

Health Care Cost Transparency Board

Annual Report

Second Substitute House Bill 2457; Section 7(2); Chapter 340; Laws of 2020

Substitute Senate Bill 5589; Section 1(3); Chapter 155; Section 1(3); Laws of 2022

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Executive summary

House Bill (HB) 2457 (2020) established the Health Care Cost Transparency Board (Board) under the Washington State Health Care Authority (HCA) because increasing health care costs have a significant impact throughout the state. Rising health care costs in Washington make health care unaffordable to working families across the state.

About **half** of U.S. adults say they have **difficulty affording health care costs**:

- About **four in ten** adults reports that they have **delayed or gone without** medical care in the last year due to cost.¹
- **Substantial shares of adults 65 or older** report **difficulty paying** for **various aspects** of health care.²
- Approximately, **a quarter of adults** say they or a family member in their household have **not filled a prescription, cut pills in half, or skipped doses of medicine** in the last year **because of the cost of prescriptions**.³

These costs also strain the budgets of businesses and government agencies which attempt to cover needed health care services.

The Board is responsible for analyzing total health care expenditures in Washington, identifying trends in health care cost growth, and establishing a health care cost growth benchmark to assist in Washington's efforts to better control increasing health care costs. The goal of the benchmark is to gain a better understanding of and respond to growing health care costs. As a part of its responsibilities, the Board also provides an annual report to the Legislature on developments over the past year.

The Board made significant progress in its work since the 2022 legislative report:

- Conducted cost driver analysis covering 2017 through 2021⁴ and began to identify potential additional focus areas.⁵ Some of the key findings from the initial analysis were:
 - All other markets except Medicare FFS experienced high growth in total expenditures.

¹KFF <https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/>

²*Ibid.*

³*Ibid.*

⁴ Note: The cost driver analysis does not include an in-depth examination of the effects of the COVID-19 pandemic on outlier impacts.

⁵ In February 2023, the Board discussed options for a second cost driver analysis. Finalization of phase two analysis is still under development. OnPoint plans to present potential phase two analysis options to the Advisory Committee on Data Issues, and the board, in fall of 2023. The second level analysis is estimated to be completed before the end of 2023.

- For total spending by categories of care, inpatient services were the highest category of spending in 2018 and continued to be the highest in 2021, with outpatient services also rising.
- There was greater overall growth in outpatient spending compared to inpatient. Outpatient PMPM growth was driven by a utilization increase of 32 percent despite no pricing increases. Prices increased for inpatient services, including both the plan paid and member responsibility, however, there was a decrease in utilization.
- For pharmacy spending, individuals had the same number of prescriptions, but prices increased by almost 25 percent.
- Medical Per Member Per Month (PMPMs) across Washington counties ranged from \$150 to \$1,200. These variations could be due to outlier patients, or differences in care delivery.
- Spending growth occurred across all age categories for both men and women.
- Initiated a two-year grant extending from 2023 to 2025 with the Institute for Health Metrics and Evaluation (IHME) to create a new Analytic Support Initiative. The Analytic Support Initiative will provide additional data and evidence to guide the Board’s recommendations in addressing health care costs.
- Continued to analyze Washington hospital cost and profit through a contract with independent consultants.⁶
- Established the Advisory Committee on Primary Care to develop recommendations to increase primary care spending to 12 percent of total health care expenditures.
- Continued the benchmark analysis including:
 - Collected data for the cost benchmark data call with a comprehensive initial report expected in fall 2023.⁷
 - Engaged with a variety of stakeholders and consultants, including the Washington State Hospital Association (WSHA), the Washington State Medical Association (WSMA), Bailit Health, and Bartholomew-Nash & Associates, to gather additional data on costs affecting the benchmark.
 - Completed the 2023 data call technical manual and submission template for the second benchmark data call.

With the information collected from the benchmark and cost driver analyses, the Board can continue ongoing conversations with all stakeholders in Washington’s health system. This next phase of discussions

⁶ In April 2023, the Board approved plans with Bartholomew-Nash & Associates for a phase two analysis of Washington hospital costs, price, and profit analysis.

⁷ Results from the first benchmark report published in 2023 will be used to define large provider entities for future reports (to be published in 2024 and beyond). No cost growth analysis will occur at the provider and payer levels until 2024.

will include identifying the best ways to curb health care spending and take meaningful action to increase health care affordability for all Washingtonians.

Background

Nationally, health care spending continues to increase. Over the past 20 years in Washington, health care costs have increased faster than inflation⁸ and premiums have increased faster than wages.⁹ The Board’s primary objective is to set a target for future cost growth and collect Washington-specific data on total health care expenditures. The Board is also tasked with analyzing growth trends in the state and by insurance market, and in future years by health insurance carrier and large provider. The board will utilize benchmark data and cost driver analysis to make informed recommendations and develop statewide health care policy to lower spending and curb health care cost growth.

To better understand and respond to growing health care costs, the Board organized its work into four different data projects:

1. Cost growth benchmark
2. Performance against the benchmark
3. Cost driver analysis
4. Primary care spending

Table 1: Health Care Cost Transparency Board data projects overview (not including specific cost driver analyses, e.g., hospital cost analysis)

	Cost growth benchmark	Performance against benchmark	Cost driver analysis / cost experience	Primary care spend measurement
What it is	The goal for the growth of spending on health care year over year.	Assessment of cost growth against the benchmark.	Assessment of key drivers of cost growth.	Measurement of expenditure on primary care in relation to overall health care expenditure.

⁸From 2000 to 2020, annual growth in health care costs averaged 5.14 percent. Health care cost growth has slowed since 2010 but remains higher than inflation. Washington Office of Financial Management, “Change in Medical Costs.”

⁹AHRG’s Medical Expenditure Survey, Tables D.1 and D.2 for 2001-2019 and Bureau of Economic Analysis

	Cost growth benchmark	Performance against benchmark	Cost driver analysis / cost experience	Primary care spend measurement
What it represents	Reflects affordability for health care consumers and purchasers.	Reflects performance of payers and providers against the cost growth benchmark at an aggregate level.	Reflects a first-level drill down analysis of factors that are contributing to health care cost growth.	Reflects the emphasis on primary care and preventive care as measured through proportion of total health care expenditure spent on primary and preventive care activities.
Analytic basis	Macro-economic indicators such as median wage, potential gross state product (PGSP).	Aggregate expenditure data, direct from all payers (carriers). Includes claims-based and non-claims-based expenditures.	Claims-based payment data that Carriers submit to WA- APCD. Includes Individual claims data – enables stratification by geography, risk, etc.	WA-APCD claims based payments; plus, not-yet-developed measurement of non-claims payments.
Risk-adjustment consideration	Does not apply. Based on macro-economic indicators.	Age and sex adjustment is being used for the analysis of performance against the benchmark. Severity-of-illness-based risk adjustment is not applicable as data are submitted by payers at an aggregate level and not at a client level.	Risk-adjustment based on severity-of-illness may be applied to WA-APCD data to better assess the impact of cost drivers for certain analyses where the adjustment would be prudent. An example might be person-oriented measures.	Yet to be discussed and developed.

	Cost growth benchmark	Performance against benchmark	Cost driver analysis / cost experience	Primary care spend measurement
Other considerations		WA-APCD only includes voluntarily reported data from PEBB/SEBB which offers an incomplete picture for self-funded plan data. For this reason, this data cannot be used for assessing provider performance against the benchmark.	For the purposes of cost-driver analyses, risk-adjustment methodology will need to be developed in collaboration with Data Advisory Committee and applied consistently to relevant analyses.	Risk adjustment typically focuses on all aspects of care for an individual. How to appropriately focus on a single category of care will need to be investigated.

Advisory committees to the Board

Since the last report in August 2022, the Board continued its work analyzing Washington health care expenditures and the Board’s advisory committees have assisted with each of the board’s data projects, including the Advisory Committee for Health Care Providers and Carriers and the Advisory Committee on Data Issues. The Advisory Committee for Health Care Providers and Carriers continues to provide expert advice from the provider and carrier perspective to support the development and analysis of the cost growth benchmark through the data call. The Advisory Committee on Data Issues is comprised of members across a broad range of stakeholders, such as the Washington Office of Financial Management, the Health Benefit Exchange, the Washington Health Alliance, and several health plans, among others. This committee provides expertise on many aspects of the benchmark data call, as well as the analysis of existing data sources to determine cost drivers.

The Board also established the Advisory Committee on Primary Care, as directed by SSB 5589 (2022), to focus on measurement of primary care spending and developing recommendations for increasing primary care spending while reducing total health care expenditures. The goal of this legislative assignment is to recommend steps to increase primary care expenditures to 12 percent of total health care expenditures by measuring and incentivizing reimbursement of primary care spending.

Cost growth benchmark

Washington is one of nine states in the nation to adopt a cost growth benchmark. It is also a participant in the [Peterson-Milbank Program for Sustainable Health Care Costs](#). The Board established the benchmark target in 2022 for the subsequent five years and will evaluate the benchmark annually moving forward. The cost growth benchmark represents a common goal for payers, purchasers, regulators, and consumers to

increase health care affordability. It serves as a starting point from which to align health care spending to ensure that spending growth does not increase at a faster rate than the economy, state revenue, or wages.

Performance against the benchmark, also referred to as the data call, is assessed by measuring annual cost growth against each annual benchmark target. Benchmark performance data will reflect the performance of payers and providers against the cost growth benchmark at an aggregate level, for each insurance market (e.g., commercial, Medicare, Medicaid). The benchmark data comes from aggregate expenditure data from all payers (carriers) and include claims-based and non-claims-based expenditures.

Cost drivers analysis

In addition to developing a cost growth benchmark, the Legislature directed the Board to analyze cost drivers in the health care delivery system. The cost driver analysis examines paid claims to assess where services have been provided, e.g., hospital inpatient, outpatient, pharmacy, etc. Unlike the work on the cost growth benchmark, cost driver analysis requires disaggregated data that is not currently captured as part of the data call.

To develop the cost driver analysis, the board contracted with OnPoint, the data vendor for the Washington State All Payer Claims Database (WA-APCD) for review of APCD data. OnPoint provided the board with the preliminary findings of its cost growth drivers study, or the cost driver analysis findings, in December 2022. The Board also worked with OnPoint to develop an interactive cost driver analysis dashboard using WA-APCD data that will be posted on the APCD website as it is completed.

The first-year cost driver analysis included a high-level review of:

- Trends in price and utilization
- Spend and trend by geography
- Spend and trend by demographics

In February 2023, the Board discussed options for a second cost driver analysis. Finalization of phase two analysis is still under development. OnPoint plans to present potential phase two analysis options to the Advisory Committee on Data Issues, and the board, in fall of 2023.

In 2022, the Board also contracted with Tom Nash and John Bartholomew, independent consultants, to perform an initial analysis of Washington hospital costs, price, and profit. This year, the Board continued its contract with Bartholomew-Nash & Associates to analyze Washington hospital costs and margins. The Board approved the framework for the secondary analysis in April 2023 with findings to be presented in fall of 2023.

Progress toward improving health care affordability

The Board achieved several significant milestones to assist with Washington’s efforts to reduce health care cost growth and increase transparency. These include:

- Furthering the work related to performance against the benchmark such as:
 - Deciding how to account for inflation’s possible effects on the benchmark.
 - Continuing to process submissions for the initial benchmark data call.
 - Preparing to issue the second benchmark data call.
- Completing the cost driver analysis for Washington and preparing for a second cost driver analysis to analyze health care price trends.
- Initiating specific analysis on health care drivers in Washington, such as hospital costs, and engaging with a variety of stakeholders and board consultants to gather additional data.
- Establishing the Advisory Committee on Primary Care to provide recommendations to the board on increasing primary care spending to 12 percent of total health care expenditures.

Ensuring flexibility within Washington’s cost growth benchmark

The benchmark target is a specific rate that carriers’ and providers’ expenditure performance will be measured against. The goal of the benchmark is to influence slower health care cost growth to ensure access to affordable health care. The Board’s benchmark target covers a five-year period, granting providers and policymakers the ability to plan for future years when calculating total expenditures. In September 2021, the Board approved Washington’s cost growth benchmark from 2022–2026 (see Figure 1, below). This benchmark is based on a hybrid of median wage and potential gross state product (PGSP) at a 70:30 ratio. Median wage was selected to link the measure to consumer affordability, and PGSP as a reflection of business cost and inflation.

In establishing the benchmark, the Board reviewed how other states created their benchmarks and considered many different factors that might influence their choice of benchmark. One of these factors included current economic indicators, such as wages and inflation. In designing Washington’s benchmark methodology, the board examined rates of health care inflation in other states with cost growth benchmarks, as well as those states’ benchmark methodologies.

