for NHEA. The three main sources of funds are private health insurance, Medicare, and Medicaid. (See Chart 2 on the following page.) Other sources include consumer out-of-pocket expenditures, Department of Defense and Department of Veterans Affairs spending, and other third-party payers and programs. These sources are insignificant compared to the three major funding sources and are not included in the charts.

Chart 2. Health Spending by Major Sources of Funds (billions)



Source: CMS, National Health Expenditure Data, Historical (2014).

Spending by the federal government on Medicaid grew at a faster rate in 2014 than spending by other sources of health care funding (such as private employers), leading to a 2-percentage-point increase in its share of total health care spending between 2013 and 2014. This is largely due to the increased enrollment from the ACA expansion.

PROJECTED HEALTH CARE SPENDING (2015—2024)

SPENDING BY TYPE OF SERVICE

CMS' projections consist of time series for all major spending categories in the NHEA. These projections reflect an analysis of probable aggregate trends in medical spending for the mix of medical services consumed and for trends in sources of payment and sources of financing. (See Chart 3 on the next page.)

The outlook on national health care spending for the period 2015–24 primarily reflects the effects of coverage expansion due to the ACA, stronger economic growth relative to the recent past, and the aging of the population.

Projections suggest that health care spending will continue to grow at higher rates than in recent years (averaging nearly 6 percent per year on a per capita basis) but is unlikely to reach the double-digit growth of previous decades.

Chart 3. Projected Health Spending by Type of Service—Personal Health Care Expenditures (billions)

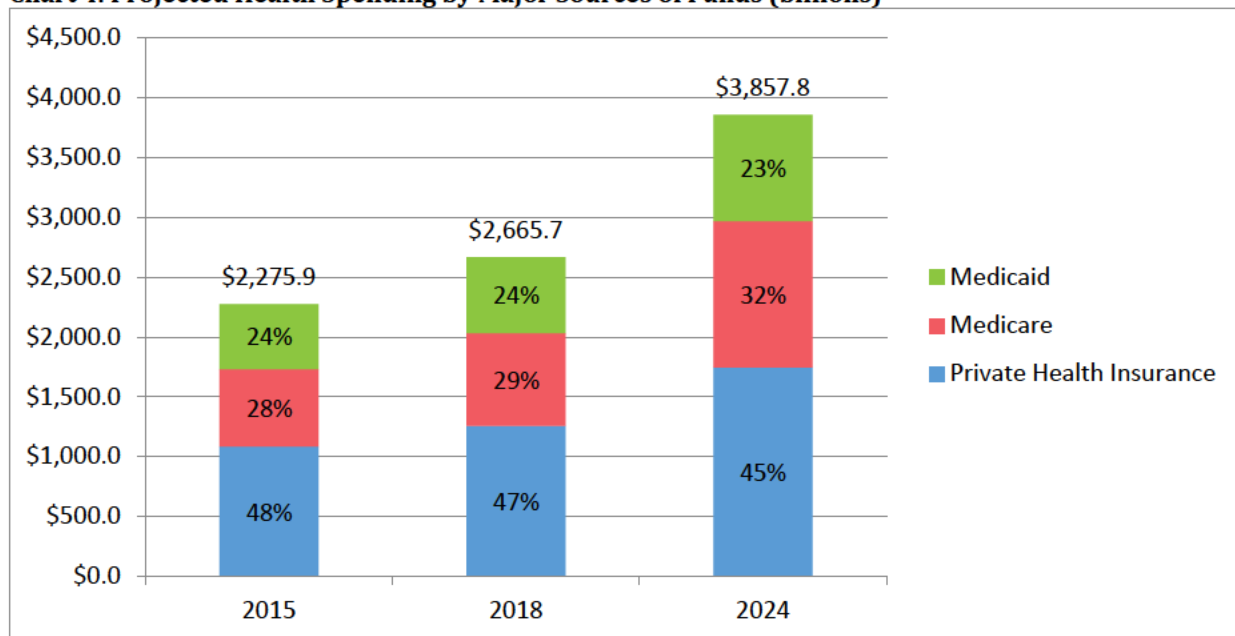


Source: CMS, National Health Expenditure Data, Projected (2014).

FUNDING SOURCES

Primarily as a result of the eligibility expansion under the ACA, Medicaid spending growth was projected at 12.0 percent in 2015, contributing most significantly—compared to spending for other payers—to the projected acceleration in national health care spending growth. Chart 4 (on the next page) shows CMS projections for health care spending by major sources of funds.

Chart 4. Projected Health Spending by Major Sources of Funds (billions)



Source: CMS, National Health Expenditure Data, Projected (2014),

In addition to shifts in the sources of payment related to Medicaid expansion and the health insurance marketplaces, the financing of health care is projected to shift further toward the federal government in the future. This change reflects both premium and cost-sharing subsidies for coverage in marketplace plans and a 100 percent initial federal match rate for Medicaid spending incurred by newly eligible enrollees. Health care spending sponsored by the federal government is projected to continue rising by double digits, partly as a result of increases in Medicare as the nation's population ages, contributing to an increase in federal, state, and local governments' collective share of total health care spending.

MEDICAID COST TRENDS AND DRIVERS, AND STATES' RESPONSES

Medicaid spending increased by about 8 percent in fiscal year (FY) 2014, rising from \$460 billion in FY 2013 to \$498 billion in FY 2014.³ Medicaid also represents a growing share of state budgets, increasing from 6.9 percent of state-funded expenditures in 1990 to 15.3 percent in 2014.⁴

The spending growth in 2014 was much higher for some services than for others, reflecting a variety of factors, including increases in enrollment and changes in enrollment mix, payment policies, and the mix of services within a service category. (See Table 1 on the next page.) A breakdown by state is included in the Appendix.

³ Medicaid and CHIP Payment and Access Commission (2015, June). Report to Congress on Medicaid and CHIP. Retrieved on June 29, 2016 from: <https://www.macpac.gov/wp-content/uploads/2015/06/June-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf>

⁴ Medicaid and CHIP Payment and Access Commission (2016, June). Report to Congress on Medicaid and CHIP. Retrieved on June 29, 2016 from: <https://www.macpac.gov/wp-content/uploads/2016/06/June-2016-Report-to-Congress-on-Medicaid-and-CHIP.pdf>

Table 1. Distribution and Annual Growth of Medicaid Benefit Spending by Type of Service (FY 2006-2016)

Type of service	Share of benefit spending 2014 ¹	Average annual growth 2006–2013	Annual growth 2013–2014	Projected growth	
				2015	2016
Hospital	38%	5%	8%	9%	6%
Other health, residential, and personal care	19	6	3	4	5
Physician and clinical	14	7	23	6	0
Nursing and retirement facilities	11	2	3	3	4
Home health	7	8	4	7	6
Prescription drugs	6	2	24	13	3
Dental	2	9	14	13	6
Other professional	1	7	17	15	6
Durable medical equipment	1	6	12	9	7

Components may not sum to 100 percent due to rounding.

Source: MACPAC 2016 analysis of OACT 2015a, 2015c.

For the categories with the highest growth—prescription drugs, as well as physician and clinical, dental, and other professional services—spending was partly driven by policy changes that included expanded coverage for adults and a mandated primary care payment increase under the ACA that required states to pay primary care providers fees that were at least equal to Medicare fees. The availability of new high-cost specialty drugs also contributed to higher than average growth for the prescription drug category in 2014.⁵ (See next section for prescription drug price details.)

