Washington State Health Care Authority

Health Care Cost Transparency Board

August 17, 2022

Washington State Health Care Authority

Health Care Cost Transparency Board
Board Book

August 17, 2022
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting materials

Washington State Health Care Authority

Agenda

TAB 1

Washington State Health Care Authority

August 17, 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 and July meeting minutes	2	AnnaLisa Gellermann, Board Manager Health Care Authority
2:10– 2:40 (30 min)	Primary Care: Overview and Next Steps	3	Dr. Judy Zerzan-Thul Chief Medical Officer Health Care Authority
2:40 -3:15 (35 min)	Washington hospital costs, price, and profit analysis	4	John Bartholomew and Tom Nash
3:15– 3:25 (10 min)	Public comment	5	Susan E. Birch, Chair, Director Health Care Authority
3:25– 4:00 (35 min)	Influence of health workforce trends on health spending growth	6	Bianca K. Frogner, PhD Professor, Dept. of Family Medicine Director, Health Workforce Studies University of Washington
4:00	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 and July meeting summaries

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.

Jesse Polin (pronouns she/her), an individual, small business owner, and member of the Washington Community Action Network.. Ms Polin shared that health care costs have a major impact on her life. Specifically, treatment for her chronic condition requires an injection costing $24,000 every eight weeks. Her insurance provider Cigna mandates purchase through their company-owned pharmacy in Tennessee, so that it must be specially packed to stay cool in transit and shipped overnight across the country. Ms. Pollan commented that given that supplies of the drug can be sourced locally, this is inefficient and has poor environmental impact. She further shared that the only way she could afford this expensive treatment was through a coupon program sponsored by the pharmaceutical manufacturer. Under coupon programs, the manufacturer pays the patient portion of the bill (the co-payment or co-insurance), and the insurance company pays the balance. While acknowledging the benefit to her personally, Ms. Polin expressed her concern that this practice permits manufacturers to raise drug prices throughout the system and mask costs to the detriment of everyone else. And she stressed that coupon programs were a tax write-off for manufacturers, so the practice did not result in any additional costs.
Ms. Polin also commented on importance of consumer representation, and the need for better representation of consumers to the Board. She encouraged the Board to consider creation of a specific consumer advisory committee.

Joselito Lopez, individual and member of the Washington Community Action Network. Mr. Lopez shared that his life and his family have been profoundly impacted by the cost of health care. 8 years ago, Mr. Lopez suffered multiple heart attacks and required surgery. As a result of losing his insurance as a Microsoft contractor, he was left with tens of thousands of dollars in medical debt which forced him to file for bankruptcy and move in with his parents. Mr. Lopez shared that he continues to struggle with severe financial barriers making many routine activities and expenses out of his reach. As a diabetic, the spikes in cost for necessary medication and supplies have proved challenging. For example, his current employer-sponsored insurance doubled the cost of his meter and test strips. As another example, he had been able to obtain a convenient and painless blood sugar monitor for $40-$70 at a local pharmacy. As a result of an insurance company decision, this monitor was now characterized as a medical benefit that would cost him over $550 a month. Mr. Lopez stated that climbing health care costs and lack of transparency are crushing vulnerable patients and families, and that because of these serious impacts consumers deserve a robust voice in the process.
Mr. Lopez noted that providers and issuers have a dedicated advisory committee to the Board. He respectfully asked that patients have a more robust voice on issues in front of the Board, either through the creation of an advisory committee or with dedicated seats on existing committees.

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.

Health Care Cost Transparency Board meeting minutes

July 20, 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

Sue Birch, chair
Lois Cook
Bianca Frogner
Jodi Joyce
Leah Hole-Marshall
Molly Nollette
Mark Seigel
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

Sonja Kellen

Call to order

Sue Birch, Board Chair, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

Approval of minutes

Ms. Gellermann shared that the June minutes contained in the Board materials were submitted in error, and had not contained a record of public comments,
Chair Birch directed that the June minutes be corrected and resubmitted for approval at the August meeting.

Advisory Committee Nomination and Vote

A candidate for the Advisory Committee of Health Care Providers and Carriers was, based on application materials included in the materials and staff recommendation. Justin Evander was nominated to replace departing member Bill Ely. Mr. Evander is the Executive Director for Care Delivery Finance for Kaiser Permanente Washington.

The application was approved.

Presentation: Washington Hospital Costs, Price, and Profit Analysis: First Look at a High Level

John Bartholomew and Tom Nash, Consultants

Mr. Bartholomew presented initial findings from his review of 2020 Medicare cost reports submitted by Washington hospitals. Mr. Bartholomew concluded that Washington hospitals, when ranked on price and cost against all other states, are higher than the median in both price and cost per patient. He also pointed out that Washington hospitals rank lower than the median in profit, as a measure of margin. He presented data over time demonstrating that hospital costs are increasing nationally and in the state. Mr. Bartholomew stated that Washington, based on its admission rate, was a relatively healthy state with lower admission rates. He shared that his review of trends in some key cost metrics show that trends increase from 2009 to 2014 that largely track national trends. He then pointed out that Washington metrics appear to trend higher beginning in 2014 to the present and suggested that further investigation and analysis might be pursued to verify and identify potential causes. He concluded that identifying hospitals of higher should lead to inquiry about what might be driving that cost, which could be a variety of factors.