Figure 1: Cost growth benchmark for Washington State

Years	Target
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

Figure 2: Reporting schedule

Year of Release of Report	Includes Data from Specified years	Data included
Fall 2023	2017-2019	State and market data only – the board will not publicly report insurance carrier* or provider cost growth for this period
Summer 2024	2020-2022	For large provider entities and carriers** - with growth target of 3.2%
Summer 2025	2022-2023	For large provider entities and carriers – with growth target of 3.2%
Summer 2026	2023-2024	For large provider entities and carriers – with growth target of 3.0%
Summer 2027	2024-2025	For large provider entities and carriers – with growth target of 3.0%
Summer 2028	2025-2026	For large provider entities and carriers – with growth target of 2.8%

*Alternatively, payers.

**Large provider entities will be determined using 2017-2019 as a historical baseline.

Inflation and the benchmark

During February and March 2022, the Board reviewed the impacts of inflation on spending trends in 2019 and 2020, and in June 2022, invited the WSHA to present on cost challenges, including the impact of COVID-19 and increasing labor costs. While the Board recognized the significant impacts of the pandemic on the system, it also considered the impact of increasing cost to residents and the need for a cost growth target to support affordable access.

The Board consulted with Bailit Health on the impact of inflation on health care spending and the implications for Washington’s cost growth benchmark. Bailit Health is a consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and employer purchasers and has worked with several other states in their cost growth benchmark efforts. Bailit Health has been involved

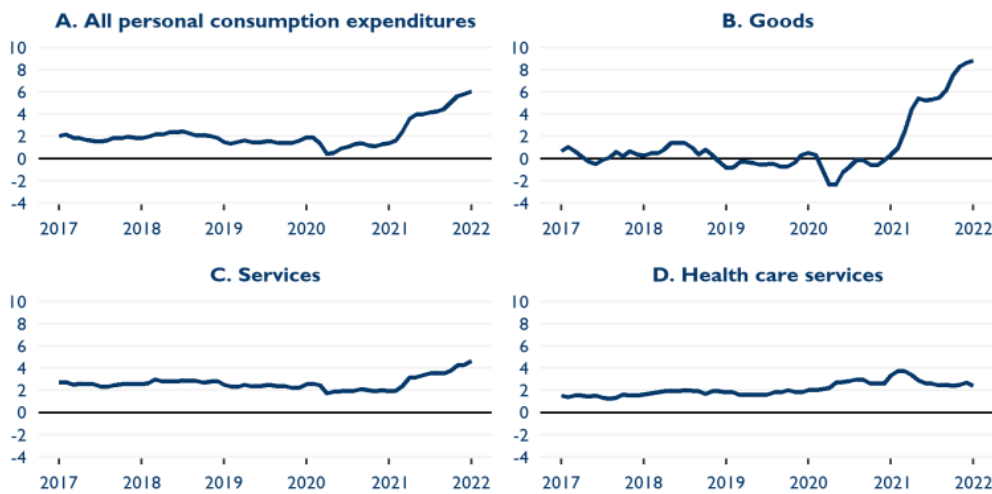
with the Board since 2021 as part of a grant and participation in the Peterson-Milbank Program for Sustainable Health Costs.

Inflation’s impact on health care spending lags compared to the prices of goods and services because rising prices in the general economy don’t impact health prices immediately for several reasons:

- Medicare prices for most services are updated annually based on projected growth in input costs.
- Commercial prices are often defined within multi-year contracts.
- Medicaid prices change infrequently and are not specifically linked to input costs.

During 2021, the price for goods increased significantly, the price for services increased somewhat, and the price for health care services remained relatively flat in comparison.¹⁰ In 2022, the prices for medical care increased at a significantly slower rate than other goods and services. Another analysis by Altarum showed that health care inflation was relatively flat through the end of 2022, despite high and sustained inflation overall.¹¹

Figure 3: Inflation by product type, January 2017–January 2022



Year-over-year percent change. Source: Inflation’s Impact on Health Care Spending and Implications for the Cost Growth Benchmark, Bailit Health. 2023. Bureau of Economic Analysis, personal consumption expenditures price indices.

All five Peterson-Milbank cost growth target states have based target values on economic indicators that are affected by inflation. For example, the cost growth benchmark established by the Board in Washington incorporates median wages and income, which are indirectly impacted by inflation. Additionally, household income tends to grow when inflation grows. As a result, these methodologies were developed under the assumption that inflation would increase at low levels.

¹⁰Source: Bureau of Economic Analysis, personal consumption expenditure prices indices.

¹¹Inflation-Adjusted Health Care Spending is Falling for the First Time in Half a Century | Altarum. 2023.

Arguments for adjusting for inflation:

- States could lose support from providers and insurers who feel the benchmark value was set using inputs that are completely different from actual experience,
- The benchmark could be viewed as unrealistic and unfair, potentially leading to lost credibility with some as a meaningful state policy and a rejection of the benchmark as a basis for contract negotiations, such as between carriers and providers.

Arguments against adjustment for inflation:

- The benchmark value purposely utilizes a methodology intended to provide long-term stability.
- It is unlikely that the benchmark value or performance against the benchmark would be adjusted if providers were posting record profits or if deflation occurred.
- Any adjustment could open the door to future calls for benchmark changes. Benchmarks matter because payers routinely invoke cost growth benchmark values at the negotiating table.

Key policy considerations:

- How the state should balance protecting consumers who face slower income growth and a potential recession while acknowledging impacts on provider organizations and insurers from increased costs.
- The precedent that might be set if the state chooses to modify benchmark values.
- The basis on which any modification should be made, and for what duration.

Several states have developed their own responses to the rise in inflation. Massachusetts adjusted their 2023 target up by 0.5 percent, and Rhode Island adjusted their 2023 through 2025 targets up by 2.7, 1.8, and .2 percentage points, respectively¹². Oregon, and Connecticut made no adjustment to the benchmark. After considering this information, the Board voted for the benchmark to remain unchanged and to account for additional inflation, if needed, when there is additional data.

¹²Massachusetts' Health Policy Commission (HPC) reviews and sets a benchmark annually. In 2023, the HPC voted to revert to the PGSP amount, 3.6 percent, which represented an increase from the prior year, but not a change in methodology. By contrast, Rhode Island changed the factors used in their benchmark methodology.

Table 2: States’ responses to the rise in inflation

State	Decision / status of stakeholder body discussions
Connecticut	Committee held initial discussions in October 2022. Committee recommended no adjustment.
Delaware	Discussed by Economic and Financial Advisory Council in January 2023. No decision yet.
Massachusetts	Adjusted 2023 target up by .5 percentage points
New Jersey	Not yet discussed.
Oregon	Advisory Committee recommended no adjustment and delaying application of accountability provisions by one year.
Rhode Island	Adjusted 2023-25 targets by 2.7, 1.8, and .2 percentage points, respectively.

Source: Inflation’s Impact on Health Care Spending and Implications for the Cost Growth Benchmark, Bailit Health. 2023.

Reporting on benchmark performance

The Board anticipates reporting on the benchmark performance in fall of 2023 for the data call that was issued in 2022, with the baseline experience for 2017, 2018, and 2019 calendar years. Like other states, Washington has been challenged with the start-up process, helping carriers/data submitters to submit, establishing data validation and review processes, and resubmission processes. Care and attention have been built in as well with a third-party validation process, which should ensure quality baseline data and a smoother process in future years.

Updates to the benchmark data call and technical manual

The board completed updates to the 2023 benchmark data call. Changes to the 2023 data call include:

- Inclusion of calendar years 2020, 2021, and 2022 in next submission.
- The performance against the benchmark will be calculated using 2021 and 2022 data.

There also will be a few updates to reference categories to clarify submission data. These updates include:

- An additional insurance category for Federal Employee Health Benefits (FEHB).
- Implementation of a new method to associate non-claims-based spending to providers without age/sex stratification.

The Board has incorporated these changes into the technical manual for submitters. Like the first benchmark call, training will be provided to submitters through a webinar.

Publishing results of the cost driver analysis

While the benchmark uses payer-collected aggregate data to identify trends, the cost driver analysis examines granular claims and encounter data to analyze cost. There is a relationship between the cost growth benchmark and the cost driver analysis. The benchmark identifies overall spending trends, while the

cost driver analysis helps determine how spending is allocated across categories of health care services and potentially what is driving trends in spending. The cost driver analysis also helps to identify opportunities for reducing cost growth and informs policy decisions.

The Board chose and utilized the WA-APCD as the primary data source for the cost driver analysis, after assessing the limitations and benefits of available data sources. The Board examined other states' areas of focus, such as Connecticut, which focused on trends in price and utilization. This approach allowed Connecticut to decipher whether increasing costs were due to increased utilization or increased payment per unit of service (price).

In addition to utilization and price, the Board focused on the importance of better understanding how Washington's geographic environment impacts cost and access to care. The Advisory Committee for Health Care Providers and Carriers and the Advisory Committee on Data Issues provided feedback to the Board on possible consequences of transparency and cost reduction efforts and recommended areas for monitoring.

Based on the research and information reviewed, the following areas of focus were identified for cost driver analysis:

- Trends in price and utilization
- Spend and trend by geography
- Spend and trend by health condition
- Spend and trend by demographics

These metrics produce robust data and reporting on cost drivers. These metrics also create a solid foundation for future areas of focus and recommendations to the Legislature.

In December 2022, the cost driver analysis was complete and the results available. The analysis utilized five years of data from the WA-APCD, from 2017 through 2021, to align with the initial cost-benchmarking period. This data set represents approximately 4 million individuals across Medicaid managed care, Medicare (fee-for-service, or FFS, data only for 2019¹³), commercial¹⁴, commercial Medicare Advantage (MA), commercial and MA Public Employees Benefits Board (PEBB), and the commercial Health Benefit Exchange (HBE) markets out of the state population of approximately seven and a half million.¹⁵

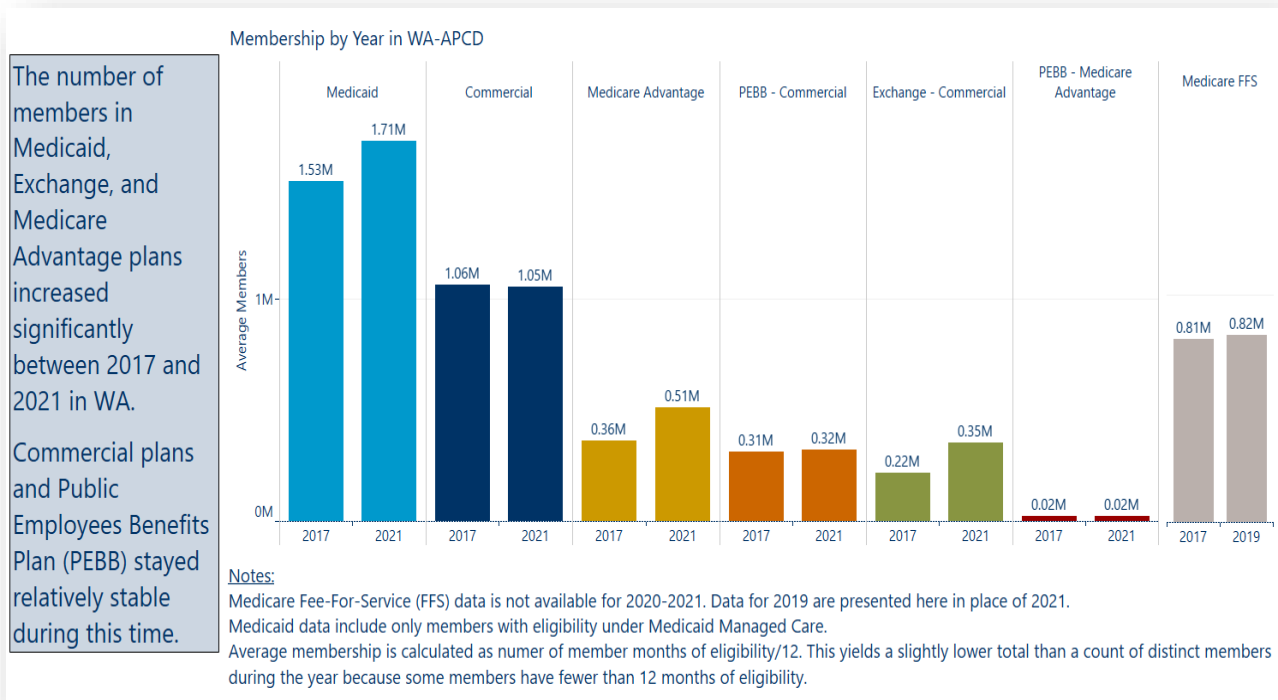
¹³Due to lags in publication of Medicare data, data from 2020 and 2021 were not available for inclusion in this initial analysis.