Spending growth increased the least for Long Term Services and Supports (LTSS), including nursing and retirement facilities and other health, residential, and personal care services, as these were the least likely to be used by the newly eligible Medicaid adult group.⁶

The CMS Office of the Actuary in 2014 projected that Medicaid spending growth rates for 2015 and beyond will be lower going forward, averaging about 5.8 percent annually over the next decade. These projections reflect factors that include the moderation of expansion effects, expiration of the primary care payment increase, and negotiation with drug manufacturers.⁷

Another big change occurred in Medicaid coverage in 2014: Medicaid enrollment in managed care organizations (MCOs) increased by 24 percent—from almost 35 million in 2013 to 43.3 million in 2014.⁸ The managed care share of Medicaid benefit spending increased by almost 6 percentage

⁵ *Ibid.*

⁶ *Ibid.*

⁷ Keehan, S. P., Cuckler, G. A., Sisko, A. M., Madison, A. J., Smith, S. D., Stone, D.A., ...Lizonitz, J. M. (2015, July). National Health Expenditure Projections, 2014–24: Spending growth faster than recent trends. *Health Affairs* 34, no. 8: 1407–1417. Retrieved on June 29, 2016 from: <http://content.healthaffairs.org/content/early/2015/07/15/hlthaff.2015.0600.full.pdf+html>

⁸ Mathematica Policy Research and CMS. (2014, Spring). Medicaid Managed Care Enrollment and Program Characteristics. Retrieved on June 29, 2016 from: <https://www.medicaid.gov/medicaid-chip-program->

points, from 31.6 percent in FY 2013 to 37.5 percent in FY 2014. Nearly all individuals gaining eligibility through the new adult group were enrolled in managed care plans, and many states, including non-expansion states, increased their use of managed care.⁹ While MCOs were not necessarily a cost driver, the increased enrollment resulted in a rise in costs for MCOs.

PRESCRIPTION DRUG SPENDING AND DRIVERS

National prescription drug spending rose 12.6 percent in 2014, the latest year for which data is available, and it is expected to rise another 7.3 percent annually through 2018.¹⁰ Recent drug price increases far outpaced the rate of general inflation, as well as the growth of medical costs.¹¹

The structure of the U.S. drug market is frequently cited as the main driver of rising pharmacy costs. Drug pricing is unregulated and lacks transparency, especially in terms of short-term affordability, long-term value or health outcomes, and the magnitude of rebates negotiated by health plans.¹² As examples: (1) the price of certain insulin products rose by over 300 percent between 2003 and 2013¹³, and (2) the prices of certain medications for multiple sclerosis have increased 21 to 36 percent annually for the last two decades.¹⁴

Some reports suggest that the rising list prices for some drugs are being offset, if not outright lowered, by increased rebates.¹⁵ However, since rebates and discounts are not disclosed and only the list price is published, this claim is difficult to confirm. Additionally, research on drug

[information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf](#)

⁹ Medicaid and CHIP Payment and Access Commission. (2015, December). Exhibit 17: Total Medicaid Benefit Spending by State and Category, FY 2014 (millions). *MACStats*. Retrieved on June 29, 2016 from:

<https://www.macpac.gov/wp-content/uploads/2015/01/Total-Medicaid-Benefit-Spending-by-State-and-Category-FY-20141.pdf>

¹⁰ Office of the Actuary, Centers for Medicare & Medicaid Services (2015, July 30). NHE Projections 2014-2024 – Forecast Summary. Retrieved on June 29, 2016 from: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2014.pdf>

¹¹ Islam, I. (2015, August 31). Rising Costs of Drugs: Where do we go from here? *Health Affairs Blog*. Retrieved on June 29, 2016 from: <http://healthaffairs.org/blog/2015/08/31/rising-cost-of-drugs-where-do-we-go-from-here/>

¹² Daniel, H. (2016, March 29). Stemming the Escalating Cost of Prescription Drugs: A Position Paper of the American College of Physicians. *Annals of Internal Medicine*. Retrieved on July 1, 2016 from <http://annals.org/article.aspx?articleid=2506848>

¹³ Hua X., Carvalho, N., Tew, M., Huang, E. S., Herman, W. H., Clarke P. (2016, April 5). Expenditures and Prices of Antihyperglycemic Medications in the United States: 2002-2013. *JAMA*. 315(13):1400-2. Retrieved on June 29, 2016 from: <http://jama.jamanetwork.com/article.aspx?articleid=2510902>

¹⁴ Hurtang, D., Bourdette, D. N., Ahmed, S. M., & Whitham, R. H. (2015, May 26). The Cost of Multiple Sclerosis Drugs in the US and the Pharmaceutical Industry: Too Big to Fail? *Neurology*. 84(21): 2185-2192. Retrieved on July 1, 2016 from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4451044/>

¹⁵ Bailin, J., Divan, V., Harris, T., Jahaj, A., McManus, T. Mehrotra, R.,...Weston, M. (2015, May 1). Rising US Rebates Limit Margin Expansion. *Credit Suisse*. Retrieved on 7/1/16 from https://doc.research-and-analytics.csfb.com/docView?language=ENG&format=PDF&source_id=csplusresearchcp&document_id=1047911451&serialid=hfXhzuK6sK6xRrBsMZzLqZ96QTl7v2YM0kkwWJRGRVU%3D

prices over time has suggested that the rebates and discounts offered do not significantly offset price increases.¹⁶

PRESCRIPTION DRUG SPENDING COST DRIVERS

SPECIALTY DRUGS

Specialty drugs are prescription drugs that require special handling, administration or monitoring that are used to treat complex, chronic and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia. For example, in commercial plans, specialty drugs for the treatment of hepatitis C are approximately \$85,000 to \$95,000 per course of treatment¹⁷; the average monthly cost for cancer drugs is \$7,158 per month or approximately \$86,000¹⁸ per year, with some treatments requiring continuous treatment for life.

Specialty drugs are often developed and used for medical conditions under the U.S. Orphan Drug Act, which was enacted to encourage the development of drugs for rare diseases when traditional therapy is insufficient or nonexistent.¹⁹ Many specialty drug manufacturers claim their products offer significant improvement in treating these rare or orphan conditions; these claims are used to justify the extreme costs associated with these drugs. Specialty drugs are also entering the market more quickly through four FDA programs that are intended to facilitate and expedite development and review of new drugs to address unmet medical needs in the treatment of serious or life-threatening conditions.²⁰ For example, a new immunotherapy medication for bladder cancer was approved based on a performance measure of tumor shrinkage (a “surrogate” outcome) but offered no additional information on actual survival outcomes or how it compared to other therapies. This new specialty drug is expected to cost \$12,500 per month.²¹

From 2014 to 2015, specialty drug spend increased 17.8 percent for the commercial market, 27.9 percent for Medicare, and 10.1 percent for Medicaid. By comparison, traditional drug spending was -0.1 percent for commercial, 4.8 percent for Medicare, and 3.3 percent for Medicaid.²² It is