One Board member asked if the information presented was adjusted for patient population, including considerations of acuity and/or health conditions and services sought. Mr. Bartholomew responded that Medicare reports contain information on the inpatient case mix, in which Washington is ranked in the middle third of the country on overall healthiness. In Colorado, Mr. Bartholomew was able to obtain additional information from their claims data base, and that this information could also be obtained from the Washington APCD.

One Board member asked for clarification of hospital cost per patient vs. cost per patient. Mr. Bartholomew explained that hospital only cost is based on what Medicare allows, while total cost per patient would include other sources of cost and revenue including investment income, and costs that vary from hospital to hospital. Mr. Nash shared that hospital only costs were generally 75-80% of total cost.

One Board member asked if they had performed an evaluation and done adjustments on Washington labor costs, and/or cost of living. Mr. Bartholomew responded that he could break down hospital costs into overhead (including salary) and medical costs, which might be interesting, but that he had not done it here. Mr. Nash responded that they had used the "C2ER" cost of living index, which was widely used.

One Board member asked why 2020 had been chosen as the data year, as it was a statistical outlier, and whether they had considered the impact of the lack of elective procedures which would be expected to have an outsize impact on cost and profit. Mr. Bartholomew responded that it was the most recent data set, and self-reported data. He recommended looking at more years and additional data sources in further study.

One Board member asked if more detail could be provided under consolidated line items, including on-patient income and cost lines and operating expense lines to better point to what drivers might be to the relatively high Washington operating expenses as reflected in the relatively low profit. Mr. Bartholomew said he could investigate and provide more information if that was of interest to the Board.

One Board member questioned whether the Board, charged with looking at overall trend and year over year increases should appropriately be focused on profit margin as a measure, especially when most Washington hospitals are non-profit. Mr., Bartholomew responded that profit could be a useful benchmark to prompt additional and deeper dives into information, agreeing that there are many reasons for variance in profit including size, geography, market power, and others.

Presentation: Washington State Hospitals: A Primer on Washington Hospital Costs

Johnathan Bennett, Vice President of Data and Analytic Services, Washington State Hospital Association
Bruce Deal, Economic Expert for the Washington State Hospital Association

Mr. Bennet began the presentation by stating that he and his team were eager to partner with the Board and payers in controlling health care costs while maintaining access to quality health care. He also wanted to provide information about Washington hospitals and the role they play in the health care ecosystem, and the challenges currently facing them.

Mr. Deal provided an overview of medical cost growth. Mr. Deal described medical cost growth as driven by three primary factors: overall inflation, cost growth beyond inflation, and increased use of care. Discussing historic trends reported by Kaiser Family Foundation, he indicated that in the last decade spending growth on hospital, physicians and prescriptions has slowed from historic growth levels, with hospital spending growing at 4.6% in the 2010s. Mr. Deal then focused on hospital spending as representing 31% of overall healthcare spending, compared to drugs at 8%, physicians and clinics at 20%, and other healthcare at 27 percent. He also contrasted Washington's benchmark values with projected estimates of health care expense increase and inflation.

Mr. Deal reviewed the Washington hospital system, including information about ownership of non-hospital services. size and location, type, and affiliation. 2/3 of patient days in the hospital are provided by 19 larger hospitals of 250 plus beds and he described this as a system driven state represented by 5 large systems and several smaller ones.

He then turned to the topic of hospital cost both generally and in Washington, relating cost to payors and individuals and its relationship to revenue, which is driven the volume of patients, services used per patient, and price per service. Mr. Deal described Washington hospital admission, utilization, and length of stay as very low compared to national standards. Washington hospital spending per beneficiary in the Medicare market is also comparatively lower. Mr. Deal cited the 2022 Rand study and pointed out that Washington hospital price levels in the Medicare market are also comparatively low, averaging in the bottom 3 of all states. He emphasized that based on the Rand results, Washington is not a particularly high-priced hospital state on a price per service basis.

He then pivoted to the cost of running a hospital, with four "buckets" of costs: employee cost, supply cost, purchased services (including travelling nurses) and facility/equipment cost. To provide a sense of where dollars are spent, he estimated that a 300-bed hospital with 50+ departments cost approximately 500M per year in costs. Salaries and benefits represent about 60% of the cost, with an average of 125,000 per FTE in salary and benefits. He detailed percentages of other costs also.

