

## **MARKET ASSESSMENT:**

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

December 2, 2016

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## EXECUTIVE SUMMARY

The Washington State Health Care Authority (HCA) submits this semi-annual report to provide context and insights to support ongoing budget and forecasting efforts. This report is intended to complement other tools such as HCA's monthly MCO utilization and cost reports. This release includes a summary of major health care cost and market trends, their effects on state budgets, and HCA's strategies for improving cost and quality performance in its purchasing programs, Apple Health (Medicaid) and Public Employee Benefits Board (PEBB). It also profiles hospitals' inpatient and outpatient cost and utilization trends.

### *HCA VALUE-BASED PURCHASING UPDATES*

Since July 2016, HCA has made progress in advancing the following value-based payment (VBP) initiatives, aimed at improving health care cost and quality for Medicaid and PEBB:

- HCA reached an “agreement in principle” on a five-year **Medicaid transformation demonstration project**. A key focus of this demonstration is supporting providers and payers in developing the capacity to move to new care delivery and payment models. HCA is currently negotiating the special terms and conditions (STCs) for the demonstration with the Centers for Medicare and Medicaid Services (CMS).
- Beginning in January 2017, **Apple Health managed care organizations' contracts** will include a 1% premium withhold based on plan performance against quality improvement and value-based purchasing targets.
- Beginning in January 2017, PEBB's **Accountable Care Program (ACP)** will be expanded to Grays Harbor, Skagit, Spokane, and Yakima counties.
- Chelan, Douglas, and Grant counties have committed to moving to **fully integrated managed care of physical and behavioral health** in January 2018.
- HCA and the Office of Financial Management (OFM) produced a report on **pharmacy costs and potential pharmacy purchasing strategies** to the legislature on November 15, 2016.

### *HOSPITAL UTILIZATION AND COST TRENDS*

Nationally, from 2000 – 2014, hospital inpatient admissions have decreased slightly while outpatient visits have grown roughly 33 percent. Inpatient revenues have decreased. On a related note, hospital margin (revenue minus costs) was at 7.3 percent in 2014, the highest rate in 15 years.

In Washington State, inpatient hospital admissions declined an average 2.5 percent annually from 2010 to 2015, while hospital outpatient visits increased an average of 2.1 percent annually during the same period. During the same period, hospital outpatient revenues had an average annual growth rate of 6.4 percent, while inpatient revenue grew by 4.6 percent annually.

From 2014 to 2015, utilization of outpatient services for PEBB's Uniform Medical Plan (UMP) members increased 16 percent per 1000 members, while inpatient utilization decreased by 5

percent. Per member per month (PMPM) outpatient costs were 5 percent lower in 2015; inpatient costs were 1 percent lower. For the Medicaid managed care population, average hospital inpatient admissions and outpatient claims stayed consistent from January 2015 to May 2016.

## PURPOSE AND PROCESS

### *PURPOSE*

The purpose of this report is to provide insights from the health care marketplace to support ongoing budget and policy efforts in Washington State. This report is meant to complement other activities led by HCA and OFM to monitor health care utilization and quality of our Public Employee Benefits and Medicaid health plans, and should not be seen as replacing those more direct indicators of cost and performance.

HCA will produce market assessment reports semi-annually, in July and November, approximately three months prior to each budget forecast.

- The July market assessment report will present a detailed 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).
- The November market assessment report will profile one major health care trend and present updates on Medicaid and PEBB's value-based purchasing initiatives.

This is the second semi-annual report.

This report is divided into the following sections:

- Updates on HCA value-based purchasing initiatives, and
- A profile of inpatient and outpatient cost and utilization trends, with links to additional information.

### *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.

After the release of the July 2016 market assessment report, HCA staff solicited feedback from legislative staff. Their feedback informed the approach for this market assessment report.