¹⁴PEBB employees were broken out separately from the rest of commercial. SEBB employees were not separated out because the SEBB was newly created in 2020 and a flag for the school employee population was not historically submitted to the APCD. School employees are in the data combined with the rest of the commercial population, due to a lack of a specific SEBB identifier prior to 2020. A SEBB flag was added in the APCD in 2020 and it may be possible to separate SEBB for 2020 and future years.

¹⁵Source: United States Census Bureau. Washington's population in 2021 was 7.739 million.

Between 2017 and 2021, enrollment (as measured in the WA-APCD) increased from 3.5 to 4 million. As a result of individual changes between insurance types during the year, e.g., from Medicaid to employer coverage, there is only partial data for the full 12 months for every enrollee. Additionally, enrollees moved in and out of state, further contributing to inexact enrollment figures. Between 2017 and 2019, enrollment in Medicaid increased from 1.5 to 1.7 million. Nationwide, MA plans became more popular, in part due to increased marketing. There was also a significant increase in Exchange enrollees, from .22 million to .35 million. Commercial plans and PEBB plans stayed relatively stable during this time. See Figure 4 below for enrollment details.

Figure 4: WA-APCD enrollment by market, 2017 and 2021



The number of members in Medicaid, Exchange, and Medicare Advantage plans increased significantly between 2017 and 2021 in WA. Commercial plans and Public Employees Benefits Plan (PEBB) stayed relatively stable during this time.

Source: Cost Driver Analysis Results. December 2022.

The cost driver analysis detailed the changes in Washington’s health care cost landscape. The insured population has grown and there have been shifts between markets, such as increases in Medicaid, Exchange, and MA enrollees, driving changes in spending. Both total and per capita expenditures have increased. Professional spending growth also occurred in most specialties and other provider categories, like physician assistants (PAs) and nurse practitioners (NPs). There are some differences in how inpatient, outpatient, and pharmacy spending growth has occurred due to pricing and utilization (See Table 4) and variation by geography, age, and gender (Figures 11 through 13), detailed in later sections of this report.

The markets analyzed included:

- Commercial (limited data from self-insured plans)

- Medicaid (managed care only)
- Medicare FFS data (only available through 2019)
- MA (Medicare benefits provided through commercial plans)
- PEBB (commercial and MA)
- Washington HBE (commercial individual health plans)
- Dual-eligibles¹⁶ (not broken out separately due to missing FFS data beyond 2019)

Categories of service for the cost driver analysis were aligned with the benchmarking initiative including:

- Hospital inpatient
- Hospital outpatient
- A narrow definition of primary care providers
- Non-primary care specialty providers
- Other providers like PAs and NPs, etc., long-term care, retail pharmacy¹⁷, and all other spending (ambulances, durable medical equipment, etc.)

There were several limitations to the parameters of the analysis, including:

- WA-ACPD does not contain Alternative Payment Model (APM) data.
- No data on self-insured plans, other than voluntarily submitted data from self-funded PEBB/SEBB Uniform Medical Plan.
- Medicaid FFS data has a longer delay in entry to the APCD.
- Long-term care data for Medicaid was not reported in the APCD.

Key findings

Changes in total expenditures

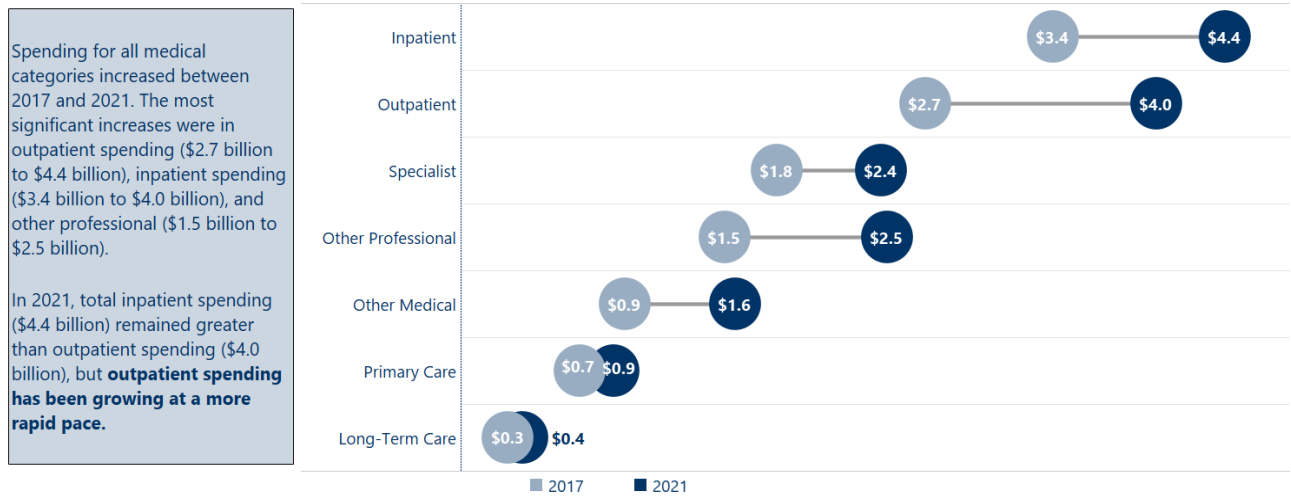
All other markets except Medicare FFS experienced high growth in total expenditures. Medicare FFS, which was broken out separately from Medicare, remained stable. For total spending by categories of care, inpatient was the highest category of spending in 2017 and continued to be the highest in 2021, with outpatient also rising. There was greater overall growth in outpatient spending compared to inpatient. The percentage of overall spending on inpatient care decreased relative to other spending, as did specialist, long-term care, and primary care. Retail pharmacy claim expenditures increased from 4.6 to 6 percent from 2017 to 2021. Pharmacy costs continue to be a key area of investigation for the Board and future analyses will

¹⁶A dual-eligible individual has both Medicare coverage and Medicaid coverage. This includes physical and behavioral health care coverage.

¹⁷This includes mail order pharmacy. Retail pharmacy includes all pharmacy claims submitted, which is distinguishable from pharmacy claims submitted through medical insurance claims. Some claims like injectable drugs would be part of medical spending and not categorized as “retail pharmacy,”

include collaboration with other efforts underway by the HCA, such as the work of the Prescription Drug Affordability Board.

Figure 5: Growth in medical claims expenditures, 2017 and 2021



Spending for all medical categories increased between 2017 and 2021. The most significant increases were in outpatient spending (\$2.7 billion to \$4.4 billion), inpatient spending (\$3.4 billion to \$4.0 billion), and other professional (\$1.5 billion to \$2.5 billion).

In 2021, total inpatient spending (\$4.4 billion) remained greater than outpatient spending (\$4.0 billion), but **outpatient spending has been growing at a more rapid pace.**

Note that these data do not include non-claims payments, Medicaid long-term care, Medicaid FFS dollars, Medicare FFS dollars, or retail pharmacy claims.

Spending in billions of dollars. Source: Cost Driver Analysis Results. December 2022.

Changes in PMPM expenditures

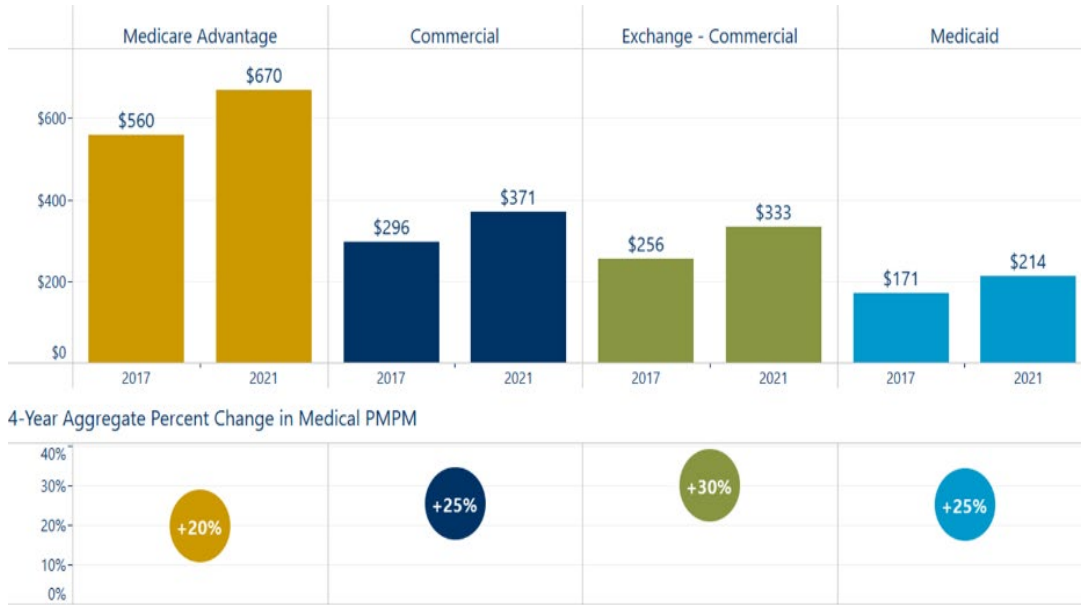
For this analysis, the PMPM calculation was derived by dividing total expenditures by member months in a group. Total medical PMPM expenditures increased from \$271 to \$340 between 2017 and 2021. The aggregate growth was \$69 per month, \$800 per year, per person. There was an aggregate change of 25 percent over time – mostly focused in 2021. This includes commercial, Medicaid, MA (as a combined rate across all markets) and does not include Medicare FFS. Different markets experienced different growth rates, for medical spending only. MA has the highest PMPMs due to enrollees’ higher health needs compared to commercial patients. There was growth across all payers, but slightly lower in MA.

The cost driver analysis also examined pharmacy¹⁸ spending by market. Pharmacy PMPMs showed the same aggregate percent increase of 25 percent over five years with an increase of \$21 per month. Spending was slightly higher under the HBE. All markets increased between 21 and 29 percent.

For PMPM spending by category, most spending was on inpatient and outpatient services. Other professional services and other medical services, while lower than inpatient and outpatient, still saw significant growth. The data and analysis revealed that inpatient and outpatient spending constituted the bulk of costs for both purchasers and consumers when compared to other spending categories.

¹⁸This refers to retail pharmacy and does not include pharmacy captured in medical claims.

Figure 6: Total medical PMPM spending by market, 2017 and 2021



There was a wide range of medical PMPM costs by payer in 2021, from \$670 PMPM for Medicare Advantage members to \$214 PMPM for Medicaid members.

PMPM spending growth for medical services ranged from 20% for Medicare Advantage to 30% for Exchange plans between 2017 and 2021.

Note that Medicaid PMPM totals include only Medicaid Managed Care claims submitted to the WA-APCD. Medicaid Fee-For-Service expenditures and non-claims spending are not included in this analysis.

Source: Cost Driver Analysis Results. December 2022.

Figure 7: PMPM by category of medical service, all markets, 2017 and 2021



Medical per member per month (PMPM) expenditures were calculated by category of spending. In 2021, spending was highest for inpatient (\$93 PMPM), and outpatient (\$85 PMPM) services.

The four-year aggregate percent growth in PMPM spending ranged from +13% for primary care to +48% for other medical services.

PMPM aggregate spending growth in other professional services (+43%) and outpatient services (+33%) were substantial.

Note that these data do not include non-claims payments, Medicaid long-term care, Medicaid FFS dollars, Medicare FFS dollars, or retail pharmacy claims.

Source: Cost Driver Analysis Results. December 2022.

Rates of growth across markets

The cost driver analysis also specifically examined inpatient, outpatient, and total pharmacy¹⁹ PMPM spending growth across markets. These three were selected due to their high impact on cost for insurance purchasers, such as Washingtonian individual health plan purchasers and employers. For inpatient spending by market, spending for MA was much higher than other plans. Outpatient spending showed a growth for MA of almost 50 percent. Individual market outpatient spending was also high, with 47 percent growth. Commercial outpatient growth remained steady, while Medicaid outpatient growth remained low. Outpatient PMPM growth was driven by a utilization increase of 32 percent despite no pricing increases.

For retail pharmacy spending, individuals had the same number of prescriptions, but prices increased by almost 25 percent. The spending increase was higher for pharmacy than for outpatient services. Prices increased for inpatient services, including both the plan paid and member responsibility, however, there was a decrease in utilization. Additional analysis was done for the top three components of cost (pharmacy, inpatient, and outpatient). Of these three cost drivers analyzed, pharmacy costs, followed by outpatient services, had the highest growth in average price per service for the commercially insured population.