Mr. Deal emphasized that Washington hospitals are currently having a major financial at this time. Specifically, per WSHA survey data hospital employee cost increased 10% in 2021-2022. He also focused on the issue of increased utilization of travelling nurses at a large increase in cost. He shared an analysis of net income of Washington hospitals showing it is historically a low profit state, with substantial variation between individual hospitals. He pointed out that hospital systems created a "portfolio effect", with hospitals in the system having varied profit levels. This resulted in some protective subsidy between hospitals in a system. He emphasized that hospital margins are deteriorating real time, and all large hospitals in the Washington state are losing money, and an average of a negative 10%. From a big picture economic perspective, he shared that while there may be a cost problem in Washington hospitals there is currently a major crisis and hospitals were highly motivated to keep cost down. But they cannot control the current rise in labor costs, and many hospitals are at risk.

One Board member shared a patient experience at the two hospitals in the region, and reported that they were very different, wondering if it could be based on a difference in prices, charges, or financial management. Mr. Deal responded that many researchers were looking at the question of variation in quality as related to cost. It was also indicated that acuity and number of patients can impact the quality of services.

One Board member queried whether profit margin was the appropriate measure for the Board to consider but appreciated the information in the presentation. She encouraged the Board to look at quality measures as well.

Public Comment

Ms. Birch called for comments from the public.

Parnian Karimi, Washington Public Interest Research Group (WashPIRG) Students, UW and Evergreen chapters. Ms. Karimi's dream is to become a doctor, but a degree is not enough when many people cannot afford or access care. She recently shadowed a neurosurgeon who had a patient with a spinal tumor and rapidly worsening condition who was told that her surgeon was out of network, resulting in a bill that they could never afford. The insurance company could not be contacted by the surgeon, and the patient was eventually forced to go to the emergency room where she luckily received treatment. No patient in her condition should have to worry about cost. As a future doctor I urge you to make sure patients are better protected and better represented on this Board.

Joelle Craft, member of Washington Community Action Network (Washington CAN). The patient experience should be centered in the work of this Board. Diagnosed with multiple sclerosis at 16, I have carried the burden of high medical debt due to unaffordable drugs and costs of care I need to survive. The high medical costs have impacted my life- I have had to live with my family due to medical bankruptcy, I live in a crowded home with more people than is comfortable all because of the cost of my necessary care. Exorbitant profits are balanced on the backs of the sick and disabled. I am calling on the Board to provide equal access and time for patients, including patient advocates who can propose solutions. Washington CAN will be submitting a formal request on this topic.

Noreen Light, member of Washington CAN. I've advocated for many friends and family, recently including a nephew who has substance use disorder and a serious accident. It was so difficult to find out available services and cost for his necessary treatment. He was released from the hospital with no home, no transportation, no prescription. I've advocated for my senior parents, and incarcerated people-trying to get them appropriate medical care. I am privileged, I have insurance, and it is still difficult for me to access care. This Board needs to center the voice of people and patients in their discussions.

Joselito Lopez, member of Washington CAN. I'm here to follow up on my comments from last month, and I'd like to hear the Board's perspective on increasing the power of patient perspectives. The mistaken June minutes were unfortunate and emphasized the point I am making that patient voices are not an afterthought but an essential stakeholder in this process. We need to hear how patients will have a more robust representation on the Board, and how consumer advocates can share sound policy solutions for the benefits of state residents. It would be the right thing to have patients on the Board, so you know how real life is affecting us. As a Latino, I see how it impacts us and I see how people cannot afford care because they are undocumented, or don't have insurance, or can't afford it. We need patient voices on the Board.

Consuela Echeverria, member of Washington CAN. I'm at a loss to understand when we're talking about excessive cost of health care why the excessive cost of billing and insurance related expenses are not being shown. I think we are still under the impression that value-based payments and the private insurance model is the only option we have. But the 2017 paper by Wollenhandler and Hammerstein, that I recommend reading, puts the total cost of administration at 1.1 trillion dollars. Moreover, per the Center of American Progress, US health care payers and providers spend almost 500,000 billion dollars on billing and insurance related costs. To truly understand the drivers of hospital loss of profit and the high cost of care, BIR needs to be included.

Presentation: Pharmacy Pricing, Purchasing and Access

Ryan Pistoresi, Assistant Chief Pharmacy Office, Health Care Authority

Due to length of the prior presentations, this presentation did not occur.

Adjournment

Meeting adjourned at 4:00p.m.

