Washington State Health Care Authority

Health Care Cost Transparency Board

July 20, 2022

Health Care Cost Transparency Board
Board Book

July 20, 2022
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting Materials — Tab

P.O. Box 45502
Olympia, WA 98504-5502
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www.hca.wa.gov

Washington State Health Care Authority

Agenda

TAB 1

Washington State Health Care Authority

July 20, 2022
2:00 p.m. – 4:00 p.m.
Zoom Meeting

Health Care Cost Transparency Board
AGENDA

Board Members:					
☐	Susan E. Birch, Chair	☐	Sonja Kellen	☐	Carol Wilmes
☐	Lois C. Cook	☐	Molly Nollette	☐	Edwin Wong
☐	Bianca Frogner	☐	Mark Siegel		
☐	Leah Hole-Marshall	☐	Margaret Stanley		
☐	Jodi Joyce	☐	Kim Wallace		

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome, roll call, and agenda review	1	Susan E. Birch, Chair, Director Health Care Authority
2:05 – 2:10 (5 min)	Approval of June meeting minutes Staff update on benchmark and cost driver analysis	2	AnnaLisa Gellermann, Board Manager Health Care Authority
2:10– 2:15 (5 min)	Advisory Committee Nomination and Vote	3	AnnaLisa Gellermann, Board Manager Health Care Authority
2:15 – 2:35 (20 min)	Washington Hospital Costs, Price, and Profit Analysis: First Look at a High Level	4	John Bartholomew and Tom Nash Consultants
2:35 – 3:15 (40 min)	Washington State Hospitals: A Primer on Washington Hospital Costs	5	Jonathan Bennett Washington State Hospital Association
3:15 – 3:20 (5 min)	Public Comment		Susan E. Birch, Chair, Director Health Care Authority
3:20 – 3:55 (35 min)	Pharmacy Pricing, Purchasing, and Access	6	Ryan Pistoresi, Asst. Chief Pharmacy Officer Health Care Authority
3:55 – 4:00 (5 min)	Adjournment		Susan E. Birch, Chair, Director Health Care Authority

Subject to Section 5 of the Laws of 2022, Chapter 115, also known as HB 1329, the Board has agreed this meeting will be held via Zoom without a physical location.

Washington State Health Care Authority

June meeting summary

TAB 2

Health Care Cost Transparency Board meeting minutes

June 16, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

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

Members present

Mich'l Needham for Sue Birch (pro-tem chair).
Lois Cook
John Doyle
Bianca Frogner
Jodi Joyce
Leah Hole-Marshall
Sonja Kellen
Molly Nollette
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

Sue Birch, chair
Mark Seigel

Call to order

Mich'l Needham, Board Chair pro-tem, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

Ms. Needham welcomed the members. She welcomed a new interim member, Leah Hole- Marshall, General Counsel and Chief Strategist at the Health Benefits Exchange. She also thanked departing member John Doyle who resigned from the Board after accepting a new position.
Ms. Needham invited Board member Kim Wallace to share her experience at the June 1-3 conference in Washington DC sponsored by the Peterson Milbank Program for sustainable health care costs. Ms. Wallace represented Washington State at the conference, along with Sue Birch, Board chair, and Vishal Chaudhry, Chief Data Officer of HCA. Ms. Wallace shared that it was an exciting opportunity to learn from the eight states and major philanthropies in attendance, describing the event as robust and energizing. She emphasized three major takeaways from the conference- the importance of clear, consistent, and regular communication on the real-world impacts of rising cost and the work of the Board, the effort required to provide transparent and actionable data,

and the need to develop a clear understanding of hospital costs and prices as an important part of overall health care cost. Ms. Needham thanked Ms. Wallace for her attendance and informed the Board that Peterson Milbank might offer a future similar opportunity on the West Coast for interested Board members.

Approval of minutes

The May minutes were approved.

Pandemic Meeting options decision

The Board heard the governor's amended proclamation on the public health emergency and Director Birch's request that public meetings administered by Health Care Authority continue to be virtual only. The Board decided to continue virtual only and revisit moving to a hybrid option (permitting both virtual and physical attendance) at a future meeting.

Presentation: Value Based Purchasing, Part II

JD Fischer, VBP Manager, Health Care Authority

Mr. Fischer returned to the Board to continue the presentation of Value Based Payment (VBP). He reminded the Board that the basic premise that payment drives transformation, and that VPB strategies should achieve the triple aim of reducing unnecessary and low-value health care (lower cost), rewarding preventative and whole-person care (better health), and rewarding the delivery of high-quality care (better quality and experience). He shared the HCA roadmap goal of 90% of VBP contracts in Medicaid PEBB and SEBB by 2021, and the 2020 actual performance of 77%, with several practical examples of contract provisions.

Mr. Fischer also discussed the challenge of evaluating impacts of VBP. Among elements "easily" measured are health plan quality performance and health plan provider contracting (based on total dollars). HCA also measures overall VBP progress, and provider experience with VBP. The program is also subject of a State Innovation Model evaluation by the University of Washington. He acknowledged that overall cost reduction is challenging to measure and attribute to VBP alone.

Looking to the future, Mr. Fischer shared the program goals which largely adopt the HPC-LAN APM goals, including accelerating the percentage of health care payments tied to quality and value in each market segment through two-sided risk contracts, and continuing to refine and develop aspects of VBP including the multi-payer primary care transformation model, the CHART grant, Medicaid Transformation renewal, and other initiatives.

Discussion and Presentation: Rural Hospitals: Challenges, opportunities, and the CHART grant

Theresa Tamura, CHART Manager, Health Care Authority
John Doyle, Board member

Ms. Tamura led a conversation with John Doyle, current Board member, on his experience as an executive with Confluence, a hospital system in the north central region of Washington State. They discussed the challenges of rural health including sparsely populated areas over large areas that cause transportation and connectivity issues (including lack of broadband and cell services, and even mail) impacting care delivery. Mr. Doyle shared that patient acuity continues to rise, based in part on the development of additional effective treatments. As a result, by the time patients come into the hospital system, they are sicker and require more expensive interventions which

require high investment in equipment and expertise. He also identified payer mix as a significant impact on the financial well-being of rural hospitals and the driver of revenue, citing a typical mix for Confluence during his tenure of approximately 20% Medicaid, 40% Medicare, 30% Commercial, and 10% self-pay. He discussed the thin margins faced by most rural hospitals as a barrier to adopting innovation, including acceptance of risk in value-based contracts.

Ms. Tamura provided the group with an overview of a new federal CHART grant, which is intended to support alternative payment models for participating rural hospitals.

Public Comment

Ms. Needham called for comments from the public.

Adjournment

Meeting adjourned at 4:01 p.m.

Next meeting

Wednesday, July 20, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Washington State Health Care Authority

Advisory committee nomination and vote

TAB 3

Washington State Health Care Authority

Washington hospital costs, price, and profit analysis: first look at a high level

TAB 4

Washington Hospital Costs, Price, and Profit Analysis

John Bartholomew & Tom Nash
Bartholomew-Nash & Associates

Health Care Cost Transparency Board

July 20, 2022

2020 Statewide Hospital Income Statement All Short-Stay Hospitals		
Description	**Washington**	**National Median**
Net patient revenue	$ 22,031,680,843	
Hospital-only operating expense	18,206,569,189	
Other operating expense	5,370,712,007	
Total operating Expense	23,577,281,196	
Patient services net income	(1,545,600,353)	
Patient services margin	***-7.0%***	***-4.60%***
Other non-patient income	2,377,532,481	
Other non-operating expense	86,166,676	
Net income	$ 745,765,452	
Total margin	***3.1%***	***7.30%***

In aggregate, WA hospitals underperform as compared to the national median using two profit measures.

Patient Services Margin is a profit margin based solely on patient services.

Total Margin is the net of other non-hospital expenses and other non-hospital revenues.

A Review of Hospital Costs, Prices, and Profits

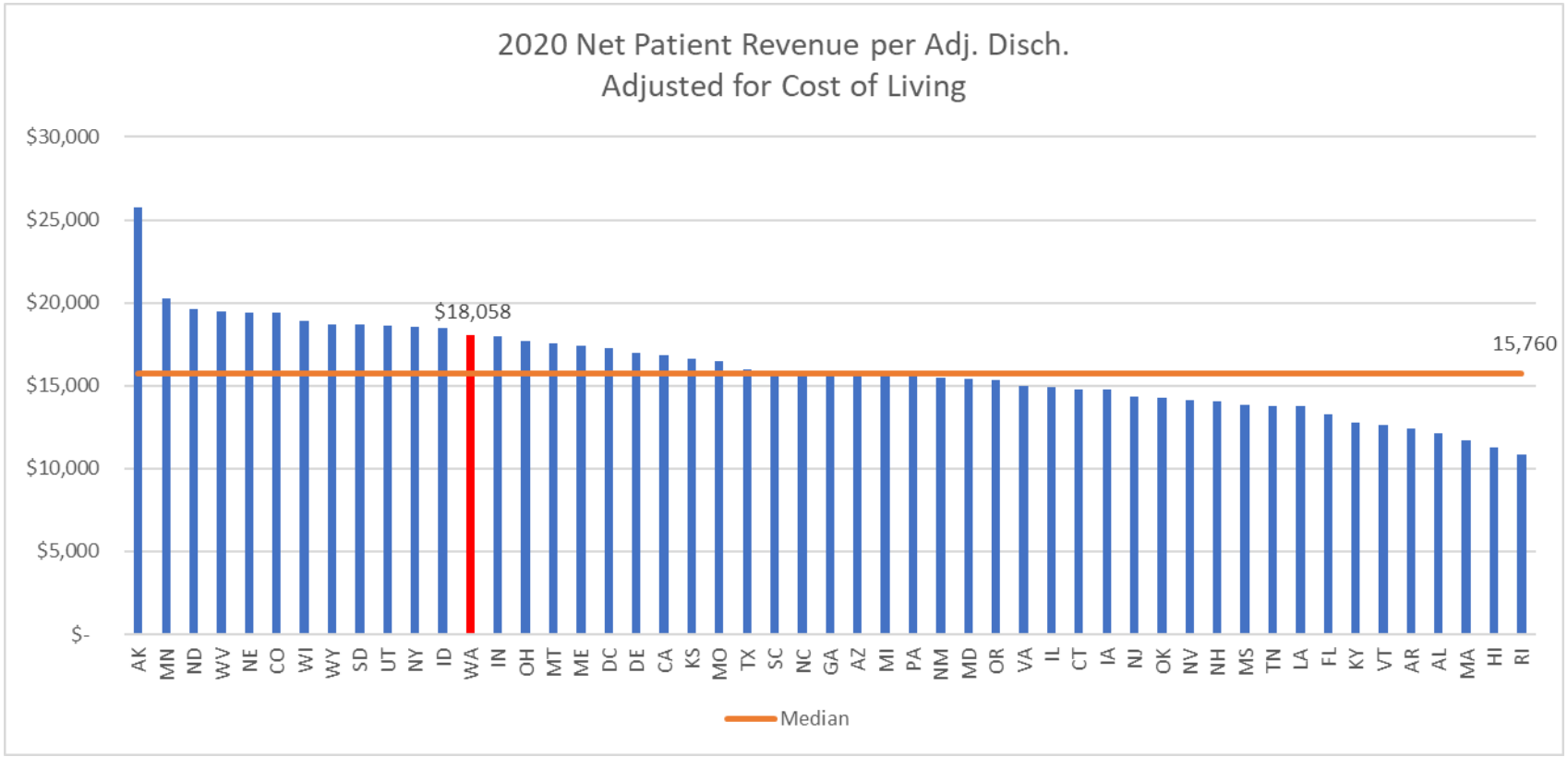
- Using 2020 hospital data, WA hospitals have lower profit margins than the national median.
  - How do WA hospitals compare on cost and price to the national median?
  - Are there hospital outliers on cost and price that may be lowering the aggregate WA hospital profit margins?
  - A deep dive is necessary at the hospital level.
- 2020 hospital data is the most recent and complete data using Medicare Cost Reports
  - It has been 18 months since 2020 and much has occurred in labor markets and other supply chain markets.
  - 2021 Medicare Cost Report data are generally complete in the fall of 2022.

The Approach to Identify Outliers

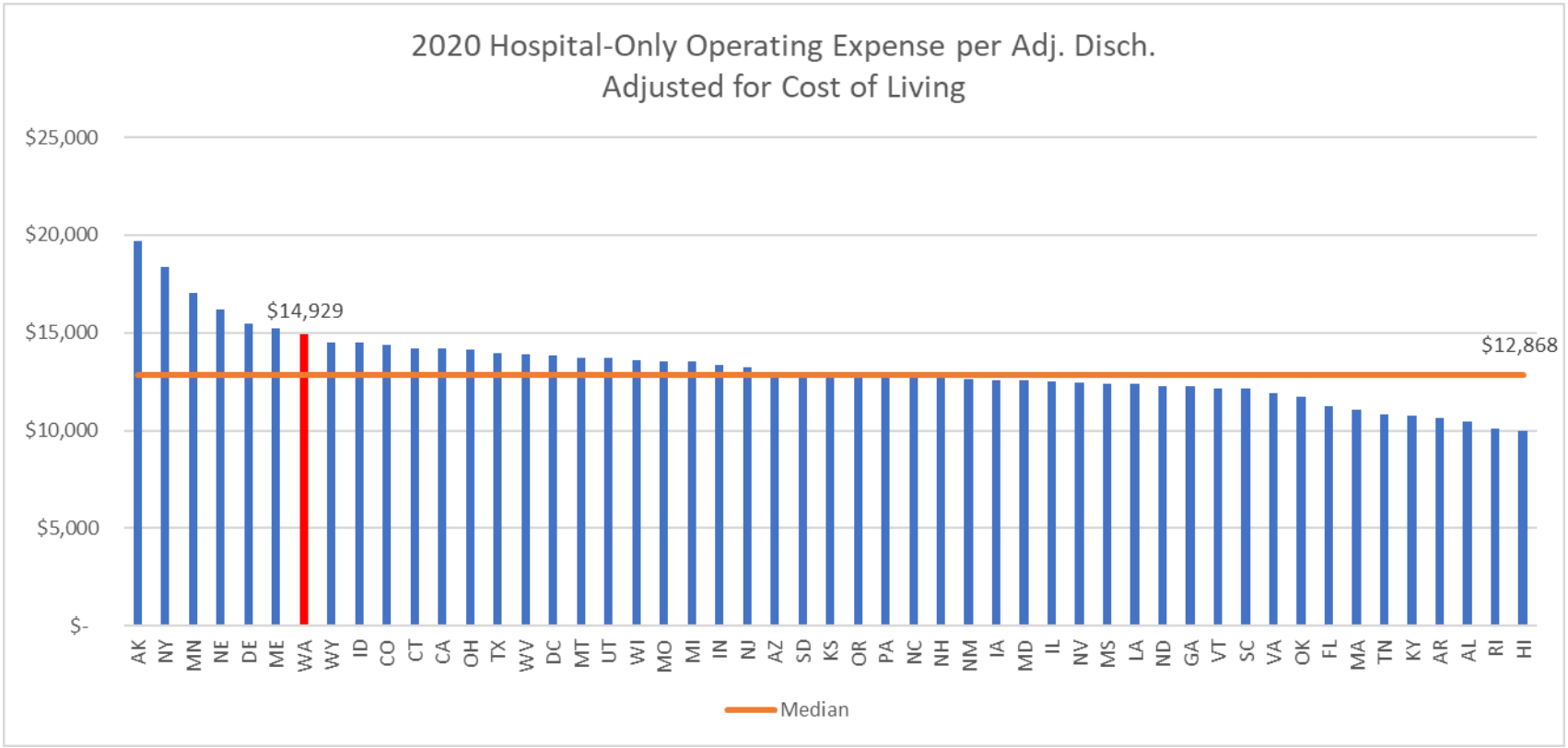
- Using Medicare Cost Report data, create metrics on Net Patient Revenue, Hospital-Only Operating Cost, and Net Income by dividing data by adjusted discharges.
    - Net Patient Revenue divided by Adjusted Discharge = **Price per Patient**
    - Hospital Only Operating Cost divided by Adjusted Discharge = **Cost per Patient**
    - Net Income divided by Adjusted Discharges = **Profit per Patient**
- Observe trends across hospital types and peer groups
    - Health systems, independents, for-profit, not-for-profit, rural, urban, teaching, and by bed size

Review National Rankings by Key Hospital Financial Metrics

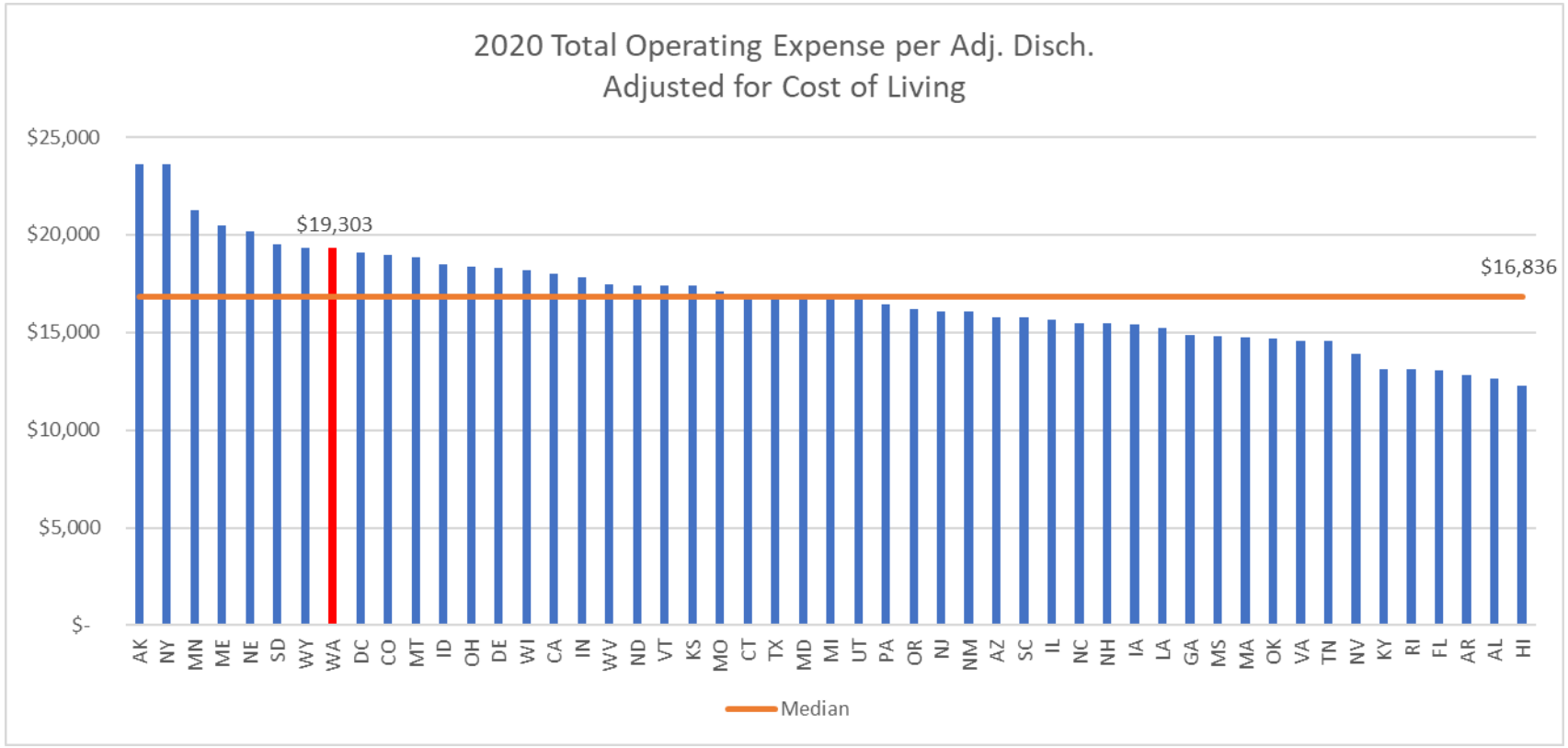
2020 Price per Patient, Cost of Living Adjusted



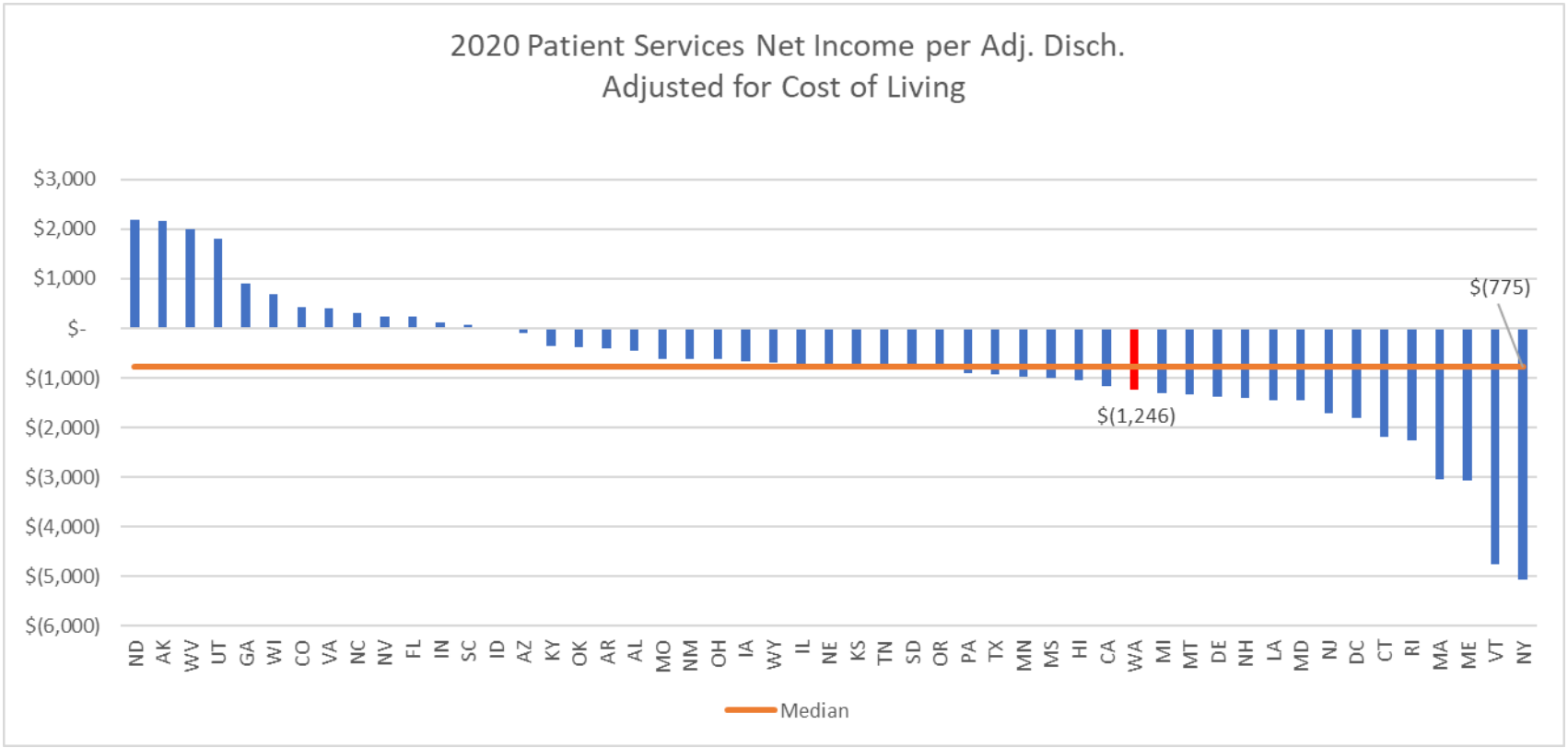
2020 Cost per Patient, Cost of Living Adjusted



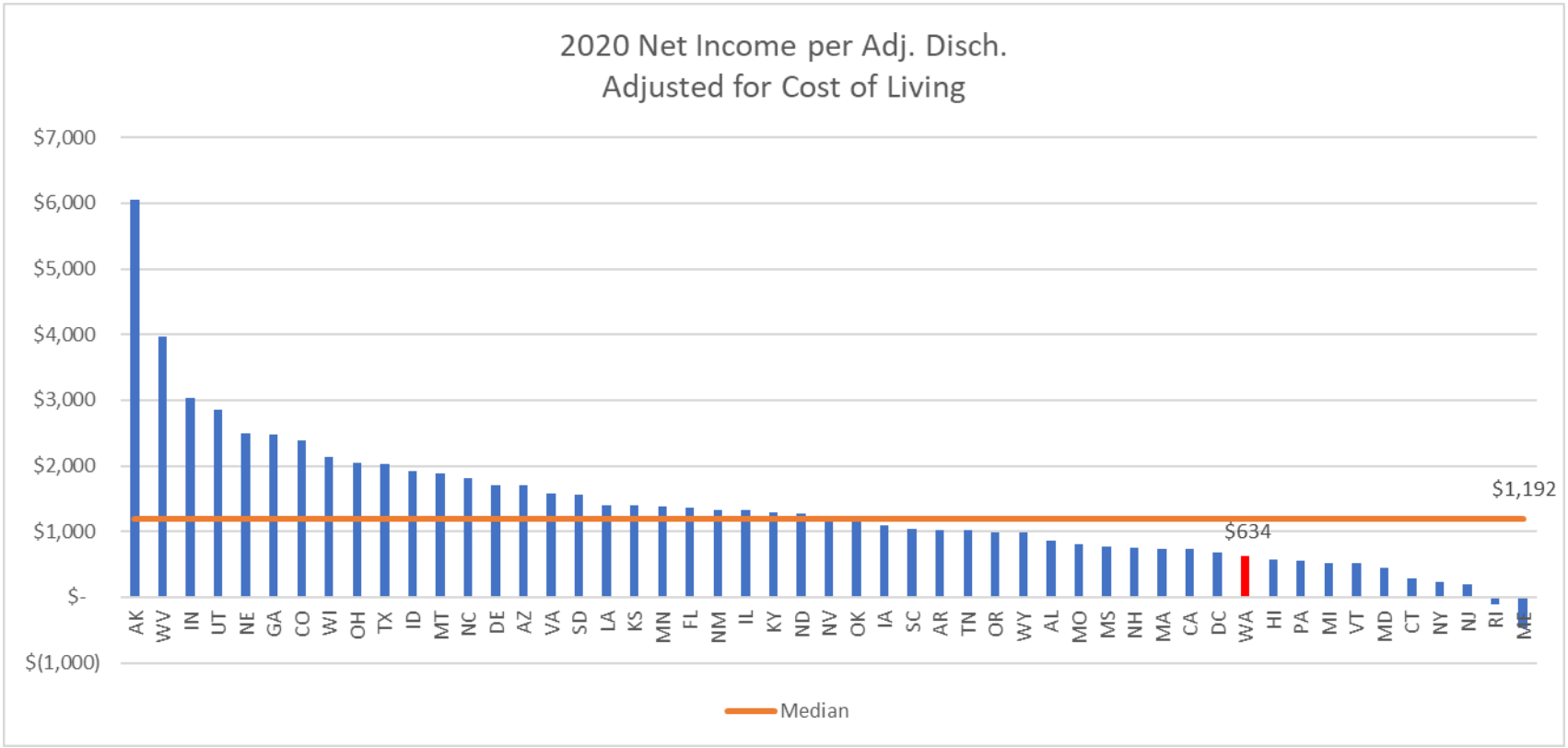
2020 Total Cost per Patient, Cost of Living Adjusted



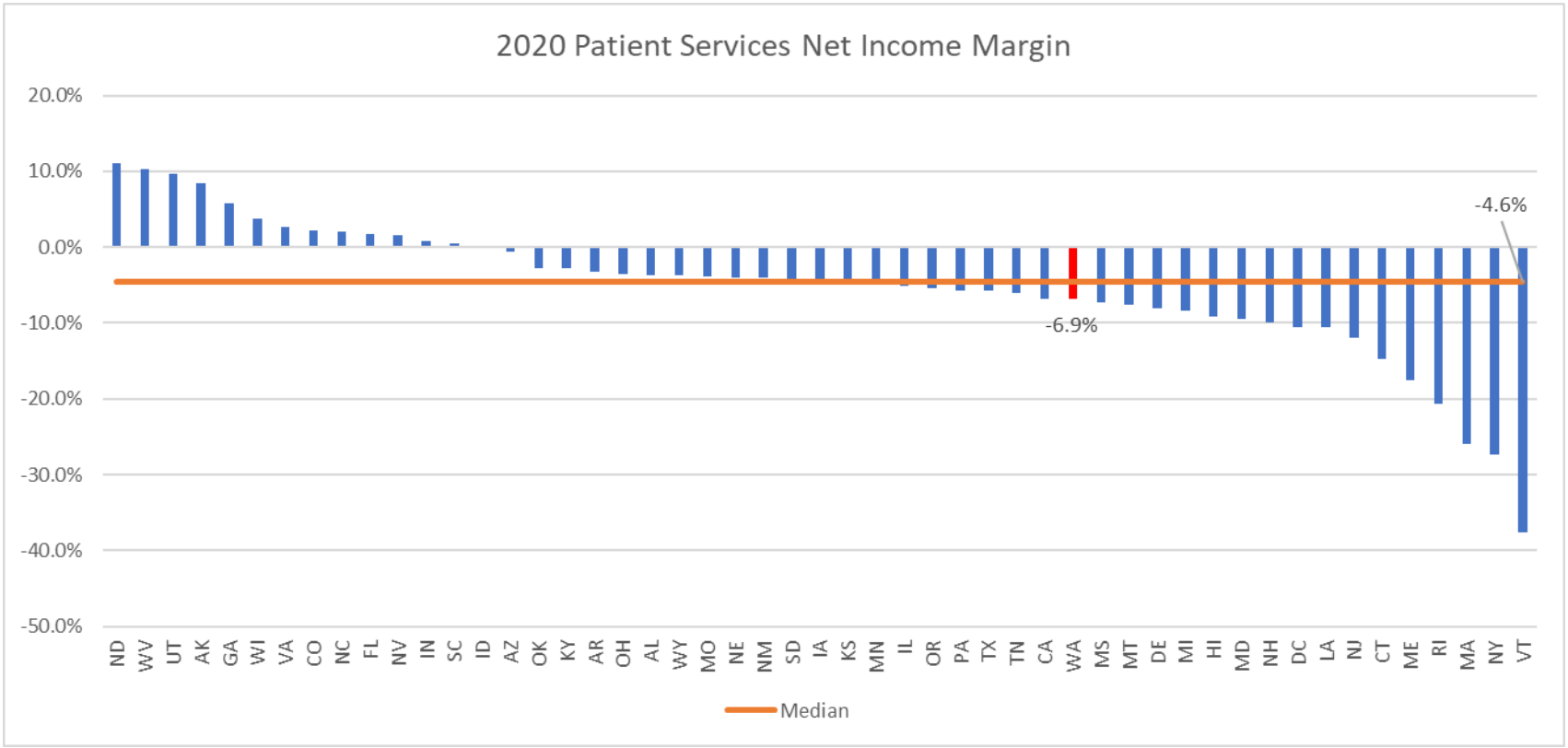
2020 Patient Profit per Patient, Cost of Living Adjusted