## HCA VALUE-BASED PURCHASING UPDATES

Since the last market assessment report (submitted in July), HCA has made progress in advancing various value-based payment (VBP) initiatives for Medicaid and PEBB. Below are updates on major VBP initiatives:

- **Medicaid transformation demonstration project.** Washington reached an “agreement in principle” with the Centers for Medicare and Medicaid Services (CMS) in October. This agreement establishes common ground on the financial and programmatic aspects of the Medicaid transformation demonstration. The next step is reaching agreement on the contract, or special terms and conditions (STCs) for the demonstration waiver. Under the demonstration, HCA and CMS will establish VBP incentives consistent with the [CMS Health Care Payment Learning and Action Network \(LAN\) Framework](#) Categories 2c-4b, providing regional and plan-level incentives for provider attainment of VBP strategies. In addition, HCA will establish tiered incentive criteria to further encourage region and plan-level attainment of provider risk arrangements that are in advanced Alternative Payment Models, consistent with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). HCA anticipates reaching final approval for the demonstration in January. When the STCs are final, the demonstration period will start and the State will move forward with implementation. See the [Medicaid transformation web page](#) for updates.
- **Apple Health VBP changes.** Medicaid is in the process of making significant changes to Medicaid contracts, starting in January 2017. Managed care organizations (MCOs) will be held accountable for attainment of quality and VBP goals. MCO contracts will require that a growing portion of premiums be used to fund direct provider incentives tied to attainment of quality. HCA will withhold 1% of the medical portion of the monthly premium payment, and the MCOs will be eligible for reimbursement of part or all of the 1% by achieving quality improvement in performance measures, making qualifying provider payments, and adopting value-based purchasing arrangements:
  - MCOs will be eligible for 12.5% of the 1% if at least 0.75% of annual premium payments are paid exclusively for provider incentive payments in value-based payment arrangements, as defined by Category 2c or higher of the CMS HCP-LAN framework.
  - MCOs will be eligible for 12.5% of the 1% if at least 30% of provider payments are paid to network providers in the form of value-based payments (LAN Category 2c or higher).
  - MCOs will be eligible for 75% of the 1% by achieving quality improvement targets for nine metrics, a subset of metrics from the Washington Statewide Common Measure Set (see Table 1, next page.)

In addition, reinvestment and challenge pools will be created to reward MCOs and Accountable Communities of Health (ACHs) for exceptional quality attainment.

**Table 1: Quality Measures Used for 1% Withhold in Apple Health Contracts**

	Quality Measure	Quality Measures Description
Adult Measures	NQF 0059	Comprehensive Diabetes Care - Poor HbA1c Control (>9%)
	NQF 0061	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)
	NQF 0018	Controlling High Blood Pressure (<140/90)
	NQF 0105	Antidepressant Medication Management – Effective Acute Phase Treatment
	NQF 0105	Antidepressant Medication Management - Effective Continuation Phase Treatment (6 Months)
Children Measures	NQF 0038	Childhood Immunization Status - Combo 10
	NQF 1516	Well-child visits in the 3rd, 4th, 5th and 6th years of life
	NQF 1799	Medication Management for people with Asthma: Medication Compliance 75% (Ages 5-11)
	NQF 1799	Medication Management for people with Asthma: Medication Compliance 75% (Ages 12-18)

Further details are presented in the [HCA VBP roadmap](#).

- **Accountable Care Program (ACP) expanded to additional counties.** The ACP program (UMP Plus) will be offered in additional counties beyond the Puget Sound region starting in January 2017. In addition to both networks being offered in the five-county Puget Sound region, Puget Sound High Value Network (PSHVN) will be available in Grays Harbor, Spokane and Yakima counties; the University of Washington Accountable Care Network (ACN) will be available in Grays Harbor and Skagit counties. Enrollment in both ACP network options increased by approximately 15% during the November open enrollment period.
- **Fully integrated managed care.** HCA has been working with a number of regional service areas to move to fully integrated managed care for physical and behavioral health care ahead of the January 2020 deadline. At this point, Chelan, Douglas and Grant counties, otherwise known as the North Central regional service area, have committed to moving to fully integrated managed care in January, 2018.
- **Report on drug costs and potential pharmacy value-based strategies.** HCA and OFM recently submitted a [report](#) to the Legislature describing potential purchasing strategies to

address prescription drug costs. The report outlined policy options in addition to current strategies in place—for controlling rising Medicaid and PEBB drug costs: (1) Alternative Payment Models; (2) supplemental rebates using a single preferred drug list; (3) pooled purchasing strategies; and (4) the 340B Drug Discount Program. The report was developed in response to a March 2016 request from 32 members of the Washington State Legislature asking HCA and OFM to convene the medical directors of all state agencies that purchase or reimburse for prescription drugs to explore strategies to improve drug pricing transparency and value-based drug purchasing approaches for state programs to maximize purchasing power under current federal law. HCA and OFM convened two meetings of the [Prescription Drug Pricing and Purchasing Summit](#) during the summer of 2016.