¹⁶ *Ibid.*

¹⁷ Neuman, T., Hoadley, J., Cubanski, J. (2014, June 5). The Cost of a Cure: Medicare’s Role in Treating Hepatitis C. *Health Affairs Blog*. Retrieved on July 7, 2016 from <http://healthaffairs.org/blog/2014/06/05/the-cost-of-a-cure-medicares-role-in-treating-hepatitis-c/>

¹⁸ Mills, D. (2016, April 28). Price of Cancer Drugs has Skyrocketed Since 2000. *Healthline*. Retrieved on July 7, 2016 from <http://www.healthline.com/health-news/price-of-cancer-drugs-hasskyrocketed>

¹⁹ U.S. Food and Drug Administration (1983, January 4). Orphan Drug Act. *P.L. 97-414 (96 Stat. 2049)*. Retrieved on July 14, 2016 from

²⁰ U.S. Food and Drug Administration (2014, May). Guidance for Industry: Expedited Programs for Serious Conditions – Drugs and Biologics. Retrieved on July 5, 2016 from

²¹ Goozner, M. (2016, May 21). Editorial: What’s a New Cancer Drug Worth? *Modern Healthcare*. Retrieved on June 29, 2016 from: <http://www.modernhealthcare.com/article/20160521/MAGAZINE/305219935/editorial-whats-a-new-cancer-drug-worth>

²² Cho, Y. (2016, June 14). Prescription Drug Trends – The National Picture. Presented at Washington Rx Drug Price and Purchasing Summit. <http://hca.wa.gov/medicaid/ebm/Documents/yohan-cho-presentation.pdf>

estimated that specialty pharmaceuticals will account for 1 to 2 percent of all prescriptions but will comprise 50% of all drug spend by 2018.²³

CONSOLIDATION OF MANUFACTURERS

Consolidation of manufacturers and associated pricing strategies is diluting the value of generic medications²⁴. New generic options that enter the market are priced similarly to brand-name counterparts, meaning drug costs do not immediately fall until other generic manufacturers enter the market to create competition. For example, ‘evergreening’ legislation, which extends patents on products about to expire, and limited distribution of pharmaceuticals by brand-name manufacturers have also prevented generic manufacturers from accessing or releasing generic versions of medications. The delay in entry and additional costs associated with these tactics has significant cost implications for payers.²⁵

LONG-TERM USE OF EXPENSIVE DRUGS

Many new therapies are approved for treating chronic medical conditions that sometimes require treatment for the remainder of the patient’s life. For example, many cancers are now being treated as chronic diseases, much like high blood pressure or high cholesterol, but often require long-term use of newer, expensive pharmaceuticals, leading to increasing drug costs. Recent research shows substantial increases in the average per patient monthly costs of oral anti-cancer medications over the last few years.²⁶

PRICING PRACTICES

Evolving pricing practices make it difficult to forecast drug spending. Prescription drug market pricing is increasingly volatile as new drugs are approved and drug manufacturers continually change their set pricing strategies. Pharmaceutical manufacturers are aggressively marketing and selling their latest high-cost treatment to highly targeted patient populations.²⁷ Additionally, using the practice of “shadow pricing”, manufacturers may raise their price following the price increase of another manufacturer’s product. For example, SSR Health, a market researcher, recently reported on the price increases of two insulin products—from Eli Lilly & Co. and Novo Nordisk—in which the

²³ Express Scripts. (2016, March). Drug Trend Report. (2015). Retrieved on June 29, 2016 from: <http://lab.express-scripts.com/lab/drug-trend-report>

²⁴ Johansen, M. E. & Richardson, C. (2016, June). Estimation of Potential Savings through Therapeutic Substitution. *JAMA Intern Medicine* 176(6):769-75. Retrieved on June 29, 2016 from: <http://archinte.jamanetwork.com/article.aspx?articleid=2520679>

²⁵ Collier, R. (2013, June 11). Drug Patents: The Evergreening Problem. *CMAJ*. Retrieved on June 29, 2016 from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3680578/>

²⁶ Bennette, C. S., Richards, C., Sullivan, S. D., Ramsey, S. D. (2016, May). Steady Increase in Prices for Oral Anticancer Drugs after Market Launch Suggest a Lack of Competitive Pressure. *Health Affairs*. Retrieved on June 29, 2016 from: <http://content.healthaffairs.org/content/35/5/805.full.pdf+html>

²⁷ Quinn, R. (2016, May 24). Phone interview with J. Birrell, Principal and Consulting Actuary, Milliman.

manufacturers matched each other's price increases three times in two years.²⁸ These types of pricing practices have been rapidly evolving over the last decade; as a result it has become increasingly difficult to adequately predict the costs of pharmaceuticals from one year to the next.

PURCHASER STRATEGIES FOR RISING DRUG PRICES

Fifteen states—California, Colorado, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Jersey, New York, North Carolina, Pennsylvania, South Dakota, Vermont, Virginia, and Washington—along with Puerto Rico introduced legislation in 2015-16 regarding prescription drug price transparency.²⁹ Massachusetts has taken a further step by attempting to place a pricing cap on how much manufacturers can charge for drugs, especially specialty drugs.³⁰

State Medicaid programs, including Washington, have tried to set limits on hepatitis C drug coverage, but these policies have been challenged and, in several cases, overturned in court.³¹ In New York, the Attorney General investigated private insurers' hepatitis C policies that restricted access. As a result, private insurers voluntarily agreed to change their policies, and the state Medicaid program followed suit.³²

Public and private employers and purchasers are investigating and implementing a variety of strategies to manage drug costs and utilization, including:

- Demanding more transparency from pharmacy benefit managers (PBMs) including 100 percent return of drug manufacturer rebates,
- Tighter performance guarantees,
- Requiring “pass-through pricing” to avoid PBMs from keeping the “spread” between pharmacy contracted price and group reimbursement rates,
- Independent third-party market checks of local retail pharmacy market rates, and
- More routine third-party audits in general.³³

²⁸ Langreth, R. (2015, May 6). Hot Drugs Show Sharp Price Hikes in Shadow Market. *Bloomberg*. Retrieved on June 29, 2016 from: <http://www.bloomberg.com/news/articles/2015-05-06/diabetes-drugs-compete-with-prices-that-rise-in-lockstep>

²⁹ National Conference of State Legislatures. (2016, June 28). 2015-2016 State Legislation on Prescription Drugs. *NCSL*. Retrieved on June 29, 2016 from: <http://www.ncsl.org/research/health/prescription-drug-statenet-database.aspx>

³⁰ Massachusetts Senate Bill 1048, (2015-16, 189th General Court). Retrieved on June 29, 2016 from: <https://malegislature.gov/Bills/BillHtml/143526?generalCourtId=12>

³¹ United States District Court Western District of Washington at Seattle, B.E and A. R. v. Teeter. Case No. C16-227-JCC . Order Granting Plaintiff's Motion for Preliminary Injunction. Retrieved on July 14, 2016 from: <http://law.justia.com/cases/federal/district-courts/washington/wawdce/2:2016cv00227/227539/40/>

³² Lee, J.J. (2016, June 6). Ele Hamburger: Medicaid programs should be taking “a long hard look” at their drug policies under state and federal law. *State of Reform*. Retrieved on June 29, 2016 from: <http://stateofreform.com/featured/2016/06/ele-hamburger-medicare-programs-should-be-taking-a-long-hard-look-at-their-drug-policies-under-state-and-federal-law/>