Consumers, employers, and other health care purchasers are experiencing higher costs, reflected by higher premiums and greater cost-sharing for needed services.²⁰ In Washington, average premiums for individual health plans have increased 39 percent since 2014²¹ and some Washingtonians have been forced to forego health care services such as pharmacy prescriptions and inpatient services.²²

¹⁹Retail pharmacy only, not including pharmacy captured in medical claims.

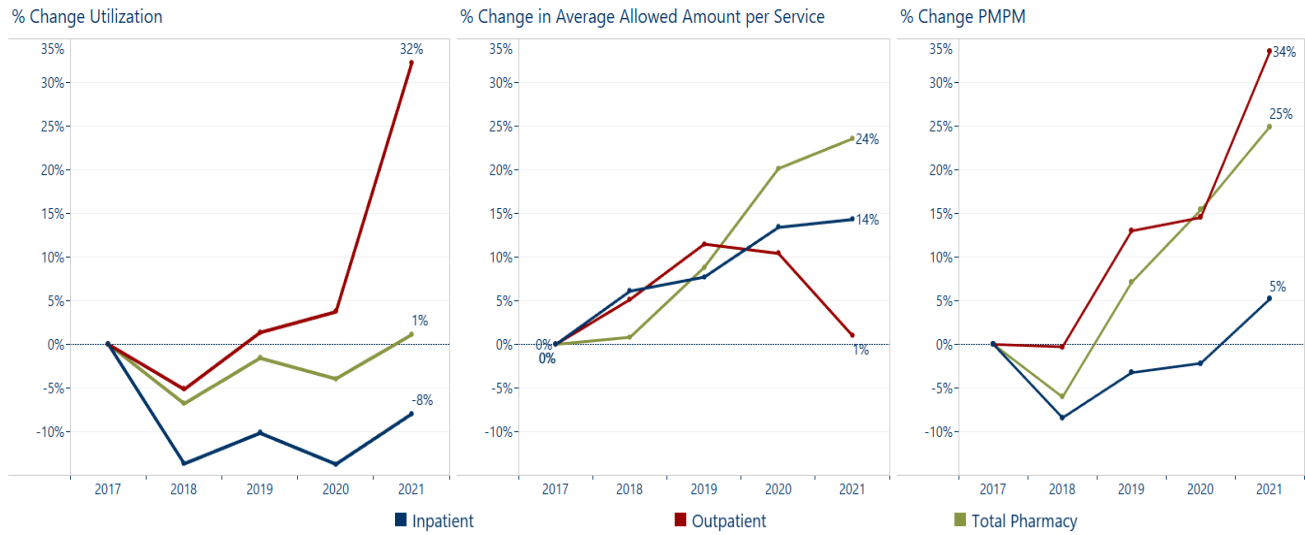
²⁰An estimated 5 to 6 percent of Washington residents remain uninsured, an issue which disproportionately affects communities of color. Source: OFM (2021),

https://ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/healthcoverage/COVID-19_impact_on_uninsured.pdf

²¹KFF Marketplace Average Benchmark Premiums, www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premium.

²²Altarum's Consumer Healthcare Experience State Survey (CHESS). 2022.

Figure 8: Changes in commercial cost drivers, 2017–2021



In the commercial population, outpatient spending PMPM grew by 34% between 2017 and 2021 (see graph on far right). This was driven by a 32% increase in outpatient services per 1,000 members during that time, while the average allowed amount per service grew by only 1%.

The pattern for pharmacy was much different. Pharmacy spending PMPM increased by 25% between 2017 and 2021, but this was primarily driven by an increased average allowed amount per service (24% increase), while pharmacy use per 1,000 members increased by only 1%.

Inpatient spending PMPM grew by 5% between 2017 and 2021. Allowed amounts per inpatient discharges increased by 14%, while inpatient discharges per 1,000 members decreased by 8%.

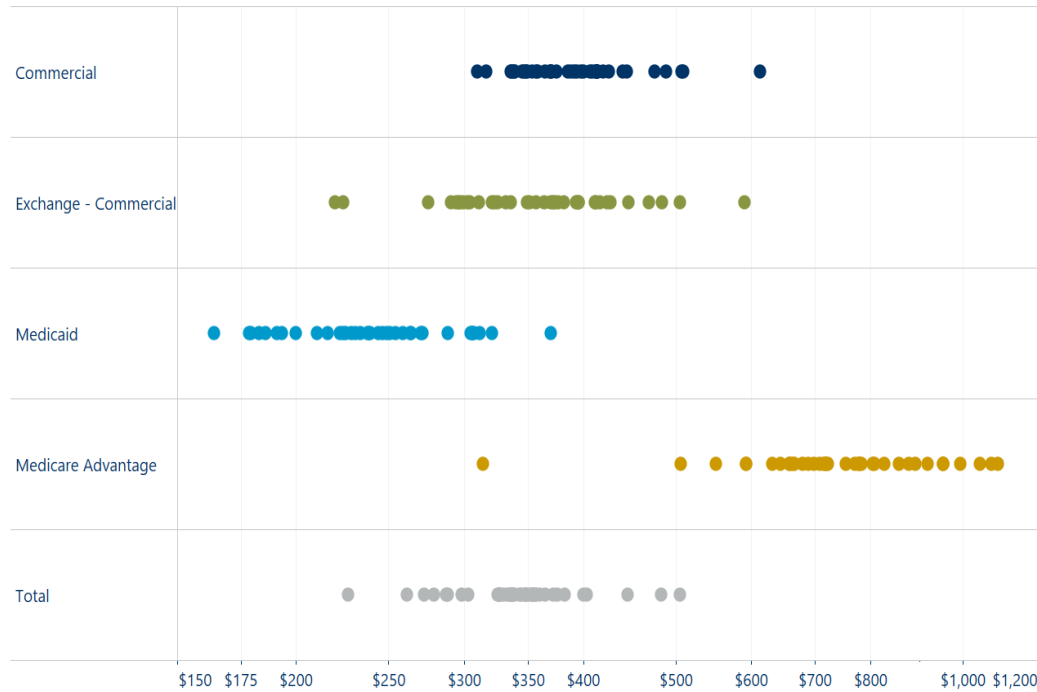
Source: Cost Driver Analysis Results. December 2022.

Regional differences in spending

Medical PMPMs across Washington counties ranged from \$150 to \$1,200. To view the full range of PMPMs by county, please refer to Appendix A. This analysis showed a wide range of geographic variation for Medicaid and MA. In addition to other regional differences, PMPM spending by Accountable Community of Health (ACH) regions showed a significant increase in spending growth for the southwest ACH region and significant variation between individual regions. These variations could be due to outlier patients, or differences in care delivery.²³

Figure 9: County-level variation in medical PMPM spending by market in 2021

County-Level Variation in Medical PMPM Spending by Product in 2021



Each mark in the figure represents a county-level medical PMPM value within the state of Washington.

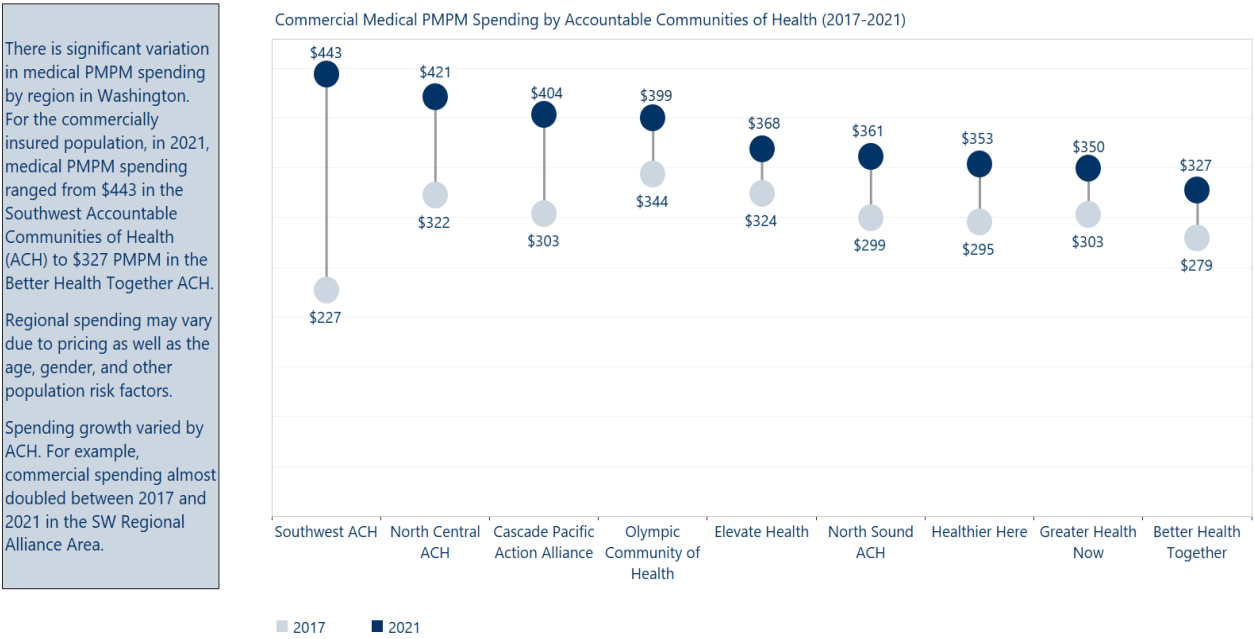
There is significant variation in medical PMPM spending by Washington county for each insurance product.

Note that data have not been adjusted to account for differences in age, gender, or other risk factors between counties.

Source: Cost Driver Analysis Results. December 2022.

²³ACHs are independent, regional organizations. They work with their communities on specific health care and social needs-related projects and activities. Health care is measured in the region and is not reflective of the ACH as an entity.

Figure 10: Commercial medical PMPM spending by accountable community of health regions, 2017 and 2021



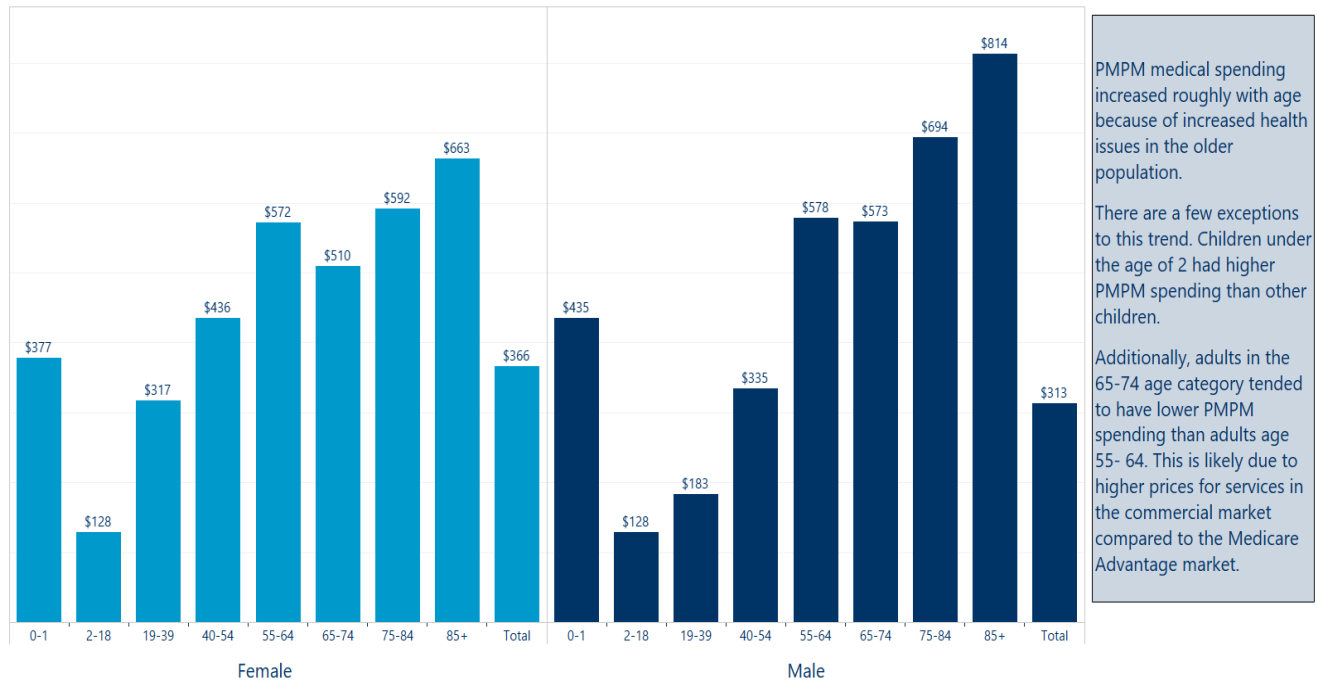
Source: Cost Driver Analysis Results. December 2022.