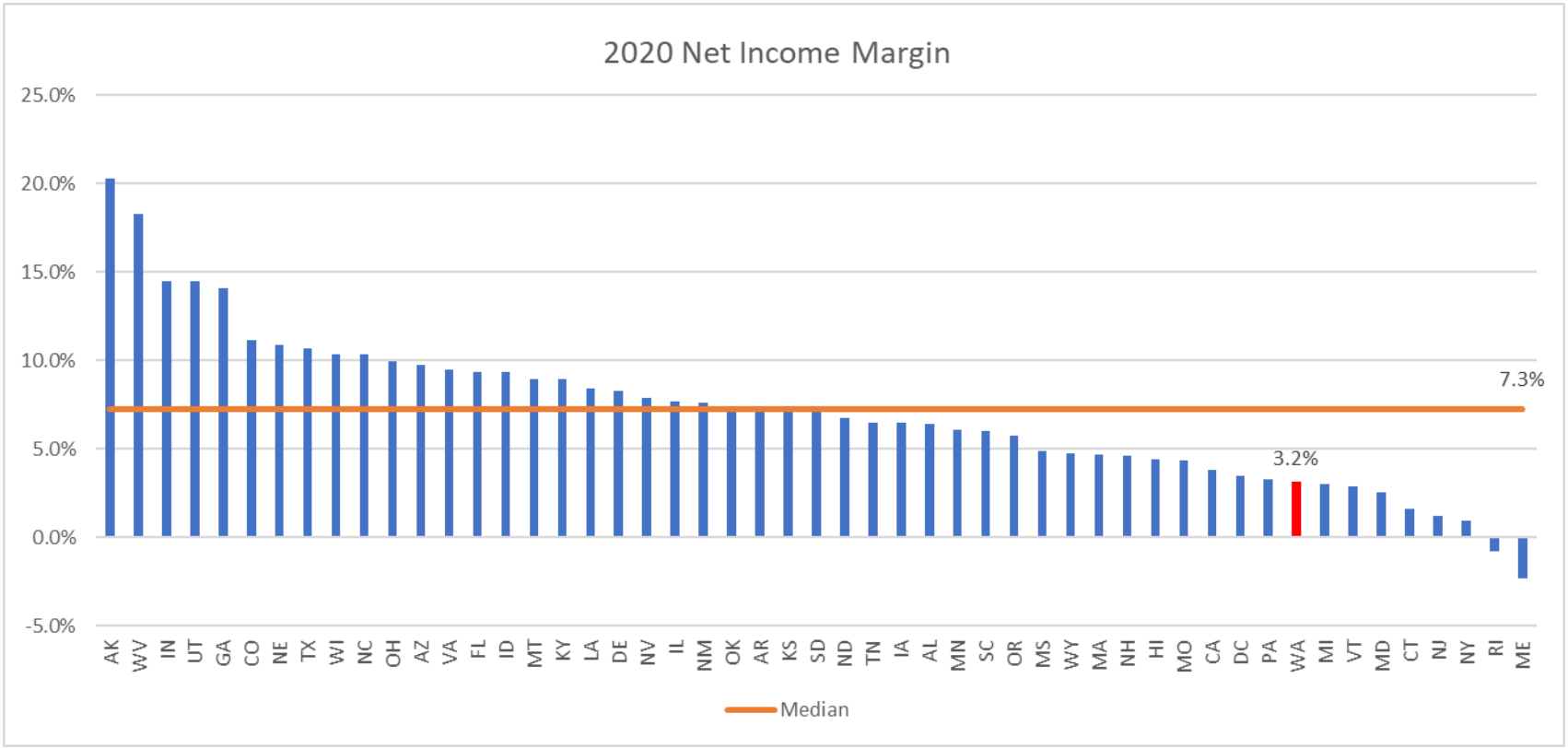
2020 Total Profit per Patient, Cost of Living Adjusted



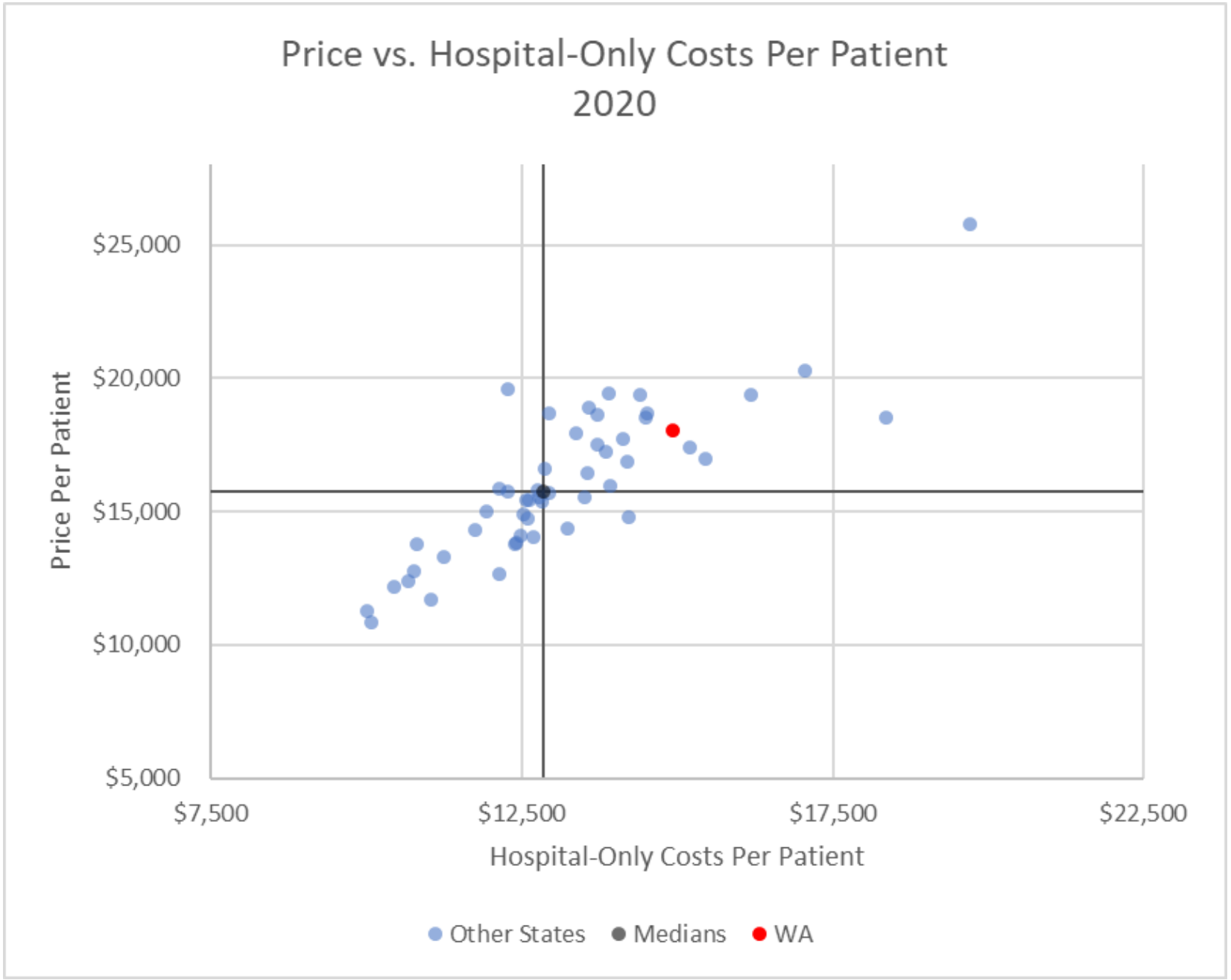
2020 Patient Profit Margin

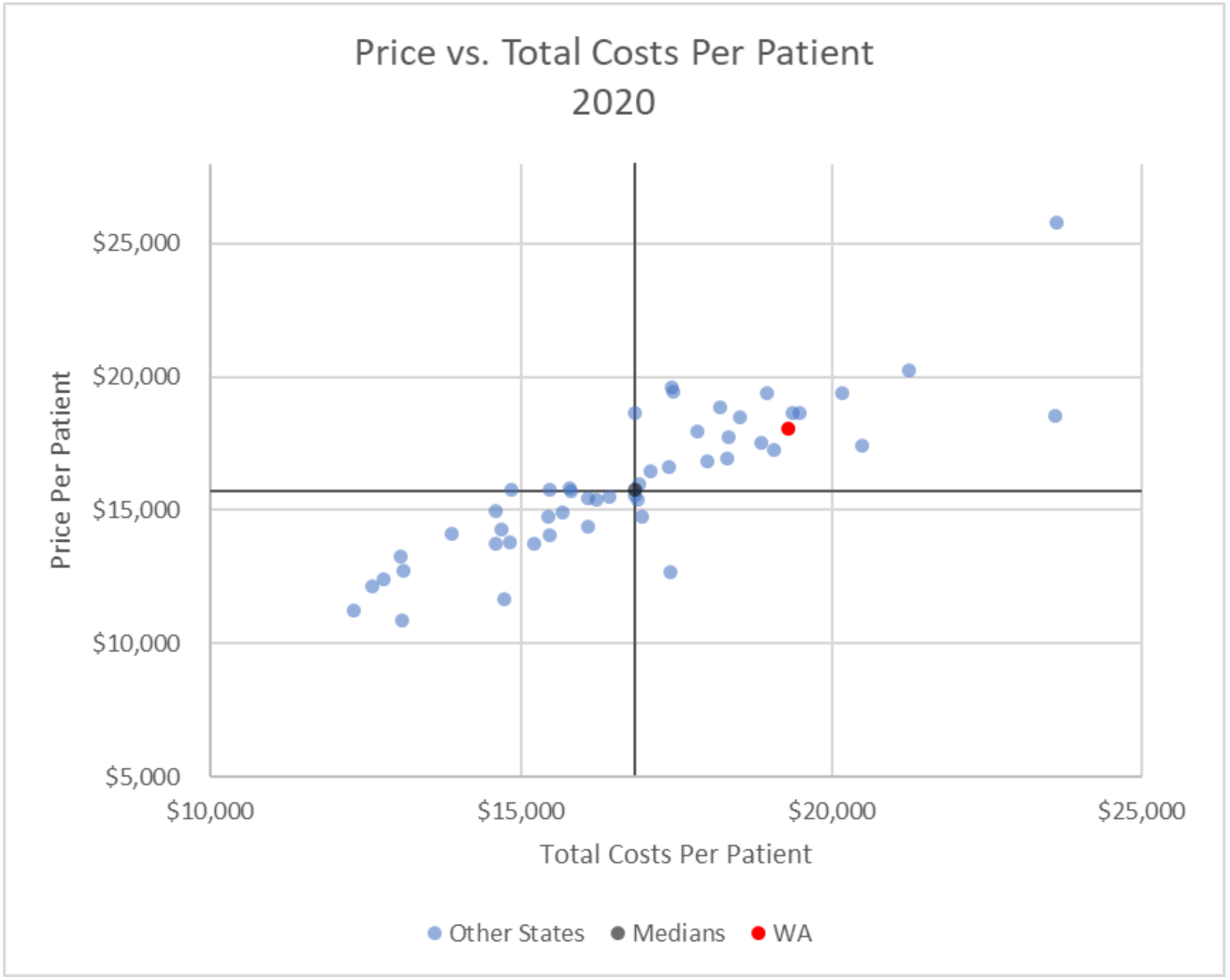


2020 Total Profit Margin



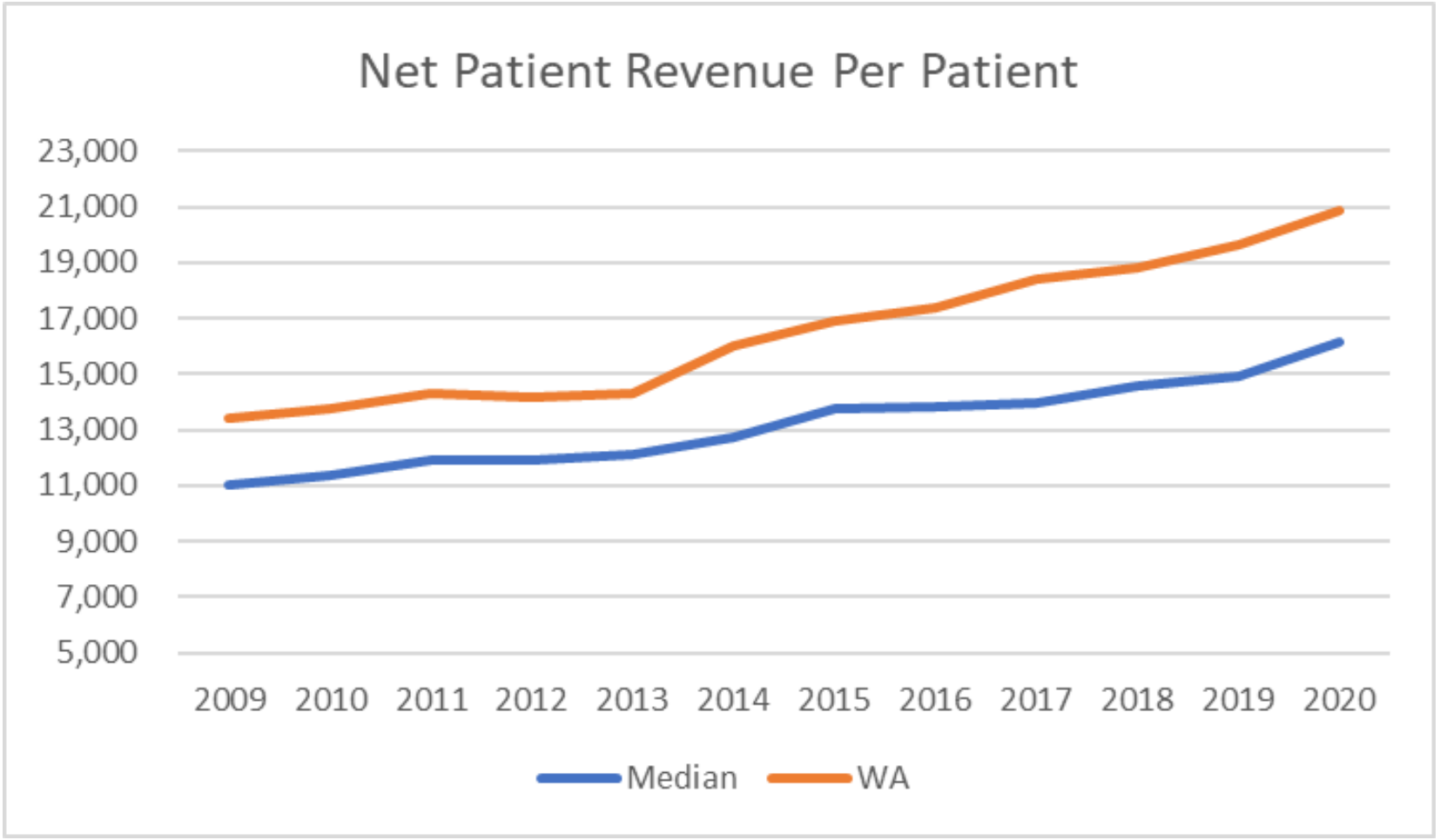
Scatterplot Review of WA Hospital Trends


Price vs. Hospital-Only Costs Per Patient
2020
$25,000
$20,000
$15,000
$10,000
$5,000
Price Per Patient
$7,500
$12,500
$17,500
$22,500
Hospital-Only Costs Per Patient
Other States
Medians
WA

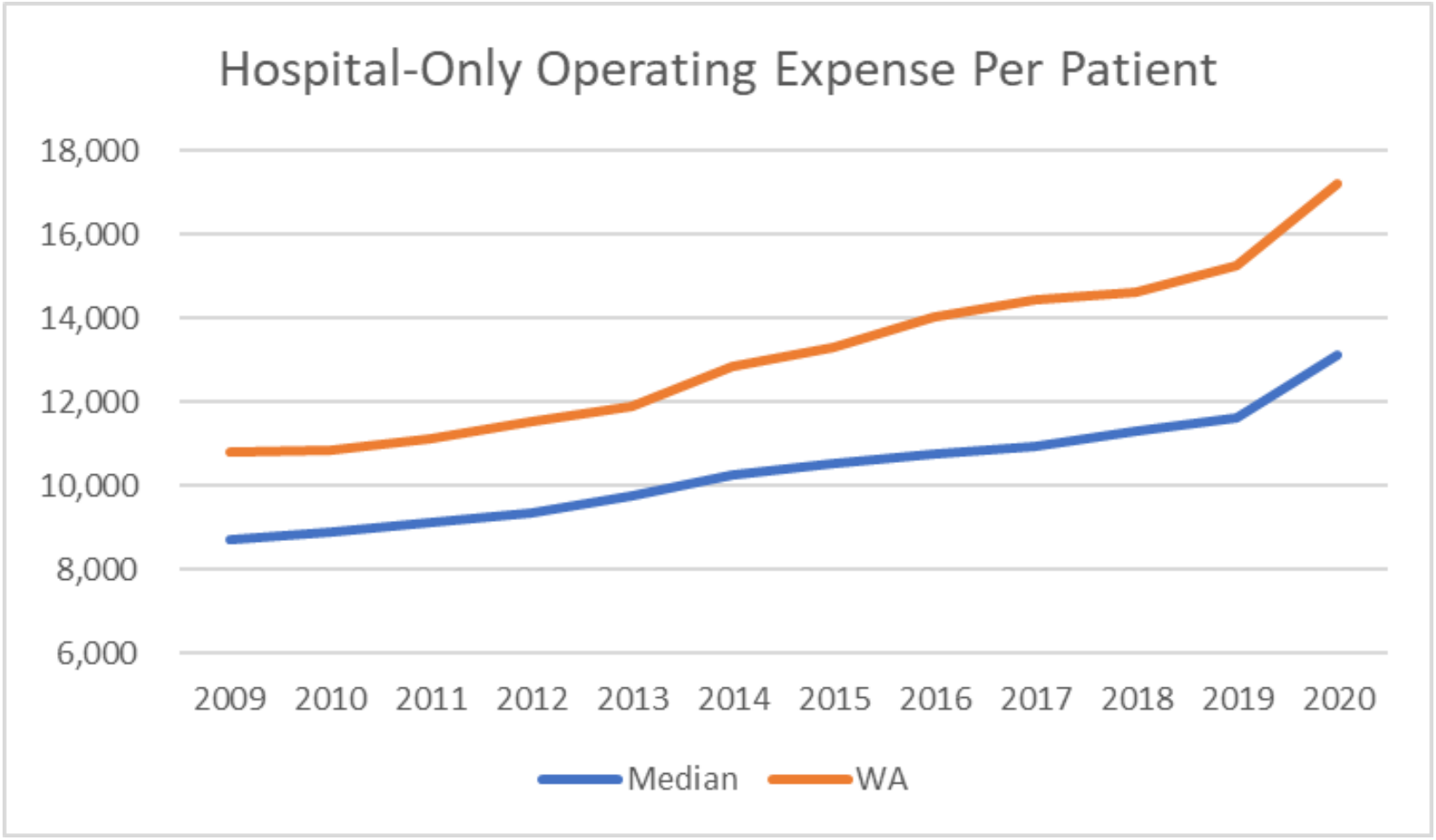

Price vs. Total Costs Per Patient
2020
$25,000
$20,000
$15,000
$10,000
$5,000
Price Per Patient
$10,000
$15,000
$20,000
$25,000
Total Costs Per Patient
Other States
Medians
WA

Review of WA Hospital Trends by Key Hospital Financial Metrics

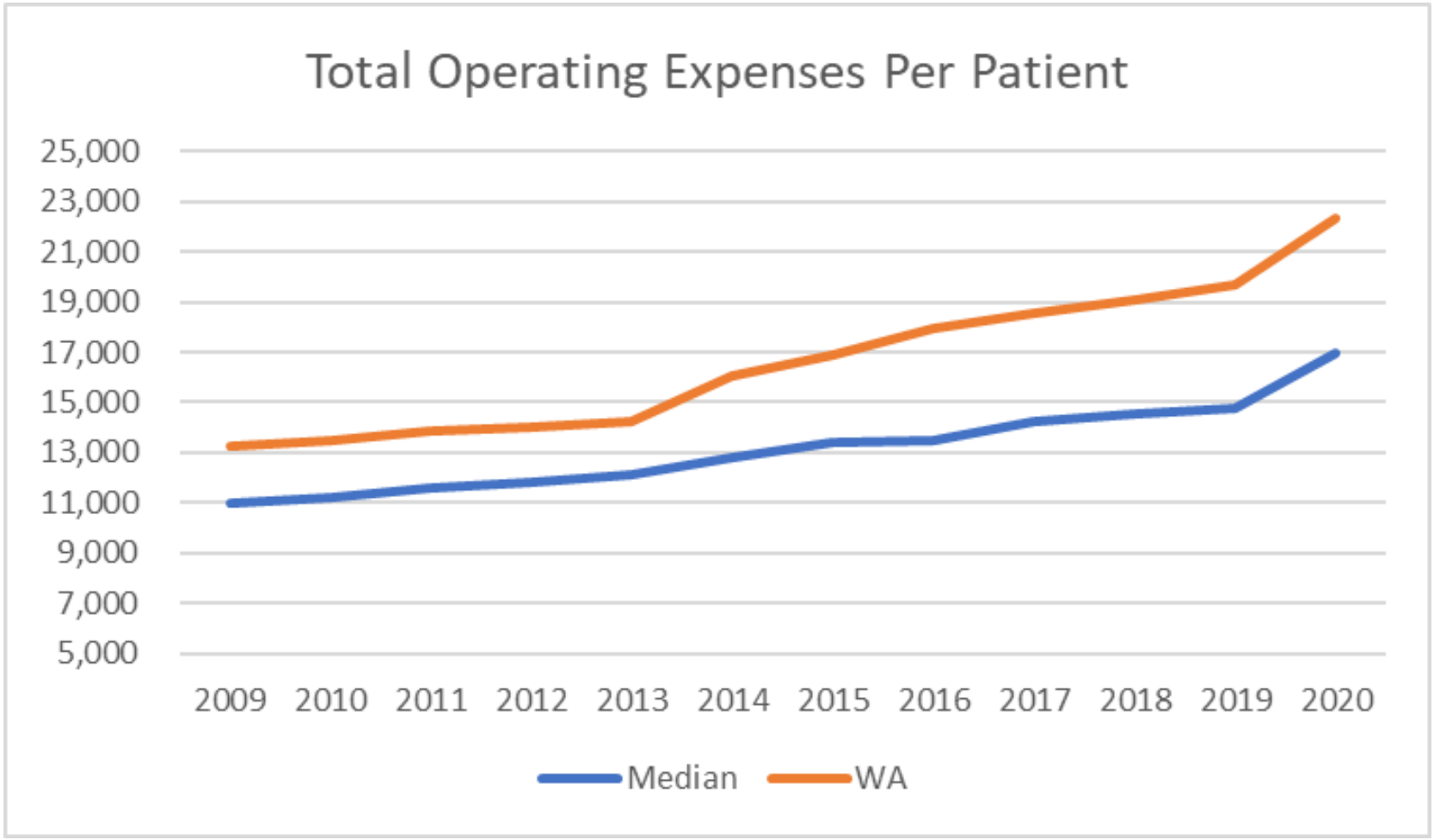
Price per Patient



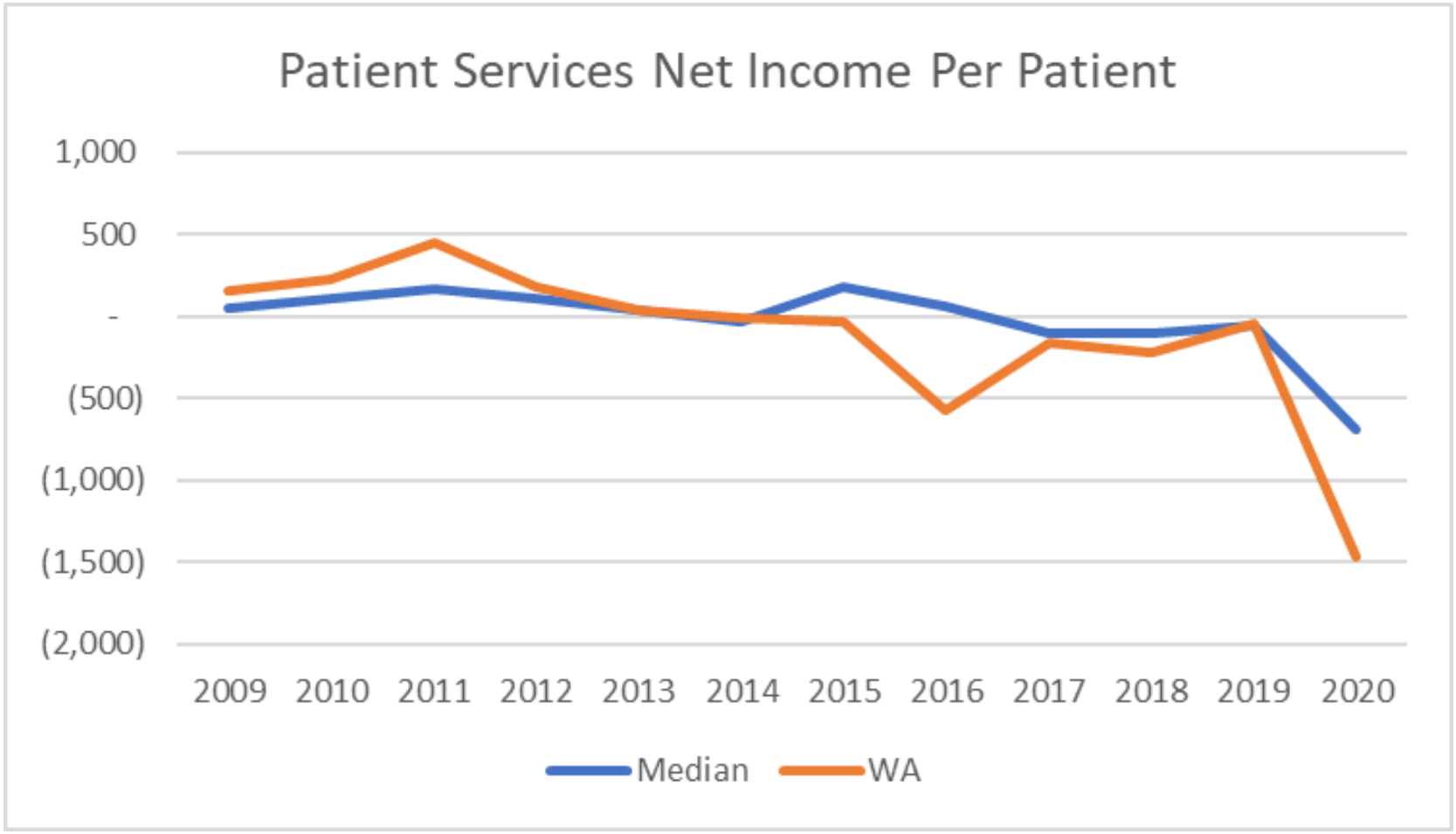
Cost per Patient



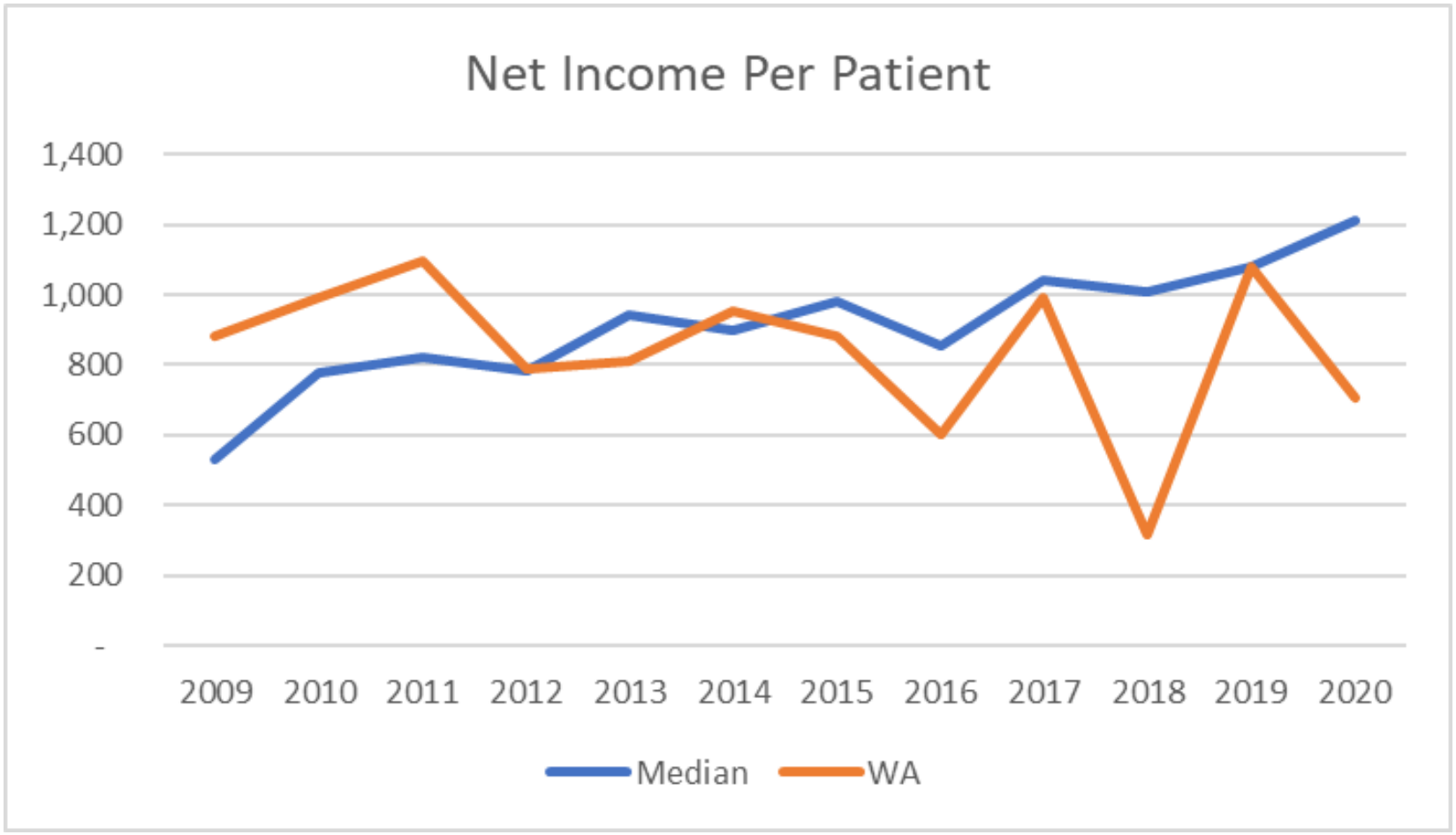
Total Cost per Patient



Patient Profit per Patient



Total Profit per Patient



Additional Questions/Comments?