³³ Stevenson, J. G. & Bruhnson, K. (2015, March 17). Strategies to Improve PBM Management of an Employee Prescription Drug Plan. *AJPB*. Retrieved on June 29, 2016 from:

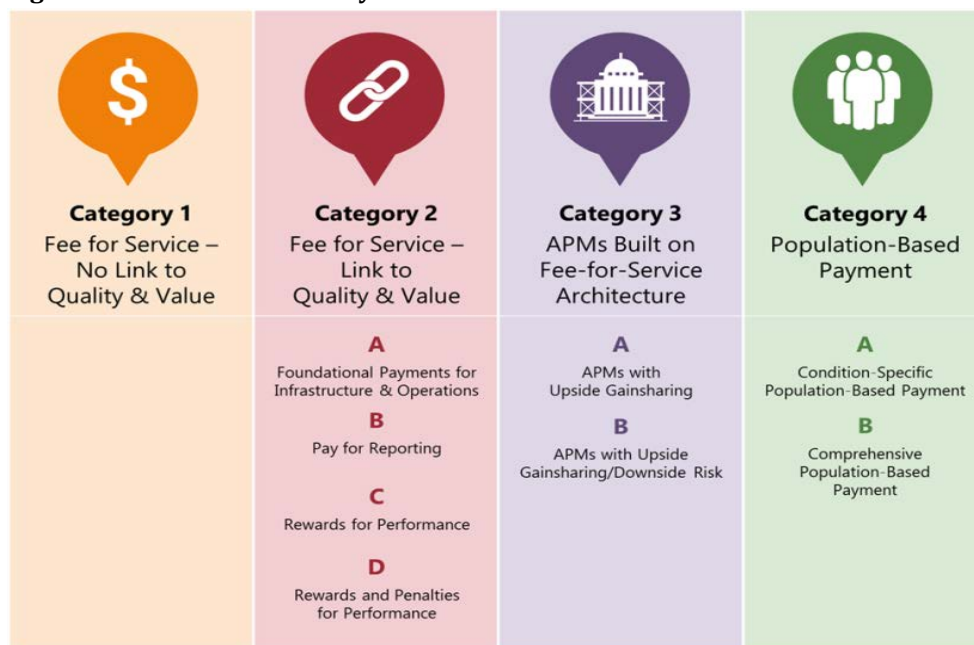
Additionally, a recent study published in the Journal of the American Medical Association (JAMA) may be of particular interest to purchasers. It estimates the potential savings through therapeutic substitution—when a generic drug is substituted for a brand-name drug within the same drug class—to be \$73.0 billion in total excess expenditure and \$24.6 billion in out-of-pocket excess expenditure within studied drug classes from 2010-2012.³⁴

STATE PURCHASING STRATEGIES TO MANAGE COSTS AND INCREASE QUALITY

THE MOVEMENT FROM VOLUME TO VALUE

There is a national movement led by Medicare, the biggest payer in the U.S., to move away from traditional volume-based health care payments to payments based on value. Payments linked to quality and efficiency are commonly referred to as value-based payments (VBPs) or alternative payment models (APMs). The Learning Action Network, a multi-stakeholder group created by CMS to accelerate APMs, created a common framework for stakeholders to define APMs. CMS' Alternative Payment Model Framework³⁵ is shown below (Figure 1).

Figure 1. CMS' Alternative Payment Model Framework



http://www.ajpb.com/journals/ajpb/2015/ajpb_januaryfebruary2015/strategies-to-improve-pbm-management-of-an-employee-prescription-drug-plan

³⁴ Ross, J. (2016, June). Therapeutic Substitution—Should It Be Systematic or Automatic? *JAMA Internal Medicine*. 176(6):776. Retrieved on July 3, 2016 from:

<http://archinte.jamanetwork.com/article.aspx?articleid=2520675>

³⁵ Health Care Payment Learning & Action Network. (2016, January 12). Alternative Payment Model (APM) Framework. Retrieved on July 14, 2016 from <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>

Under the Medicare Access and CHIP Re-Authorization Act (MACRA), federal legislation signed in April 2015, Medicare lays out its long-term plan to link Medicare provider payments to value and quality, starting in 2019 (based on quality improvement activities and VBP models in effect in 2017). Proposed rules for MACRA were released in March and will be finalized in the fall.³⁶

In concert with Medicare, many states are leveraging their own purchasing power and implementing VBP approaches for their Medicaid populations and public employees. Since most states are the largest public purchaser in their market, these efforts are likely to impact states' overall health care spending. Recognizing the purchasing leverage of states, the federal government, through the Center for Medicare and Medicaid Innovation (CMMI) has invested over \$900 million under the State Innovation Model (SIM) initiative. SIM is providing financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models to improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states.³⁷

MEDICAID

With a great number of Medicaid beneficiaries in Medicaid managed care, states are increasingly leveraging Medicaid MCO contracts as vehicles to change how providers are paid for delivering health services, with the goal of creating greater accountability for medical and pharmacy costs as well as quality from MCOs and providers.³⁸ For example, states are requiring contracted MCOs to promote VBP goals by requiring them to adopt a standardized VBP model, make a specific percentage of provider payments through approved VBP arrangements, and move towards implementation of more sophisticated VBP approaches over the life of the contracts.

Second, numerous states—including New York, Alabama, Virginia and California—have or are pursuing Medicaid Section 1115 waivers³⁹ to allow flexibility and federal financing of innovative delivery approaches.

Third, several states (including Washington) are moving toward integrating or “carving-in”

³⁶ The Advisory Board Co. (2016, June 3). C-Suite Cheat Sheet: Medicare Access and CHIP Reauthorization Act (MACRA). Available from HCA upon request. Retrieved on June 29, 2016 from: <https://www.advisory.com/research/health-care-industry-committee/members/resources/cheat-sheets/macra>

³⁷ Centers for Medicare & Medicaid Innovation. (2016, May 16). State Innovation Models Initiative: General Information. *Centers for Medicare & Medicaid Services*. Retrieved on June 29, 2016 from: <https://innovation.cms.gov/initiatives/state-innovations>.

³⁸ Leddy, T., McGinnis, T., & Howe, G. (2016, February). Value-Based Payments in Medicaid Managed Care: An Overview of State Approaches. *Center for Health Care Strategies, Inc.* Retrieved on June 29, 2016 from: http://www.njhcqi.org/wp-content/uploads/2016/04/VBP-BriefCHCS_022216_FINAL.pdf

³⁹ In general, this type of waiver is for demonstrations and evaluations of policy approaches for expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible, providing services not typically covered by Medicaid, or using innovative service delivery systems that improve care, increase efficiency, and reduce costs. Section 1115 waivers are approved for an initial five-year period and can be extended for an additional three years. For more information, see <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html>

behavioral health services with physical health to provide better continuity and coordination of services, often termed “whole-person care”. Washington State has its own mandate to complete full integration of physical and behavioral health services in managed care by January 2020.⁴⁰

Fourth, a couple of states are looking at reforming oral health by testing creative ways to integrate dental care into primary care delivery.⁴¹

Last, in addition to implementing new VBP arrangements, states continue to adjust their Medicaid programs in response to new federal Medicaid rules. For example, CMS released its final rules on April 25, 2016 pertaining to Medicaid managed care, the first major update in over a decade. Much of the final rule is designed to better align with market place regulations, streamline patient transitions between Medicaid and Qualified Health Plans (QHPs) and simplify administration.^{42,43,44}

STATE PUBLIC EMPLOYEE PROGRAMS

As Medicaid reforms, a number of states are also implementing various VBP strategies for their public employees⁴⁵, including:

- Steering members to high-performing providers, supported by price and quality transparency;
- Changing benefit designs to offer incentives to members to lead healthier lives and choose high-value clinical care, along with corresponding disincentives;
- Enhancing care coordination, including patient-centered medical homes (PCMHs) and accountable care organizations (ACOs); and
- Implementing multi-payer approaches to payment reform and delivery system redesign.