Spending variation by age and gender

Washingtonian’s health care spending increased in every age category.²⁴ Spending growth occurred across the age categories for both men and women. There was higher spending for men in most age categories and higher spending in comparison for infants as well.

²⁴This analysis did not include individuals over 65, as most are covered under Medicare.

Figure 11: Age and gender categories (PMPMs), 2021



Source: Cost Driver Analysis Results. December 2022.

Moving forward with the cost driver analysis

Future cost driver analyses will continue evaluating subsequent years' data to monitor and examine the various markets for changes in health care costs in Washington including:

- Trends in price and utilization
- Spend and trend by geography
- Spend and trend by health condition
- Spend and trend by demographics

The Board is currently evaluating its resources to determine if it might also include future in-depth cost-driver analysis on specific topics. These additional topics would supplement the other strategic in-depth topical analysis the Board is currently working on, such as hospital cost analysis.

Other cost driver analyses

To build on and complement OnPoint's cost driver analyses, the Board has engaged in further analysis that is targeted at specific cost drivers that constitute the top areas of health care spending. Hospital costs remain a high-priority area of investigation for the Board and the Board has continued its work with Bartholomew-Nash & Associates to examine Washington hospital costs, including workforce trends and administrative

costs. These additional areas provide key information to develop cost growth mitigation strategies, including those that reduce the total cost of care.

Hospital costs

Phase one hospital cost analysis by Bartholomew-Nash & Associates

Bartholomew-Nash & Associates have worked with the board since 2022 to examine hospital costs in Washington. Bartholomew-Nash & Associates developed the Colorado-specific hospital costs analysis. In June 2022, Bartholomew-Nash & Associates detailed and released the Washington hospital costs, price, and profit analysis.²⁵ The research was based on Medicare Cost Reports, submitted annually to the federal government by hospitals as a condition of participation in Medicare. These reports contain information about facilities and cost data, including utilization, charges by cost center in total and for Medicare, and financial statement data.

The first stage of analysis revealed that the price of services versus total costs of patient care in Washington hospitals is above the national average.²⁶ Additionally, hospital-only operating expense per patient is much higher in Washington as compared to the national average. After reviewing the results of the initial study, the Board has engaged in a second phase of hospital cost analysis from Bartholomew-Nash & Associates.

Phase two hospital cost and margin analysis

In April 2023, the Board approved plans with Bartholomew-Nash & Associates for a phase two analysis of Washington hospital costs, price, and profit analysis. The second level analysis will include two types of methodology enhancements and additional financial review, consisting of:

- Calculated adjustments to the first level analysis of costs
- Creation of additional groupings beyond bed size, to allow for comparisons to the national database²⁷
- Washington hospital margin analysis

To inform the next phase of analysis, Bartholomew-Nash & Associates formed a workgroup to review the assumptions to address methodology enhancements for second level hospital financial analysis with a collection of Washington subject member experts. Workgroup members included representatives from WSHA, HealthTrends, University of Washington (UW) Medicine, HCA leadership, Tom Nash, and John

²⁵Washington Hospital Costs, Price, and Profit Analysis. John Bartholomew & Tom Nash Bartholomew-Nash & Associates. 2022.

²⁶Ibid.

²⁷The national database system is the Healthcare Cost Report Information System (HCRIS) as published by the Centers for Medicare and Medicaid (CMS). The HCRIS database includes the most recent Medicare cost report filings for nearly every hospital in the nation. The Medicare cost report is the most comprehensive and standardized reporting mechanism available for hospital financial information. HCRIS data is supplemented with case mix and wage index information from other CMS public use files and cost of living information obtained from the Council for Community and Economic Research (C2ER).

Bartholomew. The workgroup held a series of meetings and conversations in early 2023 and finalized the recommendations for phase two analysis.

Adjustments to the cost data will include an adjustment to hospital-only operating expense by removing C2ER as a cost-of-living adjustment. The analysis will utilize the labor wage index information from CMS wage index files and from the Medicare Cost Report at the hospital level. The labor wage index will be applied to the salary amount of costs of each hospital, with remaining costs applying the C2ER statistic.

The second analysis will contain additional groupings beyond bed size to create more informed peer groupings for hospital comparisons, both within Washington, and nationally, using data from the Medicare Cost Report. In addition to bed size, the secondary analysis will utilize one or a combination of the following measures to further refine the ability to compare “like” hospitals:

- **Teaching intensity measure:** A physician-resident-to-bed ratio measure which identifies the level of teaching at a hospital grouped into percentage ranges.
- **Service intensity measure:** A measure which calculates intensive care costs as a percentage of total costs and captures the degree to which a hospital offers intensive care services, grouped into percentage ranges.
- **Medicare case mix index (CMI)²⁸:** A measure reported in the Medicare final rule public use files which is an index that captures the level of acuity at a hospital, grouped into ranges.

Finally, the second level analysis will review the payer mix measure. The payer mix measure is a ratio of hospital charges from Medicare and Medicaid, divided by total charges, and grouped into percentages. The second level analysis is estimated to be completed before the end of 2023.

WSHA hospital cost analysis

In July 2022, Jonathan Bennett, Vice President of Data and Analytic Services for WSHA and Bruce Deal, Economic Expert for WSHA, presented their analysis of Washington State hospitals and hospital costs. WSHA sought to provide a supplementary analysis to Bartholomew-Nash & Associates’ hospital cost analyses.

Two-thirds of patient days in the hospital are provided by 19 larger hospitals in Washington.²⁹ The Washington state hospital system is comprised of five large systems and several smaller ones. Compared to national standards, Washington hospital admissions, utilization, and length of stay are very low.³⁰

²⁸The secondary analysis will include Medicare CMI, which is based on inpatient utilization. The dataset will include a CMI adjustment to total adjusted discharges, as well as a CMI adjustment to only the inpatient discharges, plus outpatient discharge equivalents. These variables will be labeled ‘CMI-Adjusted Discharges’ and ‘CMI-Adjusted Inpatient Discharges Plus Outpatient Discharge Equivalents.’

²⁹A larger hospital is one with over 250 beds in the hospital.

³⁰Bennett, Jonathan, WSHA and Deal, Bruce, WSHA. Washington State Hospitals: A Primer on Washington Hospital Costs. July 2022.

Table 3: Washington hospitals by size

Size Category (Available Beds)	Hospital Count	% of Hospital Patient Days
Large (250+ beds)	19	67%
Mid-Sized (99-249 beds)	22	25%
Small (22-98 beds)	21	6%
Very small (CAH)	39	2%
Total	101	100%

Source: A Primer on Washington State Hospitals. WSHA. 2022. Note: CAH refers to Critical Access Hospital.

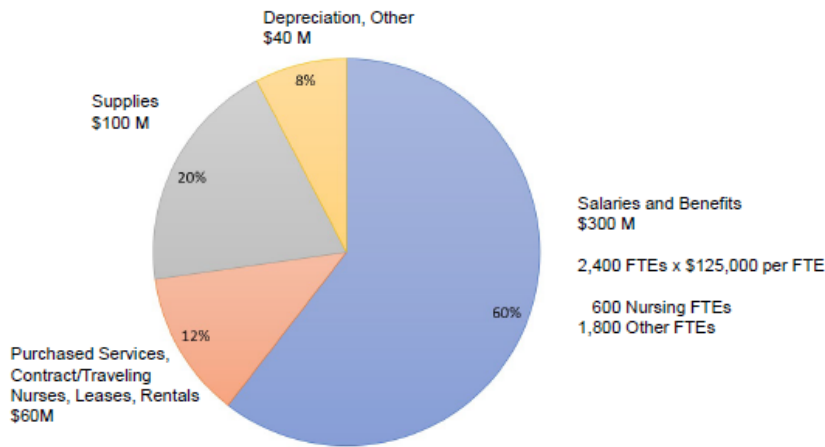
Table 4: Washington hospitals by system affiliation

	System Name	Number of Hospitals
5 Largest Systems	Providence/Swedish, MultiCare, Virginia Mason Franciscan Health, UW Medicine, PeaceHealth	40
	Smaller Multi-Hospital Systems	15
	Independent PPS Hospitals	10
	Independent CAH Hospitals	32
	Other (LTAC, Psych, etc)	4
	Total	101

Source: A Primer on Washington State Hospitals. WSHA. 2022. Note: LTAC refers to long-term acute care hospitals and Psych refers to psychiatric hospital.

The costs of running a hospital were also outlined, including employee costs, supply costs, purchased services (including travelling nurses) and facility/equipment costs. For example, a 300-bed hospital with over 50 departments would cost approximately \$500 million annually. Salaries and benefits would represent about 60 percent of total costs, with an average of \$125,000 per full-time-employee (FTE) in salary and benefits.

Figure 12: Hospital cost example



Source: WA DOH Hospital Financial Reports

Workforce trends

In August 2022, Dr. Bianca Frogner, Board Member and Director of the Center for Health Workforce Studies for UW, relayed her findings on workforce trends in Washington to the Board. Dr. Frogner provided details on the:

- Health workforce and its connection to health care spending.
- Effects of the COVID-19 pandemic on the health care workforce.
- National health care workforce shortage and support strategies.

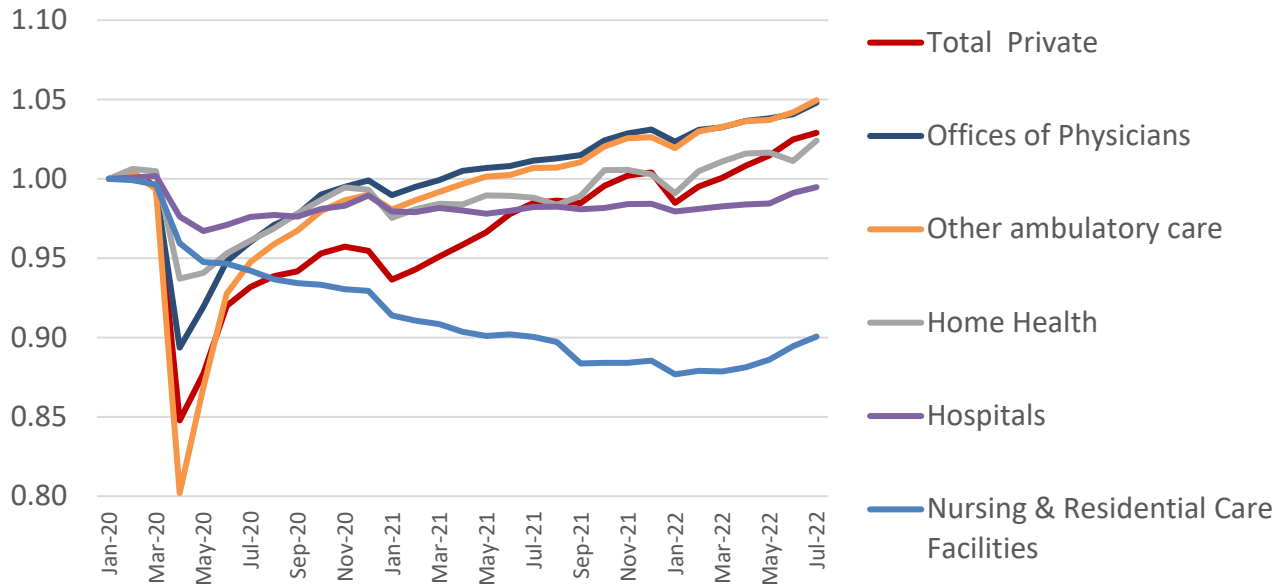
Health care labor and wage rates have generally grown at a smooth rate, but the contribution of labor to health care spending is not well understood, especially at the state level. Dr. Frogner also presented research on:

- Various sectors within the health care industry and how much employment they represent.
- Occupations within the health care industry.
- Average education in each sector.
- Racial and ethnic distribution.

At the peak of the pandemic, in April 2020, 1.4 million health care jobs were lost in the United States. Various researchers and analyses tracked turnover among health care workers during the pandemic and looked at turnover rates per COVID phase by sector, occupation, race/ethnicity, and gender/parenthood. COVID has had the largest effect on long-term care employment. Additionally, since the start of the pandemic, wage rates have increased nationally and continue to increase at a faster rate in Washington.

Figure 13: Relative number of health care employees by segment, January 2020–July 2022

(January 2020=1.00)



Source: Influence of health workforce trends on health spending growth, Calculations by Bianca Frogner, 2022. <https://www.bls.gov/news.release/empsit.t17.htm>.

Currently, there is a low health care labor supply.³¹ There are several reasons for this, including lack of availability to work due to COVID and caregiving responsibilities, or unwillingness to work due to safety concerns or burnout. There is also a lack of qualified applicants because training is unavailable, slow, and expensive to complete. The availability of health care workers has fluctuated significantly over the pandemic and has not yet returned to pre-pandemic levels. As the economy recovers, competition will arise from other industries and within the health care sector. Labor shortages will continue to hamper access to care, and the board will continue to monitor the impact of workforce trends on health care costs.