Washington State Health Care Authority

Washington State Hospitals: a primer on Washington hospital costs

TAB 5

Washington State Hospital Association

WSHA wants to be a partner with payors, governmental leaders, and others in finding ways to control costs while maintaining access to high-quality and efficient healthcare.

ANALYSIS GROUP

Washington State Hospitals: A Primer on Washington Hospital Costs

Jonathan Bennett, Washington State Hospital Association (WSHA)
Bruce Deal, Economic Expert for WSHA

July 2022

Overview

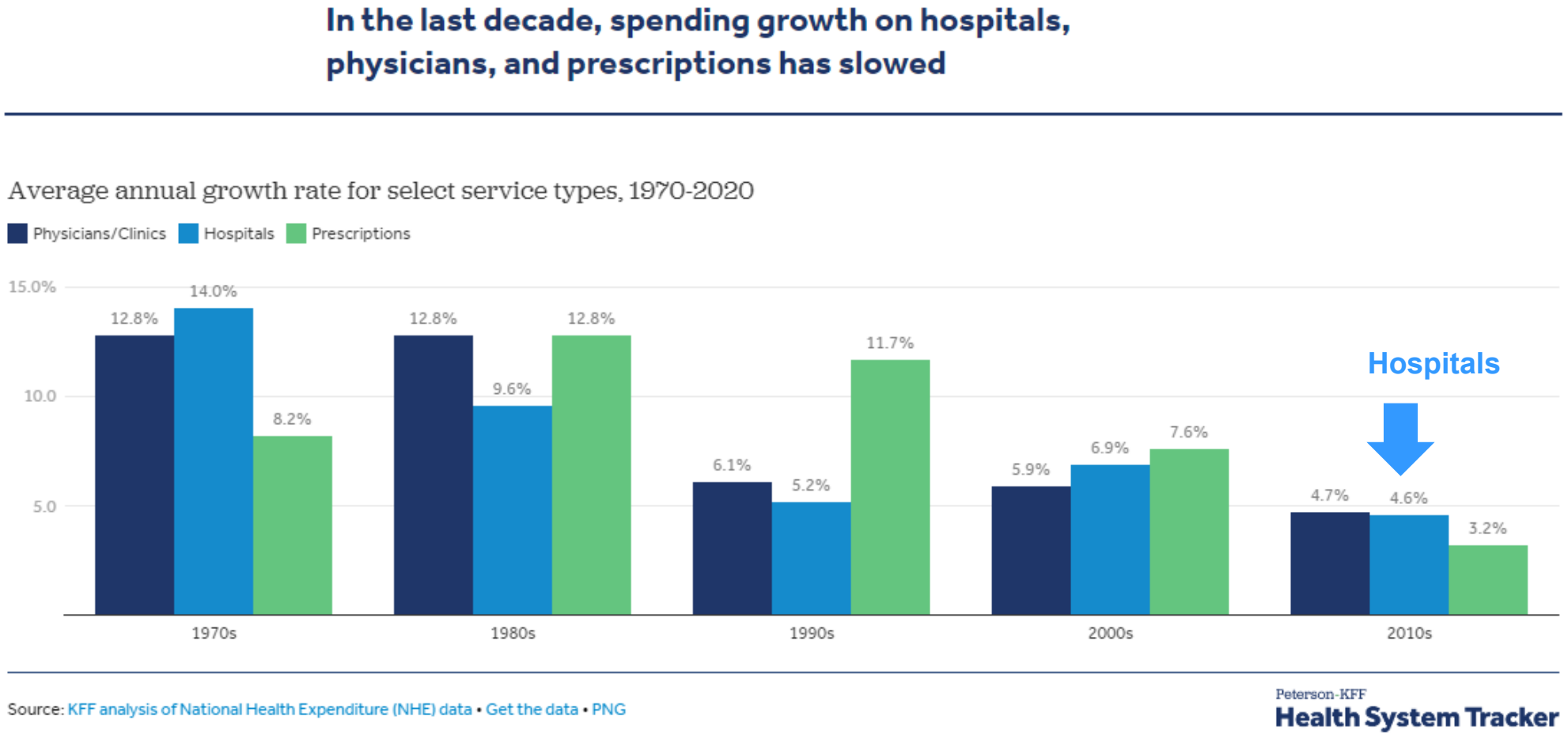
1. Background on medical and hospital costs
2. Who are the Washington State Hospitals?
3. What does controlling hospital costs mean?
4. Operating margins for Washington hospitals
5. Who are the major payors and how are hospitals paid?
6. Other factors in analyzing hospital costs

Medical Cost Growth is Driven by Three Primary Factors

		1		2		3
Medical Costs	=	Overall Inflation	x	Cost Growth Beyond Inflation	x	Increased Use of Care

ANALYSIS GROUP

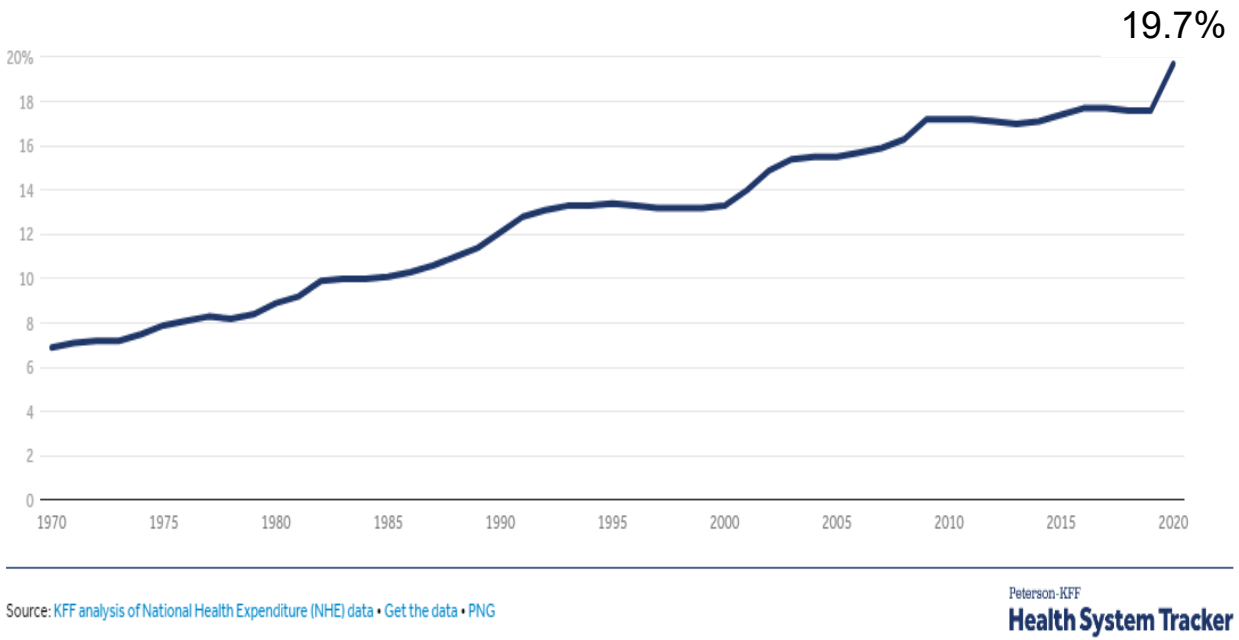
50 Year Trends in Healthcare and Hospital Spending



Source: KFF

Medical Costs in the U.S.

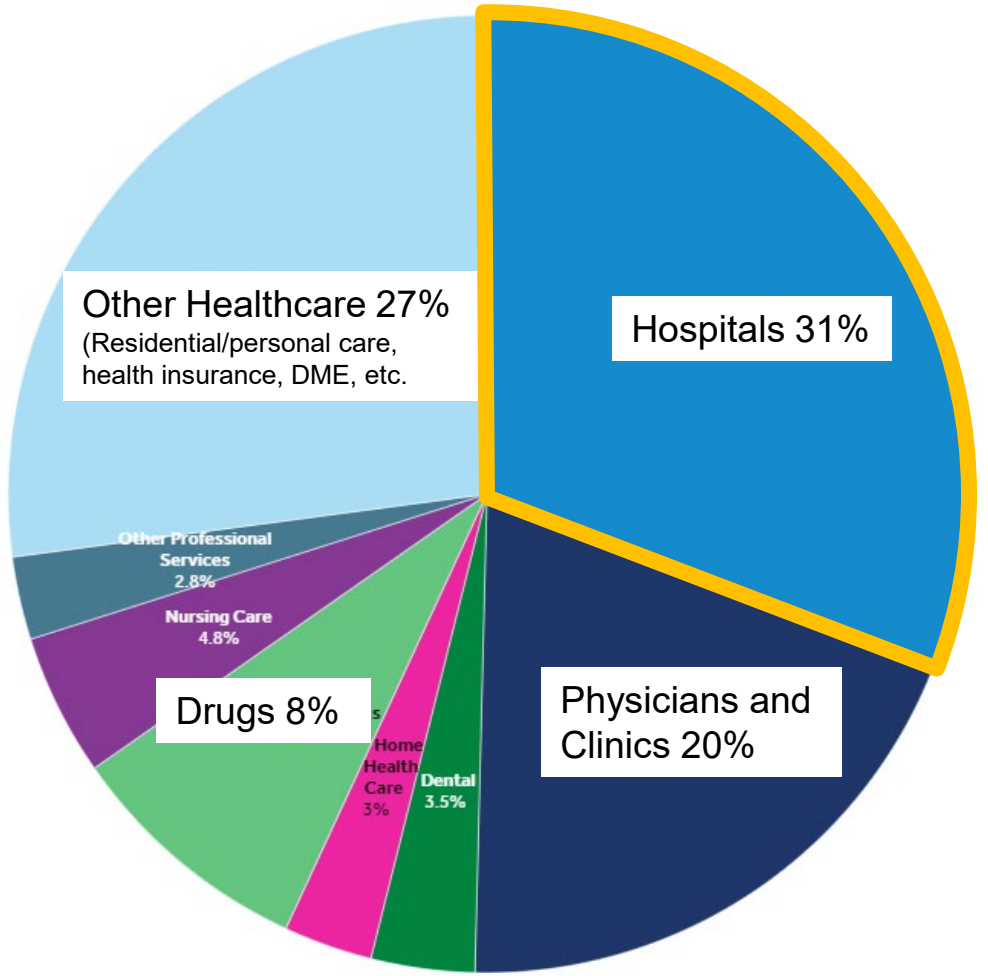
Healthcare Spending as a Percent of GDP



Source: KFF analysis of National Health Expenditure (NHE) data • Get the data • PNG

Peterson-KFF Health System Tracker

Breakdown of Healthcare Spending



Source: KFF

Health Care Cost Benchmark and U.S. Govt. Health Spending Estimates

WA Healthcare Cost Growth Benchmark

What's the board been up to?

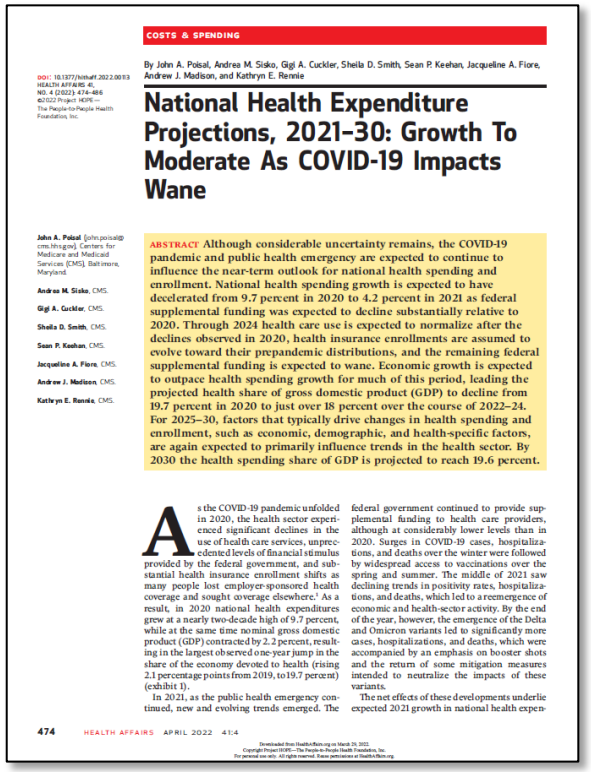
In summer 2021, the board established the benchmark for Washington State:

Calendar year	Cost growth benchmark values
2022	3.2%
2023	3.2%
2024	3%
2025	3%
2026	2.8%

https://www.hca.wa.gov/health-care-cost-transparency-board-taking-steps-toward-making-health-care-more-affordable

April 2022 U.S. Government Estimates of National Health Expenditure Increase

Year	Projected National Health Expenditure Increase
2022	4.6%
2023	5.0%
2024	5.1%
2025	5.3%
2026	5.3%



COSTS & SPENDING

By John A. Poisal, Andrea M. Sisko, Gigi A. Cuckler, Sheila D. Smith, Sean P. Keehan, Jacqueline A. Fiore, Andrew J. Madison, and Kathryn E. Rennie

DOI: 10.1377/hlthaff.2022.00113
HEALTH AFFAIRS 41, NO. 4 (2022): 474–486
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National Health Expenditure Projections, 2021–30: Growth To Moderate As COVID-19 Impacts Wane

John A. Poisal (john.poisal@cms.hhs.gov), Centers for Medicare and Medicaid Services (CMS), Baltimore, Maryland.
Andrea M. Sisko, CMS.
Gigi A. Cuckler, CMS.
Sheila D. Smith, CMS.
Sean P. Keehan, CMS.
Jacqueline A. Fiore, CMS.
Andrew J. Madison, CMS.
Kathryn E. Rennie, CMS.

ABSTRACT Although considerable uncertainty remains, the COVID-19 pandemic and public health emergency are expected to continue to influence the near-term outlook for national health spending and enrollment. National health spending growth is expected to have decelerated from 9.7 percent in 2020 to 4.2 percent in 2021 as federal supplemental funding was expected to decline substantially relative to 2020. Through 2024 health care use is expected to normalize after the declines observed in 2020, health insurance enrollments are assumed to evolve toward their prepandemic distributions, and the remaining federal supplemental funding is expected to wane. Economic growth is expected to outpace health spending growth for much of this period, leading the projected health share of gross domestic product (GDP) to decline from 19.7 percent in 2020 to just over 18 percent over the course of 2022–24. For 2025–30, factors that typically drive changes in health spending and enrollment, such as economic, demographic, and health-specific factors, are again expected to primarily influence trends in the health sector. By 2030 the health spending share of GDP is projected to reach 19.6 percent.

As the COVID-19 pandemic unfolded in 2020, the health sector experienced significant declines in the use of health care services, unprecedented levels of financial stimulus provided by the federal government, and substantial health insurance enrollment shifts as many people lost employer-sponsored health coverage and sought coverage elsewhere.[1] As a result, in 2020 national health expenditures grew at a nearly two-decade high of 9.7 percent, while at the same time nominal gross domestic product (GDP) contracted by 2.2 percent, resulting in the largest observed one-year jump in the share of the economy devoted to health (rising 2.1 percentage points from 2019, to 19.7 percent) (exhibit 1).

In 2021, as the public health emergency continued, new and evolving trends emerged. The federal government continued to provide supplemental funding to health care providers, although at considerably lower levels than in 2020. Surges in COVID-19 cases, hospitalizations, and deaths over the winter were followed by widespread access to vaccinations over the spring and summer. The middle of 2021 saw declining trends in positivity rates, hospitalizations, and deaths, which led to a reemergence of economic and health-sector activity. By the end of the year, however, the emergence of the Delta and Omicron variants led to significantly more cases, hospitalizations, and deaths, which were accompanied by an emphasis on booster shots and the return of some mitigation measures intended to neutralize the impacts of these variants.

The net effects of these developments underlie expected 2021 growth in national health expen-

Source: CMS, Office of the Actuary, National Health Statistics Group

Health Care Cost Benchmark and U.S. Govt. Inflation Estimates

WA Health Care Cost Benchmark

What's the board been up to?

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2022 U.S. Government (CBO) Estimates of CPI and Employment Cost Increases

Congressional Budget Office
Nonpartisan Analysis for the U.S. Congress

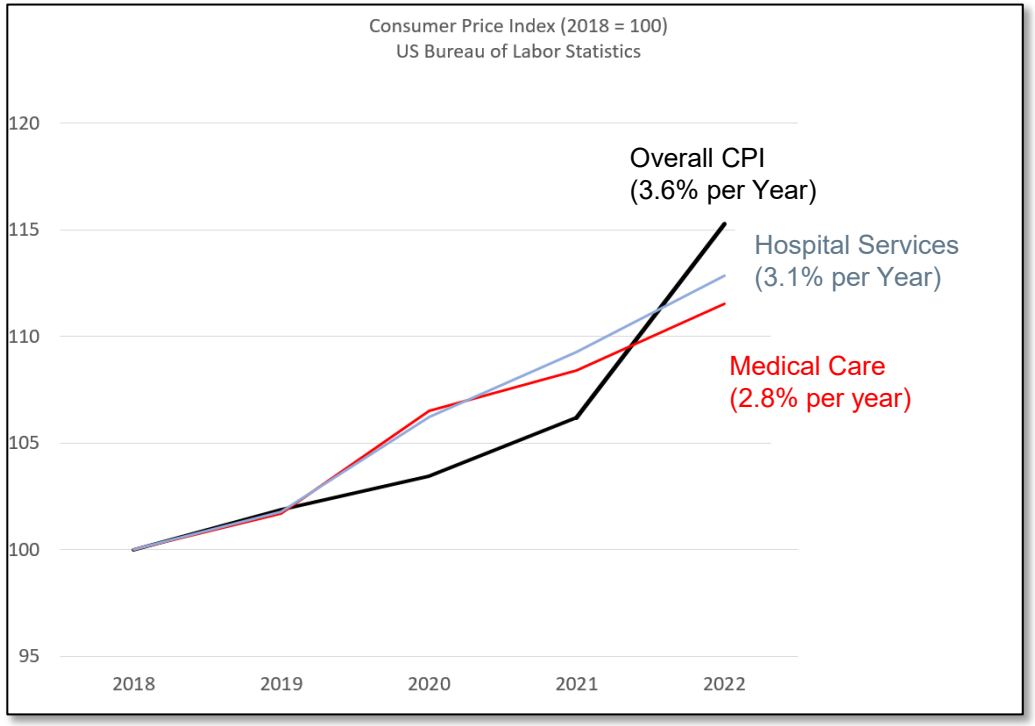
Year	CPI Inflation	Employment Cost Index
2022	6.1%	5.6%
2023	3.1%	4.5%
2024	2.4%	3.8%
2025	2.3%	3.5%
2026	2.3%	3.3%

Source: CBO Estimates

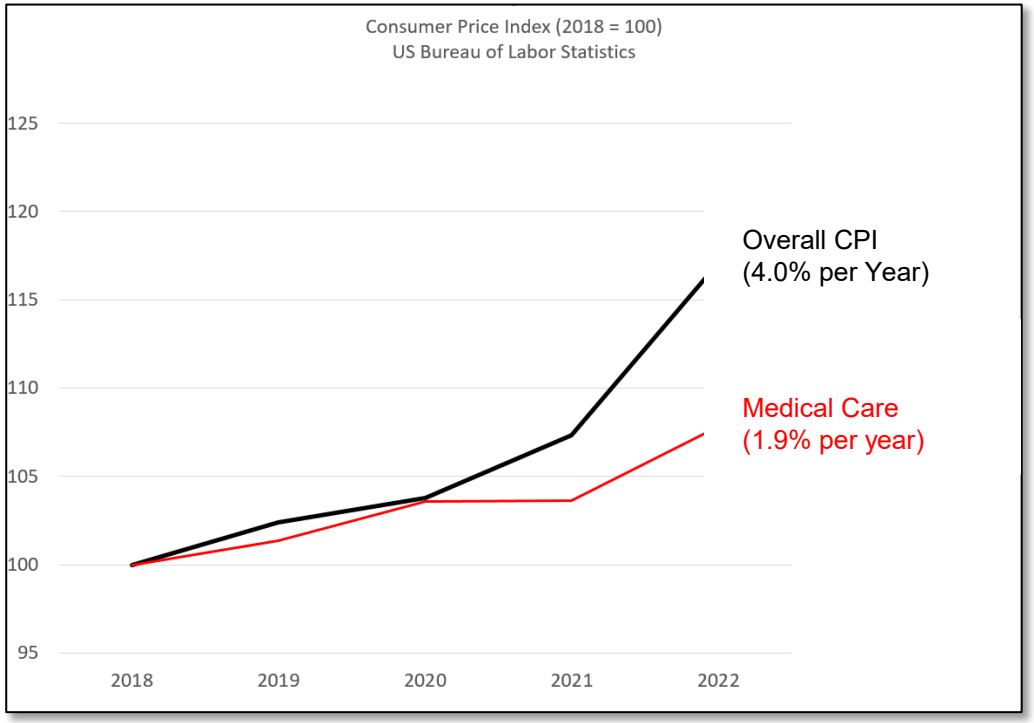
ANALYSIS GROUP

Medical Care and Hospital Price Growth (Inflation) in the Past 5 Years

Overall U.S.



Puget Sound
(Hospital Services Not Reported Separately)



Source: U.S. CPI Statistics from Bureau of Labor Statistics

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What is a Hospital?

Hospital employees include nurses, therapists, and other clinical and administrative personnel.

Facility Where Various Medical Services are Provided:

- Inpatient Acute Care
- Outpatient
- Emergency

Physicians receive medical staff "privileges" to use the hospital, but are typically not employees of the hospital and bill separately

Hospitals may also own other non-hospital healthcare services, such as primary care clinics, home health, imaging centers, etc.

Washington State Hospitals Often Own Other Non-Hospital Services

Examples

9% own skilled nursing facilities

82% own hospital-affiliated clinics

28% own free-standing clinics

13% own a home health agency

Source: WSHA calculations from 2019 WA DOH Hospital Financial Reports

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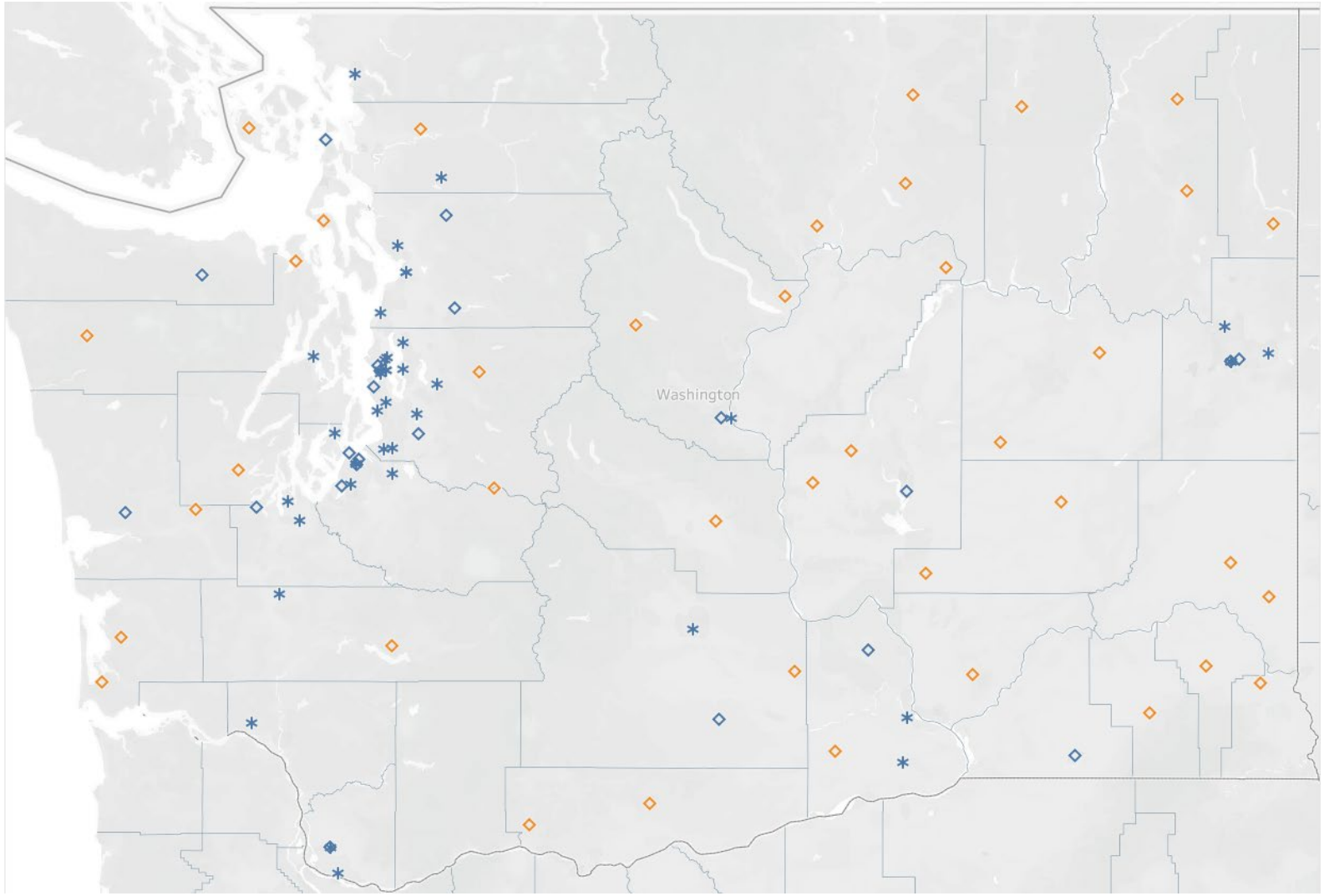
WA Hospitals by Size and Location

WA has **101** hospitals*

39 are Critical Access Hospitals (CAHs), which are up to 25 acute care beds and usually more than 35 miles from another hospital.

62 are larger hospitals, some serving their own community and some the entire state.



* Excluding Eastern State Hospital, Western State Hospital Forensic Center, Western State Hospital Civic Center, Naval Hospital Bremerton, Madigan Army Medical Center, VA Puget Sound Healthcare System, Kaiser Permanente Washington, Child Study & Treatment Center, and Mann-Grandstaff VA Medical Center.

Source: WSHA Calculations from DOH YE & Cost Report and AHA survey, where applicable

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WA 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%**

* Excluding Eastern State Hospital, Western State Hospital Forensic Center, Western State Hospital Civic Center, Naval Hospital Bremerton, Madigan Army Medical Center, VA Puget Sound Healthcare System, Kaiser Permanente Washington, Child Study & Treatment Center, and Mann-Grandstaff VA Medical Center.

Source: WSHA Calculations from 2019 DOH YE Reports

ANALYSIS GROUP

WA Hospitals By Type

Type	Public	Not For Profit	For Profit	Total
General*	40	44	2	86
Children's	-	3	-	3
Behavioral Health	-	2	7	9
Other Specialty	-	2	1	3
Total	**40**	**51**	**10**	**101**

* CAH: 32 hospitals are public hospitals, 6 are not-for-profit, and 1 is for-profit

Source: WSHA from 2019 DOH YE Reports

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WA 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

* Excluding Eastern State Hospital, Western State Hospital Forensic Center, Western State Hospital Civic Center, Naval Hospital Bremerton, Madigan Army Medical Center, VA Puget Sound Healthcare System, Kaiser Permanente Washington, Child Study & Treatment Center, and Mann-Grandstaff VA Medical Center.