⁴⁰ Washington State Legislature. Senate. *AN ACT Relating to improving the effectiveness of health care purchasing and transforming the health care delivery system by advancing value-based purchasing....* (E2SHB 2572). 63rd Legislature, 2014 Regular Session. Retrieved on June 29, 2016 from: <http://lawfilesexultleg.wa.gov/biennium/2013-14/Pdf/Bills/House%20Passed%20Legislature/2572-S2.PL.pdf>

⁴¹ Chazin, S., Crawford, M. (2016, May). Oral Health Integration in Statewide Delivery System and Payment Reform. *Center for Health Care Strategies, Inc.* (Rep.) Retrieved on June 29, 2016 from: <http://www.chcs.org/media/Oral-Health-Integration-Opportunities-Brief-052516-FINAL.pdf>

⁴² Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. 81 FR §27497 (2016). Retrieved on June 29, 2016 from: <https://federalregister.gov/a/2016-09581>

⁴³ Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability. 80 FR §31097 (2016). Retrieved on June 29, 2016 from: <https://federalregister.gov/a/2015-12965>

⁴⁴ Quinn, R. (2016, June). Phone interview with the Health Plan Advisory Council.

⁴⁵ KPMG Government Institute. (2015, October). Value-Based Purchasing Strategies for State Employees. *KPMG*. Retrieved on June 29, 2016 from: <http://www.kpmg-institutes.com/content/dam/kpmg/governmentinstitute/pdf/2014/state-purchasing-strategies.pdf>

THE CHANGING LANDSCAPE OF DELIVERY SYSTEMS AND HEALTH PLAN BUSINESS

As purchasers move toward VBPs, delivery systems and health plans are rapidly changing their practices to prepare for the new world of accountable care and risk-based contracts.

For delivery systems, reforms include building necessary infrastructure to support risk-based contracts, including health information technology (i.e., electronic health records) to support care coordination, quality measurement and reporting, and data analytics. For health plans, reforms include increasing the number of risk-based contracts with providers, as well as developing new business strategies to support the value-based payment movement, including offering data and analytic support to providers.⁴⁶

Both delivery systems and health plans have been making steady progress with risk-based contracts, but fee-for-service physician payment is still dominant. A recent study from McKesson Health Solutions surveyed 465 payers and hospitals about their transition to value-based care models. Overall, payers reported that they are now 58 percent along the continuum toward full value-based reimbursement, up from 48 percent in 2014. Hospitals are at about 50 percent, up from 46 percent in 2014.⁴⁷

During the same time frame, HCA surveyed providers and health plans in Washington State to track VBP movement locally. Providers self-reported approximately 30 percent and health plans self-reported approximately 50 percent of their business is in VBP arrangements.⁴⁸

Delivery system and health plan adoption of risk-based contracts will most likely accelerate over the next year as MACRA rules are finalized because, under MACRA, Medicare provider payments in 2019 will be dependent on quality improvement activities and VBP in operation in 2017.

HCA is continuing its efforts to assist providers with the transition to value. For instance, the Practice Transformation Hub⁴⁹ will provide technical assistance to providers as they transition to the new value-based payment world.

⁴⁶ Gerhardt, W., Korenda, L., Morris, M., & Vadnerkar, G. (2015, March 20). The Road to Value-Based Care. *Deloitte University Press*. Retrieved on June 29, 2016 from: <http://dupress.com/articles/value-based-care-market-shift/>

⁴⁷ Murphy, B. (2016, June 20). Payers Estimate 59% of Payments will be Value-Based by 2021: 5 Quick Stats. *Becker's Hospital Review*. Retrieved on June 29, 2016 from: <http://www.beckershospitalreview.com/payer-issues/payers-estimate-59-of-payments-will-be-value-based-by-2021-5-quick-stats.html>

⁴⁸ Health Care Authority's Paying for Value Survey. Survey released March 27th, 2016. Survey is posted on HCA's Paying for Value website: http://www.hca.wa.gov/hw/Pages/paying_for_value.aspx. A final report summarizing HCA's Paying for Value Survey findings is forthcoming and will be shared with key health care stakeholders upon its release.

⁴⁹ Washington Health Care Authority. (2016). Practice Transformation Hub. (website). Retrieved on June 29, 2016 from: http://www.hca.wa.gov/hw/Pages/practice_transformation_hub.aspx

PROVIDER AND HEALTH PLAN CONSOLIDATION

2014 was a high-water mark for mergers and acquisitions in the health care sector, with 1,299 mergers and acquisitions, valued at \$307 billion. Health care mergers and acquisitions were up 26 percent from 2013-2014, and the value of those deals rose 137 percent.⁵⁰

Consolidation in the provider sector slowed in the beginning of 2014 but picked up at the end of the year. 79 hospital mergers were recorded for the year, down from 94 in 2012, and 58 physician practice groups merged or were purchased, down from 65 in 2013.⁵¹

The most frequently cited reasons for provider consolidation are:

- Dominant hospital systems purchasing smaller systems for more market share and leverage with health plans,
- A greater amount of capital for innovation, and
- Efficiency of services.⁵²

Also, hospitals can help providers offset costs of health IT, as well as administrative and clinical processes that are necessary to engage in risk-based contracts.⁵³

For health plans, the estimated national market share for the five largest insurers in 2014 was 83 percent, up from 79 percent in 2010 and 74 percent in 2006.⁵⁴ Over the past year, three mergers have been announced: Aetna/Humana, Anthem/Cigna, and Centene/HealthNet. All three mergers are currently being reviewed by the U.S. Department of Justice, before being finalized.⁵⁵

Health plan mergers occur for three general reasons: economies of scale, negotiating leverage in

⁵⁰ Phillips, L. (2015, January 23). Health Care M&A Broke Records in Q4 2014, and for Full Year, According to Health Care M&A News. *Irving Levin Associates*. Retrieved on June 29, 2016 from: <http://www.levinassociates.com/pr2014/pr1501mamq4>

⁵¹ PricewaterhouseCoopers (2015, February). US health services deals insights: Analysis and trends in US health services activity 2014 and 2015 Outlook. *PricewaterhouseCoopers Deals Practice*. Retrieved on June 29, 2016 from: <http://www.pwc.com/us/en/healthcare/publications/assets/pwc-health-services-deals-insights-2014.pdf>

⁵² Benton, B. (2015, March 17). Building a Strategy: Mergers & Acquisitions in Healthcare. *Dixon Hughes Goodman LLP*. Retrieved on June 29, 2016 from: <https://www.dhglp.com/resources/publications/article/967/building-a-strategy-mergers-acquisitions-in-healthcare>