Administrative costs

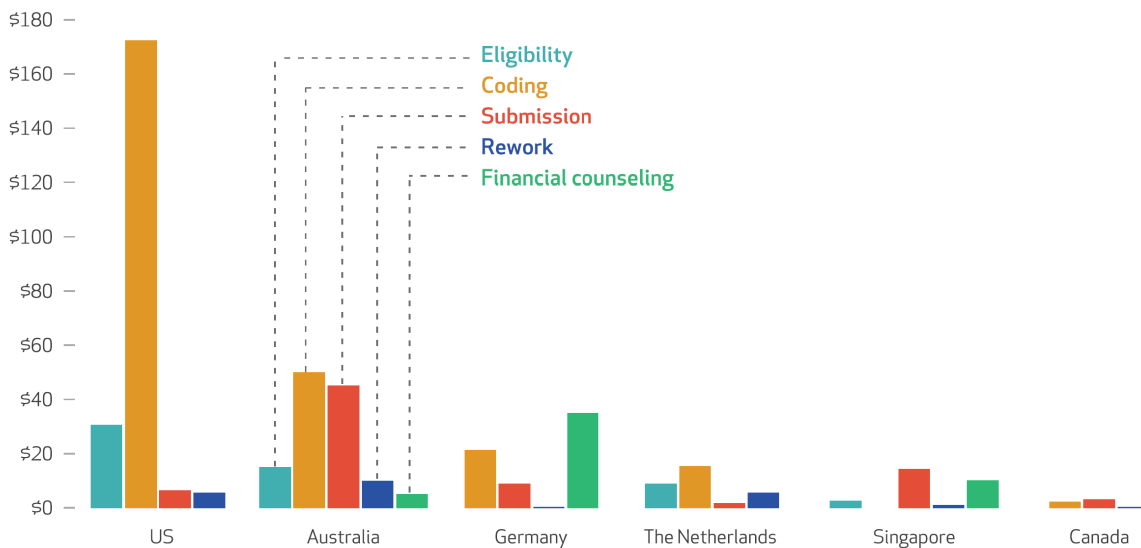
At the October 2022 board meeting, Dr. Mika Sinanan, M.D., Ph.D., Medical Director for Contracting and Value-Based Specialty Care, University of Washington Medicine, and Jeb Shepard, director of policy for WSMA, gave a joint presentation to the board on administrative costs using data from WSMA, the American Medical Association (AMA) and Health Affairs. In their presentation, WSMA cited a study from the Annals of Internal Medicine that determined physicians spend only 27 percent of their total time with patients compared to 49 percent spent completing administrative work, e.g., work with electronic health records

³¹Influence of health workforce trends on health spending growth. Frogner, Bianca K. University of Washington Center for Health Workforce Studies. August 2022.

(EHRs).³² The same study found that on average, clinicians spend one to two hours of personal time each day doing additional clerical work, e.g., responding to patient emails, etc., which has contributed to burnout, both before and during the pandemic.

WSMA reviewed several examples of administrative burdens in the health care system, including insurance approvals, prior authorization requests, coding and billing, and practice management. Increased administrative costs can be associated with several negative consequences, including more complicated coding systems, variable contractual agreements, and non-standard health care service authorization processes. Time spent on administrative work has resulted in less time spent with patients, reduced access to care, poorer clinical outcomes, and increased practice and treatment costs.³³ Data from a 2022 Health Affairs study that compared billing and insurance-related costs across six countries found that coding costs were significantly higher in the U.S. compared to the other countries.³⁴ The same cross-national analysis found that administrative costs consumed 25 to 31 percent of total health care spending in the U.S. The Board will continue to monitor administrative costs and their impact on total health care cost growth.

Figure 14: Billing and insurance-related costs in six countries, by activity category, derived from a time-driven activity-based costing study, 2018–2020



Cost per bill, purchasing power parity adjusted. Source: The Cost of Administrative Burden, WSHA, October 2022

³²The Cost of Administrative Burden. WSMA. 2022. [Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties | Annals of Internal Medicine \(acpjournals.org\)](https://www.acpjournals.org)

³³The Cost of Administrative Burden. WSMA. 2022.

³⁴<https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00241>

IHME analysis

IHME will be partnering with HCA on a two-year, \$1.7 million grant, funded jointly by the Peterson Center on Healthcare and Gates Ventures, to create a new Analytic Support Initiative. The grant runs from 2023 through 2025 and will combine in-house expertise in health care spending, state data, and policy with world-class analytics capabilities at IHME. This partnership with IHME builds on Washington's efforts to improve health care affordability and transparency. The Analytic Support Initiative will provide additional data and evidence to guide the Board's recommendations in addressing health care costs. This grant builds on prior research by IHME on the drivers of health care cost growth, funded by the Peterson Center on Healthcare and Gates Ventures, as well as the Peterson-Milbank Program for Sustainable Health Care Costs that helps states build capacity to set and track health cost growth targets.

Advisory committee on primary care

Background

Primary care is a fundamental component of the health care system. Primary care promotes healthier outcomes through preventive care and addresses a range of issues, including short and long-term health problems. Over time, expectations related to primary care service delivery have increased, while practitioners remain understaffed and underpaid in comparison to other medical specialties. This has led to multiple issues with primary care delivery, including sharp reductions in the primary care workforce, limited access to care, and inequitable care delivery.³⁵ Strong evidence supports the value of investing in primary care to deliver higher quality health outcomes and lower total health care costs.³⁶

Nationally, primary care spending remains low compared to other medical expenditures, e.g., other professional services, prescription drugs, and hospital care.³⁷ Washington primary care spending is also low, but current reporting could be refined to account for additional data. While Washington tracks claims-based spending, the state does not yet track non-claims-based primary care spending, unlike Oregon and Rhode Island.³⁸ Non-claims-based payments are payments made for services other than through traditional fee-for-service payments. Non-claims-based spending includes but is not limited to capitated payments, sub-capitated payments, bundled payments, quality incentive payments, shared savings/risk arrangement payments, and infrastructure payments.

³⁵National Academies of Sciences, Engineering, and Medicine 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.

³⁶Mark Friedberg, Peter S. Hussey, and Eric C. Schneider, "Primary Care: A Critical Review of the Evidence on Quality and Costs of Health Care" *Health Affairs* 29, no. 5 (2010): 766-772.

³⁷Centers for Medicare and Medicaid Services, Office of the Actuary, All Payments.

³⁸Washington State Office of Financial Management, Forecasting and Research, [Primary Care Expenditures, Summary of current primary care expenditures and investment in Washington](#), Report to the Legislature, December 2019.

With the passage of SSB 5589 in 2022, the Legislature directed the board to build on previous efforts to define and measure primary care spending, and to consider work from the Office of Financial Management (OFM), the Dr. Robert Bree Collaborative (Bree Collaborative), other states, and the HCA in its recommendations. Washington became one of 19 states with statutory or regulatory actions to measure primary care spending and one of 11 states publishing annual reports on primary care spending. However, there is no standard definition of primary care in use at a national level or a universal method for measuring primary care expenditures, making it difficult to directly compare primary care spending between different states.

In October 2022, the Board established the Advisory Committee on Primary Care to develop recommendations for consideration by the Board to define and measure primary care spending. Under the legislation, the Board is responsible for:

- Defining primary care.
- Detailing how to achieve Washington’s target to increase primary care expenditures to 12 percent of total health care expenditures.
- Effectively measuring primary care, including identifying any barriers to access and use of data, and how to overcome them.

In December 2022, the Board released an [initial legislative report](#) on primary care spending. The report detailed the establishment of the primary care committee and the committee’s initial progress reviewing existing primary care work in Washington. The report also previewed the committee’s work to create a high-level definition of primary care, based on an amalgamation of the National Academy of Engineering and Medicine (NASEM) and the Bree Collaborative’s definitions of primary care.

Objective 1: Defining primary care

In February 2023, the board approved the Advisory Committee on Primary Care’s recommended definition of primary care. The definition was later amended by the Advisory Committee on Primary Care after additional stakeholdering with WSHA and other members of the public. The final definition of primary care is:

“Team-based care led by an accountable primary care clinician that serves as a person’s source of primary contact with the larger healthcare system. Primary care includes a comprehensive array of equitable, evidence-informed services to support patients in working toward their goals of physical, mental, and social health and the general wellbeing of each person, through illness prevention, and minimizing disease burden, through a continuous relationship over time. This array of services is coordinated by the accountable primary care clinician but may exist in multiple care settings or be delivered in a variety of modes.”

Recommendation for a claims-based measurement methodology

The Board also recently approved and adopted the Advisory Committee on Primary Care’s recommendations regarding a claims-based measurement approach to primary care providers, facilities, and services. Providers were grouped into narrow and broad categories (see tables 5 and 6) for measurement and modeled closely on the providers selected by OFM in their 2019 primary care expenditures report. The committee’s list of

primary care facilities was developed with significant input from researchers at UW Medicine (see Figure 16). Finally, to select the list of service codes, committee members reviewed information compiled by the California Health Care Foundation, which consolidated code-level primary care service definitions from across 11 states (including Washington), as well as two health care organizations, Milliman and the New England States Consortium Systems Organization (NESCSO).

Table 5: Primary care service providers – narrow

Primary Care Provider Types and Relevant Subtypes - Narrow	
<ul style="list-style-type: none"> • Advanced Practice Registered Nurse <ul style="list-style-type: none"> ○ Nurse practitioner ○ Nurse midwife • Family medicine <ul style="list-style-type: none"> ○ Adolescent medicine ○ Adult medicine ○ Geriatric medicine • General practice • Internal medicine <ul style="list-style-type: none"> ○ Internal medicine/pediatrics ○ Geriatric medicine 	<ul style="list-style-type: none"> • Naturopath • Pediatrics <ul style="list-style-type: none"> ○ Adolescent medicine • Physician assistant • Prevention medicine, Preventive/Occupational environmental medicine

Table 6: Primary care service providers – broad

Primary Care Provider Types and Relevant Subtypes - Broad	
<ul style="list-style-type: none"> • Advanced Practice Registered Nurse <ul style="list-style-type: none"> ○ Nurse practitioner ○ Nurse midwife ○ Psychiatric mental health • Counselors <ul style="list-style-type: none"> ○ Addiction (substance use disorder) ○ Mental Health • Family medicine <ul style="list-style-type: none"> ○ Addiction Medicine ○ Adolescent medicine ○ Adult medicine ○ Bariatric Medicine ○ Geriatric medicine ○ Hospice and Palliative Care • General practice • Internal Medicine <ul style="list-style-type: none"> ○ Pediatrics ○ Addiction Medicine ○ Bariatric Medicine 	<ul style="list-style-type: none"> • Marriage and Family Therapist • Naturopath • OBGYN • Physician Assistant <ul style="list-style-type: none"> ○ Psychiatric Mental Health • Psychologist <ul style="list-style-type: none"> ○ Addiction (substance use disorder) ○ Clinical ○ Adult Development and Aging ○ Etc. • Prevention medicine, preventive/occupational environmental • Registered Nurse • Social Worker <ul style="list-style-type: none"> ○ Clinical ○ School

○ Geriatric	
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Note: The broad definition includes all provider types and subtypes from the narrow definition

Table 7: Primary care facilities

Primary Care Facilities	
<ul style="list-style-type: none"> • Ambulatory Health Clinic/Center • Community Health Clinic/Center • Critical Access Hospitals (CAHs) with Method II Billing • Federally Qualified Health Center (FQHC) • Indian Health Services Facility • Long-term Care Facility 	<ul style="list-style-type: none"> • Multi-specialty Clinic/Center • Primary Care Clinic (including on-site at hospitals) • Rural Health Clinic (RHC) • School-based Health Center • Urgent Care Clinic with PCP • Virtual Care