Source: WSHA from 2019 DOH YE Reports

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One Definition of "Hospital Cost" is Cost to Payors and Individuals

Hospital revenue is driven by three factors

		1		2		3
Revenue	=	Volume of Patients	x	Services Used per Patient	x	Price per Service

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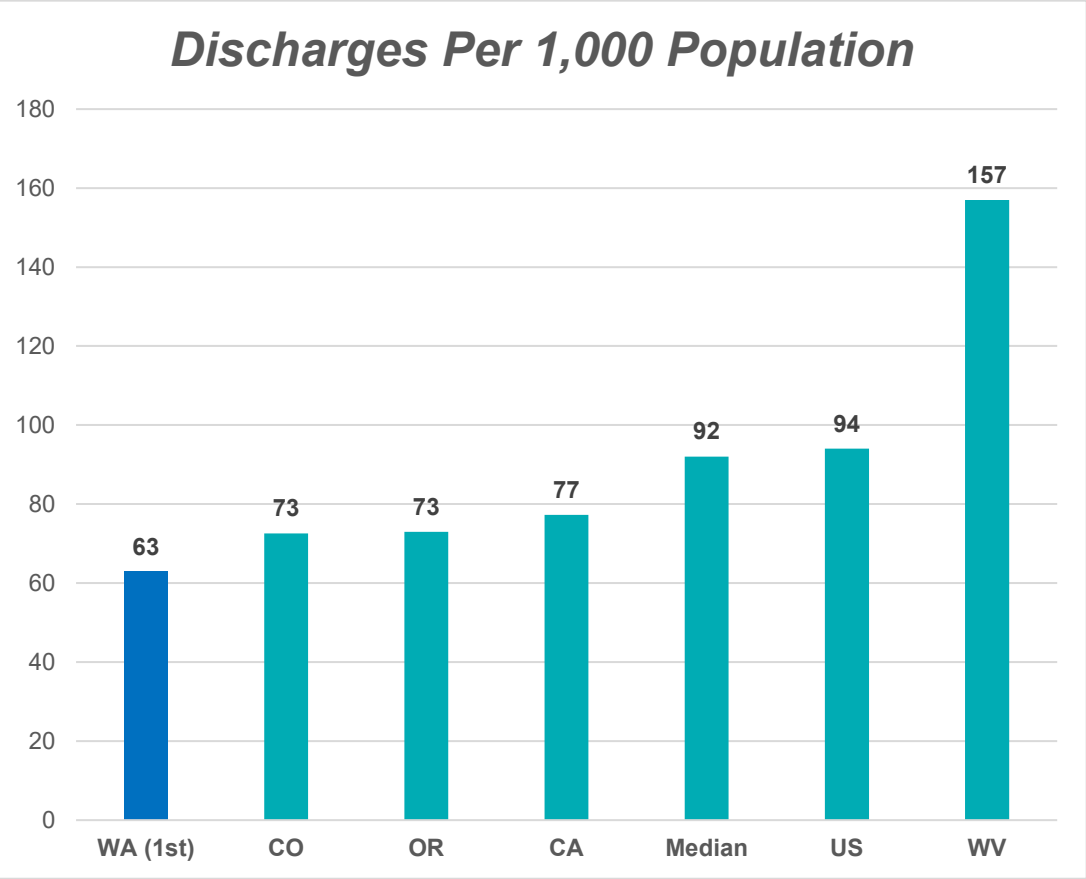
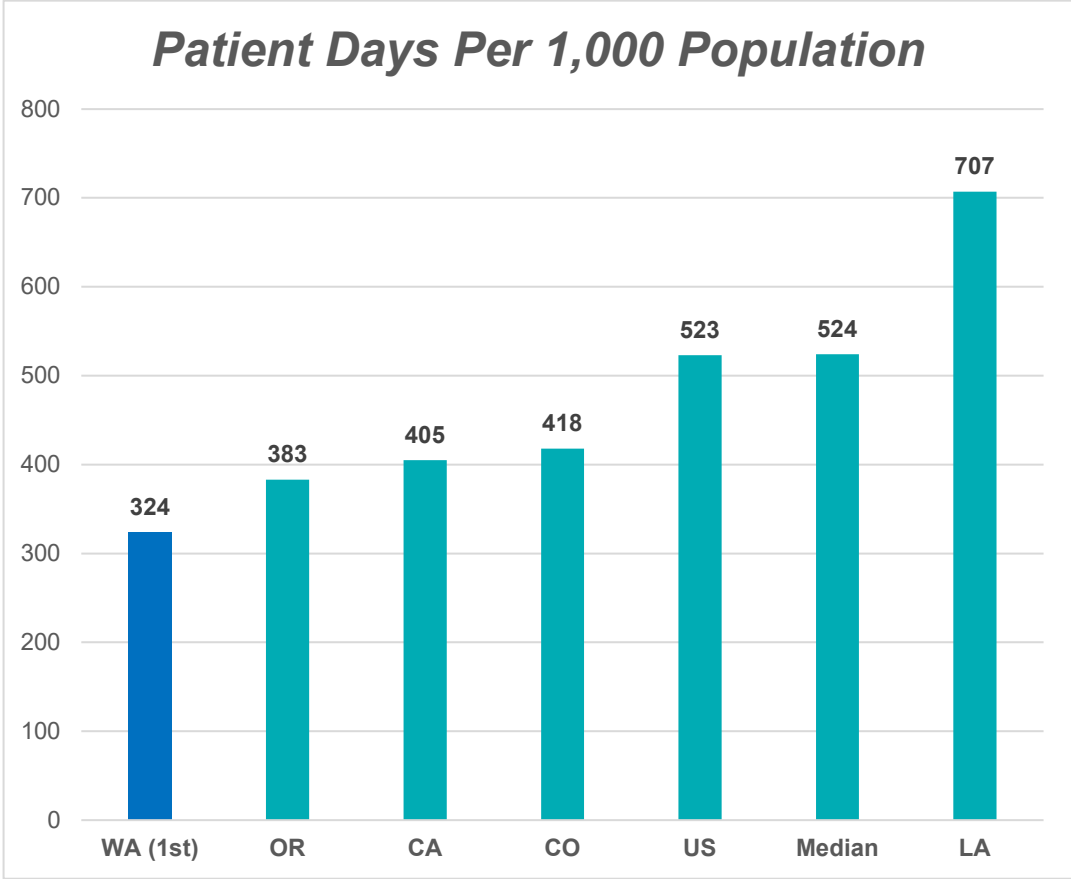
ANALYSIS GROUP

WA Hospital Admission Utilization is Very Low by National Standards

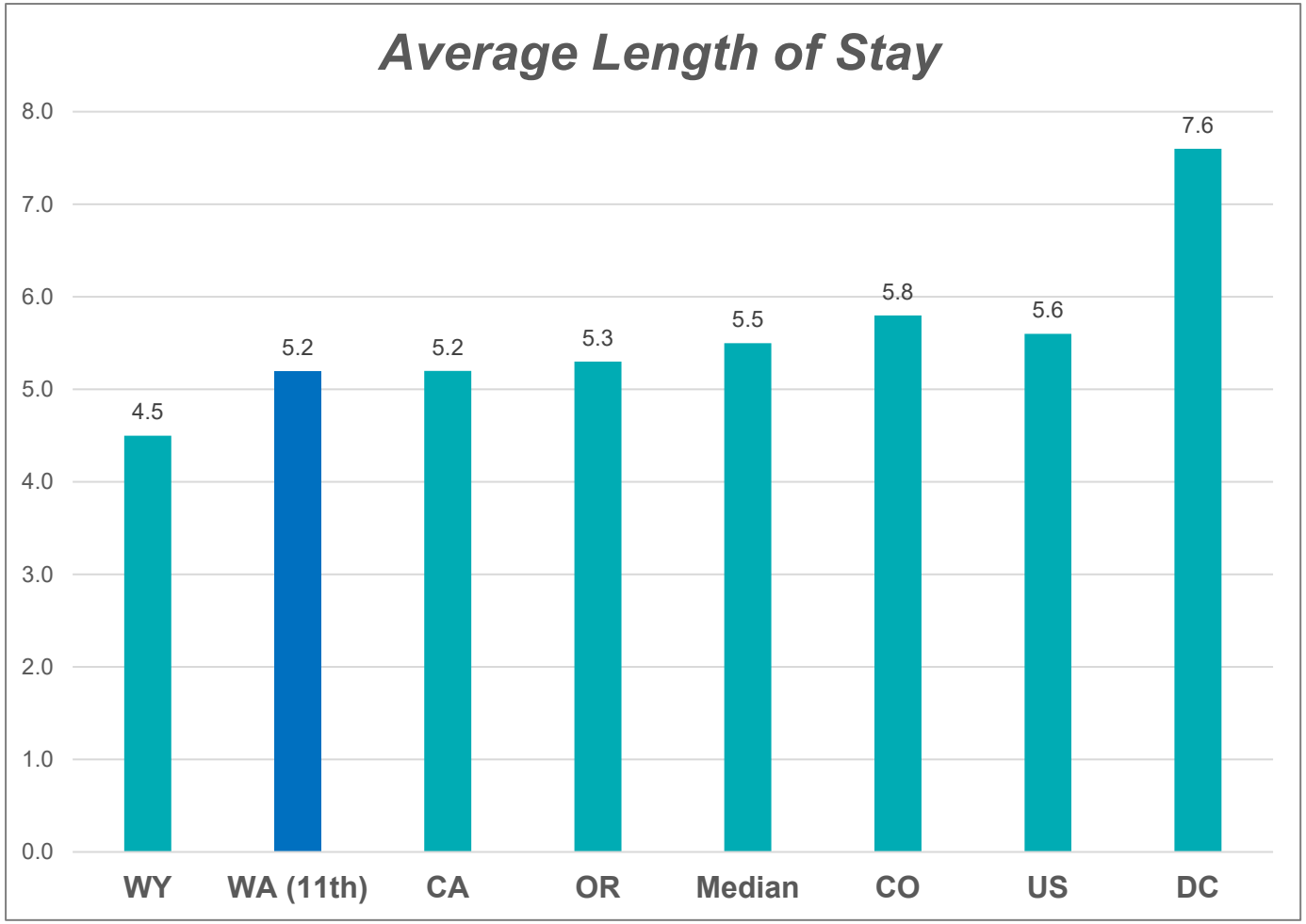




Source: Medicare Cost FY 2020 Reports

ANALYSIS GROUP

WA Hospital Length of Stay is Low by National Standards



Source: Medicare Cost FY 2020 Reports

One Definition of "Hospital Cost" is Cost to Payors and Individuals

Hospital revenue is driven by three factors

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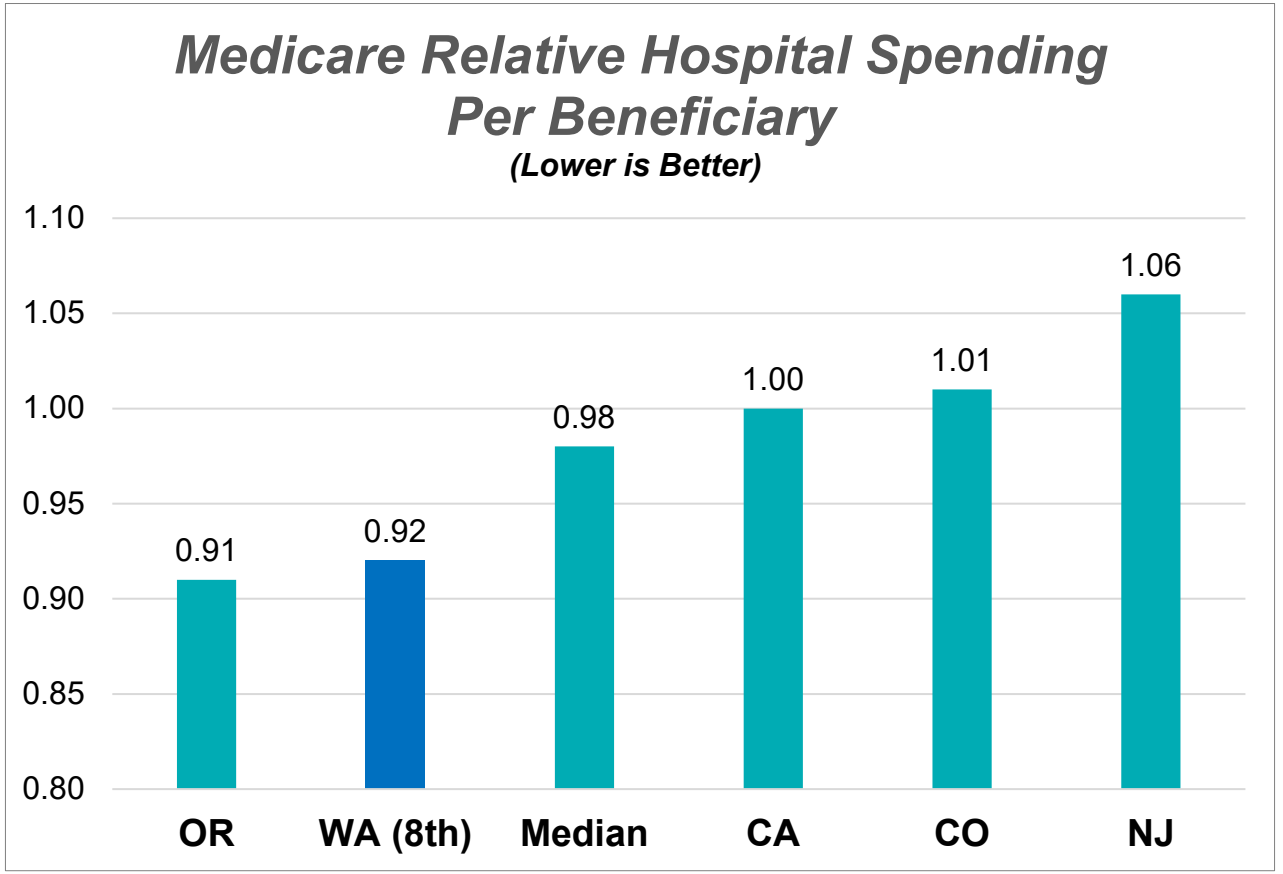
WA Medicare Hospital Spending is Low by National Standards



This measure shows whether Medicare spends more, less, or about the same for an episode of care.

Source: Medicare Cost FY 2020 Reports

One Definition of "Hospital Cost" is Cost to Payors and Individuals

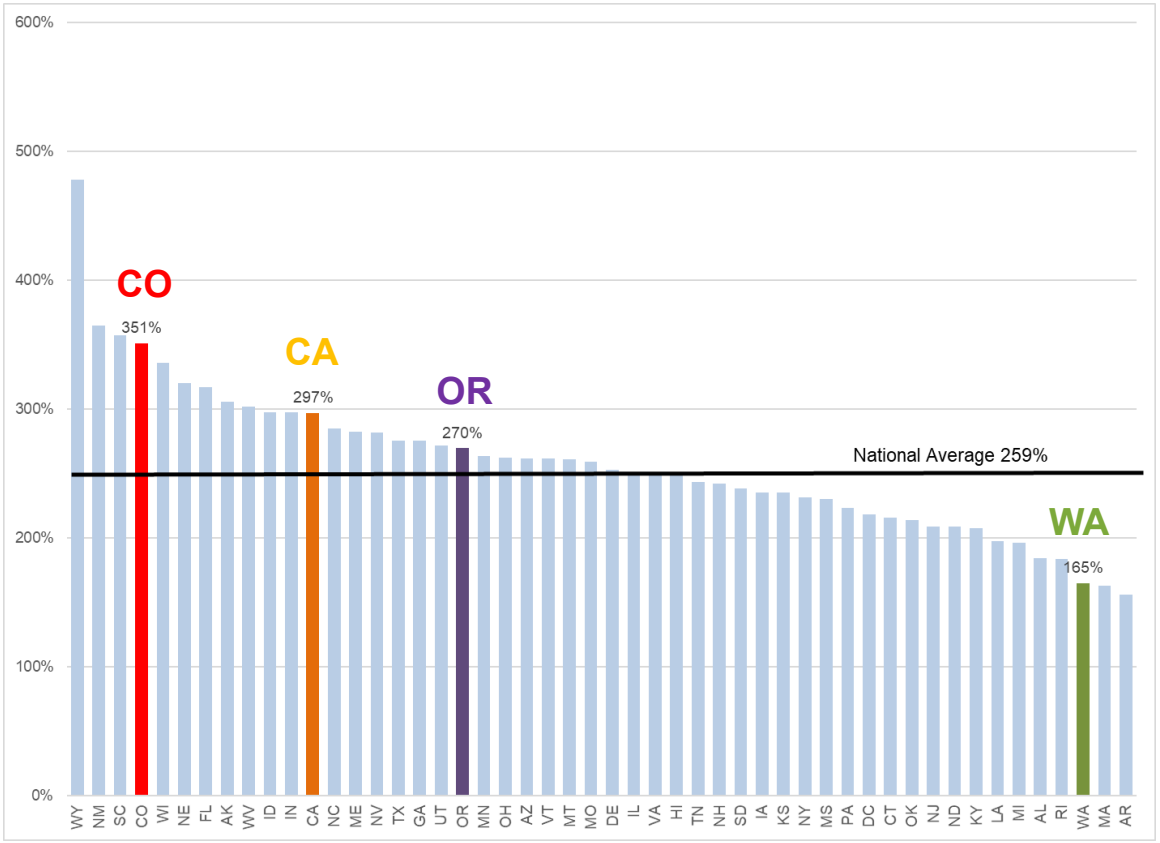
Hospital revenue is driven by three "levers"

		1		2		3
Revenue	=	Volume of Patients	x	Services Used per Patient	x	Price per Service

ANALYSIS GROUP

Hospital Price Levels in WA State are Relatively Low: Commercial Payment Levels vs. Medicare Payments (RAND 2022)

Non-CAH Hospitals Inpatient/Outpatient Combined
(Typically ~95% of State Hospital Revenue)



Source: RAND 2022

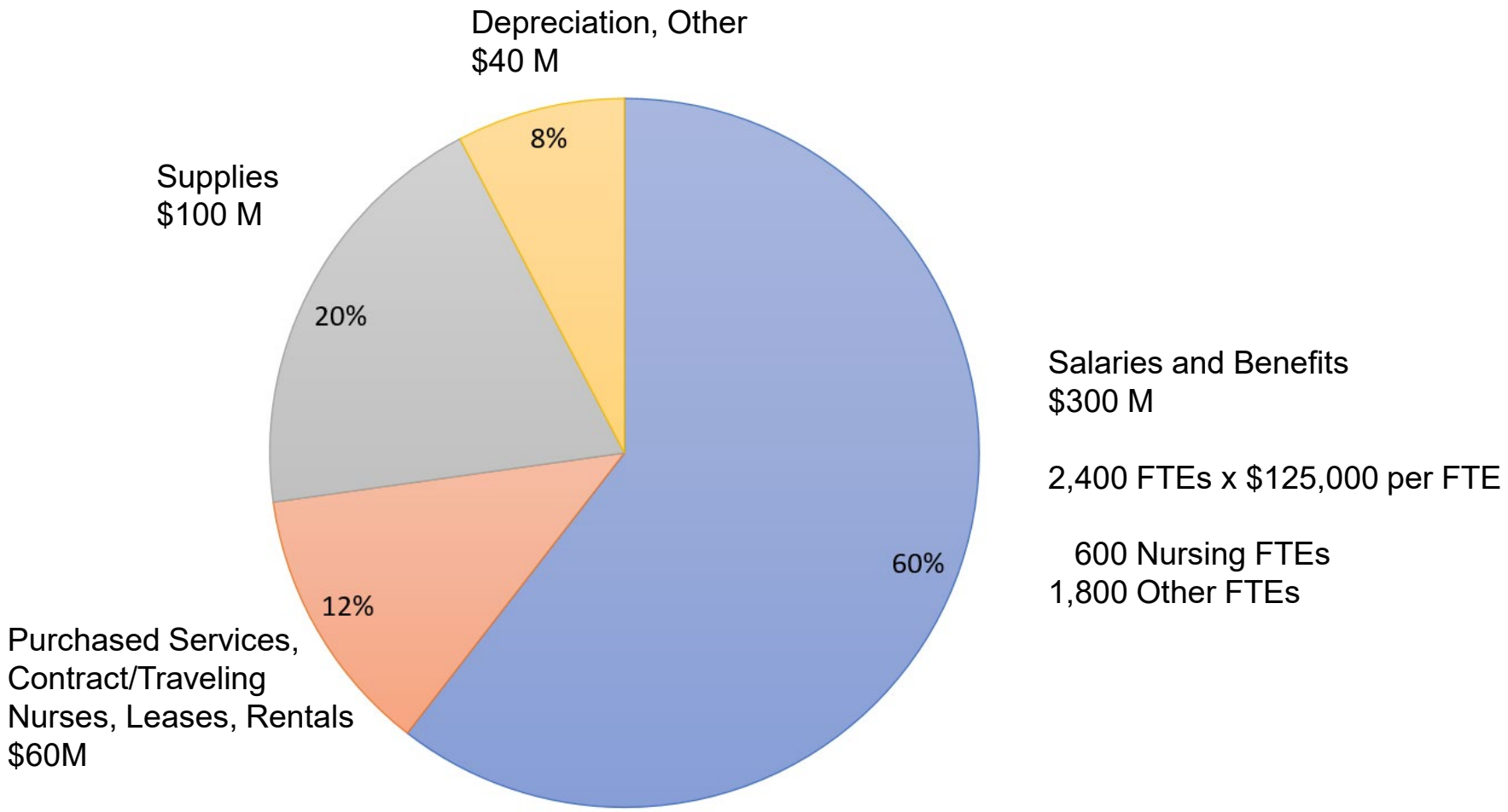
"Hospital Cost" to a Hospital is the Cost of Running the Various Departments

Hospital costs are driven by four primary factors

		1		2		3		4
Costs	=	Employee Cost	+	Supply Cost	+	Purchased Services	+	Facilities/ Equipment
		[Number of Employees x Salary/Benefits per Employee]				Including Traveling Nurses		

ANALYSIS GROUP

Hospital Cost Example: 300 Bed Hospital, 50+ Departments, ~$500 M per Year in Costs



Source: WA DOH Hospital Financial Reports

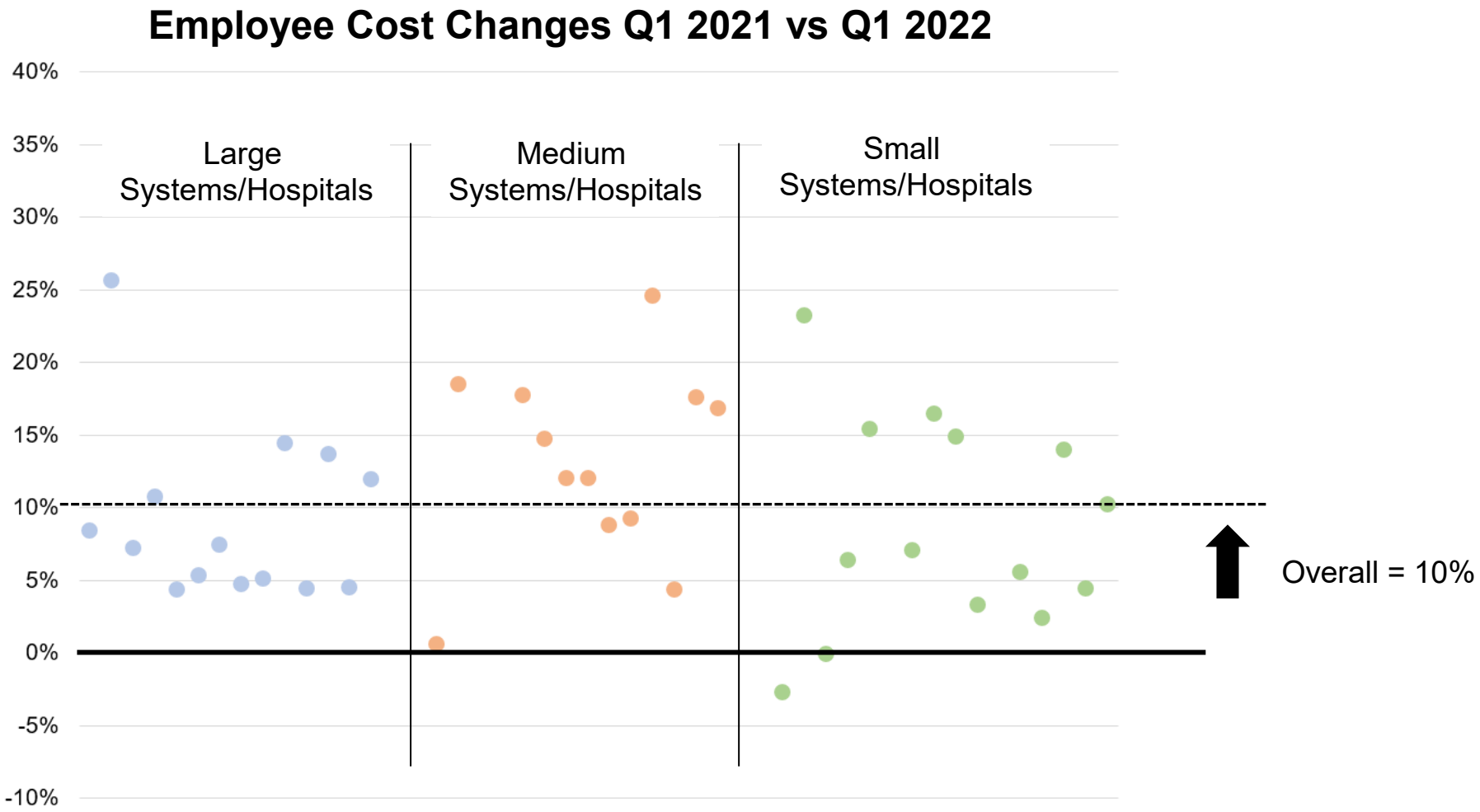
"Hospital Cost" to a Hospital is the Cost of Running the Various Departments

Hospital costs are driven by four primary factors

Costs = **1** Employee Cost (Number of Employees x Salary/Benefits per Employee) + **2** Supply Cost + **3** Purchased Services (Including Traveling Nurses) + **4** Facilities/ Equipment

ANALYSIS GROUP

Current Serious Cost Pressure: WA Hospital per-FTE Employee Cost Increased 10% 2021-2022



Source: WSHA Hospital Financial Survey Q1 2022

ANALYSIS GROUP

Current Serious Cost Pressure Example: St. Michael Medical Center (Kitsap Peninsula)

Kitsap Sun

Kitsap Sun: The deal includes 12.5% wage increases in year one, 4% in year two and 4% in year three, according to documents posted by the union.

https://www.kitsapsun.com/story/news/2022/07/01/st-michael-medical-center-nurses-approve-new-contract/7783027001/

Source: Kitsap Sun

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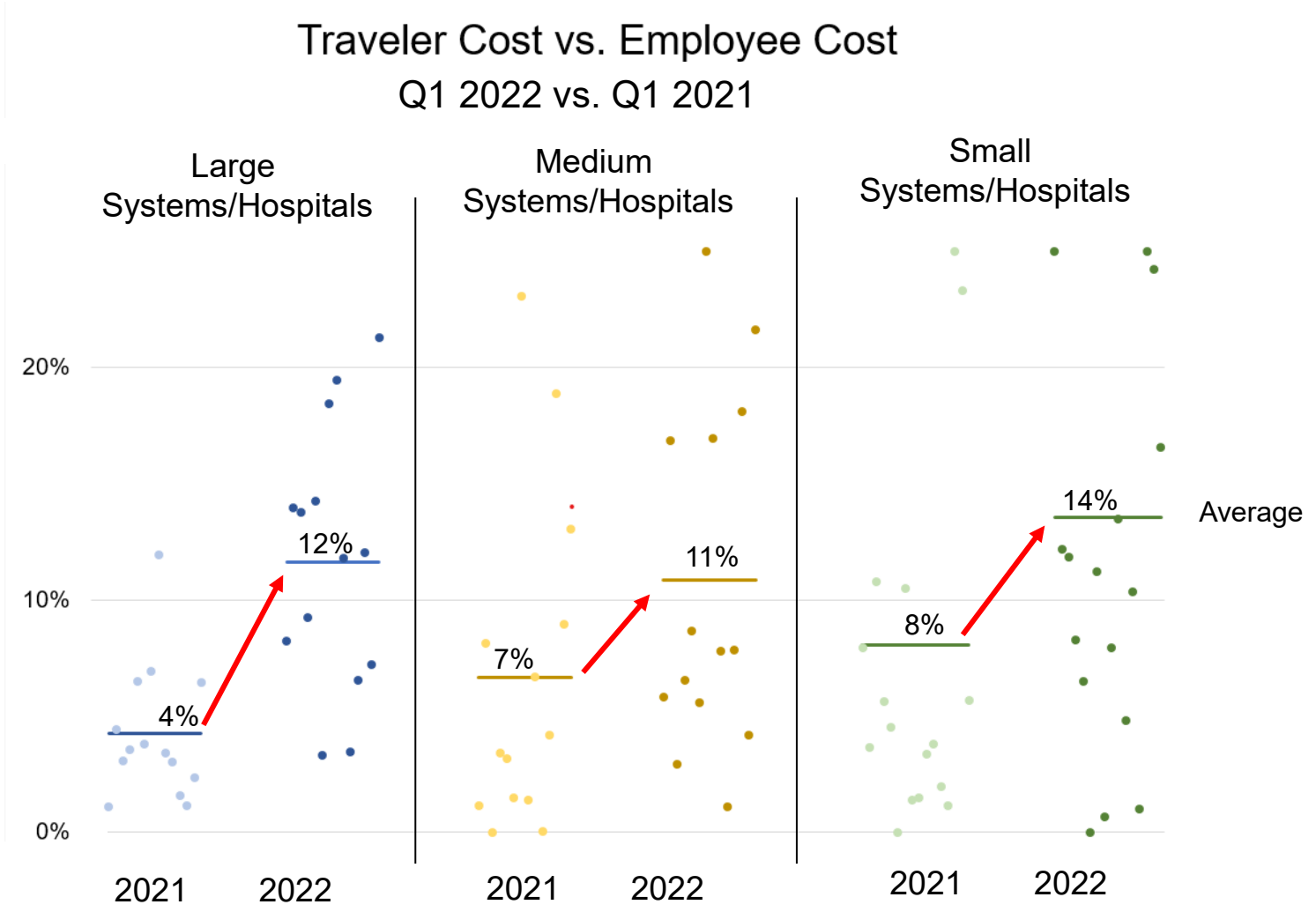
Costs	=	Employee Cost	+	Supply Cost	+	Purchased Services	+	Facilities/ Equipment
		[Number of Employees x Salary/Benefits per Employee]				Including Traveling Nurses		

ANALYSIS GROUP

Current Serious Cost Pressure: WA Hospital Traveler Costs Have Increased 200+%



WA Hospital Traveler costs increased from $140 M in Q1 2021 to $430 M in Q1 2022, a 200+% increase