⁵³ Weeks, W. (2015, October). Potential Advantages of Health System Consolidation and Integration. *The American Journal of Medicine* 128(10): 1050 – 105. Retrieved on July 3, 2016 from: [http://www.amjmed.com/article/S0002-9343\(15\)00462-3/fulltext](http://www.amjmed.com/article/S0002-9343(15)00462-3/fulltext)

⁵⁴ Dafny, L. (2015, September 22). Testimony: Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask? *Senate Committee on the Judiciary*. Retrieved on June 29, 2016 from: <http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf>

⁵⁵ von Ebers, P. (2016, January 22). Mega Health Insurance Mergers: Is Bigger Really Better? *Health Affairs Blog*. Retrieved on June 29, 2016 from <http://healthaffairs.org/blog/2016/01/22/mega-health-insurance-mergers-is-bigger-really-better/>

hospital and physician contracting, and diversification.⁵⁶

Research regarding the impacts of provider and health plan consolidation is mixed. Some proponents argue that provider consolidation may be necessary to achieve the care coordination and efficiency goals of the new world of VBP. Opponents argue that consolidation leads to higher costs for consumers.⁵⁷

In Washington State, the most recent provider mergers are DaVita HealthCare Partners, a national company, which acquired the Everett Clinic in March 2016, and Providence Health & Services, acquired by St. Joseph Health in California in July 2016.

Earlier this year, Kaiser Permanente announced its intention to purchase Group Health Cooperative (GHC). GHC currently holds around 17 percent of the health plan market in Washington. The merger will increase Kaiser's market share to around 20% in Washington State.⁵⁸

In addition to acquisitions and mergers, delivery systems and providers are forming legally binding partnerships to create clinically integrated networks to support risk-based contracts.⁵⁹

Providence/Swedish ACO, Puget Sound High Value Network (led by Virginia Mason Medical Center, MultiCare, Evergreen Health Partners, and Overlake), and University of Washington Accountable Care Networks are the newest clinically-integrated networks in Washington State, in addition to Group Health Cooperative's clinically-integrated Health Maintenance Organization (HMO). Other clinically integrated networks may emerge over the next year.

REFORMING OUR WASHINGTON STATE PURCHASING (MEDICAID AND PUBLIC EMPLOYEE)

HCA is responsible for purchasing the benefits for the Apple Health (Medicaid) program, as well as for state employees in the Public Employee Benefits (PEB) program. In 2015, HCA purchased Apple Health benefits for 1.87 million Washingtonians, at a cost of \$7.9 billion for FY 2016.⁶⁰ For the PEB program, HCA purchased health benefits for 359,000 state employees, at a cost of \$1.6 billion in calendar year 2015⁶¹. It is through these two programs, which cover nearly a third of all Washingtonians, that HCA has initiated its health purchasing reform efforts.

Over the last few years, in response to rising health care costs and in response to 2014 legislation to

⁵⁶ *Ibid.*

⁵⁷ Neprash, H., Chernew, M. E., Hicks, A. L., Gibson, T., & McWilliams, M. (2015, October 19). Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices. *JAMA Internal Medicine*. Retrieved on June 29, 2016 from: <http://archinte.jamanetwork.com/article.aspx?articleid=2463591>

⁵⁸ State of Washington Office of Insurance Commissioner. (2016). 2015 Market Information Report. Retrieved on July 5, 2016 from: <https://www.insurance.wa.gov/about-oic/reports/market-information-reports/2015-mi-report/>

⁵⁹ See footnote 49.

⁶⁰ Based on HCA's state fiscal year 2016 Medicaid funding, inclusive of both state and federal funds.

⁶¹ Non-Medicare enrollees only, and includes medical, dental, pharmacy and administrative costs. Life insurance and long-term disability is not included.

increase VBP strategies in public programs⁶², Washington State has implemented new purchasing strategies, including VBP, to achieve better health and better care, and manage health care costs. For example, under the Accountable Care Program for public employees, the two provider networks are accountable for the total of cost of care, including pharmacy, for enrollees.

Building on payment models under Healthier Washington, HCA released its Value-based Purchasing Road Map in June 2016.⁶³ This guide braids together major components of Healthier Washington (payment redesign model tests, Statewide Common Measure Set and Accountable Communities of Health [ACHs], for example), the Medicaid transformation waiver, and the Bree Collaborative care transformation principles into a unified approach.

The Road Map is built on the following principles:

- Reward the delivery of patient-centered, high-value care and increased quality improvement across all Medicaid and PEBB programs.
- Reward performance of Medicaid Managed Care Organizations (MCOs) and provider systems for increased adoption of value-based payments.
- Align payment and delivery reform approaches with CMS for greatest impact and to simplify implementation for providers. (Publicly funded health insurance programs—Medicaid, Medicare, and PEB—cover nearly 50 percent of Washington State’s population.)

Washington has applied for a Section 1115 waiver and is continually tracking other states’ 1115 waivers to identify emerging and nascent healthcare spending approaches that improve effectiveness. If approved, Washington’s Medicaid transformation waiver will focus on three delivery system initiatives:

- Transformation of the health care delivery system through Accountable Communities of Health with investments in:
 - Health systems capacity building—Support for development of new primary care models; workforce development, including non-conventional service sites; and improvements in data collection and analytic capacity.
 - Care delivery redesign—Bi-directional integration of physical and behavioral health care; improved care coordination, including clinical-community linkages; and better transitions between services and settings.
 - Prevention and health promotion—Focusing on chronic disease prevention and management, and maternal and child health, for Medicaid beneficiaries.
- Broaden the array of service options to enable individuals to stay at home to delay or avoid the need for more intensive Long-term Services and Supports; and

⁶² See footnote 37.

⁶³ Washington Health Care Authority. (2016, June). HCA Value-Based Road Map, 2017-2021. Retrieved on June 29, 2016 from: http://www.hca.wa.gov/hw/Documents/vbp_roadmap.pdf

- Provide targeted foundational community supports—supportive housing and supported employment services—which promote stability and positive health outcomes in order to avoid homelessness, costly medical and behavioral health care, and long-term institutional care.

PRESCRIPTION DRUG PRICES AND PUBLIC PURCHASING

Over the last ten years, HCA has been actively working to control costs and improve price transparency. Current strategies include:

- Operating two drug programs: Washington Preferred Drug List (PDL) (since 2003)⁶⁴ and joint purchasing with the State of Oregon through the NW Drug Consortium (since 2005).⁶⁵
- Working in partnership with and holding Medicaid managed care and health plans and the PEBB Prescription Benefit Manager accountable for managing utilization (through negotiation price and discounts) and implementing value-based drug strategies.

Earlier this month HCA, in response to the Legislature, convened a summit on prescription drug price and purchasing strategies with national pharmacy experts, providers, health plans, and other health care stakeholders to have a community discussion on solutions to pharmacy costs. HCA will use the outcomes of presentations and discussions from the summit⁶⁶, along with other input it will elicit from key organizations, to develop a briefing paper for state agencies and legislators to inform next steps in addressing the rapid rise in pharmacy costs. The briefing paper will be shared with legislators and other interested parties by November 15, 2016.