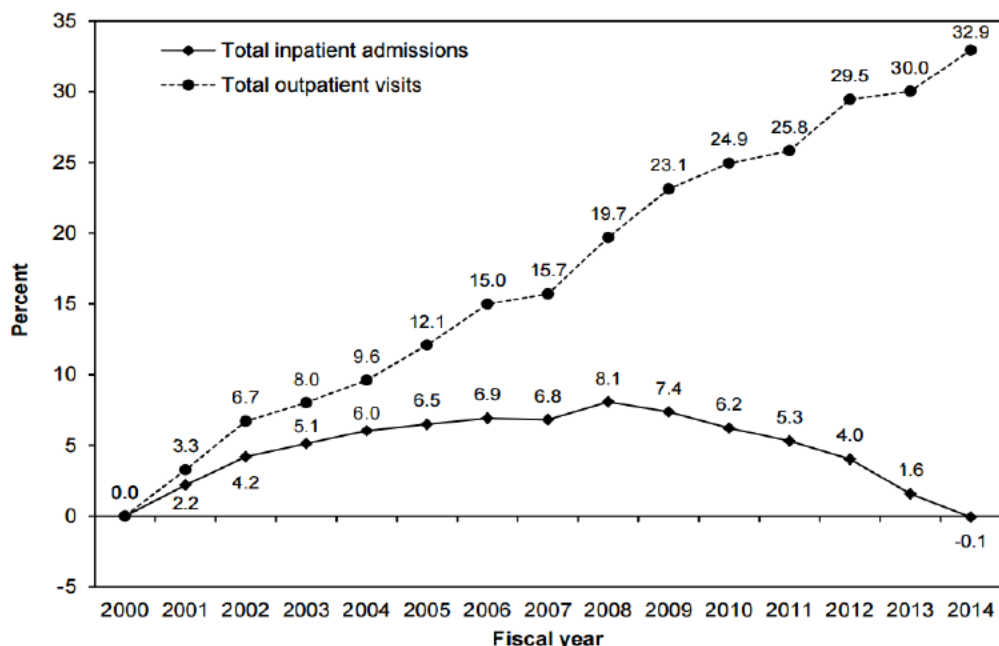


## PROFILE: NATIONAL HOSPITAL UTILIZATION AND COST TRENDS

### OVERVIEW

Nationally, hospital inpatient admissions have decreased slightly among all payers while outpatient visits have grown roughly 33 percent from 2000-2014<sup>1</sup> (see Chart 1 below). According to the American Hospital Association (AHA), hospital outpatient visits per 1,000 persons consistently trended upward, increasing from about 1,500 visits in 1994 to approximately 2,000 visits per 1,000 persons in 2014.<sup>2</sup> Similarly, CMS reported that there has been a 33 percent increase in Medicare clients' use of outpatient services from 2006 to 2013.<sup>3</sup>

**Chart 1: Cumulative change in total all-payer patient admissions and outpatient visits, 2000-2014**



Note: "Cumulative change" is the total percent increase from 2000 through 2014. Data reflect admissions (all payers) to and outpatient visits at about 5,000 community hospitals. "Community hospitals" are defined as all nonfederal, short-term general, and other specialty hospitals. "Other specialty hospitals" include obstetrics and gynecology; eye, ear, nose, and throat; rehabilitation; orthopedic; and other individually described specialty services. Community hospitals include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals. Excluded are hospitals not accessible by the general public, such as prison hospitals or college infirmaries.

Source: American Hospital Association, AHA Hospital Statistics.

<sup>1</sup> Medicare Payment Advisory Commission. (2016). *Acute inpatient services Short-term hospitals Inpatient psychiatric facilities* (Section 6 of Medpac A Data Book: Health care spending and the Medicare program). Washington, DC: Medicare Payment Advisory Commission. Available at: <http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-6-acute-inpatient-services.pdf?sfvrsn=0>.