Source: WSHA Hospital Financial Survey Q1 2022

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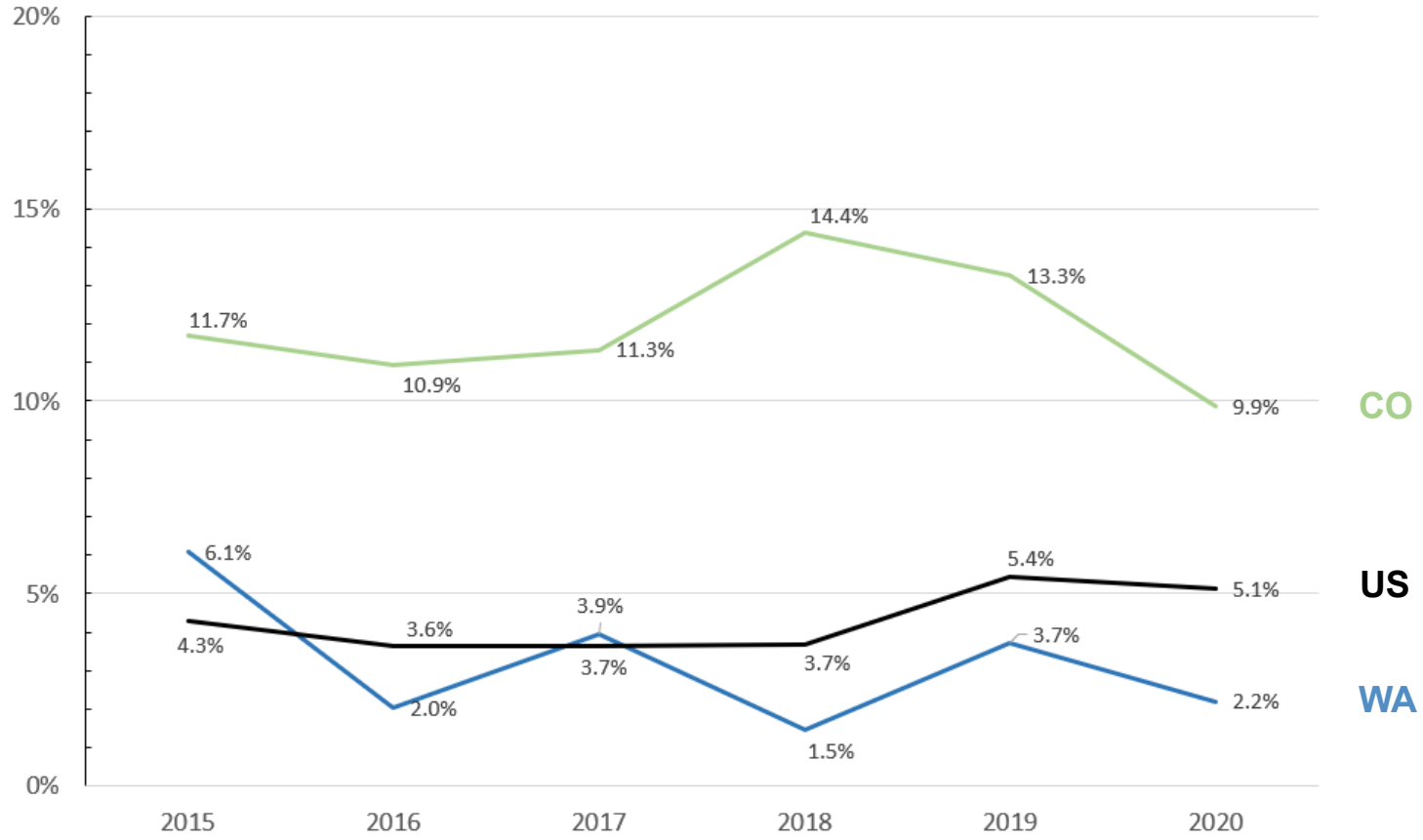
WA Hospital
Net Operating Revenue
2015 – 2019 ($ Billions)

Source: Medicare Cost Reports

ANALYSIS GROUP

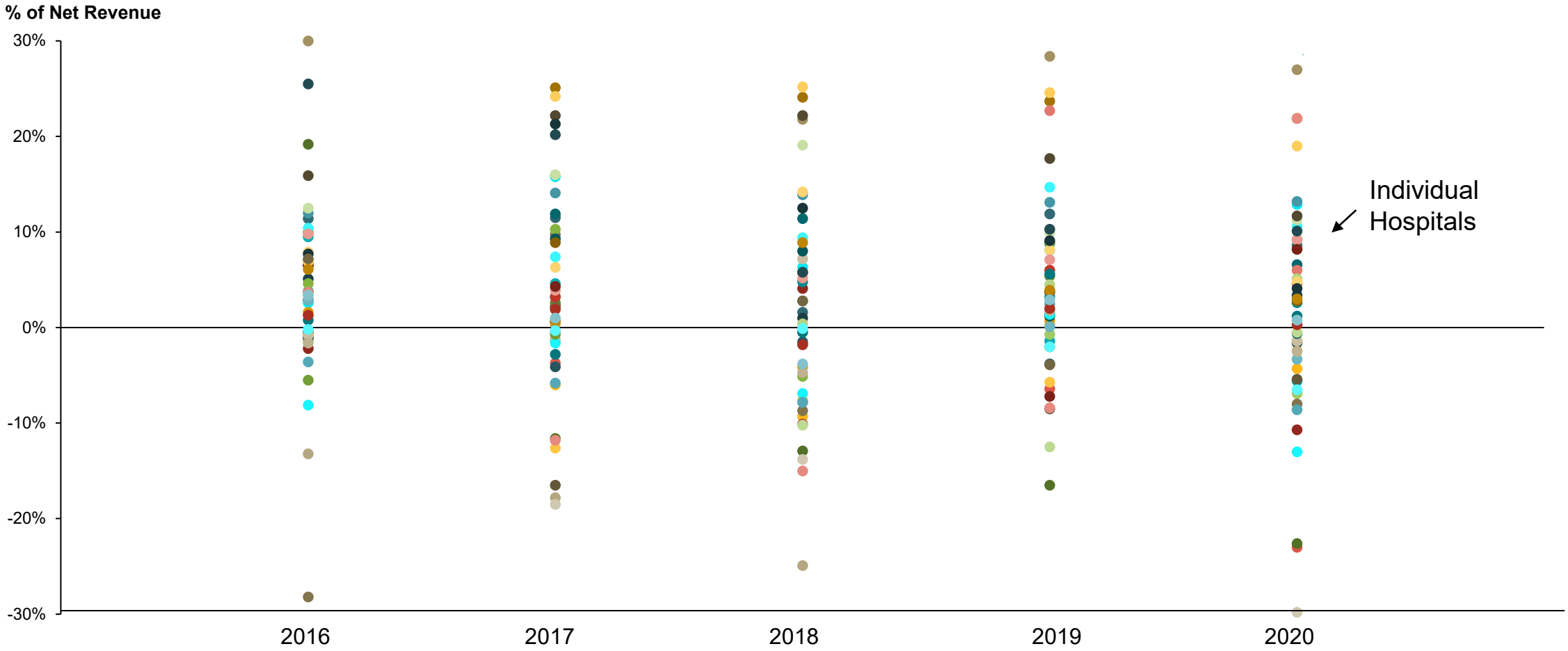
Net Income as a % of Total Operating Revenue of WA Hospitals



Source: Medicare Cost Reports

ANALYSIS GROUP

Individual Hospitals Historical Operating Margins Show Substantial Variation



Source: Medicare Cost Reports

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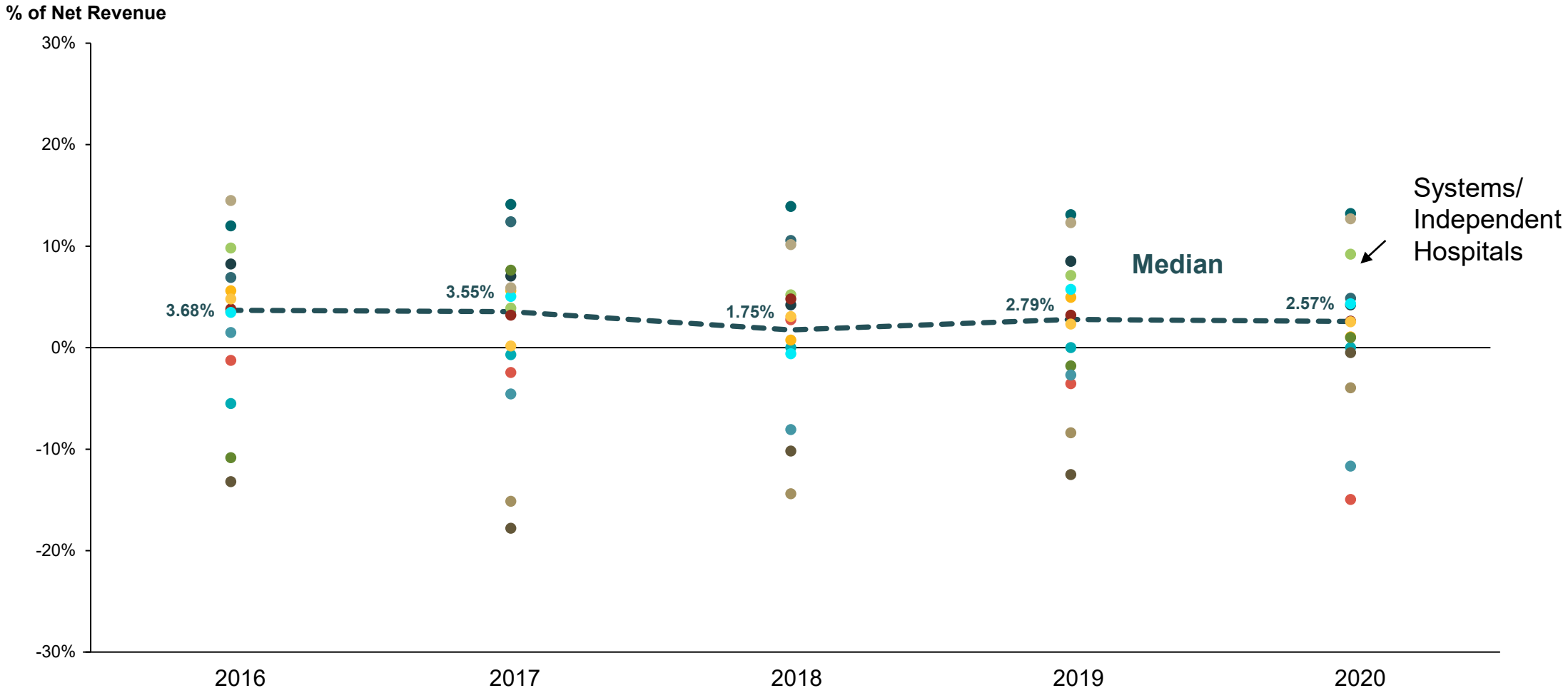
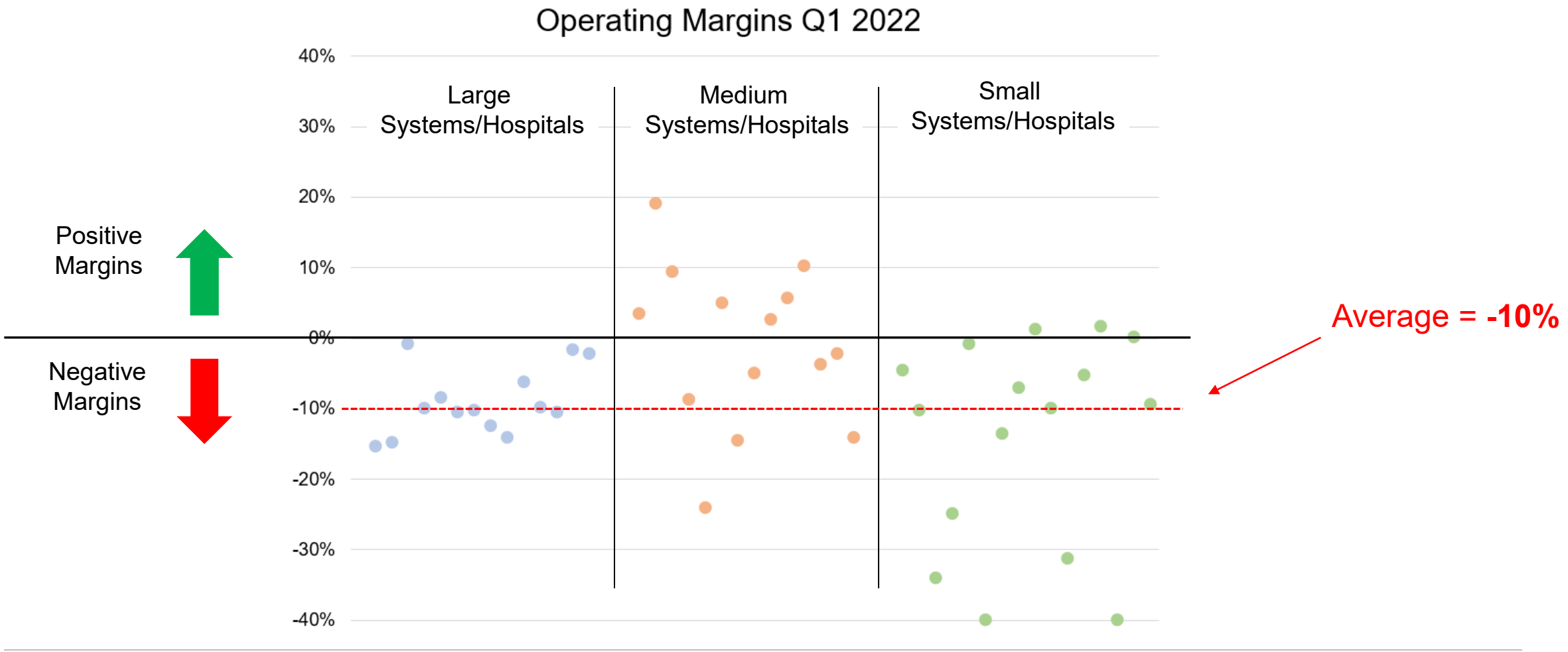
…But Variation is Much Less at the System/Independent Hospital Level



Source: Medicare Cost Reports

ANALYSIS GROUP

Current Serious Financial Pressure:
Q1 2022 WA Hospital Financial Margins Average Negative 10%



Source: WSHA Quarterly Survey of Hospitals

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Revenue: Who Pays For Hospital Care and How Do They Pay?

Who are the major payors?

Medicare
- Traditional fee for service (FFS)
- Medicare Advantage

Medicaid
- Traditional fee for service (FFS)
- Managed care

Commercial
- Self-funded employer
- Fully insured employer
- Individual and family (IFP)

Other government
- Worker's compensation
- Military, etc.

Other
- Self-pay
- Charity care

How is care typically billed?

- Hospital maintains a "chargemaster" with thousands of individual items and billed charges
- Each item has a standardized code for that services or supply (CPT code)
- Each patient is billed for each service using the standardized codes

What payment methods are used?

Per-Case Prospective Payment
- Fixed amount per discharge (DRG)
- Fixed amount per procedure (APG/EAPG)

Volume-Based
- Full billed charges (rare)
- Percent discount from billed charges
- Fixed amount per day (per diem)
- Fixed amount per CPT code (fee schedule)

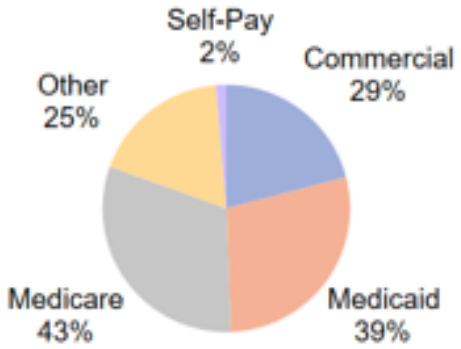
Capitation (Rare)
- Fixed amount per member per month

ANALYSIS GROUP

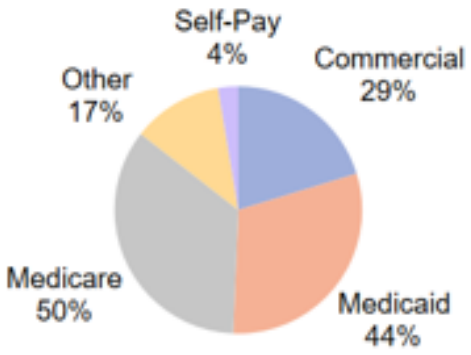
Hospital Payor Breakdown Using Inpatient Patient Days

Breakdown of Payer Type in 2020 by Type of Hospital (Days)

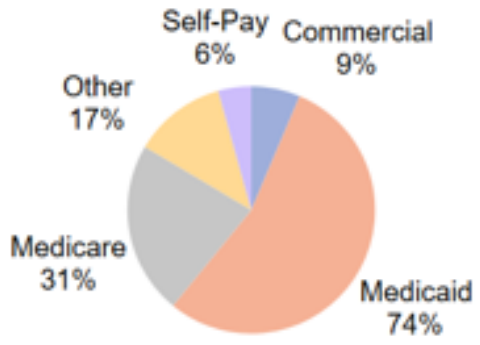
53 General Non-CAH



39 Critical Access Hospitals

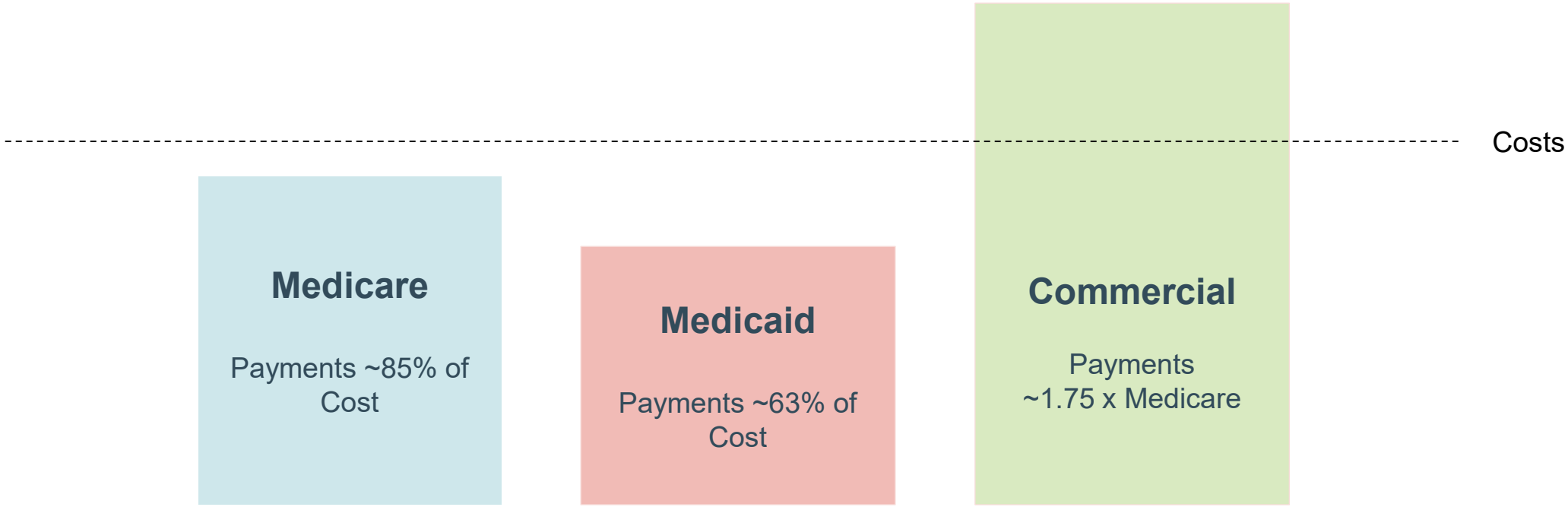


9 Behavioral Health Hospitals



Source: CHARS

Three Major Payors: Medicare, Medicaid, Commercial



Payment Method:

- Prospective per Encounter (DRG, APC)
- Small increases per year

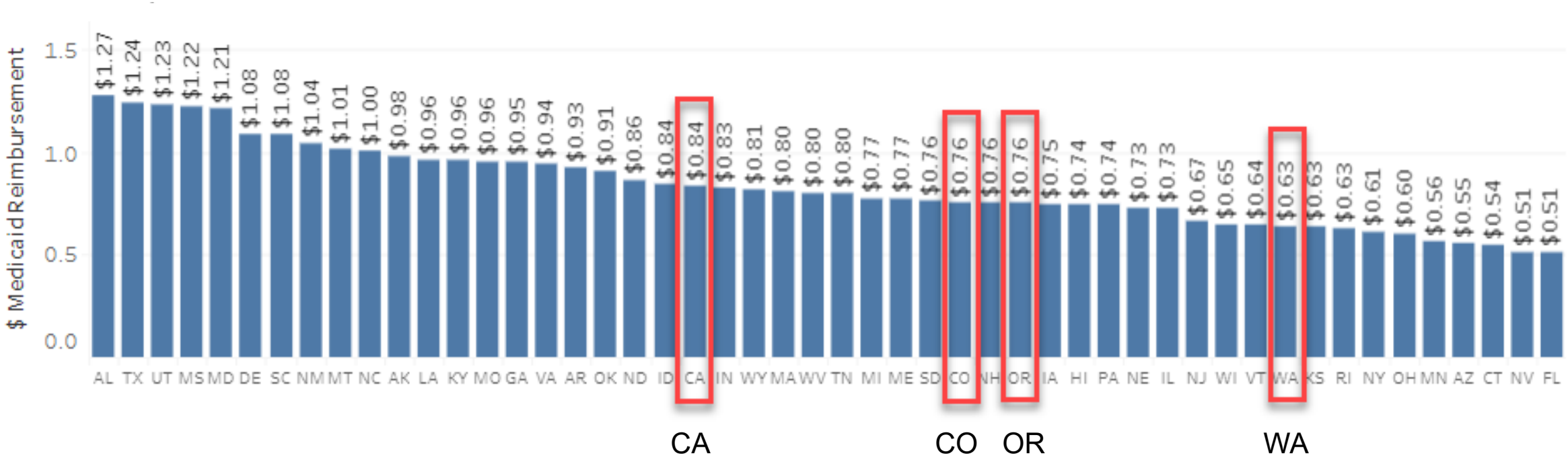
- Prospective per Encounter (DRG, EAPG)
- No base increase in 20 years
- Supplemental safety net assessment programs provide appx. additional 7% net payment

- Various payment methods
- Negotiated contracts

ANALYSIS GROUP

WA Medicaid Payments Only Cover 63% of Costs and Are Low by National Standards

Medicaid and DSH Reimbursement (Operating Revenue v. Expense)



Source: Medicare Cost Report: FY 2020

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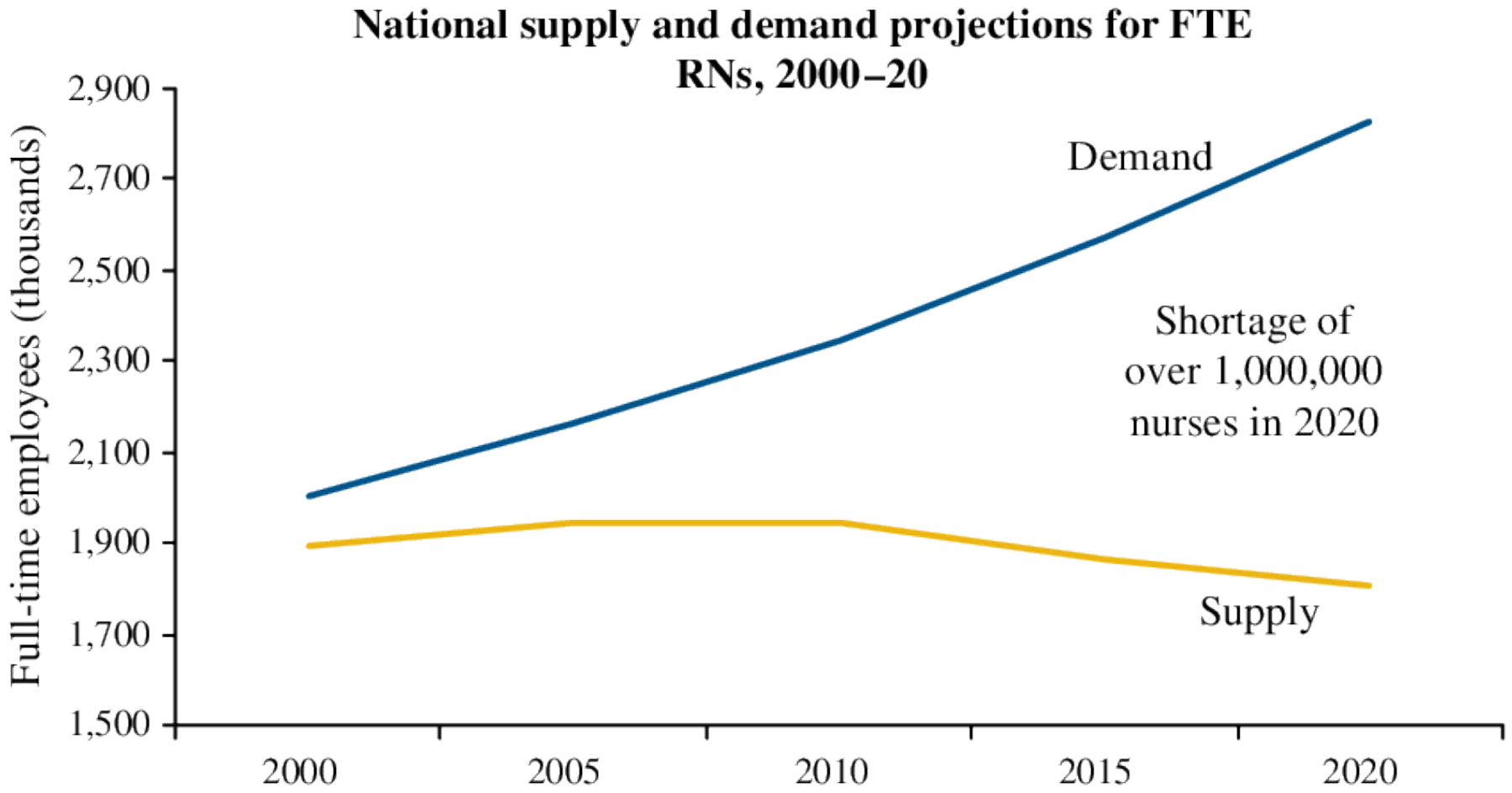
Other Factors in Analyzing Hospital Costs: Ongoing Nationwide Nursing Shortage



Source: Columbia Business School Research Archive

ANALYSIS GROUP

Other Factors in Analyzing Hospital Costs: Acuity and Case-Mix Differences

Medicare assigns a weight to each inpatient admission and pays in proportion to the weight

A hospital that does more complex procedures will have higher weights, longer lengths of stay, and higher costs, all else equal

Example DRG Number and Description	DRG Weight	Average Length of Stay
471 Cervical spinal fusion with major complications	5.0197	9.0
975 HIV with major related condition with complications	1.2821	5.3
639 Diabetes without complications or major complications	0.6096	2.5

Source: CMS

ANALYSIS GROUP

Patient Acuity Differences Must be Considered When Doing Cost Comparisons
(e.g. Average DRG Weight = Case Mix Index)

Case mix can change over time as patient mix changes:

Year	WA Hospitals Median	WA Hospitals Average
2016	.94	1.03
2017	.92	1.05
2018	.94	1.08
2019	.91	1.05

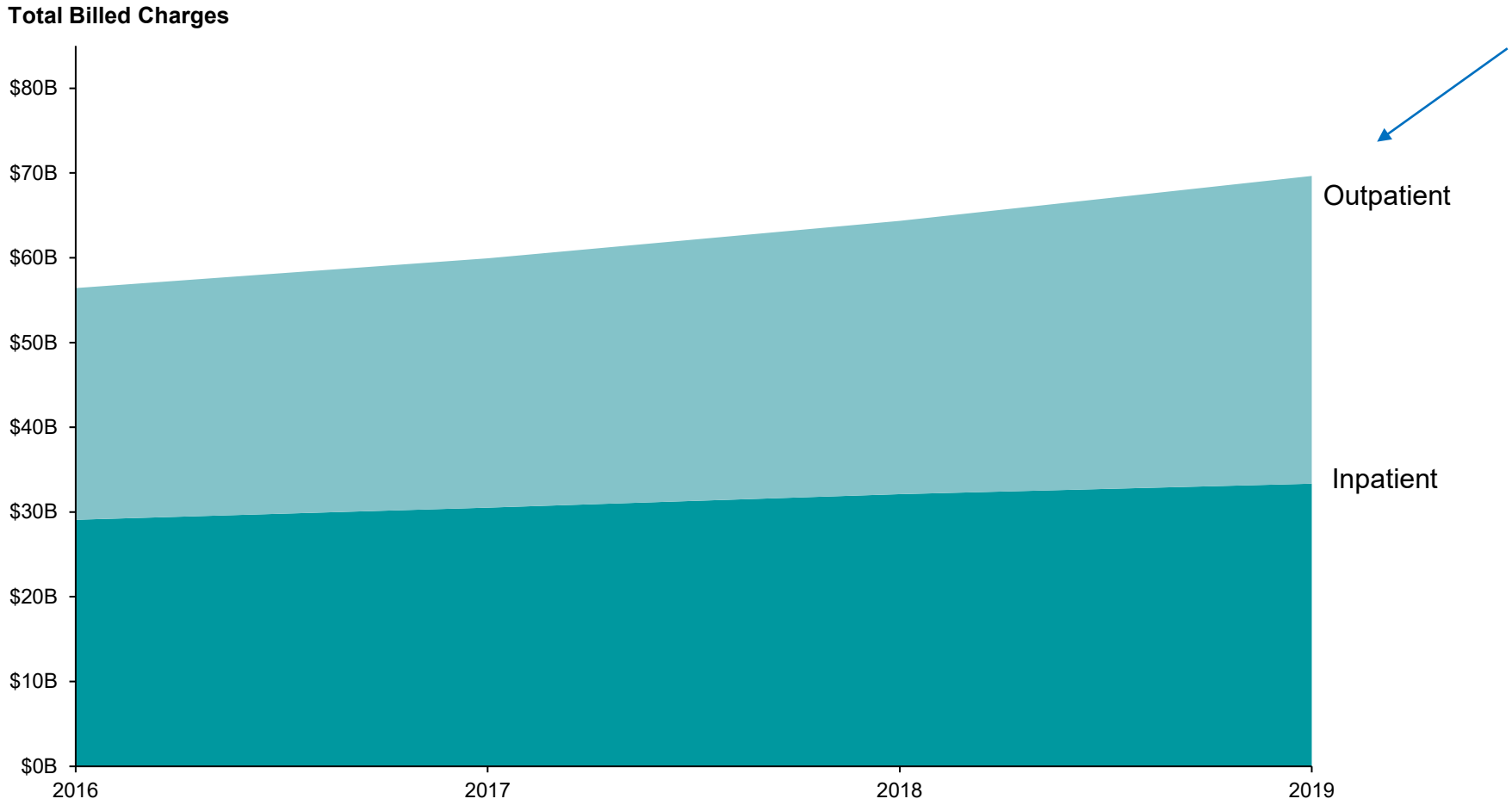
Service mix differences often result in large case mix differences among hospitals:

Year	Swedish Cherry Hill	Swedish First Hill
2016	2.13	0.91
2017	2.08	0.91
2018	2.06	0.91
2019	2.10	0.90

Source: Medicare Cost Reports

ANALYSIS GROUP

Other Factors in Analyzing Hospital Costs: Mix of Inpatient and Outpatient Services Impacts Comparisons



Outpatient continues to be a larger share of hospital revenue:

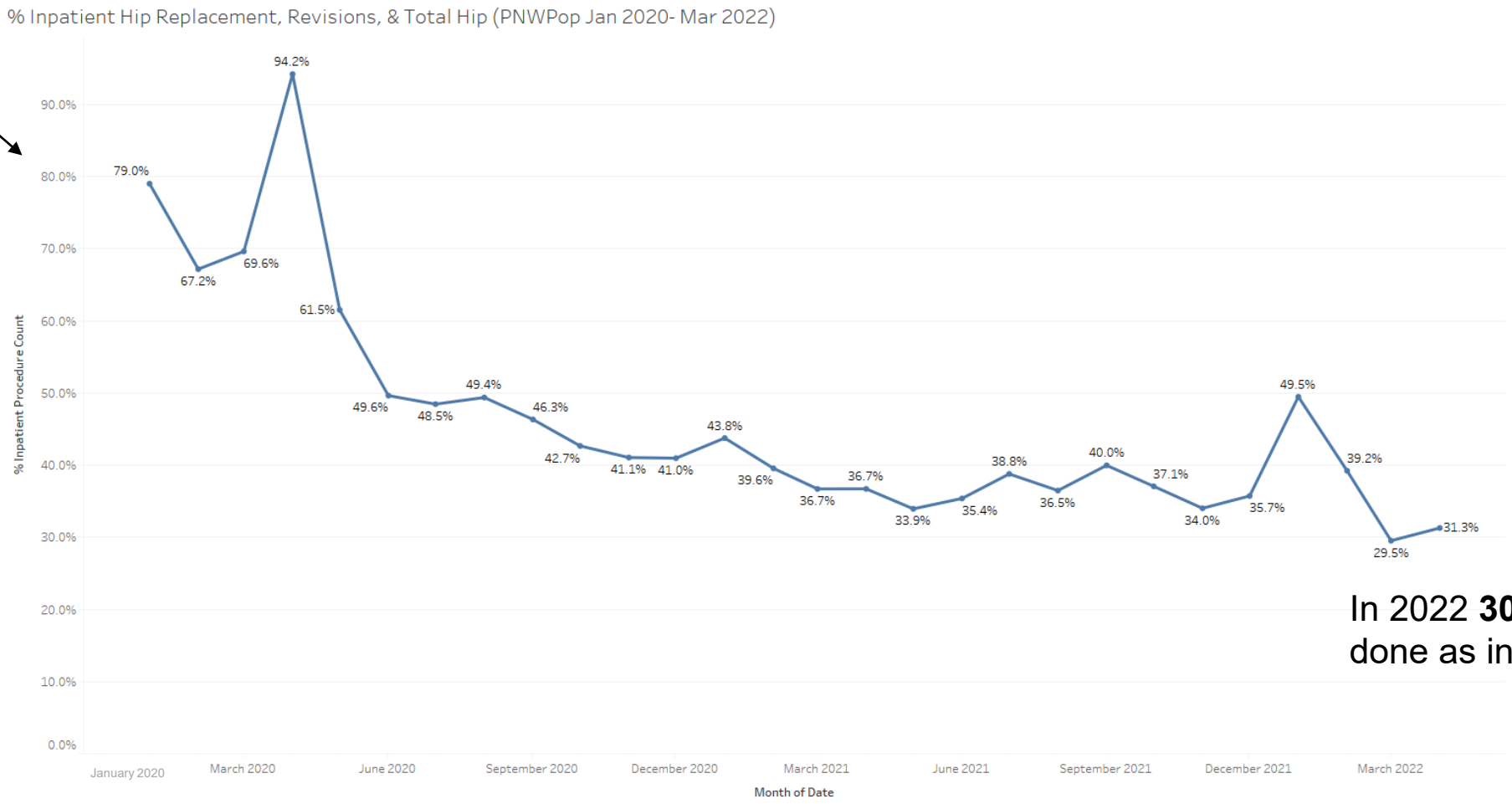
- More complex services can be done on an outpatient basis (lowers total costs)
- Hospitals have added more outpatient services
- Outpatient units of service are much more varied than inpatient (admissions, patient days)

Source: WA DOH YE Hospital Financial Reports

ANALYSIS GROUP

Example of Moving Services to Outpatient Settings: Hip Replacements

In early 2020 **80%** were done as inpatients



In 2022 **30%** were done as inpatients

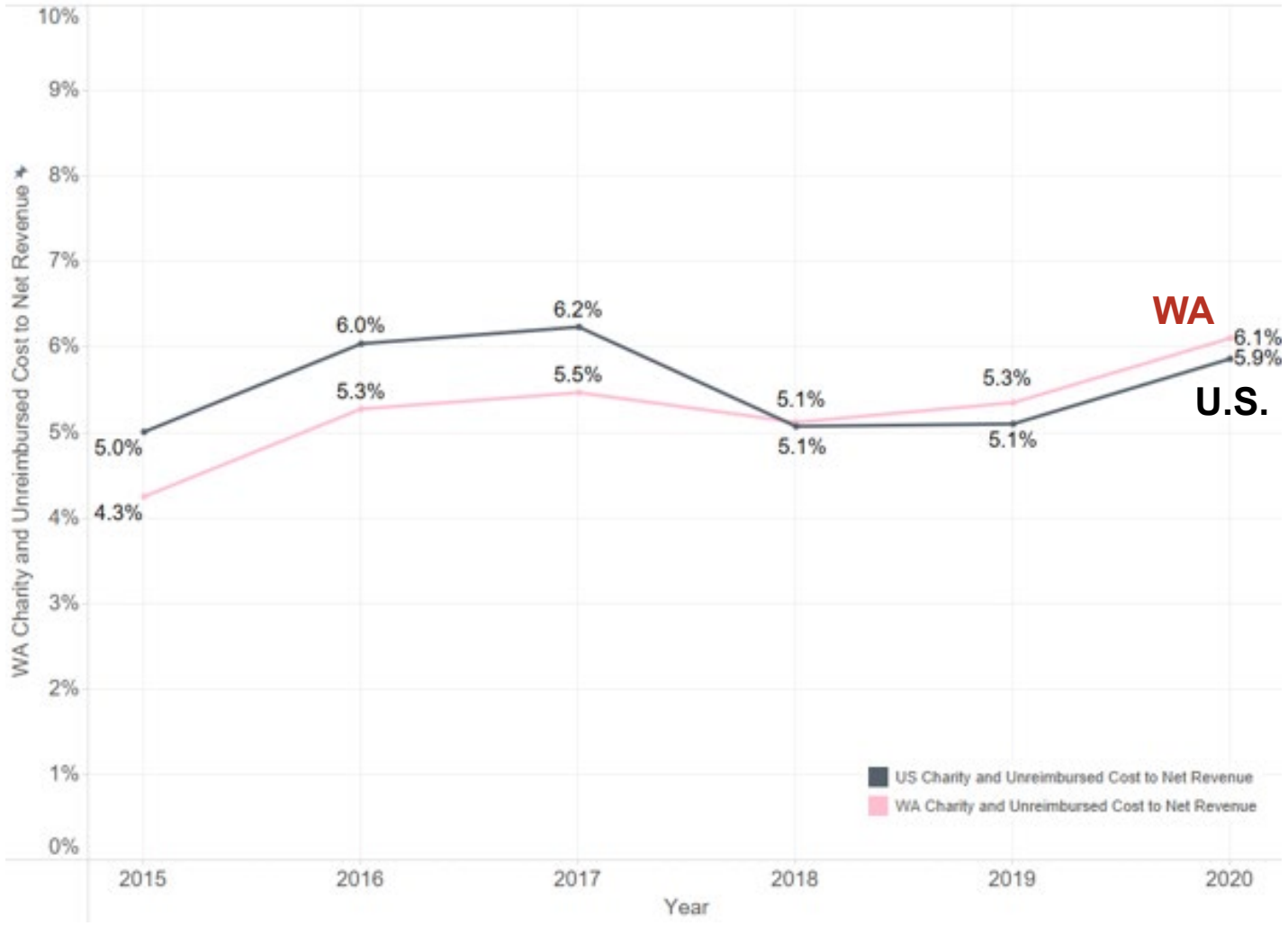
Source: PNWPop (Claims 2020 – March 2022)

ANALYSIS GROUP

Other Factors: Community Benefit for Uncompensated Care

Uncompensated care includes:

- Cost of charity care
- Unreimbursed cost for Medicaid patients



Source: CMS Cost Report Data

ANALYSIS GROUP

Other Factors: WA Hospitals Have Tens of Thousands of Patient Days for Patients With No Stable Discharge Location, Costing $ Millions per Year

Examples:

- Guardian Needed
- Dementia
- Substance Use
- Homeless
- Dialysis Unavailable

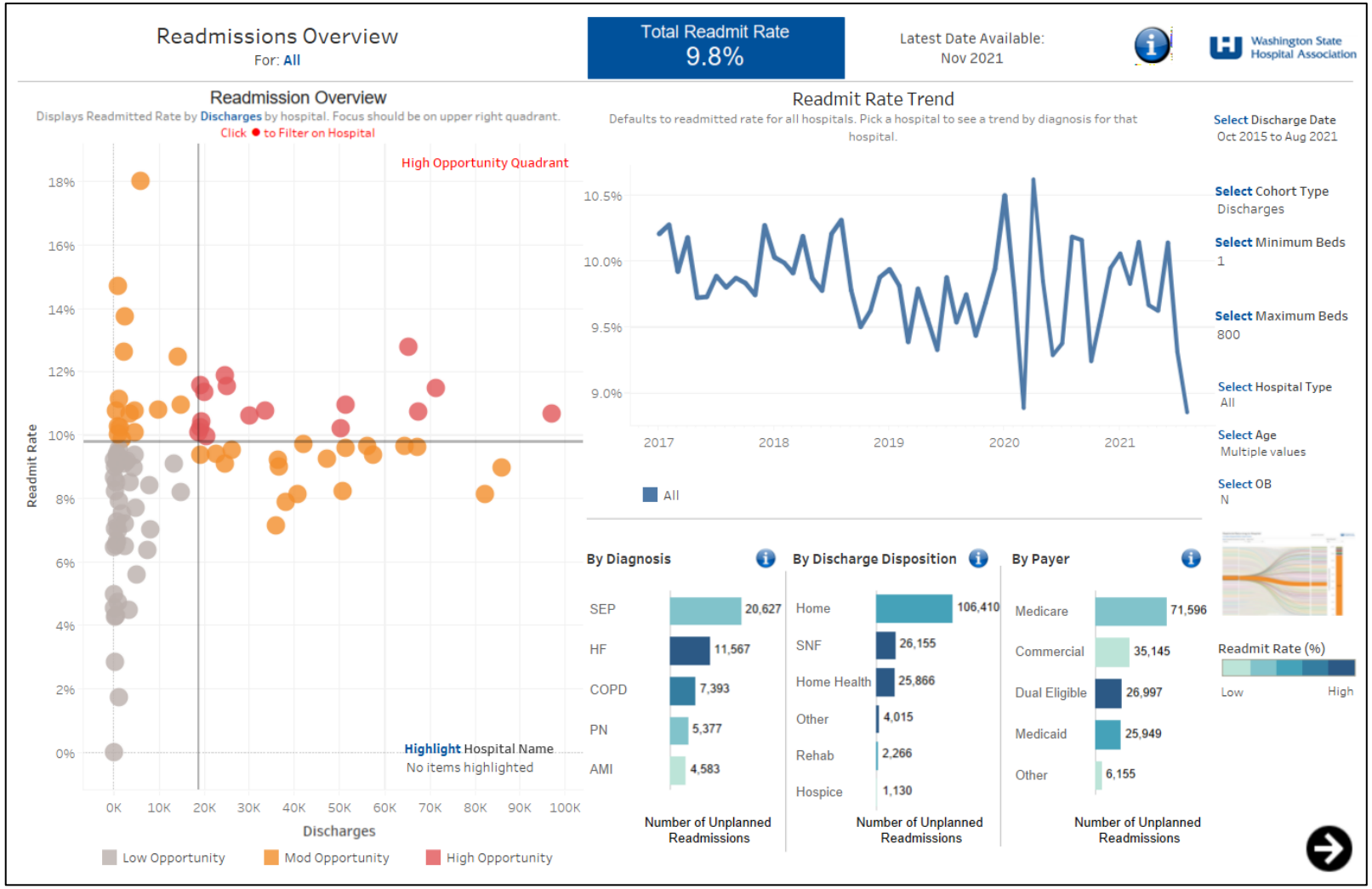
Barrier to Discharge	Count of Patients	Number of hospital avoidable days
Other (Specify in Comments)	172	6,653
Delay from Home & Commu..	108	4,747
Guardian Needed	98	8,751
Behaviors	79	4,432
Alzheimer's / Dementia / TBI	62	2,781
Low or inadequate funding ..	50	2,597
Delayed Insurance Auth / P..	44	387
Substance Use/Current or ..	36	960
Null	36	336
Lack of Family cooperation	30	1,953
Bariatric	25	1,449
Wound care	24	1,952
Dialysis unavailable	21	469
DDA Delays	17	1,405
Inpatient Psych Unit / Delay	14	123
Homeless	13	419
Hospice	12	192
Home Health/ Home Care	11	1,574
Lack of Psych Support / Ser..	10	146
CPS/APS	10	722
DME	8	248
Undocumented	7	685
Transfer Hospital to Hospit..	6	50
Legal: sex offender/Arson/ ..	6	685
COPES	6	171
Transfer to Western/Easte..	3	101
Grand Total	908	43,988

Source: WSHA Survey

ANALYSIS GROUP

Other Factors: Ongoing Hospital Quality Improvement and Cost Control Efforts

Example of WSHA-sponsored dashboard for reducing readmission rates



Source: WSHA Calculation based on WA DOH CHARS

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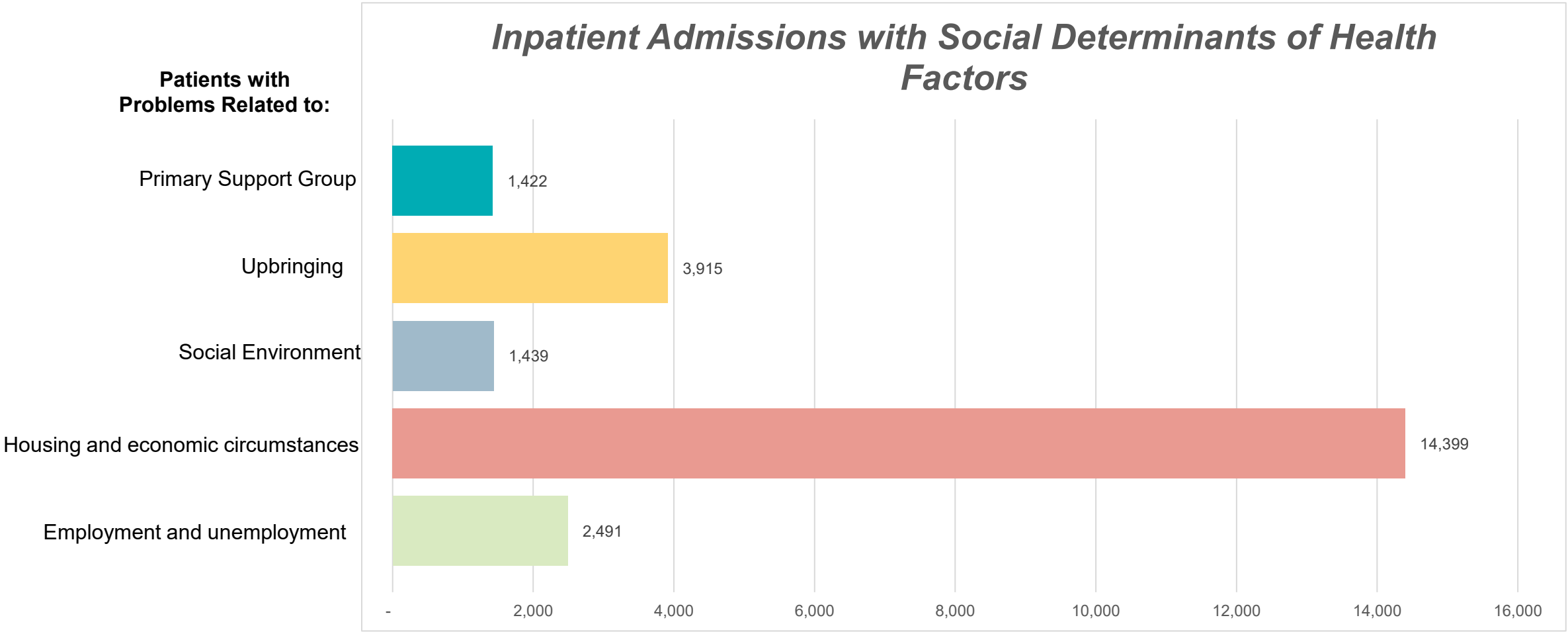
Other Factors: Hospitals End up Dealing with Problems Beyond Their Control



Source: WSHA Calculation based on WA DOH CHARS

Washington State Hospital Association

Questions?

What else would you like to know about hospital costs in future sessions?

Public comment

Washington State Health Care Authority

Washington State Health Care Authority

Pharmacy pricing, purchasing, and access

TAB 6

Health Care Cost Transparency Board: Pharmacy Pricing, Purchasing, and Access

July 20, 2022

Washington State Health Care Authority

Learning Objectives

- Explain how drug purchasing for federal programs gave rise to the current structure of drug pricing.
- Understand how monopolistic competition and market incentives lead to drugs being priced at what the market will bear.
- Recognize options states have in addressing drug affordability.

Our Goal:

All Washingtonians to have access to prescription drugs at an affordable price.

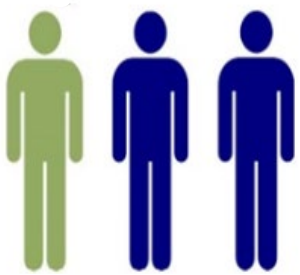
Level set

What We Do at HCA

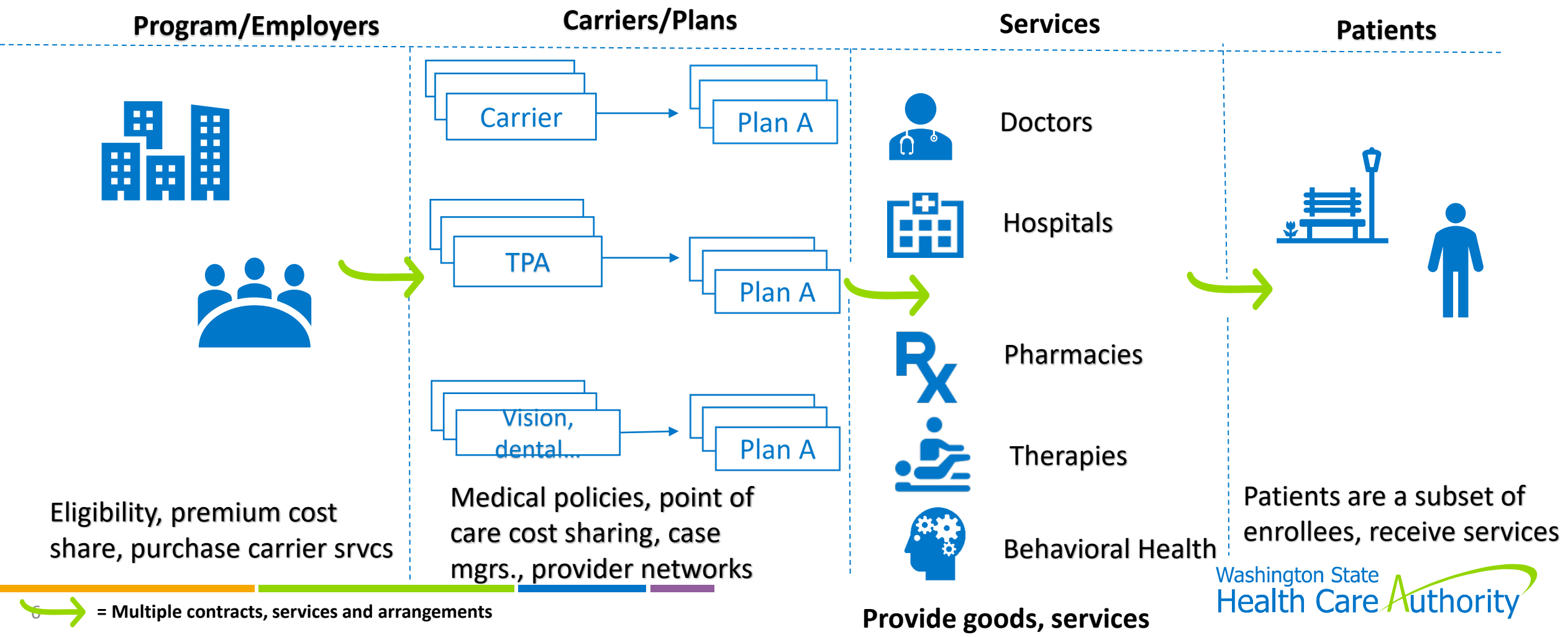
State's largest health care purchaser:

- Medicaid (Apple Health)
  - 1.9 million people
- Public Employees Benefits
  - 370,000 people
- School Employees Benefits
  - 250,000 people

We purchase care for 1 in 3 non-Medicare Washington residents with an annual spend over $14B, $2.5B is drug costs



Simplified-US Healthcare System Overview



Washington State Health Care Authority

All Types of Payers purchase drugs

- Public, privates, and uninsured purchase drugs from the same drug distribution system.
  - From manufacturer to wholesaler to pharmacy to patient.

- Federal laws regulate how federal programs reimburse for drugs based off pricing benchmarks, using percentages off prices that manufacturers set.

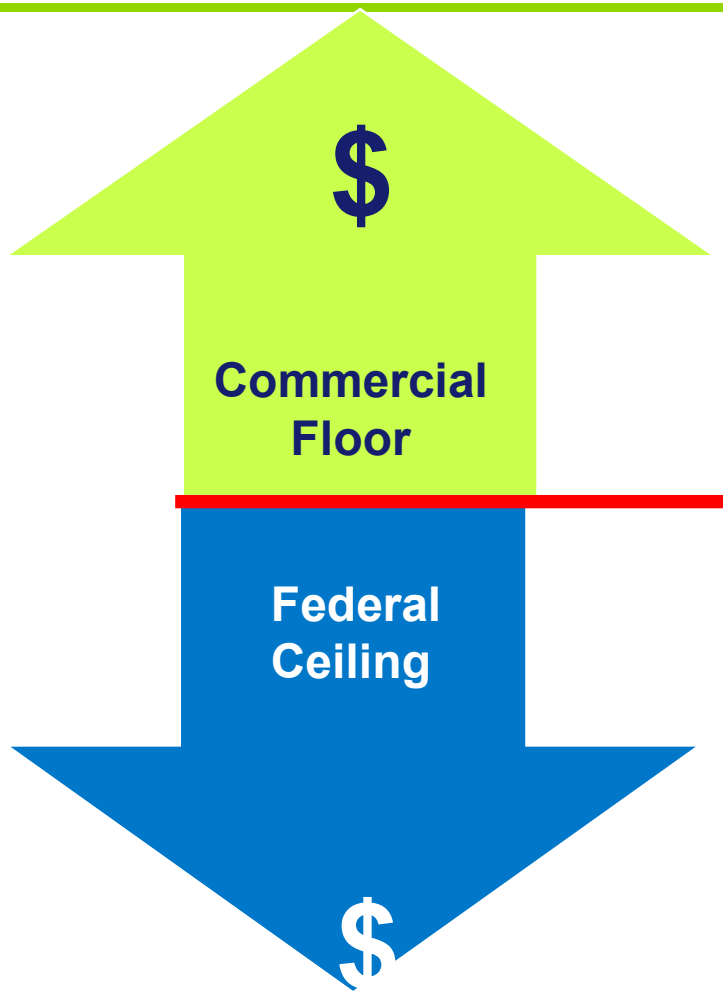
- Manufacturers can set prices high enough to ensure revenue from payers will compensate for discounts required under federal programs (Medicaid).

Pricing Dynamics

Drug Price Benchmarks

- **Wholesale Acquisition Cost (WAC)**
  - Manufacturer-reported prescription drug "list price" for sale to wholesalers.
  - Not accurate representation of what wholesaler or end provider actually pays; WAC does not include discounts such as rebates, volume purchase agreements, or prompt-pay agreements.
- **Average Manufacturers Price (AMP)**
  - Average price paid by wholesalers to manufacturer for drugs distributed to the retail class of trade net of customary prompt pay discounts.
- **Medicaid Best Price**
  - Lowest price available from manufacturer to any wholesaler, retailer, health care provider, HMO, non-profit or government entity except IHS, 340b, FSS, Medicare Part D and Medicaid during the rebate period (typically less than AMP – 23.1%).
- **Consumer Price Index (CPI) Penalty**
  - AMP rises 1% faster than inflation; manufacturer must pay the difference in additional rebates.
- **Federal Supply Schedule (FSS)**
  - Participation required to be eligible for Medicaid.
  - Available to all direct federal purchasers; intended to be no more than AMP.
- **Federal Ceiling Price (FCP) or "Big Four Prices"**
  - Available only to DOD, VA, PHS, US Coast Guard.
  - By law, are 24% lower than AMP; Generally do not apply to generic drugs (38 U.S.C §8126(a)(2)).
- **340B**
  - Available to qualifying entities (safety net providers).
  - Ceiling price: the most a manufacturer can charge a 340B entity is 24% lower than AMP.

Impact of Medicaid Best Price



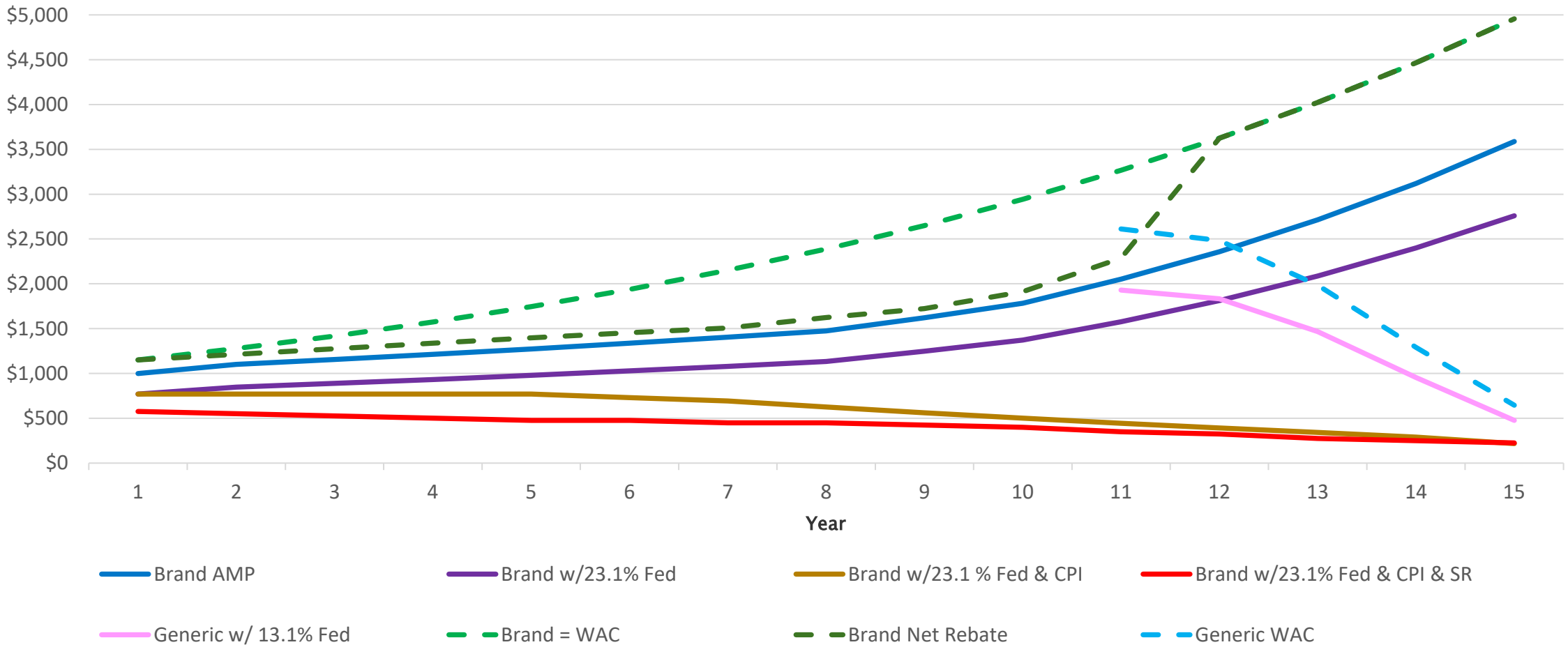
Non-government programs

- Fully-insured commercial plans
- Self-insured employers
- Medicaid managed care

Average manufacturer's price (AMP)

- AMP – 23.1% (Medicaid Drug Rebate Program (MDRP)
- 340B ceiling price cannot exceed AMP-fed rebate
- AMP – 24% = Veterans Affairs pricing
- Federal Supply Schedule