⁶⁴ Washington Preferred Drug List (PDL) includes the lowest net cost, equally safe and equally effective drugs for three state agencies: Medicaid, UMP and L&I. Each agency also has patient prior authorization requirements in place (i.e., step therapy, expedited authorization, or full review), specific drug quantity limits, the ability to set pharmacy reimbursement rates, and implementing benefit restrictions like “split-fills” for high cost specialty drugs to avoid potential waste.

The NW Drug Consortium provides 100% transparent purchaser contracts where all pharmacy discounts are passed through to member groups or individuals and any administrative expense is fixed and transparent. In addition, all manufacturer rebates are passed through at 100% (including rebates on Specialty drugs). HCA Consortium drug prices have proven better than commercial rates currently available to other large groups in either state (backed by a Most Favored Nation guarantee) and are audited annually (by 3rd party) as well as guaranteed to yield results favorable to what other large employer groups receive in the Northwest. Finally, (cont.) HCA Consortium groups have access a second audit (by 3rd party) to assure actual group payments compare to contracted price guarantees. Both market and benefit audits are paid by Contractor.

⁶⁶ Washington Health Care Authority. (2016, June 14). Washington Prescription Drug Price and Purchasing Summit Series: Part 1. Retrieved June 29, 2016 from: <http://www.hca.wa.gov/medicaid/ebm/Pages/prescription-drug-price-purchasing-summit.aspx>.

Appendix

Total Medicaid Benefit Spending by State and Category, FY 2014 (millions)

State ¹	Total spending on benefits	Fee for Service									Managed care and premium assistance	Medicare premiums and coinsurance	Collections
		Hospital	Physician	Dental	Other practitioner	Clinic and health center	Other acute	Drugs	Institutional LTSS	Home and community-based LTSS			
Alabama	\$5,213	\$1,909	\$503	\$84	\$49	\$89	\$499	\$293	\$1,003	\$459	\$96	\$258	-\$30
Alaska	\$1,412	\$308	\$119	\$74	\$21	\$208	\$112	\$39	\$159	\$363	\$0	\$24	-\$15
Arizona	\$9,185	\$1,175	\$37	\$5	\$5	\$148	\$264	\$5	\$72	\$5	\$7,300	\$225	-\$54
Arkansas	\$4,840	\$1,009	\$339	\$74	\$22	\$49	\$903	\$185	\$998	\$489	\$529	\$299	-\$56
California	\$63,384	\$13,274	\$1,446	\$593	\$25	\$2,485	\$5,835	\$1,408	\$5,682	\$9,010	\$21,838	\$2,257	-\$469
Colorado	\$5,919	\$1,910	\$493	\$146	–	\$154	\$250	\$280	\$710	\$1,064	\$843	\$109	-\$41
Connecticut	\$6,821	\$1,972	\$396	\$171	\$116	\$264	\$471	\$467	\$1,613	\$1,380	\$0	\$380	-\$411
Delaware	\$1,692	\$54	\$13	\$34	\$1	\$58	\$64	\$106	\$37	\$108	\$1,218	\$35	-\$34
District of Columbia	\$2,368	\$379	\$46	\$24	\$3	\$149	\$117	\$79	\$372	\$408	\$769	\$37	-\$13
Florida	\$20,303	\$4,942	\$1,330	\$184	\$42	\$184	\$1,446	\$417	\$1,836	\$1,224	\$7,459	\$1,361	-\$123
Georgia	\$9,397	\$2,139	\$431	\$39	\$32	\$15	\$714	\$277	\$1,380	\$932	\$3,194	\$334	-\$89
Hawaii	\$1,950	\$114	\$3	\$36	\$0	\$37	\$4	\$3	\$10	\$106	\$1,628	\$53	-\$45
Idaho	\$1,586	\$434	\$111	-\$0	\$18	\$22	\$184	\$62	\$272	\$299	\$165	\$41	-\$23
Illinois	\$16,616	\$6,722	\$892	\$183	\$109	\$288	\$1,189	\$414	\$2,508	\$1,733	\$2,286	\$401	-\$110
Indiana	\$9,094	\$1,906	\$320	\$184	\$11	\$394	\$357	\$463	\$2,358	\$1,059	\$1,907	\$172	-\$36
Iowa	\$3,922	\$802	\$196	\$54	\$23	\$79	\$368	\$126	\$941	\$745	\$559	\$144	-\$116
Kansas ²	\$2,728	\$146	\$21	\$0	\$3	\$5	\$46	-\$1	\$82	\$139	\$2,240	\$85	-\$37
Kentucky	\$7,793	\$458	\$57	\$3	\$4	\$113	\$386	\$36	\$1,148	\$735	\$4,769	\$198	-\$115
Louisiana	\$7,056	\$2,212	\$328	\$82	–	\$89	\$314	\$234	\$1,334	\$835	\$1,659	\$271	-\$303
Maine	\$2,365	\$510	\$102	\$27	\$43	\$233	\$384	\$75	\$428	\$439	\$3	\$213	-\$92
Maryland	\$9,210	\$1,210	\$128	\$125	\$25	\$57	\$936	\$291	\$1,338	\$1,103	\$3,892	\$267	-\$162
Massachusetts	\$14,251	\$2,257	\$387	\$227	\$23	\$332	\$1,002	\$339	\$1,901	\$2,368	\$5,339	\$427	-\$352
Michigan	\$13,503	\$1,486	\$440	\$71	\$9	\$230	\$513	\$288	\$2,034	\$799	\$7,315	\$397	-\$79
Minnesota	\$9,918	\$642	\$237	\$36	\$192	\$63	\$647	\$118	\$1,003	\$2,387	\$4,554	\$177	-\$138
Mississippi	\$4,865	\$1,661	\$198	\$4	\$23	\$95	\$375	\$147	\$1,096	\$315	\$763	\$207	-\$19
Missouri	\$8,829	\$2,881	\$42	\$14	\$12	\$445	\$819	\$648	\$1,389	\$1,298	\$1,055	\$320	-\$95
Montana	\$1,072	\$302	\$56	\$28	\$19	\$20	\$190	\$41	\$193	\$175	\$25	\$36	-\$13
Nebraska	\$1,772	\$186	\$33	\$34	\$3	\$5	\$67	\$59	\$421	\$340	\$566	\$103	-\$45
Nevada	\$2,281	\$514	\$126	\$33	\$16	\$32	\$202	\$98	\$275	\$187	\$697	\$120	-\$19