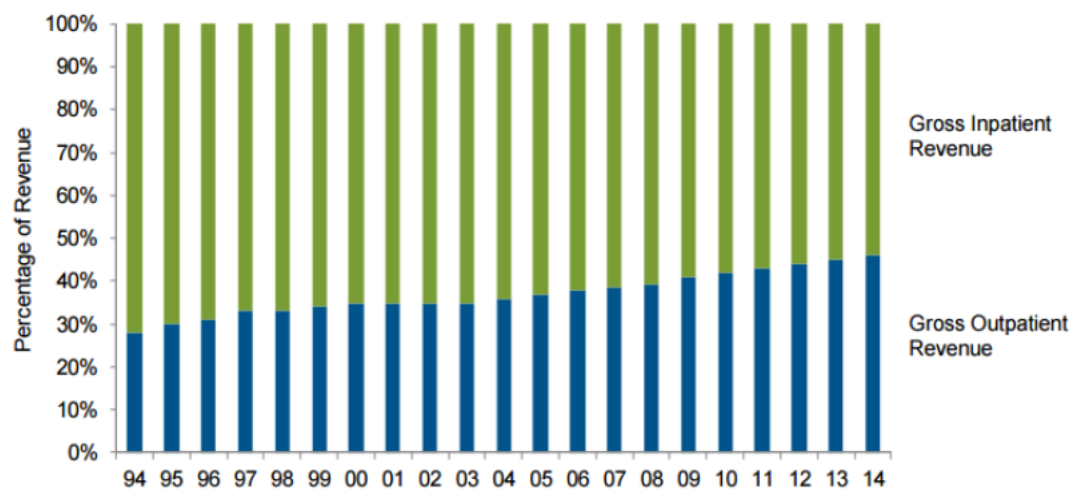
<sup>2</sup> American Hospital Association. (2016). *Chapter 3 Utilization and Volume* (Chartbook 2016 Trends Affecting Hospitals and Health Systems). Chicago, IL: American Hospital Association. Available at: <http://www.aha.org/research/reports/tw/chartbook/2016/chapter3.pdf>

<sup>3</sup> Miller, M. E. (2015). *Statement before the Committee on Ways and Means U.S. House of Representatives* (Medicare Payment Advisory Commission Testimony Hospital policy issues). Washington, DC: Medicare Payment Advisory Commission. Available from: <http://www.medpac.gov/docs/default-source/congressional-testimony/testimony-hospital-policy-issues-ways-and-means-.pdf?sfvrsn=0>

From 1994-2014, inpatient revenues declined while outpatient revenues increased<sup>4</sup> (see Chart 2 below). The average length of stay in a hospital consistently decreased from 6.7 days in 1994 to 5.5 days in 2014.<sup>5</sup> Reasons cited for declining inpatient revenue include: high-deductible plans that drive patients to obtain care in less expensive settings, hospitals placing patients on “observation” status instead of admitting them, clinical transformation efforts among providers to standardize care, and an increasing number of value-based payment arrangements, and more focus on care coordination to prevent future hospitalizations.<sup>6</sup> On a related note, hospital margin (revenue minus costs) for all payers was at 7.3 percent in 2014, which is the highest it has been since 2002 to 2014.<sup>7</sup>

For more information, see the American Hospital Association Chartbook on hospital trends.<sup>8</sup>

**Chart 2: Distribution of outpatient vs. inpatient revenues, 1994-2014**



Source: Analysis of American Hospital Association Annual Survey data, 2014, for community hospitals.

<sup>4</sup> American Hospital Association. (2016). *Chapter 4 Trends in Hospital Financing*. (Chartbook 2016 Trends Affecting Hospitals and Health Systems). Chicago, IL: American Hospital Association. Available at: <http://www.aha.org/research/reports/tw/chartbook/2016/chapter4.pdf>

<sup>5</sup> American Hospital Association. (2016). *Chart 3.5 Average Length of Stay in Community Hospitals, 1994-2014* (Chartbook 2016 Trends Affecting Hospitals and Health Systems). Chicago, IL: American Hospital Association. Available at: <http://www.aha.org/research/reports/tw/chartbook/2016/chart3-5.pdf>.

<sup>6</sup> Grube, M. and Kaufmann, K. (2013). Decline in Utilization Rates Signals a Change in the Inpatient Business Model. *Health Affairs*. Available at: <http://healthaffairs.org/blog/2013/03/08/decline-in-utilization-rates-signals-a-change-in-the-inpatient-business-model/> and Evans, M. (2015). Hospitals face closures as ‘a new day in healthcare’ dawns. *Modern Healthcare*. Available at: <http://www.modernhealthcare.com/article/20150221/MAGAZINE/302219988>

<sup>7</sup> Medicare Payment Advisory Commission. (2016). *Acute inpatient services Short-term hospitals Inpatient psychiatric facilities* (Section 6 of Medpac A Data Book: Health care spending and the Medicare program). Washington, DC: Medicare Payment Advisory Commission. Available at: <http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-6-acute-inpatient-services.pdf?sfvrsn=0>.