Drug Price Increases Over Time



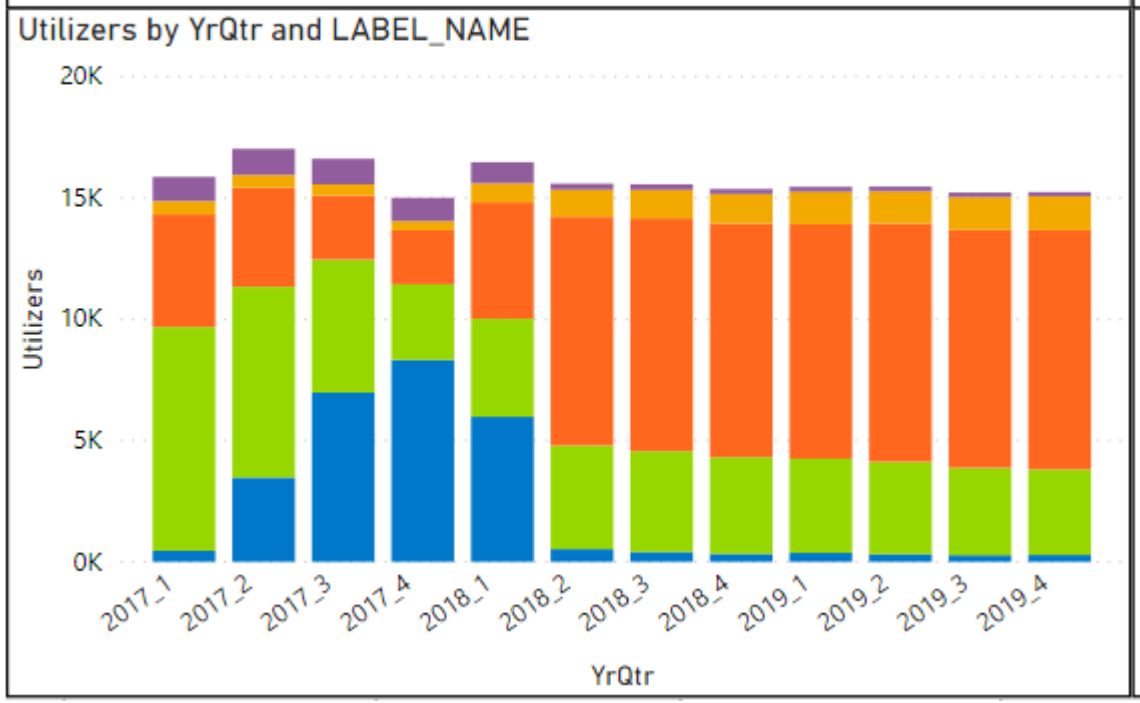
Washington State Health Care Authority

Examples
Medicaid Net Price

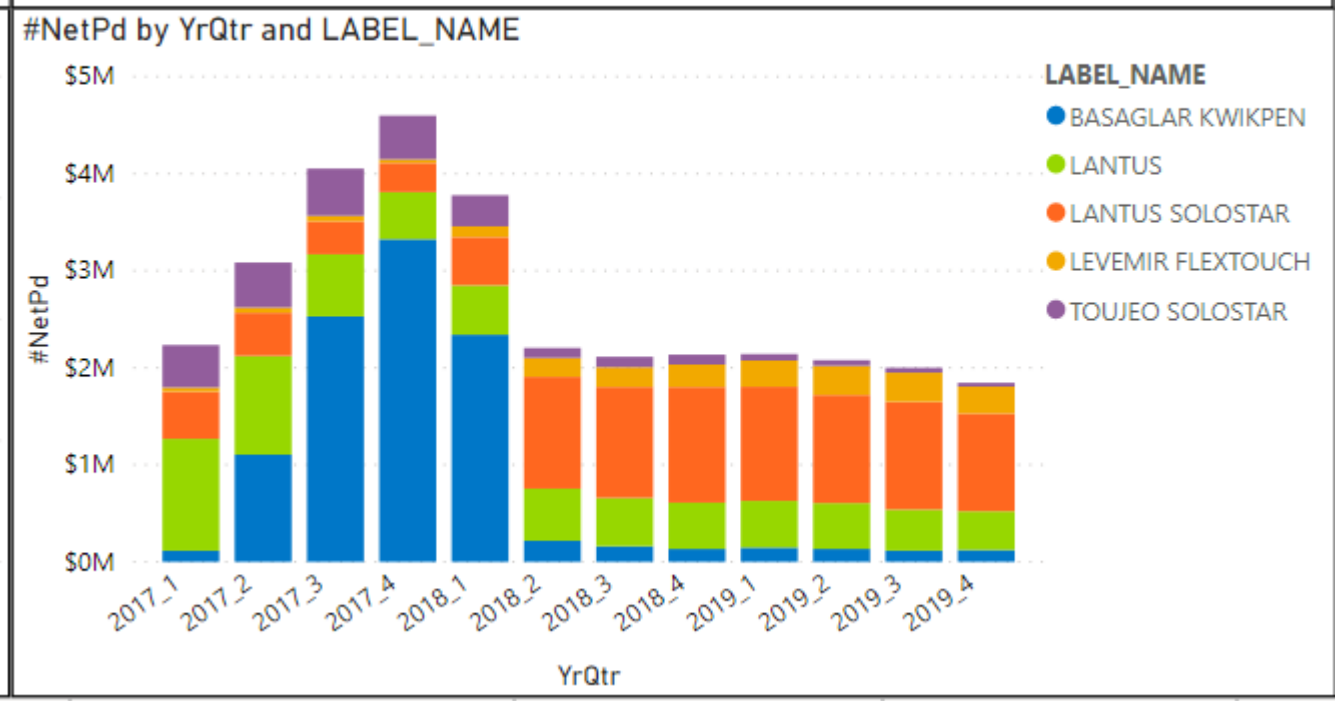
Washington State Health Care Authority

Antidiabetics : Insulin – Long Acting – Implemented Q1 2018, GF 1/2018 to 3/2018

Total Utilizers for Top 5 Label Names with Highest Cost



Total Net Paid for Top 5 Label Names

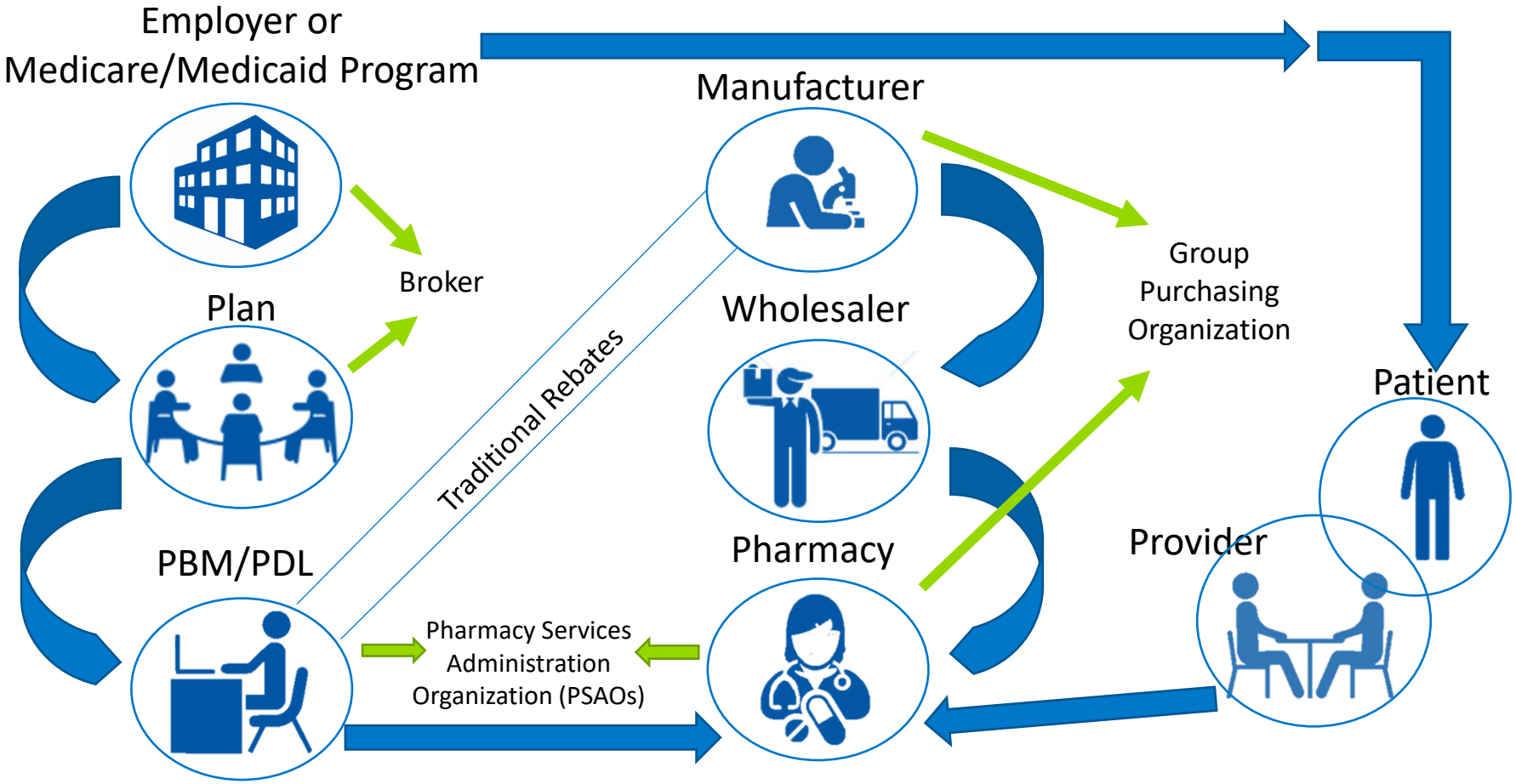


*Disclaimer: Data reported Q3 and Q4 2019 are incomplete due to rebate lag. In addition, all data points may experience some degree of change after the creation of this presentation.

Washington State Health Care Authority

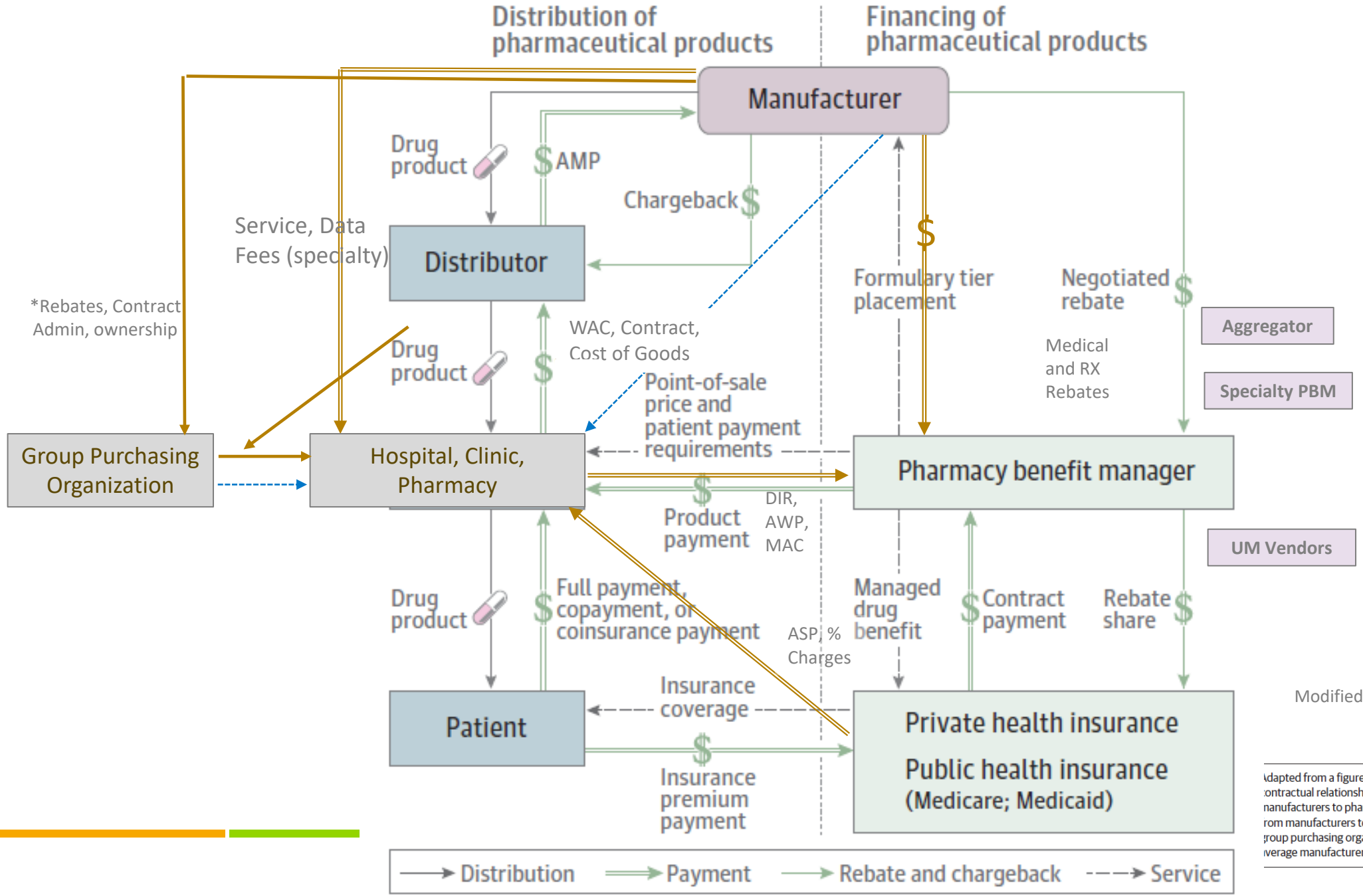
Drug Purchasing Channel

Pharmacy Distribution/Purchasing Overview – Simplified



Washington State Health Care Authority

Figure. Flow of Pharmaceutical Funds, Products, and Services



Modified MM 1/2021

Adapted from a figure by the Congressional Budget Office.[1] Services represent contractual relationships between entities. Rebates are payments from manufacturers to pharmaceutical benefit managers. Chargebacks are payments from manufacturers to distributors. Retailers include pharmacies, hospitals, group purchasing organizations, and mail-order programs. AMP indicates average manufacturer price; WAC, wholesale acquisition cost.

Cost to the Dispensing Pharmacy

- Simplest design:
  - Manufacturer makes the product.
    - For brand-name drugs, this manufacturer holds the patent.
  - Wholesalers buy the products in bulk from manufacturers and are the logistical agents to get the drugs to pharmacies.
  - Wholesalers sells to pharmacies:
    - Receive and offer volume discounts.
    - Can have different contracts based on the pharmacy's (dispenser's) "class of trade".
    - May get a "charge back" from the manufacturer if they bought the drug at a price higher than what is paid by the pharmacy.

Cost to the Dispensing Pharmacy

- Group Purchasing Organizations:
  - GPOs aggregate drug purchasers (pharmacies) to get a volume discount. Negotiate on behalf of the pharmacy to receive a steeper discount which the GPO negotiated using both upfront discounts and back-end rebates from the manufacturer.
  - The degree of the discount is tied volume and to a manufacturer's defined class of trade (hospital, LTC facility, outpatient clinic, etc).
  - Some GPOs designate the wholesaler/distributor the pharmacy must use in exchange for discounts to the wholesaler's administration fee.
  - The pharmacy pays the wholesaler/distributor the GPO negotiated price plus the wholesaler's admin fee.
  - If the wholesaler paid the manufacturer more than the GPO price then the wholesaler charges-back to the manufacturer the difference between the GPO price and what the wholesaler originally paid.

The Billing of Prescription Claims

- **Health plan** contracts with PBM to administer pharmacy benefit.
- **PBMs** contract with pharmacies and set reimbursement rates.
  - Administers the plan design including clinical policy and patient cost share.
  - Negotiates rebates with manufacturer which is usually based on WAC.
  - Invoices and rebates from manufacturer and pass on to purchaser.
  - establishes a pharmacy network and set the amount paid to the pharmacies typically a percentage of WAC or AWP.
- **Pharmacies bill PBM** their usual and customary charge based on what they paid the wholesaler plus their overhead and desired profit (administrative fee).
  - **PBM pays the pharmacies** their contracted amount less patient cost share.
  - Note: In Medicaid fee-for-service the Pharmacy Unit is the PBM and HCA's Finance team develops the rates paid to pharmacies. There is no patient cost share.
- **The PBM bills the health plan** what they paid the pharmacy less plus their administrative fee.
- **The health plan bills the employer/program** what they paid the PBM plus their administrative fee via the premiums they charge.

What does it cost the patient?

- Health plan determines the pharmacy benefit (copay/coinsurance/deductible).
- Patient Cost Depends on the type of plan.
  - Uninsured pays full usual and customary retail price.
  - WA Medicaid has no cost share, although nominal copays are allowed federally.
  - High deductible plans will have higher upfront costs for its members. Members pay 100% of cost of drug as negotiated by the PBM until deductible is met. Typical HDHP deductibles are $5000/year.
  - Traditional health plan with flat dollar copays or percentage coinsurance, typically have a lower deductible, if any, for prescription drugs (hundreds of dollars per year).

The Cost of One Month Supply of Lantus
(commonly used insulin)

Member pays 100%

Retail Cash Prices

✓Costco = $ 321.36

✓Walmart = $304.99

✓WDPD Discount Card = $277.89

Annual cost = $3,334.68

Uninsured

No member cost sharing

Cost to the Medicaid =

NADAC + Dispensing Fee =

$272.00 + 4.25 = $276.25

Net of federal rebate cost to Medicaid is nominal.

Medicaid

Deductible = $1,400 per year

PBM negotiated price to pharmacy = $277.89/mo

Member pays $277.89/mo x5.3, then $13.89/mo after deductible. Member has $700 HSA contribution to use.

Annual cost is $865.89

UMP CDHP 2020
($300 Annual Premium)

Deductible = $100 per year

PBM negotiated price to pharmacy = $277.89/mo

Member pays $108.89 for first month then $13.89/mo after meeting deductible.

Annual cost is $261.68

UMP Classic 2020

($1,248 Annual Premium)

How plans manage the pharmacy benefit

Strategies of Cost Management

- US payers manage drug spend by limiting access to certain drugs when there are equally effective, less costly alternatives.
  - Creates delays or barriers to access and causes providers to do additional work for prior authorization.
  - Creates system where manufacturers offer rebates for more favorable access.
- Pharmacy expenditure is the product of prescription drug pricing (few management options) and prescription drug utilization (more options).
- Price strategies: negotiating supplemental rebates or discounts.
- Plan design strategies: cost sharing to incentivize choices.
  - Higher patient cost when accessing higher cost drugs and there is an equally effective and lower cost alternative.
  - Lower patient prices when the specialty pharmacy is accessed.
  - These strategies are not typically available in the Medicaid program.
- Access strategies: creates financial incentives based on how drugs are received (mail order, specialty, physician offices, carve out networks…)

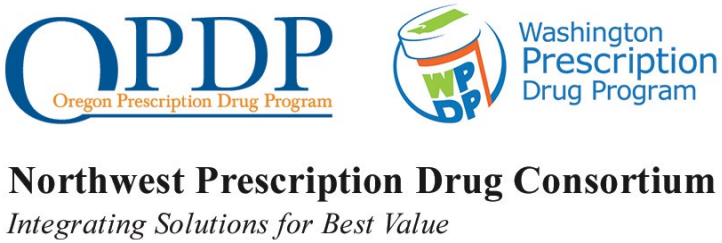
Utilization Management

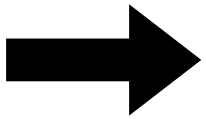
- The purpose of utilization management is:
  - to ensure appropriate use of drugs;
  - preferred drug lists (formularies) – to direct patients and providers to the most cost-effective, clinically appropriate drugs; also established patient cost-share.
  - help reduce fraud, waste, and abuse.
- Payers develop clinical policies
  - Based on evidence comparative safety, effectiveness, and value.
  - FDA approves drugs based on safety and efficacy.
- Clinical policy strategies can include:
  - prior authorization – clinical appropriateness is reviewed prior to fill
  - step therapy – patient is required to try and fail in accordance with clinical protocol more conservative options before moving to other, potentially more expensive options

Step Therapy - Example

- If a member has a prescription history for a first line drug then the second line drug is usually covered without further authorization requirements.
- If there is not a prescription history for a first line drug the second line drug is not covered unless the member:
  - Has previously tried the first line drug and had an adverse outcome (did not adequately treat the intended condition, side effects, drug interactions, etc)
  - Is allergic to the drug
  - Has a medically necessary reason why the first line drug is not appropriate for them

Working strategies: ArrayRx





- An inter-state agreement between the States of Oregon and Washington designed to meet the pharmacy program needs of public and private entities.
- Overseen by WPDP and OPDP, ArrayRx offers services including:
  - PBM services (network management, rebating, claims payment, billing and reconciliation)
  - GPO Program (managed via a national GPO, aggressive class of trade pricing, integration with PBM services where applicable, r egular market checks)
  - A discount card program (Discount card offers individual consumers pricing comparable to participating groups under the NW Consortium.
- There is a legislative requirement for state purchasers to participate in the Consortium unless they are receiving a better price (RCW 70.14.060).
- Participation in the Consortium is available for other states and organizations.

Washington State Health Care Authority

Program services

PBM Services	Discount Card	Voucher Programs	ASO Rebate Services	Medicaid Programs

Oversight and governance focused on transparency, auditability and collaboration

True pass-through program pricing

Custom formulary & clinical services

PBM Services	Discount Card	Voucher Programs	ASO Rebate Services	Medicaid Programs
Group Rx Benefits	State-Sponsored Discount Cards	Corrections	Group Rx Benefits	Managed Medicaid
Workers' Comp		State Hospitals	Workers' Comp	Fee-for-Service Medicaid
		County Health Departments	Medicaid Programs	

Fixed administration fee

Industry relations & rebates

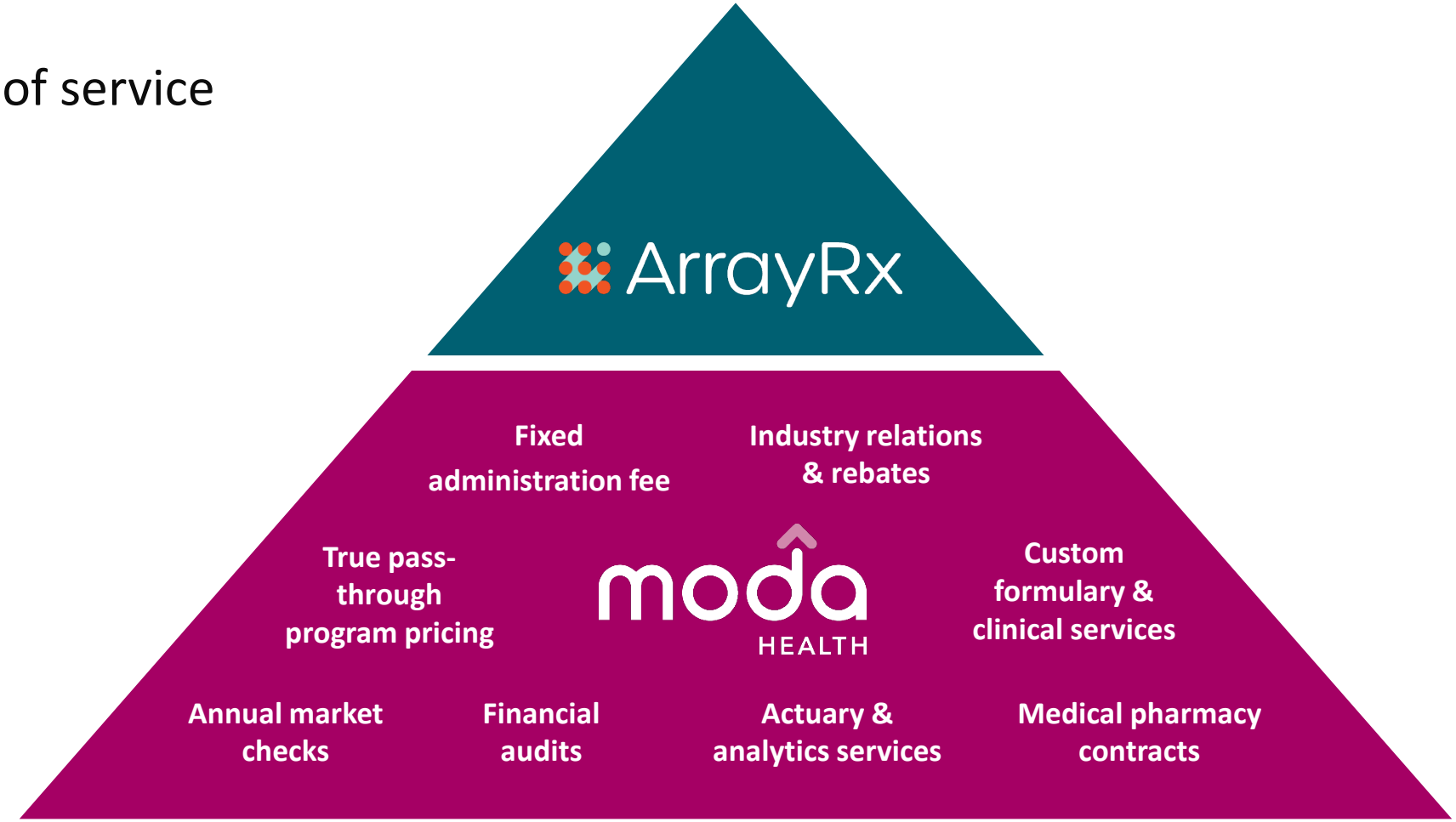
Medical pharmacy contracts

Annual market checks

Financial audits

Actuary & analytics services

Delivery of service



NAVITUS PHARMACY BENEFITS REINVENTED™

- Point of service (POS) claims platform
- National PBM network – narrow and broad networks
- Industry relations services

The next generation of transparency

Predictability

- Most favored nation
- Fixed administration fee
- Aggressive network guarantees

Transparency

- Pass-through pricing
- 100% rebate pass-through
- Comprehensive reporting

Auditability

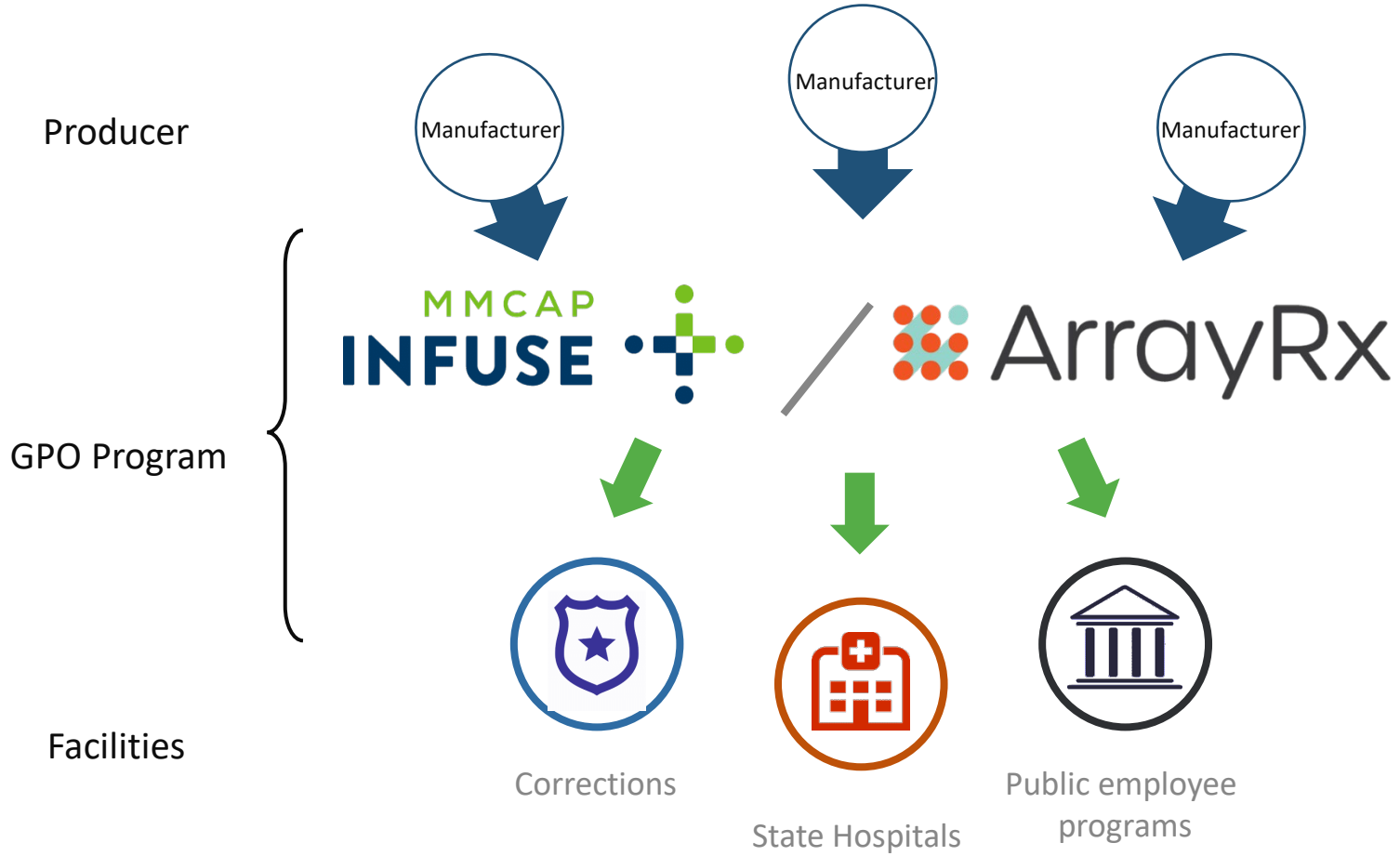
- State oversight and governance
- Annual market checks
- Financial audits

= Working for States

Saves money | **Increases understanding** | **Builds confidence** | **Maximizes potential** | **Validates savings** | **Peace of mind**

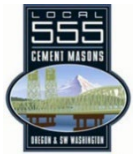
ArrayRx

ArrayRx GPO Services



- Partner to provide GPO services via national public sector GPO partner
- Class of trade pricing
- Partner to provide PBM services where applicable
- Regular market checks to ensure competitiveness

Program participants



Working strategies: Modified Subscription Model

- Direct negotiations with the manufacturer which allows HCA and other state agencies to pay a discount over previous prices.
- For Medicaid, the drug price is negligible once a target threshold is reached. Due to Medicaid Best Price regulations, manufacturers will only offer this to Medicaid.
- HCA, based on a Governor's Directive, signed a first-in-nation arrangement with AbbVie for the treatment of HCV using its Mavyret product under this model.
- The AbbVie contract also requires AbbVie to provide outreach and training support in alignment with DOH's public health outreach campaign.

Working strategies: Apple Health Single PDL

- All AH clients are on a single formulary
- Creates simplicity for the providers
- Minimizes disruption when clients change plans
- Allows us to set the policy based on considering all of the rebates the state is eligible to receive, specifically penalty rebates.