State ¹	Total spending on benefits	Fee for Service									Managed care and premium assistance	Medicare premiums and coinsurance	Collections
		Hospital	Physician	Dental	Other practitioner	Clinic and health center	Other acute	Drugs	Institutional LTSS	Home and community-based LTSS			
New Hampshire ²	\$1,323	\$163	\$38	\$21	\$7	\$5	\$145	-\$9	\$404	\$301	\$243	\$27	-\$21
New Jersey	\$12,470	\$1,776	\$71	\$8	\$3	\$196	\$838	\$19	\$2,967	\$1,057	\$5,307	\$333	-\$104
New Mexico ²	\$4,169	\$360	\$35	\$11	\$38	\$28	\$41	-\$14	\$34	\$321	\$3,236	\$91	-\$13
New York ²	\$51,806	\$7,707	\$388	\$76	\$216	\$1,263	\$5,101	-\$1,489	\$9,661	\$6,117	\$23,861	\$1,302	-\$2,398
North Carolina	\$11,993	\$3,471	\$730	\$318	\$320	\$247	\$1,046	\$610	\$1,377	\$860	\$2,697	\$421	-\$105
North Dakota	\$402	\$63	\$26	\$6	\$5	\$6	\$26	\$10	\$163	\$92	\$8	\$6	-\$7
Ohio	\$19,439	\$2,459	\$387	\$53	\$26	\$118	\$1,539	\$77	\$2,859	\$2,603	\$9,078	\$385	-\$143
Oklahoma	\$4,666	\$1,673	\$491	\$116	\$43	\$389	\$359	\$297	\$770	\$526	\$157	\$146	-\$300
Oregon	\$6,784	\$514	\$31	\$2	\$23	\$78	\$540	\$65	\$411	\$1,235	\$3,762	\$169	-\$47
Pennsylvania	\$23,462	\$1,822	\$105	\$28	\$2	\$103	\$346	\$14	\$4,896	\$3,530	\$12,203	\$574	-\$161
Rhode Island	\$2,437	\$365	\$16	\$10	\$1	\$29	\$567	\$3	\$239	\$2	\$1,177	\$43	-\$14
South Carolina	\$5,321	\$1,089	\$159	\$94	\$22	\$241	\$325	\$6	\$812	\$488	\$2,140	\$178	-\$232
South Dakota	\$778	\$193	\$64	\$15	\$2	\$91	\$57	\$32	\$165	\$136	\$2	\$28	-\$7
Tennessee	\$9,205	\$856	\$53	\$142	\$1	\$40	\$235	\$485	\$259	\$684	\$6,163	\$346	-\$58
Texas	\$31,385	\$5,471	\$1,690	\$85	\$237	\$38	\$4,542	\$346	\$3,692	\$2,445	\$12,634	\$1,023	-\$817
Utah	\$2,064	\$303	\$76	\$19	\$3	\$11	\$93	\$63	\$275	\$238	\$975	\$37	-\$30
Vermont ²	\$1,526	\$44	\$2	\$0	\$0	\$1	\$1,428	-\$74	\$120	\$8	-\$0	\$6	-\$9
Virginia	\$7,547	\$992	\$202	\$128	\$33	\$50	\$1,006	\$44	\$1,246	\$1,326	\$2,356	\$228	-\$64
Washington	\$10,250	\$1,080	\$193	\$155	\$29	\$536	\$380	\$59	\$910	\$1,710	\$5,022	\$331	-\$154
West Virginia	\$3,331	\$622	\$199	\$40	\$18	\$47	\$261	\$156	\$747	\$586	\$552	\$121	-\$18
Wisconsin	\$7,396	\$779	\$130	\$44	\$23	\$312	\$676	\$321	\$956	\$899	\$3,033	\$322	-\$99
Wyoming	\$539	\$117	\$46	\$14	\$13	\$36	\$28	\$18	\$133	\$128	\$2	\$14	-\$8
Subtotal	\$467,639	\$85,432	\$13,960	\$3,955	\$1,912	\$10,209	\$38,235	\$8,034	\$65,687	\$55,795	\$177,277	\$15,084	-\$7,941
American Samoa	\$25	\$23	–	–	–	–	\$1	\$0	–	–	–	–	–
Guam	\$74	\$15	\$9	\$2	\$0	\$1	\$27	\$17	\$1	\$0	–	\$1	–
N. Mariana Islands	\$34	\$22	–	\$1	–	\$3	\$3	\$2	–	\$1	\$0	\$1	–
Puerto Rico	\$1,842	–	–	–	–	–	\$30	–	–	–	\$1,811	–	\$1
Virgin Islands	\$71	\$44	\$4	\$1	\$1	\$3	-\$2	\$6	\$5	\$0	–	\$8	-\$0
Total	\$469,683	\$85,537	\$13,973	\$3,960	\$1,913	\$10,216	\$38,294	\$8,059	\$65,692	\$55,796	\$179,089	\$15,094	-\$7,940
Percent of total, exclusive of collections	–	17.9%	2.9%	0.8%	0.4%	2.1%	8.0%	1.7%	13.8%	11.7%	37.5%	3.2%	–

State ¹	Total spending on benefits	Fee for Service									Managed care and premium assistance	Medicare premiums and coinsurance	Collections
		Hospital	Physician	Dental	Other practitioner	Clinic and health center	Other acute	Drugs	Institutional LTSS	Home and community-based LTSS			

Notes: LTSS is long-term services and supports. Includes federal and state funds. Service category definitions and spending amounts shown here may differ from other Centers for Medicare & Medicaid (CMS) data sources, such as the Medicaid Statistical Information System (MSIS). The specific services included in each category have changed over time and therefore may not be directly comparable to earlier editions of MACStats. Collections include third-party liability, estate, and other recoveries. Zeroes indicate amounts between -\$0.5 and \$0.5 million that round to zero. Dashes indicate amounts that are true zeroes. Table originally posted online March 25, 2015.

Additional detail on categories:

- Hospital includes inpatient, outpatient, critical access hospital, and emergency hospital services, as well as related disproportionate share hospital (DSH) payments.
- Physician includes physician and surgical services, both regular payments and those associated with the primary care physician payment increase.
- Clinic and health center includes non-hospital outpatient clinic, rural health clinic, federally qualified health center, and freestanding birth center.
- Other acute includes lab/X-ray; sterilizations; abortions; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings; emergency services for unauthorized aliens; non-emergency transportation; physical, occupational, speech, and hearing therapy; prosthetics, dentures, and eyeglasses; preventative services with U.S. Preventive Services Task Force (USPSTF) Grade A or B and Advisory Committee on Immunization Practices (ACIP) vaccines; other diagnostic screening and preventive services; school-based services; health home with chronic conditions; tobacco cessation for pregnant women; private duty nursing; case management (excluding primary care case management); rehabilitative services; hospice; and other care not otherwise categorized.
- Drugs are net of rebates.
- Institutional LTSS includes nursing facility, intermediate care facility for individuals with intellectual disabilities, and mental health facility.
- Home and community-based LTSS includes home health, waiver and state plan services, and personal care.
- Managed care and premium assistance includes comprehensive and limited-benefit managed care plans, primary care case management (PCCM), employer-sponsored premium assistance programs, Programs of All-inclusive Care for the Elderly (PACE); comprehensive plans account for about 90 percent of spending in the managed care category. Managed care also includes rebates for drugs provided by managed care plans, and managed care payments associated with the primary care physician payment increase, Community First Choice option, and preventive services with USPSTF Grade A or B and ACIP vaccines.

¹ Not all states have certified their CMS-64 FMR submissions as of February 25, 2015. California and Colorado's 2nd, 3rd, and 4th quarter submissions are not certified; North Dakota's 3rd and 4th quarter submissions are not certified; South Carolina's 2nd quarter submission is not certified; Rhode Island's 4th quarter submission is not certified. Figures presented in this table may change if states revise their expenditure data after this date.

² State reports negative fee-for-service (FFS) drug spending after the application of drug rebates. The negative net amount may reflect a shift of some FFS drug spending into Medicaid managed care or the state not separately reporting the FFS and managed care drug rebates. Vermont's negative drug spending is due to the fact that it reports most of its benefits spending as other care services in its CMS-64 submission.

Source: MACPAC, 2015, analysis of CMS-64 Financial Management Report (FMR) net expenditure data as of February 25, 2015.