<sup>8</sup> American Hospital Association. (2016). *Chapter 3 Utilization and Volume*. (Chartbook 2016 Trends Affecting Hospitals and Health Systems). Chicago, IL: American Hospital Association. Available at: <http://www.aha.org/research/reports/tw/chartbook/2016/chapter3.pdf>.

## WASHINGTON HOSPITAL UTILIZATION AND COST TRENDS

In Washington State, inpatient hospital admissions declined an average 2.5 percent annually from 2010 to 2015, while hospital outpatient visits increased an average of 2.1 percent annually during this same time period.<sup>9</sup> Even though Washington hospital inpatient revenue still surpassed outpatient revenue from 2010-2015, Washington outpatient hospital revenue grew at a faster rate. Hospital outpatient revenues had an average annual growth rate of 6.4 percent, while inpatient revenue grew by 4.6 percent annually on average from 2010 to 2015.<sup>10</sup>

For more information, see the Department of Health Hospital Year End Reports for financial and utilization data.<sup>11</sup>

## PEBB AND MEDICAID UTILIZATION AND COST TRENDS

Utilization of outpatient services per 1000 Non-Medicare Uniform Medical Plan (UMP) members increased 16 percent from 2014 to 2015. Inpatient utilization per 1000 cases decreased 5 percent from 2014 to 2015. Per Member Per Month (PMPM) outpatient costs per case were 5 percent lower in 2015 compared to 2014, and PMPM inpatient costs were 1 percent lower in 2015 compared to 2014. The Public Employee Benefits (PEB) trend model predicts that outpatient PMPM costs will consistently grow at a faster rate relative to inpatient PMPM costs through October 2020.<sup>12</sup> Looking at the State's Medicaid managed care population, average hospital inpatient admissions have stayed consistent from January 2015 to May 2016 as have the number of hospital outpatient claims during this same time period.<sup>13</sup>

## ANALYSIS

Academic researchers, providers, and financial analysts (e.g. Fitch) have offered several explanations for the shift from inpatient to outpatient services, including the following:

- Clinicians can perform an increasing number of procedures in an outpatient setting because of improved medical technology and less invasive surgical and other medical procedures.<sup>14</sup> One systemic analysis of inpatient versus outpatient orthopedic surgeries found that patients at low

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<sup>9</sup> Washington State Department of Health. (2010-2015). *Payer Tables (Excel)* (Year End Reports by Hospital). Tumwater, WA: Washington State Department of Health. Available at:

<http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalFinancialData/YearEndReports>  
Please click on the desired year and open "Payer Tables" spreadsheet and reference columns "Total Hosp Admissions" and "Total Hosp O/P Visits".

<sup>10</sup> Washington State Department of Health. (2010-2015). *Payer Tables (Excel)* (Year End Reports by Hospital). Tumwater, WA: Washington State Department of Health. Available at:

<http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalFinancialData/YearEndReports>  
Please click on desired year and open "Payer Tables" spreadsheet and reference columns "columns Total Facility I/P and Total Facility O/P revenue".

<sup>11</sup> Washington State Department of Health (2010-2016). *Fiscal Year End Reports by Hospital*. Available at:

<http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalFinancialData/YearEndReports>.

<sup>12</sup> Koenig, D. (2016). *Trend Update-Calendar Year 2016 through 2020*. (PEBB Trend Model). Seattle, WA: Milliman

<sup>13</sup> Hua-Ly, T. (2016). *Managed Care Financial Report September 2016*. Olympia, WA: Washington State Health Care Authority.