Challenges to managing the pharmacy benefit

Patent Expiration/Patent Purchase

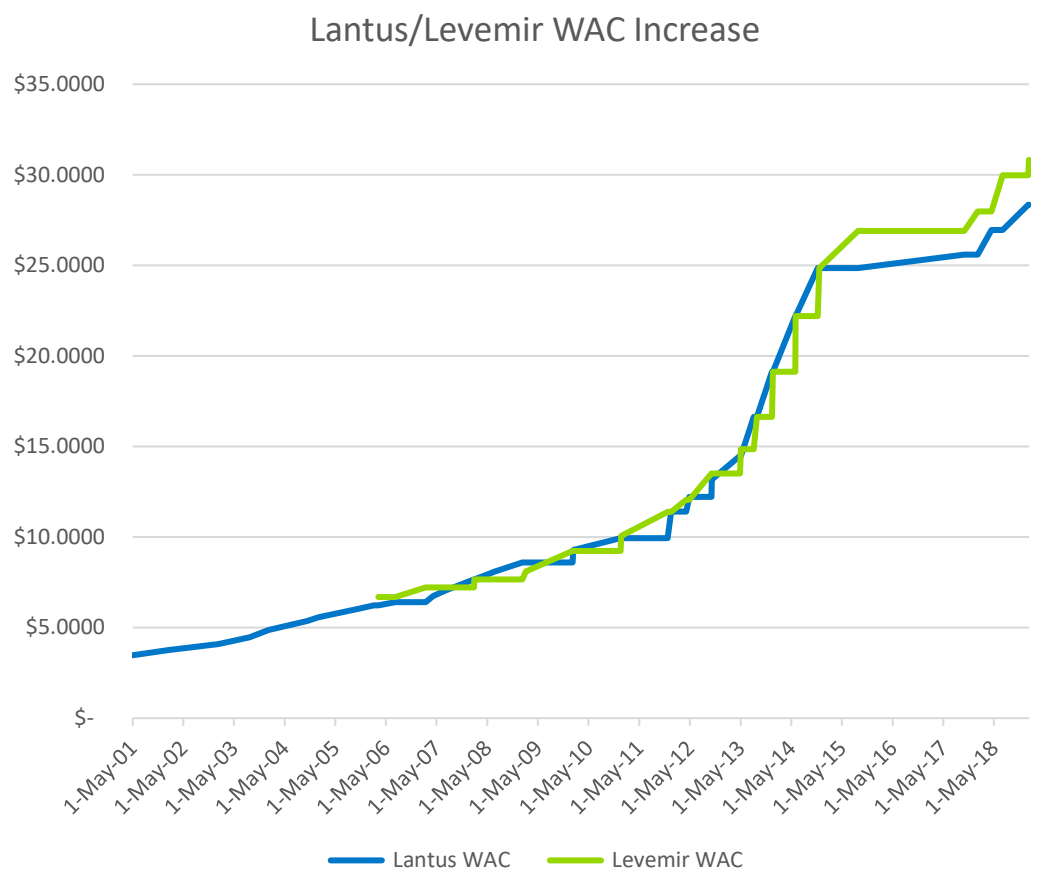
- Revenue from drug innovation is essentially limited to patent period where manufacturer can recover “sunk costs” in R&D.
  - Manufacturers who create novel drugs or originator products are granted a monopoly for their work where they can charge any dollar amount for the drug.
- Manufacturers are incentivized to maximize profits during their limited patent exclusivity before “free market” competition with generics begins.
  - Manufacturers will set the price of a drug on what the market will bear, not related to the “clinical value” of the drug like how other countries negotiate prices.
  - Patent exclusivity depends on when the patent is granted and how long it takes to gain FDA approval.

Patent Expiration/Patent Purchase

- Drug Changes:
  - Manufacturer makes a relatively small change such as a change in dosage form (e.g. extended release tablets) to the drug and pursue a new patent and NDC.
  - The NDC is specific to the dosage form of the drug therefore changes to the NDC creates a new opportunity to re-price the drug.
  - They may then discontinue making the previous drug in its previous dosage form so only the higher cost version of the drug is available.
  - Additionally, the new drug is not considered equivalent therefore substitutions are no longer allowed at the pharmacy level. For example, a cream became available as a lotion with the same strength, however the pharmacist can't substitute the significantly cheaper cream for the lotion.
- Patent Purchase
  - Manufacturers may buy the patent of an old formula and based on the lack of competition, significantly increase the price. Example: Daraprim.

Price Increases

- As manufacturers determine the WAC they'd like to charge; the impacts are felt throughout the system, especially if there are no other comparable drugs.
- No control over price. Purchasers can only negotiate rebates and manage utilization.
- 258 NDCs had a price increase in July 2021. Ranging from a 1% increase to a 908% increase.



Washington State Health Care Authority

Manufacturer Tools for Circumventing the PDL

- Coupons: Since plans impose cost sharing based on the amount paid for equally effective drugs, manufacturers offer coupons to circumvent that cost control. (Prohibited in gov't programs).
- Advertising – Allowing direct consumer advertising is unique to the US.
- Partnering with advocacy groups to apply political pressure.

New Drugs to Market

- To incentivize manufacturers to invest in drugs to treat rare diseases and pediatric indications, the federal government has created incentives including lower Medicaid rebates, extended patent life, fast track approval, and a voucher for a future drug to be fast tracked. This voucher can be sold.
- FDA Approval:
  - FDA approval does not consider the drug effectiveness relative to other options.
  - The FDA can also allow for single arm trials (i.e. there is no comparator group).
  - Accelerated approval may be based on interim outcomes such as ability to increase production of a protein, without evidence of clinical benefit (Aduhelm).
  - FDA approval may be for usage in a broader population that what was included in the trial (Exondys51, Spinraza).

Where we go from here…

- We’re implementing 5195 and 5203.
  - GPO, manufacturer, PBM, wholesaler, pharmacy.
- There are limited levers we have as a state to lower the drug costs.
- We are here to provide technical assistance.
  - Do not hesitate to use us as a resource.
- In the mean-time we will continue to innovate within our operating framework.

Questions?

Appendix-Acronyms and Definitions

- **AMP-** the WAC that includes the discounts and compensation received by wholesalers. Reported by the manufacturers to CMS.
- **APCD-** All Payer Claims Database. A tool used to collect health care claims data for reporting, analytics, and help the public make health care decisions.
- **AWP-** Average Wholesale Price. An average of what pharmacies pay wholesalers
- **CFR-** Code of Federal Regulations. The set of regulations used to govern Medicaid that is updated by CMS.
- **CPI-** Consumer Price Index. Measures recent and historical drug price inflation.
- **FFS**- Fee-For-Service. Is a model that healthcare providers and physicians are reimbursed on the basis of the number of services using ProviderOne System.

Appendix- Acronyms and Definitions

- **FUL-** Federal upper limit. A ceiling price set by the federal government as the highest amount they will pay for a drug; Medicaid can limit the amount paid to more than this amount. It equals no less than 175% of the weighted avg of the most recently reported AMP.
- **GNUP-** Guaranteed Net Unit Price. What the PBM negotiates with the manufacturer as the maximum they will pay for the drug net of all rebates
- **GPI**– generic product identifier which is a standardized enumeration of drugs by their ingredients or "unique interchangeable product" as developed by MediSpan
- **GPO**- group purchasing organization where serval hospitals/pharmacies jointly negotiate wholesale prices
- **MAC-** Maximum Allowable Cost. Amount a payer will spend for a generic drug regardless of how much the pharmacy bills for the drug

Appendix- Acronyms and Definitions

- **MCO**- Managed Care Organization. A managed care organization (MCO) is a health care provider or a group or organization of medical service providers who offers managed care health plans.
- **MME-** Milligram Morphine Equivalent. A value assigned to opioids to represent their relative potencies.
- **NADAC**- National Average Drug Acquisition Cost. Another ways to calculate what the pharmacies pay on average to the wholesalers. Created from surveys of prices reported by pharmacies to CMS
- **NCD-** National Coverage Determination. A nationwide determination as to whether an item or service is paid for by Medicare.
- **NDC**- a 10 digit code that enumerates the manufacturer, drug and quantity.
- **NPI-** National Provider Identifier. A billing number used by healthcare providers.

Appendix- Acronyms and Definitions

- **PBM-** Pharmacy Benefit Manager. They are companies that manage prescription drug benefits on behalf of health insurers, Medicare part D drug plans, large employers, and other payers.
- **PMP-** Prescription Monitoring Programs. A state-run program which collects and distributes data about the prescription and dispensing of federally controlled substances
- **POS-** Point of Sale System. A pharmacy claims processing system capable of receiving and adjudicating claims online.
- **PSAO-** Pharmacy Services Administrative Organization. They are cooperative networks for independent pharmacies.
- **340B-** A program that provides discounts on outpatient drugs to certain safety net health providers, including Title X agencies.

Appendix- Acronyms and Definitions

- **SSA-** Social Security Act. Federal law that established Medicare and Medicaid and set out the basic rules for each program around services and eligibility.
- **TPA**- Third-Party Administrators. A third-party administrator (TPA) is an organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity.
- **TCN** – this is the same as the claims number in the point-of sale system (CONFIRM WITH AMY)
- **URA-** Unit Rebate Amount Calculation. This is the unit amount computed by the Centers for Medicare & Medicaid Services to which the Medicaid utilization information may be applied by States in invoicing the Manufacturer for the rebate payment due.
- **WAC-** Wholesale Acquisition Cost. Manufactures published price and basis of what wholesalers pay to the manufacturers

Washington State Health Care Authority

INDEX

KAISER PERMANENTE®

Susan E. Birch
Washington State Health Care Authority
Health Care Cost Transparency Board
Olympia, WA
RE: Nomination of Justin Evander to the Advisory Committee of Health Care Providers and Carriers

July 11, 2022

Dear Chair Birch and Board Members,

Kaiser Permanente is pleased to nominate Justin Evander to serve on the Health Care Cost Transparency Board's Advisory Committee of Health Care Providers and Carriers. Bill Ely has been honored to represent Kaiser Permanente on the Advisory Committee, and as he retires, Mr. Evander looks forward to bringing his own expertise and dedicated engagement to this important work.

Mr. Evander is the Executive Director for Care Delivery Finance for Kaiser Permanente Washington. In this role, he leads financial business case development for care delivery operational decisions. Previously, he served as the Hospital Administration and Chief Operating Officer for the Sunnyside Medical Center and as the Regional Administrator for Surgical Services for five of the local medical and surgery centers in Kaiser Permanente's Northwest Region, after over a decade in financial services and leadership.

Mr. Evander's combination of on-the-ground experience in our medical centers, financial expertise and insights, and his work to utilize reporting to continually improve productivity and care will make him a valuable and insightful member of the Advisory Committee.

Thank you for your consideration of this nomination.

Sincerely,

Rebecca Williams
Chief Financial Officer
Kaiser Permanente, Washington and Northwest

1300 SW 127th Street
Renton, WA 98057

JUSTIN EVANDER
PO Box 658, Napavine, WA 98565
Cell: (503) 826-4318
Justin.N.Evander@kp.org

PROFESSIONAL EXPERIENCE

Kaiser Permanente Washington Region

Executive Director Care Delivery Finance **2019 - Present**
Integrated Health Plan with 650K+ membership

- Lead financial business case development for all care delivery operational decisions.
- Direct team of 20 analyst that support operating budget development and tracking.
- Implemented and improved tracking of volume standards for the region to improve productivity.
- Drive the implementation of a position control process and variance reporting process that has supported care delivery in hitting budgeted targets.

Kaiser Permanente Northwest Region – Oregon and Southwest Washington

Hospital Administrator & Chief Operating Officer **– Sunnyside Medical Center** **2016 – 2019**
300 + bed Tertiary Medical Center

Regional Administrator Surgical Services
300 + bed Tertiary Medical Center
125 + bed Community Medical Center
Three Ambulatory Surgery Centers

- Implemented daily rounding model that increased rounding on staff and patients from 15% to 80%.
- Successfully bargained or implemented multiple key tactics with different labor unions.
- Directed patient flow initiatives in partnership with CMO that reduced 4,900 patient days from 2017 to 2018 at Sunnyside Medical Center.
- Developed Campus Optimization team with physicians that lead to successful capital project execution included new OR construction and proper case placement between acute care hospitals.
- Lead hospital through a successful CMS joint commission accreditation three-year survey.
- Achieved 100+ FTE reduction in 2018 at Sunnyside Medical Center.
- Successfully lead regional surgical services to a -1% total cost trend in 2018.
- Implemented overtime initiatives that reduced incremental overtime by 23%.
- Developed strategic planning process to improve hospital goal cascade process and alignment with regional strategic plan.
- Improved overall KP's hospital patient safety composite from performance needs improvement status to accomplishing stretch targets for three straight years.
- Achieved "A" grade status from LeapFrog every year as COO, and Top 100 hospital in 2018 for patient safety results at Sunnyside.
- Decreased C. difficile infection rates for three straight years.

JUSTIN EVANDER
PO Box 658, Napavine, WA 98565
Cell: (503) 826-4318
Justin.N.Evander@kp.org

Chief Financial Officer **–Hospital and Ambulatory Surgery Center Operations** **2011 – 2016**
300 + bed Tertiary Medical Center
125 + bed Community Medical Center
Three Ambulatory Surgery Centers

- Successfully introduced Truven ActionOI productivity benchmarking in a Kaiser Foundation Hospital. The project was recognized as a best practice and spread to all Kaiser Hospitals throughout the program.
- Implemented new staffing office software that move the department from paper to fully web-based staffing system.
- Co-sponsored projects with hospital operational leaders that developed a new neuro/spine surgical service line, expanded an existing cardio service line, redesigned an orthopedic service line, and opened a level three NICU.
- Designed and implemented a flex budgeting tool system for both medical centers
- Facilitated and directed efforts with physician partners that improved patient flow in the emergency department, labor and delivery arena, and nursing units.
- Lead management teams in multiple labor negotiations with local nursing union and SEIU to improve expense trends within the hospitals.
- Directed the regional patient access and regional staffing office departments to reach high performing customer service targets, which lead to 50% improvement in Press Ganey scores.

Kaiser Permanente Hawaii Region

Director of Finance **- Moanalua Medical Center – Honolulu, HI** **2010 - 2011**
300 + bed Tertiary Medical Center

- Directed Health Information Management, Finance, Admitting, Registration, and Financial Counseling Departments.
- Chair of the ICD-10 Committee for Hawaii Region.
- Lead in the development of a capitol budget prioritization process for information technology projects and medical equipment requests for continuing care, hospital, and ancillary services.
- Established unit of service tracking system for departments within the hospital, continuing care, and ancillary services for the Hawaii region.

Providence Health and Services – Washington Region

Business Manager Outpatient Infusion Services **– Southwest Washington** **2009 - 2010**
Three outpatient infusion centers

- Directed revenue analysis, forecasting, and projections for a $70 million-dollar revenue stream.
- Solved a key CMS physician coding billing issue that increased the clinics net revenue stream by over $1 million dollars per year.
- Ensured clinics met all Joint Commission and CMS requirements.
- Planned and implemented financial growth opportunities for cancer service line. Cancer clinics increased net revenue by 15%.

JUSTIN EVANDER
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Cell: (503) 826-4318
Justin.N.Evander@kp.org

Finance Manager **- Providence Centralia Hospital - Centralia, WA** **2008 - 2009**
127 + bed Community Medical Center

- Directed operating budget, long range financial plans, and capital budget to meet strategic goals.
- Developed and audited financial documents and metric dashboards.
- Served on Operations Task Force Committees for Southwest Washington Service Area.
- Created staff training tools, processes, and policies to improve financial learning for all managers.
- Consulted Chief Financial Officer, Vice Presidents, Directors, and other Managers in financial and strategic health care analysis related to their service line.

Providence Centralia Hospital
Senior Financial Analyst**, 127 + bed Community Medical Center** **2006 – 2008**

Providence St. Peter Hospital
Financial Analyst**, 375 + bed Tertiary Medical Center** **2004 - 2006**

Department of Licensing – Washington State
Licensing Compliance Auditor 2 **– Olympia, WA** **2003 - 2004**

Morgan Stanley
Financial Advisor **– New York, NY & Olympia, WA** **2001 - 2003**

Indian Summer Country Club
Accounts Payable Lead **– Olympia, WA** **2000 - 2001**

EDUCATION

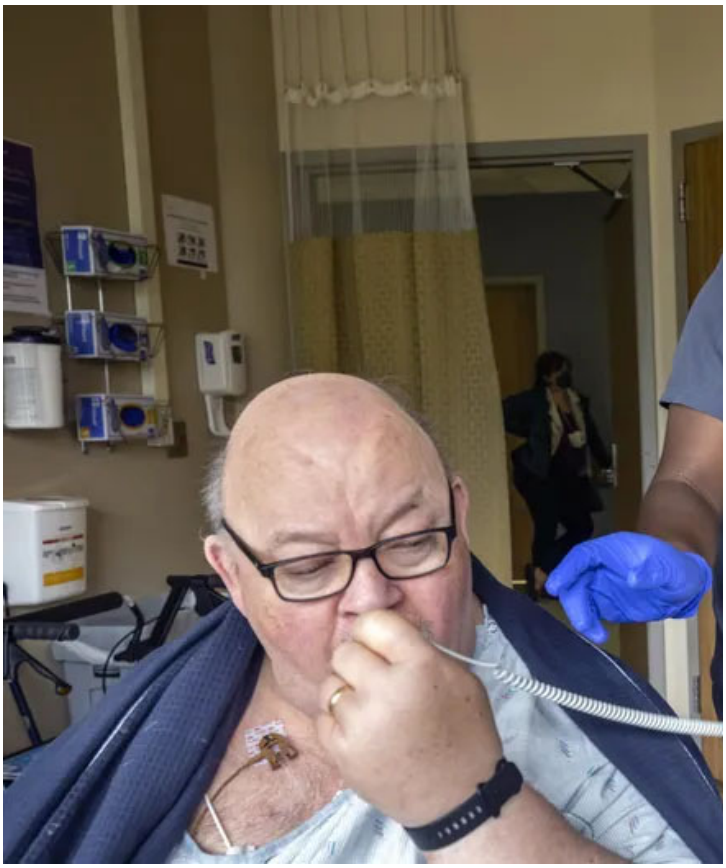
- **Harvard Business School,** Executive Leadership Program (2018)
- **St. Martin's University**, BA in Business Administration (2000)
- **Louisiana State University,** MHA in progress
- Six Sigma Change Facilitator

The Seattle Times

https://www.seattletimes.com/seattle-news/health/an-industry-at-a-crossroads-after-years-of-pandemic-weariness-world-of-nursing-begins-to-recover/

How nursing in WA is recovering from staff shortages and pandemic burnout

June 26, 2022 at 6:00 am



1 of 4 | Allan Kinyua, a certified nursing assistant at UW Medicine's Northwest campus, checks the temperature of patient Charlie Beck of Seattle. Kinyua is... (Ellen M. Banner / The Seattle Times) More

By Elise Takahama

Seattle Times staff reporter

When Allan Kinyua arrives for his evening shift at the UW Medical Center near Northgate, the special care unit buzzes with energy. Staffers cart meals and medical equipment in and out of

patient rooms, pausing occasionally to check records and doctor notes.

Kinyua, a certified nursing assistant, is in charge of eight of the 17 patients. One has COVID-19. Another is legally blind and coming from the intensive care unit. Some need assistance breathing or help going to the bathroom. Many have heart or lung issues.

The day was already busy, though routine. But in this hospital's hallways, the trauma of the pandemic lurks in haunting memories.

Evening after evening in early 2020, Kinyua would start a shift by taking a COVID patient to the bathroom. By morning, they'd be intubated. When he would return the following night, the patient would be dead, the room already getting prepped for the next one.

Terrified co-workers broke down in tears often, he said. "It was just happening so fast. You couldn't even take time to process what was going on. ... I think to some extent, I became numb to the pain."

Since then, more than 13,000 Washingtonians have died from COVID. Still, Kinyua, who moved from Kenya 3½ years ago, has pushed forward in the health care field, even deciding last year to pursue his nursing degree in an accelerated program.

As thousands of students like him finish their classes this summer, the state's newest crop of registered nurses will start to bolster the strained health care systems throughout the region. Recent legislative action has boosted efforts to patch staffing holes within hospitals and long-term care facilities. But nationwide attrition rates among health care workers reveal a lot has been lost, leading to big questions over the future of an industry at a crossroads.

While omicron's contagious subvariants led to a spring surge of infections and hospitalizations, COVID antivirals became more accessible and deaths stayed low. But it's still a difficult time for health care staffers while patients, now mostly people whose conditions have worsened after delaying care, continue to pour in.

“I think back to when I graduated from nursing school” about 30 years ago, said Darcy Jaffe, senior vice president for safety and quality at the Washington State Hospital Association. “There were staffing shortages back then as well, but we didn’t have as much unknown as we have right now about what health care is going to look like in the next few years,” she said.

Kinyua, on his recent shift, heads into his first room of the evening. He cheerily greets the patient, sitting upright in bed, before checking his temperature and pulse. Minutes later Kinyua is on to the second room, where a patient sleeps and a CPAP machine hums.

He continues down the hall, popping in and out of rooms.

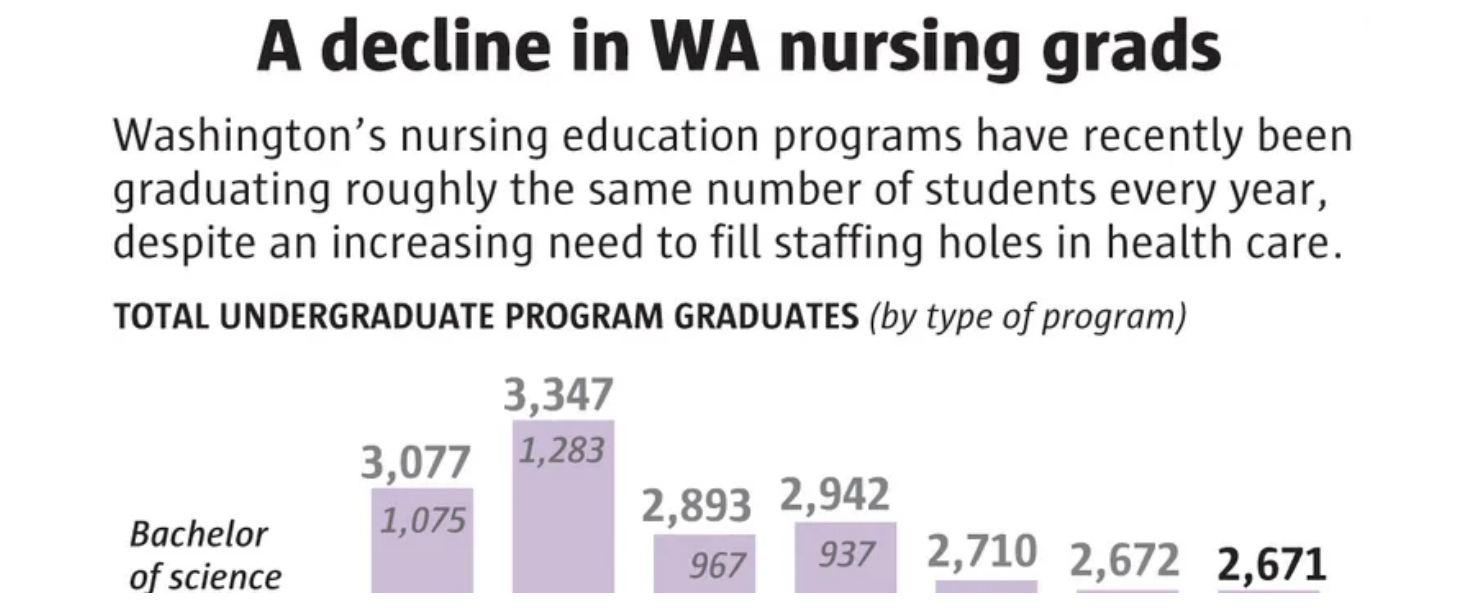
It’s not yet apparent, but it is going to be a long night.

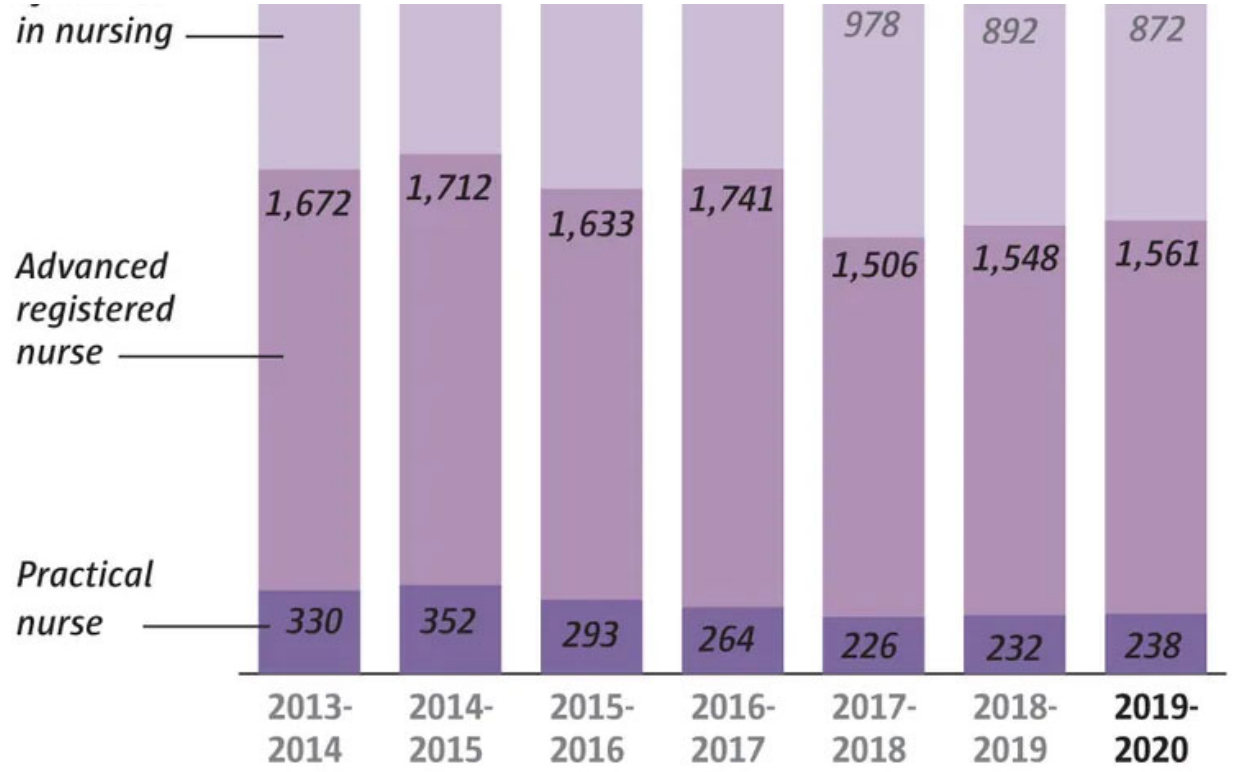
Long-term problems

Constant staffing holes and overwhelming patient loads have ranked high as top reasons for health care worker burnout in Washington and throughout the U.S. But other factors also weigh on the industry, like the rising demand for medical services as baby boomers age into retirement.

Meanwhile, the number of students completing undergraduate nursing programs has declined in recent years, despite the growing need, according to a 2020 state Department of Health report.

In 2015, 3,347 undergraduate nursing students completed their programs in the state, the report found, compared to 2,671 graduates in 2020.





Source: Washington state Department of Health

MARK NOWLIN / THE SEATTLE TIMES

Washington doesn't track how many health care workers leave the industry every year, but the U.S. Bureau of Labor Statistics recently reported nearly 1.7 million Americans quit their health care jobs between January and April alone. In addition, the field lost about 20% of its workforce in 2019 and 2020, including 30% of nurses, according to a 2021 American Hospital Association survey.

More new nurses are also asking to start off part-time, said Jaffe, of the state hospital association. She's glad to see new employees ease into the job, but she worries the staffing shortage will only worsen.

"The pandemic has had that impact on a lot of the staff in general about reevaluating their work-life balance," she said. "I do think it's tough for new grads right now because they're entering hospitals that are not quite in recovery."

The shortages are expected to persist, she said.

Despite the long hours and enormous emotional burden, many health care workers, including Kinyua, stick with it. New nurses are filled with hope.

When he moved to Washington state, Kinyua planned to go to graduate school for project management. He landed in health care instead after a friend asked him to

temporarily fill a shift at an adult family home.

“I just completely loved it,” he said. “I’ve worked in many industries, but there’s a lot of satisfaction in helping people who need it. … Even though the pandemic was pushing (health care workers) in one direction, leaning on each other helped us push back a bit.”

Creative solutions

While most health care systems in the state still grapple with day-to-day burnout, some new long-term solutions are in the works.

Chelene Whiteaker, senior vice president of government affairs for the state hospital association, spent much of the past year advocating for new policies to boost health care education and alleviate staffing strains.

Meanwhile, health care labor unions last year pushed for hospitals and other care facilities to do more for their staffers, like ending mandatory overtime policies and offering retention bonuses.

During this year’s session, Washington lawmakers made a series of moves to address health care challenges, including adding 220 new nursing education slots at the University of Washington and in community colleges and introducing a new bachelor of nursing degree at Eastern Washington University.

Lawmakers also funded Gov. Jay Inslee’s hospital staffing initiative, incentivizing long-term-care facilities to take more patients ready to be discharged from the hospital and establishing more than 200 more nursing home beds.

“It’s a good starting point,” Whiteaker said.

New education programs are also popping up throughout the region, including one at Providence Mount St. Vincent in West Seattle.

The Mount this year received state approval to create its own four-week certified nursing assistant program.

“It’s a great way to get exposure in a way that’s safe and supportive,” said Kayett Asuquo, director of clinical facilities at Providence. “After that, they’re guaranteed a job as Providence employees.”

In January, UW's School of Nursing also added a externship program for students interested in long-term care, sending them into nursing homes and other facilities to give them a taste of a non-hospital environment.

Program leaders are hoping the experience will renew interest in long-term care jobs, a particularly difficult corner of health care during COVID because older adults were at a higher risk of getting severely sick.

"There was a mass exodus of long-term care jobs during the pandemic," said Tatiana Sadak, who's leading the UW program. "Those jobs became impossible."

The new programs are finding some early success, though. This year, six students signed up for the pilot version of UW's long-term care externship. Next year's program has already enrolled 14.

Looking forward

Keetra Kartes has worked in health care for years and is now a registered nurse on an acute-care floor at Harborview Medical Center. She loves her co-workers and her job — but she'll never forget the daily feeling of watching patients with COVID get sicker and sicker.

She recently saw a video on social media posing a question: If you had to go back to nursing school knowing where you are now, would you?

"I had to really think about that," Kartes said. "And that was really jarring to me."

But there are signs that new nurse classes are diving into the health care field with a different energy, she's noticed. There's a stronger desire to be advocates for their fellow health workers, push for new legislation and become more involved with labor unions. And graduates know that regardless of how tough the job can be, it likely won't be worse than the past two years.

Julie Trotter, one of Kinyua's nursing classmates at UW, said for her and many of her peers, the passion for the job outweighs their fears.

"We applied for the program knowing that COVID was a thing, knowing the pandemic was ongoing, but a lot of us have worked in health care spaces already so I think we know firsthand the challenges are not something we're going to let stop us," Trotter said.

She, Kinyua and dozens of their peers have one more quarter left at UW this summer before many will apply for their nursing licenses.

Back at UW Medical Center, Kinyua continues to check in on patients in the special care unit. Another certified nursing assistant's shift is almost up, so she walks Kinyua through her patient notes before she leaves.

As his night winds down, he checks on staffing levels elsewhere in the hospital. He's not surprised to see shortages — and quickly volunteers to help in a couple of surgical units. He often takes the hours where he can and when there is need.

Kinyua is scheduled to clock out after eight hours at 11:30 p.m. But it's 7:30 a.m. before he heads home.

He's exhausted, but his goal of becoming a critical care nurse in the ICU remains. He hasn't looked back.

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