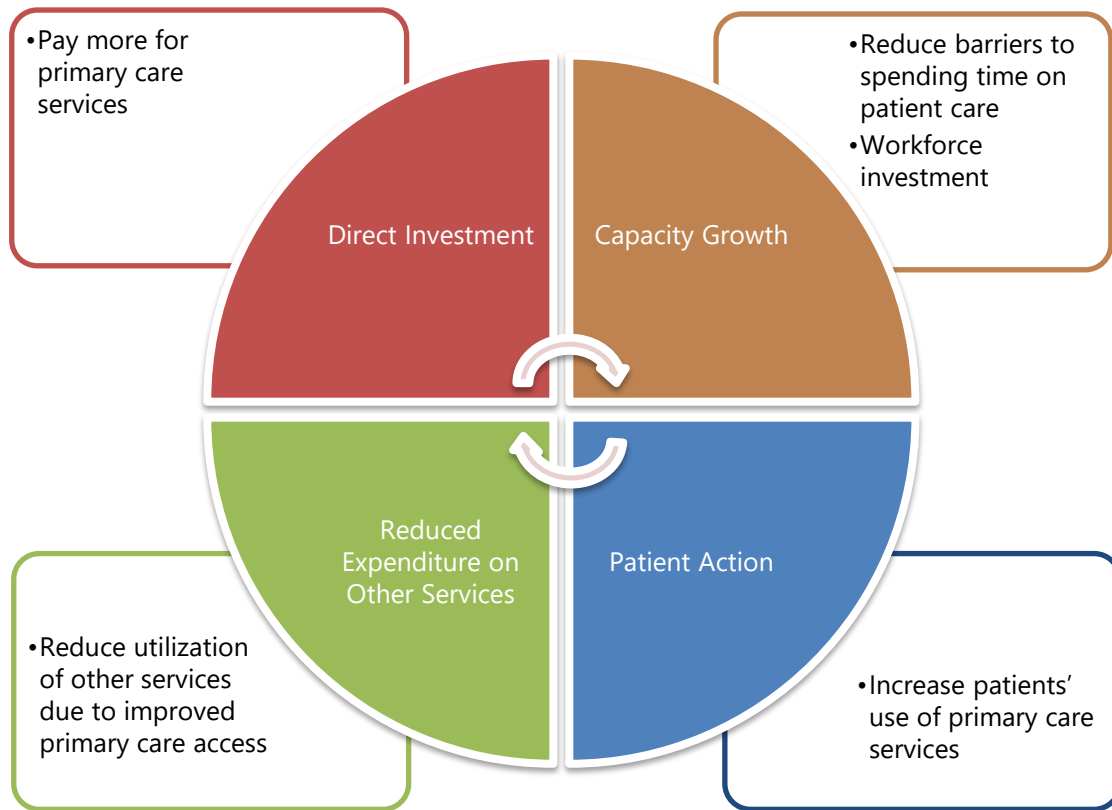
Recommending a non-claims-based measurement methodology

In May 2023, the Primary Care Committee heard joint presentations from the State of Oregon and Bailit Health on non-claims-based measurement methodologies. To date, the committee has initiated discussions of possible non-claims-based approaches for use in Washington.

Objective 2: Detailing how to achieve Washington’s target to increase primary care expenditures to 12 percent of total health care expenditures

In April 2023, the committee began a discussion of policies to achieve the 12 percent primary care expenditure target. The committee used a four-domain framework to begin exploration of different types of policies that could support the expenditure target goal. The four domains (direct investment, capacity growth, patient behavior, and reduced expenditure on other services) are shown in Figure 15.

Figure 15: Four-component primary care policy framework



A key observation that emerged from the committee’s discussion was that while direct investment is critically important, it is insufficient to achieve the primary care expenditure target and the goal of ensuring access to and appropriate utilization of high-quality primary care services for the population. With that concept in mind, the committee developed a preliminary list of policies across three of the domains that committee members were interested in exploring further. Reduced expenditures on other services as a means of achieving the 12 percent expenditure target was not discussed, as ideally this will occur naturally as a result of implementation of other policies to support primary care. The preliminary list below was informed by strategies implemented in other states, strategy recommendations at the national level, and committee member ideas. The initial list of policies, ordered by level of committee support, included the following:

1. Direct Investment - Increase primary care reimbursement.
2. Capacity Growth - Payer focus on reducing administrative burden/costs for providers.
3. Capacity Growth - Forgiveness for non-compete clause penalties incurred by primary care clinicians who leave a position to work elsewhere in Washington State.
4. Patient Behavior - Encourage employers to support/incentivize/encourage patients in selecting a PCP.
5. Capacity Growth - State funded expansion of loan forgiveness opportunity.
6. Capacity Growth - Work with education system to bolster pipeline of healthcare professionals.

7. Direct Investment - Increasing Medicaid reimbursement for primary care services
8. Capacity Growth - Multipayer collaboration to develop and implement payment models that offer greater financial flexibility and incentives while growing access and improving quality.
9. Capacity Growth - Provide options for practice teams to have a fully capitated system.
10. Direct Investment - Increase fee-for-service for remote patient monitoring services and chronic care management.
11. Direct Investment - Increase fee-for-service reimbursement for care team members such as clinical pharmacists, care coordinators / Community Health Workers, registered nurses, etc.

In addition to the aforementioned policies, the committee also discussed data and information technology policies that would be important to support effective delivery of primary care, maximize capacity, improve patient behavior through patient navigation and care coordination, and monitor the delivery system. The preliminary list of policies the committee members expressed interest in was informed by recommendation at the national policy level, opportunities related to existing efforts in Washington state, and ideas from committee members. The initial list of policies, ordered by level of committee support, included the following:

1. Invest in and support HCA's EHR-as-a-Service initiative which will provide access to certified EHR for BH, small, and rural providers.
2. Invest in and support HCA's Electronic Consent Management (ECM) initiative to support exchange of health information.
3. Maximize utility of OneHealthPort through investment and other policy initiatives.
4. Maximize comprehensiveness/utility of APCD by encouraging self-funded plans to contribute data.
5. Support Master Patient Index by promoting use of a uniform patient identifier.
6. Expand the reach of the Clinical Data Repository through investment and other policy initiatives.

The committee will continue to explore policy options and refine policy recommendations that support achieving the 12 percent expenditure target over the course of the remaining committee meetings in 2023.

Objective 3: Effectively measuring primary care, including identifying any barriers to access and use of data

Work is currently underway with HCA's data team to develop a data strategy that addresses primary care data collection challenges. The data strategy also will clarify who is responsible for measuring and reporting on primary care data. This work will continue throughout the remainder of 2023.

Next steps

Committee work to-date has largely focused on development of a primary care definition and initial exploration of policies that will support achieving the 12% primary care expenditure target. Next steps for the committee include the following:

- Finalize claims/nonclaims-based measurement methodology recommendations,
- Finalize development of a suite of policy recommendations to achieve the 12% expenditure target and related strategies to incentivize achievement of the target and present these options to the Board for potential adoption, and
- Identify and recommend strategies to remediate challenges in measuring primary care expenditures.

Conclusion

The Board's continued efforts on its data projects—the benchmark, performance against the benchmark (the data call), cost driver analysis, and primary care spending—will support more comprehensive health care cost reporting and creation of effective recommendations for the Legislature. Thorough research and understanding of increasing health care costs will facilitate and enhance efforts to improve affordability. The Board's evidence-based approach to health care cost data will provide a common understanding of spending trends for consumers, purchasers, and regulators to help make health care more affordable in Washington.

Additional information

For additional information on the board and its committees, including membership rosters, meeting materials and schedules, and the benchmark data call specifications, [visit the website](#).

Appendix A – County level PMPM data

Note: Medicare Advantage and Medicare FFS do not include pharmacy or total medical and pharmacy values because Part D missing for 2020 and 2021. Medicare FFS data not available for 2020 and 2021 and Medicare FFS is not included in the "Total" product. Data for categories with 1-10 services have been omitted due to privacy concerns.

Year	Product	Category of Spending	Geography Type	Region	PMPM
2021	Medicaid	Total Medical	County	Franklin	\$ 135
2021	Medicaid	Total Medical	County	San Juan	\$ 139
2021	Medicaid	Total Medical	County	Adams	\$ 154
2021	Medicaid	Total Medical	County	Walla Walla	\$ 169
2021	Medicaid	Total Medical	County	Grant	\$ 169
2021	Medicaid	Total Medical	County	Yakima	\$ 169
2021	Medicaid	Total Medical	County	Douglas	\$ 173
2021	Medicaid	Total Medical	County	Benton	\$ 183
2021	Medicaid	Total Medical	County	Chelan	\$ 184
2021	Medicaid	Total Medical	County	Clark	\$ 193
2021	Medicaid	Total Medical	County	Whatcom	\$ 201
2021	Medicaid	Total Medical	County	Skamania	\$ 205
2021	Medicaid	Total Medical	County	King	\$ 207
2021	Medicaid	Total Medical	County	Kitsap	\$ 215
2021	Medicaid	Total Medical	County	Skagit	\$ 216
2021	Medicaid	Total Medical	County	Okanogan	\$ 217
2021	Medicaid	Total Medical	County	Snohomish	\$ 219
2021	Exchange - Commercial	Total Medical	County	Garfield	\$ 220
2021	PEBB - Commercial	Total Medical	County	Columbia	\$ 220
2021	Total	Total Medical	County	Franklin	\$ 220
2021	Medicaid	Total Medical	County	Whitman	\$ 223
2021	Exchange - Commercial	Total Medical	County	Columbia	\$ 224

2021	Medicaid	Total Medical	County	Thurston	\$ 226
2021	Medicaid	Total Medical	County	Lincoln	\$ 229
2021	Medicaid	Total Medical	County	Spokane	\$ 232
2021	Medicaid	Total Medical	County	Pierce	\$ 233
2021	Medicaid	Total Medical	County	Stevens	\$ 239
2021	Medicaid	Total Medical	County	Pend Oreille	\$ 240
2021	Medicaid	Total Medical	County	Asotin	\$ 244
2021	Medicaid	Total Medical	County	Lewis	\$ 245
2021	Medicaid	Total Medical	County	Cowlitz	\$ 246
2021	Medicaid	Total Medical	County	Island	\$ 251
2021	Total	Total Medical	County	Yakima	\$ 255
2021	Medicaid	Total Medical	County	Kittitas	\$ 255
2021	Medicaid	Total Medical	County	Klickitat	\$ 263
2021	Total	Total Medical	County	Adams	\$ 265
2021	Medicaid	Total Medical	County	Wahkiakum	\$ 267
2021	Medicaid	Total Medical	County	Mason	\$ 270
2021	Total	Total Medical	County	Benton	\$ 273
2021	Exchange - Commercial	Total Medical	County	Yakima	\$ 275
2021	Total	Total Medical	County	Grant	\$ 278
2021	PEBB - Commercial	Total Medical	County	Yakima	\$ 282
2021	Total	Total Medical	County	Pend Oreille	\$ 284
2021	PEBB - Commercial	Total Medical	County	Franklin	\$ 289
2021	Exchange - Commercial	Total Medical	County	Thurston	\$ 290
2021	Medicaid	Total Medical	County	Clallam	\$ 292
2021	Total	Total Medical	County	Whitman	\$ 292
2021	Exchange - Commercial	Total Medical	County	Whitman	\$ 294

2021	Total	Total Medical	County	Walla Walla	\$ 294
2021	Medicaid	Total Medical	County	Jefferson	\$ 296
2021	Exchange - Commercial	Total Medical	County	Franklin	\$ 296
2021	Exchange - Commercial	Total Medical	County	Pend Oreille	\$ 297
2021	PEBB - Commercial	Total Medical	County	Island	\$ 299
2021	Medicaid	Total Medical	County	Columbia	\$ 299
2021	Exchange - Commercial	Total Medical	County	Klickitat	\$ 299
2021	PEBB - Commercial	Total Medical	County	Whitman	\$ 302
2021	Exchange - Commercial	Total Medical	County	Snohomish	\$ 302
2021	Medicaid	Total Medical	County	Ferry	\$ 303
2021	Medicaid	Total Medical	County	Pacific	\$ 304
2021	Exchange - Commercial	Total Medical	County	Spokane	\$ 304
2021	PEBB - Commercial	Total Medical	County	Asotin	\$ 305
2021	Commercial	Total Medical	County	Pend Oreille	\$ 309
2021	Medicaid	Total Medical	County	Grays Harbor	\$ 309
2021	Exchange - Commercial	Total Medical	County	Pierce	\$ 311
2021	PEBB - Commercial	Total Medical	County	Jefferson	\$ 312
2021	Medicare Advantage	Total Medical	County	Ferry	\$ 314
2021	PEBB - Commercial	Total Medical	County	San Juan	\$ 314
2021	Commercial	Total Medical	County	Spokane	\$ 316
2021	PEBB - Commercial	Total Medical	County	Benton	\$ 317
2021	Exchange - Commercial	Total Medical	County	King	\$ 321
2021	Total	Total Medical	County	Asotin	\$ 321
2021	Total	Total Medical	County	Klickitat	\$ 322
2021	PEBB - Commercial	Total Medical	County	Adams	\$ 322
2021	Total	Total Medical	County	Okanogan	\$ 323