<sup>14</sup> Bernstein, A.B. and Hing, E (2003). *Health Care in America Trends in Utilization*. (DHHS Publication N2004-1031). Hyattsville, MD: National Center for Health Statistics. Available at: <http://www.cdc.gov/nchs/data/misc/healthcare.pdf>

risk for complications had an equal or better postoperative experience in an outpatient setting.<sup>15</sup>

- Vertical consolidation, where hospitals integrate free-standing physicians' offices and create Hospital Outpatient Departments (HOPDs), is another influential trend to consider. From 2007 to 2013, salaried physicians working in hospitals, as opposed to independent practices, grew from 96,000 to 182,000.<sup>16</sup> While consolidation enables smaller practices to participate in Accountable Care Organizations (ACOs) and to coordinate care with hospitals, this organizational restructuring has cost implications. Consolidation has been associated with price increases for services. One study of 7.3 million non-elderly privately insured patients found that a 5.2 % increase in vertical consolidation was correlated to a \$75 per patient per year in outpatient spending.<sup>17</sup> Vertical consolidation that creates fully integrated organizations, where the hospital assumes ownership of the physician practice, has been shown to increase hospital prices and spending by limiting competition in the market place.<sup>18</sup>

For more information, please see the footnoted Health Affairs article for a brief summary of findings on vertical integration.<sup>19</sup>

## POLICY SOLUTIONS

Given the trends toward vertical consolidation and associated price increases in the market, incentivizing primary care is critical to lowering costs and improving patient health outcomes. Primary care is at the foundation of new value-based payment models because it provides a medical home to coordinate the totality of a patient's care that keeps all providers accountable for patient outcomes. The patient can have an ongoing relationship with their Primary Care Physician (PCP) when they are healthy, and they have a place to seek cost-effective care for problems early.

Results from multiple studies indicate that a more robust primary care network (as measured by the number of primary care doctors in an area and individuals possessing a PCP) is correlated with decreased health care costs, improved care quality, lower hospitalization rates, lower mortality, greater use of preventative services, improved management of chronic illnesses, and better patient satisfaction.<sup>20</sup>

Primary care is at the foundation of HCA's VBP efforts. For example:

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<sup>15</sup>Crawford, D.C., and Chuan, S.L. (2015). Clinical and Cost Implications of Inpatient *Versus* Outpatient Orthopedic Surgeries: A Systematic Review of the Published Literature. *National Institute of Health*. 7(4): 6177 doi: [10.4081/or.2015.6177](https://doi.org/10.4081/or.2015.6177). Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4703913/>.

<sup>16</sup> Government Accountability Office (2015). *Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform*. Washington, DC: Government Accountability Office. Available at: <http://www.gao.gov/assets/680/674348.pdf>

<sup>17</sup> Nephrahs, H.T. and Chernew, M. E. Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices. *JAMA*. 175(12):1932-1939. doi:10.1001/jamainternmed.2015.4610. Available at: <http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2463591>.

<sup>18</sup> Baker, L.C., and Bundorf, M.K. (2014). Vertical Integration: Hospital Ownership of Physician Practices with Higher Prices and Spending. *Health Affairs*. 33, (5):756-763. doi: 10.1377/hlthaff.2013.1279. Available at: <http://content.healthaffairs.org/content/33/5/756.full.pdf+html>

<sup>19</sup> Baker, L.C., and Bundorf, M.K. (2014). Vertical Integration: Hospital Ownership of Physician Practices with Higher Prices and Spending. *Health Affairs*. 33, (5):756-763. doi: 10.1377/hlthaff.2013.1279. Available at: <http://content.healthaffairs.org/content/33/5/756.full.pdf+html>

<sup>20</sup> Sepulveda, M-J and Bodenheimer, T. (2008). Primary Care: Can It Solve Employers' Health Care Dilemma? *Health Affairs*. 27, (1): 151-158. doi: 10.1377/hlthaff.27.1.151. Available at: <http://content.healthaffairs.org/content/27/1/151.full>.

- Primary care clinics in both ACP networks are required to achieve National Committee on Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) Level 3 certification or equivalent by the end of the contract. NCQA PCMH certification is based on six standards: (1) patient-centered access; (2) team-based care; (3) population health management; (4) care management and support; (5) care coordination and care transitions; and (6) performance management and quality improvement.
- Under UMP Plus, primary care visits are free. UMP Plus encourages members to select a primary care provider, who can coordinate their care and support most of the patient’s health needs.
- By 2020, all of Washington State will have integrated the financing and provider networks of Medicaid-financed physical and behavioral health. With a global budget, providers and managed care plans will have the financial flexibility to deliver whole person care and offer patients a coordinated, whole-person experience.

For more Information on Value-based Payment Initiatives please see the Healthier Washington “Paying for Value” page.<sup>21</sup>

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<sup>21</sup> Health Care Authority. (2016). *Paying for Value*. Available at: <http://www.hca.wa.gov/about-hca/healthier-washington/paying-value>