2021	Exchange - Commercial	Total Medical	County	Walla Walla	\$ 323
2021	Exchange - Commercial	Total Medical	County	Island	\$ 325
2021	Total	Total Medical	County	Lincoln	\$ 325
2021	Total	Total Medical	County	Skamania	\$ 327
2021	Total	Total Medical	County	San Juan	\$ 331
2021	Total	Total Medical	County	Snohomish	\$ 331
2021	Total	Total Medical	County	King	\$ 332
2021	Exchange - Commercial	Total Medical	County	Asotin	\$ 332
2021	Total	Total Medical	County	Stevens	\$ 333
2021	Total	Total Medical	County	Spokane	\$ 334
2021	PEBB - Commercial	Total Medical	County	Stevens	\$ 334
2021	Commercial	Total Medical	County	Asotin	\$ 335
2021	Total	Total Medical	County	Columbia	\$ 335
2021	Exchange - Commercial	Total Medical	County	Benton	\$ 336
2021	Commercial	Total Medical	County	Thurston	\$ 336
2021	PEBB - Commercial	Total Medical	County	Spokane	\$ 336
2021	Commercial	Total Medical	County	Whitman	\$ 338
2021	PEBB - Commercial	Total Medical	County	Whatcom	\$ 338
2021	Commercial	Total Medical	County	Benton	\$ 339
2021	Total	Total Medical	County	Chelan	\$ 339
2021	Total	Total Medical	County	Lewis	\$ 340
2021	Total	Total Medical	County	Pierce	\$ 341
2021	Total	Total Medical	County	Skagit	\$ 344
2021	Commercial	Total Medical	County	Island	\$ 345
2021	Total	Total Medical	County	Douglas	\$ 346
2021	Total	Total Medical	County	Kitsap	\$ 346
2021	Commercial	Total Medical	County	Franklin	\$ 346
2021	Total	Total Medical	County	Thurston	\$ 347

2021	Total	Total Medical	County	Whatcom	\$	348
2021	Commercial	Total Medical	County	Grays Harbor	\$	348
2021	PEBB - Commercial	Total Medical	County	Walla Walla	\$	349
2021	Exchange - Commercial	Total Medical	County	Skagit	\$	349
2021	Commercial	Total Medical	County	Yakima	\$	349
2021	Exchange - Commercial	Total Medical	County	Skamania	\$	351
2021	PEBB - Commercial	Total Medical	County	Skagit	\$	351
2021	Total	Total Medical	County	Kittitas	\$	353
2021	Commercial	Total Medical	County	King	\$	353
2021	PEBB - Commercial	Total Medical	County	Kitsap	\$	353
2021	Total	Total Medical	County	Jefferson	\$	354
2021	Total	Total Medical	County	Ferry	\$	354
2021	Commercial	Total Medical	County	Walla Walla	\$	356
2021	Exchange - Commercial	Total Medical	County	Jefferson	\$	357
2021	Total	Total Medical	County	Grays Harbor	\$	358
2021	Commercial	Total Medical	County	Snohomish	\$	358
2021	PEBB - Commercial	Total Medical	County	Lewis	\$	361
2021	Medicaid	Total Medical	County	Garfield	\$	363
2021	Exchange - Commercial	Total Medical	County	Kitsap	\$	364
2021	Commercial	Total Medical	County	Skagit	\$	365
2021	Total	Total Medical	County	Island	\$	367
2021	Commercial	Total Medical	County	Pierce	\$	368
2021	Commercial	Total Medical	County	Whatcom	\$	369
2021	Exchange - Commercial	Total Medical	County	Mason	\$	370
2021	PEBB - Commercial	Total Medical	County	Pierce	\$	370
2021	Commercial	Total Medical	County	Kitsap	\$	371

2021	Exchange - Commercial	Total Medical	County	San Juan	\$ 372
2021	PEBB - Commercial	Total Medical	County	Snohomish	\$ 372
2021	Total	Total Medical	County	Garfield	\$ 373
2021	Exchange - Commercial	Total Medical	County	Lewis	\$ 373
2021	Commercial	Total Medical	County	Lincoln	\$ 374
2021	PEBB - Commercial	Total Medical	County	Thurston	\$ 376
2021	Exchange - Commercial	Total Medical	County	Kittitas	\$ 376
2021	Total	Total Medical	County	Pacific	\$ 378
2021	PEBB - Commercial	Total Medical	County	King	\$ 378
2021	Exchange - Commercial	Total Medical	County	Stevens	\$ 381
2021	PEBB - Commercial	Total Medical	County	Wahkiakum	\$ 382
2021	PEBB - Commercial	Total Medical	County	Kittitas	\$ 384
2021	PEBB - Commercial	Total Medical	County	Pend Oreille	\$ 385
2021	Commercial	Total Medical	County	Grant	\$ 385
2021	Commercial	Total Medical	County	Garfield	\$ 388
2021	PEBB - Commercial	Total Medical	County	Klickitat	\$ 391
2021	Commercial	Total Medical	County	Kittitas	\$ 391
2021	Total	Total Medical	County	Mason	\$ 392
2021	Exchange - Commercial	Total Medical	County	Clark	\$ 393
2021	Commercial	Total Medical	County	Columbia	\$ 394
2021	Exchange - Commercial	Total Medical	County	Ferry	\$ 394
2021	Exchange - Commercial	Total Medical	County	Lincoln	\$ 395
2021	Exchange - Commercial	Total Medical	County	Whatcom	\$ 395
2021	Commercial	Total Medical	County	Mason	\$ 397
2021	Total	Total Medical	County	Clallam	\$ 398
2021	Commercial	Total Medical	County	Skamania	\$ 400
2021	PEBB - Commercial	Total Medical	County	Clallam	\$ 405
2021	PEBB - Commercial	Total Medical	County	Clark	\$ 405

2021	Commercial	Total Medical	County	Stevens	\$ 406
2021	PEBB - Commercial	Total Medical	County	Garfield	\$ 408
2021	Commercial	Total Medical	County	Lewis	\$ 409
2021	PEBB - Commercial	Total Medical	County	Mason	\$ 409
2021	PEBB - Commercial	Total Medical	County	Grant	\$ 410
2021	Exchange - Commercial	Total Medical	County	Okanogan	\$ 411
2021	Exchange - Commercial	Total Medical	County	Adams	\$ 412
2021	Commercial	Total Medical	County	Klickitat	\$ 412
2021	Commercial	Total Medical	County	Jefferson	\$ 413
2021	Commercial	Total Medical	County	Chelan	\$ 413
2021	Commercial	Total Medical	County	Ferry	\$ 414
2021	PEBB - Commercial	Total Medical	County	Pacific	\$ 416
2021	Exchange - Commercial	Total Medical	County	Grant	\$ 416
2021	PEBB - Commercial	Total Medical	County	Grays Harbor	\$ 419
2021	Commercial	Total Medical	County	San Juan	\$ 419
2021	Exchange - Commercial	Total Medical	County	Chelan	\$ 424
2021	Commercial	Total Medical	County	Pacific	\$ 425
2021	PEBB - Commercial	Total Medical	County	Lincoln	\$ 426
2021	Exchange - Commercial	Total Medical	County	Grays Harbor	\$ 427
2021	PEBB - Commercial	Total Medical	County	Chelan	\$ 438
2021	Commercial	Total Medical	County	Okanogan	\$ 440
2021	Total	Total Medical	County	Clark	\$ 442
2021	Commercial	Total Medical	County	Clark	\$ 444
2021	Exchange - Commercial	Total Medical	County	Pacific	\$ 445
2021	PEBB - Commercial	Total Medical	County	Douglas	\$ 452
2021	PEBB - Commercial	Total Medical	County	Cowlitz	\$ 463
2021	Exchange - Commercial	Total Medical	County	Wahkiakum	\$ 468

2021	Commercial	Total Medical	County	Adams	\$	474
2021	Total	Total Medical	County	Cowlitz	\$	477
2021	PEBB - Medicare Advantage	Total Medical	County	Grays Harbor	\$	481
2021	Exchange - Commercial	Total Medical	County	Clallam	\$	483
2021	PEBB - Commercial	Total Medical	County	Okanogan	\$	484
2021	Commercial	Total Medical	County	Clallam	\$	488
2021	Total	Total Medical	County	Wahkiakum	\$	503
2021	Exchange - Commercial	Total Medical	County	Douglas	\$	504
2021	Medicare Advantage	Total Medical	County	Lewis	\$	505
2021	Commercial	Total Medical	County	Cowlitz	\$	507
2021	Commercial	Total Medical	County	Douglas	\$	508
2021	PEBB - Medicare Advantage	Total Medical	County	Wahkiakum	\$	535
2021	PEBB - Commercial	Total Medical	County	Skamania	\$	538
2021	Medicare Advantage	Total Medical	County	Snohomish	\$	551
2021	Exchange - Commercial	Total Medical	County	Cowlitz	\$	589
2021	Medicare Advantage	Total Medical	County	Thurston	\$	592
2021	Medicare Advantage	Total Medical	County	King	\$	592
2021	Commercial	Total Medical	County	Wahkiakum	\$	613
2021	Medicare Advantage	Total Medical	County	Island	\$	631
2021	PEBB - Medicare Advantage	Total Medical	County	Skagit	\$	634
2021	PEBB - Medicare Advantage	Total Medical	County	Lewis	\$	642
2021	Medicare Advantage	Total Medical	County	Whatcom	\$	643
2021	Medicare Advantage	Total Medical	County	Yakima	\$	657
2021	Medicare Advantage	Total Medical	County	Skagit	\$	658
2021	Medicare Advantage	Total Medical	County	Pierce	\$	662

2021	Medicare Advantage	Total Medical	County	Spokane	\$ 665
2021	Medicare Advantage	Total Medical	County	Franklin	\$ 679
2021	PEBB - Medicare Advantage	Total Medical	County	Whatcom	\$ 681
2021	Medicare Advantage	Total Medical	County	Kitsap	\$ 688
2021	Medicare Advantage	Total Medical	County	Stevens	\$ 697
2021	PEBB - Medicare Advantage	Total Medical	County	Kitsap	\$ 701
2021	PEBB - Medicare Advantage	Total Medical	County	Spokane	\$ 702
2021	Medicare Advantage	Total Medical	County	Clallam	\$ 707
2021	Medicare Advantage	Total Medical	County	Benton	\$ 714
2021	Medicare Advantage	Total Medical	County	Jefferson	\$ 717
2021	PEBB - Medicare Advantage	Total Medical	County	Island	\$ 718
2021	Medicare Advantage	Total Medical	County	San Juan	\$ 719
2021	Medicare Advantage	Total Medical	County	Okanogan	\$ 721
2021	PEBB - Medicare Advantage	Total Medical	County	Thurston	\$ 749
2021	PEBB - Medicare Advantage	Total Medical	County	Snohomish	\$ 751
2021	Medicare Advantage	Total Medical	County	Walla Walla	\$ 754
2021	PEBB - Medicare Advantage	Total Medical	County	Mason	\$ 758
2021	Medicare Advantage	Total Medical	County	Douglas	\$ 770
2021	Medicare Advantage	Total Medical	County	Mason	\$ 778
2021	Medicare Advantage	Total Medical	County	Chelan	\$ 778
2021	Medicare Advantage	Total Medical	County	Grays Harbor	\$ 782
2021	PEBB - Medicare Advantage	Total Medical	County	King	\$ 789

2021	PEBB - Medicare Advantage	Total Medical	County	Pierce	\$ 797
2021	Medicare Advantage	Total Medical	County	Asotin	\$ 804
2021	Medicare Advantage	Total Medical	County	Garfield	\$ 807
2021	Medicare Advantage	Total Medical	County	Kittitas	\$ 826
2021	Medicare Advantage	Total Medical	County	Grant	\$ 857
2021	Medicare Advantage	Total Medical	County	Columbia	\$ 878
2021	PEBB - Commercial	Total Medical	County	Ferry	\$ 886
2021	Medicare Advantage	Total Medical	County	Cowlitz	\$ 892
2021	Medicare Advantage	Total Medical	County	Adams	\$ 918
2021	Medicare Advantage	Total Medical	County	Clark	\$ 952
2021	Medicare Advantage	Total Medical	County	Lincoln	\$ 952
2021	Medicare Advantage	Total Medical	County	Wahkiakum	\$ 953
2021	Medicare Advantage	Total Medical	County	Klickitat	\$ 992
2021	Medicare Advantage	Total Medical	County	Whitman	\$ 1,040
2021	PEBB - Medicare Advantage	Total Medical	County	Cowlitz	\$ 1,062
2021	Medicare Advantage	Total Medical	County	Skamania	\$ 1,070
2021	Medicare Advantage	Total Medical	County	Pend Oreille	\$ 1,088
2021	PEBB - Medicare Advantage	Total Medical	County	Clark	\$ 1,124
2021	PEBB - Medicare Advantage	Total Medical	County	Skamania	\$ 1,176
2021	Medicare Advantage	Total Medical	County	Pacific	\$ 1,262