Next meeting

Wednesday August 17, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Washington State Health Care Authority

Primary care: overview and next steps

TAB 3

Primary Care Next Steps: Overview and Discussion

Dr. Judy Zerzan-Thul
Health Care Authority
August 17, 2022

Washington State Health Care Authority

Recommendations: Overview

- Definition of Primary Care
- Claims-Based Measurement
- Non-Claims-Based Measurement
- Reporting Requirements; barriers and how to overcome them

Building the WA Washington Primary Care Transformation Model (PCTM)

2019 & 2020

- Multi-payer Collaborative (MPC) formed
- In person and virtual stakeholder summits
- 8 WA payers sign MOU to form aligned model
- Public comment on initial model white paper

2021

- MPC continues to meet
- Virtual stakeholder summits
- Public comment periods on developing model components
- Common primary care measure set approved

2022

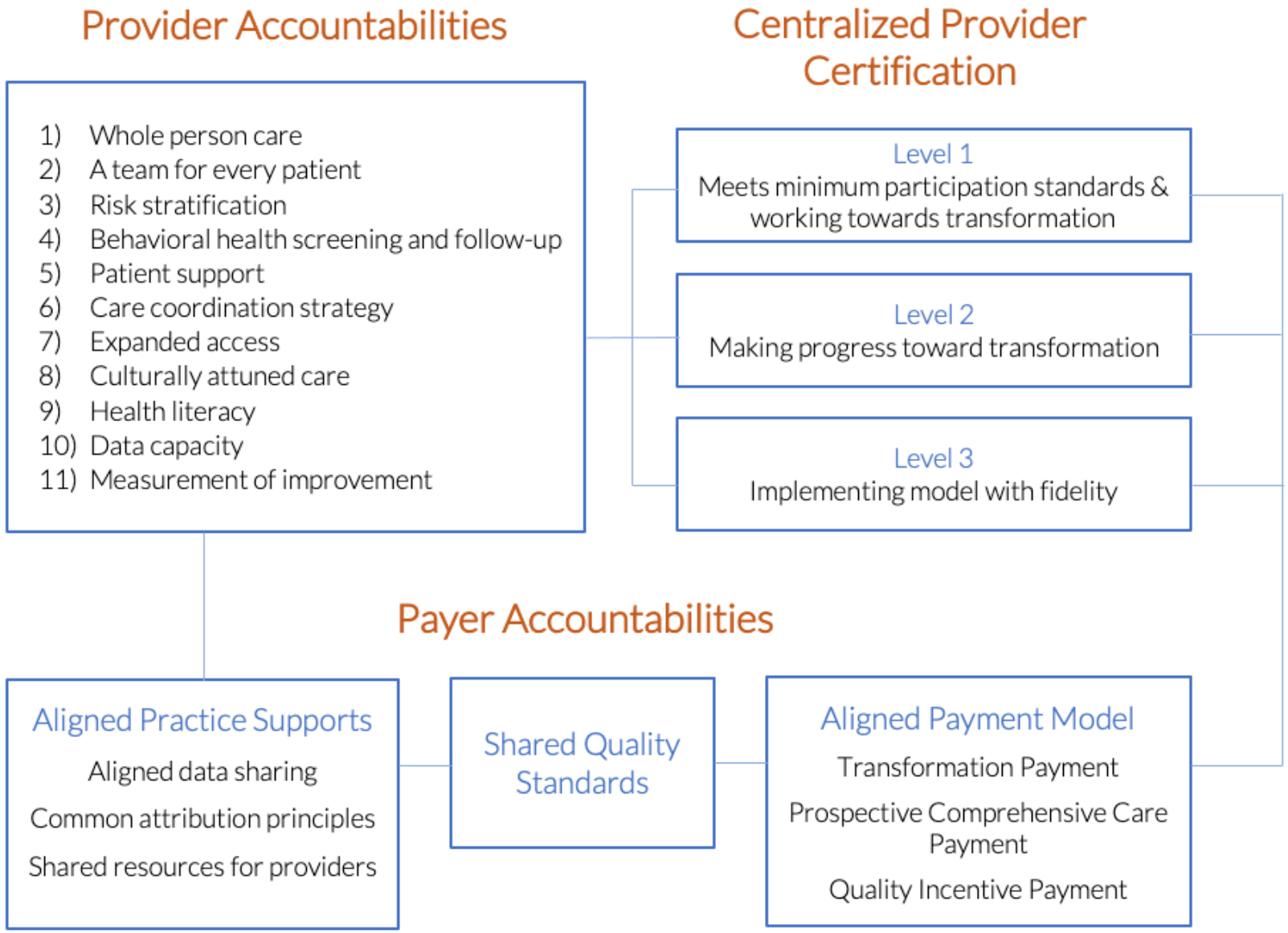
- MPC continues to meet
- Model description finalized
- Centralized Certification Workgroup begins to meet
- Stakeholder input opportunities to continue planning

2023

- Begin implementation of initial phases of PCTM
- Continued development and implementation

Washington State Health Care Authority

Key Components of the Primary Care Transformation Model (PCTM)



Definition of Primary Care

- Primary Care Transformation Model (PCTM)
  - Defining payer/provider Accountabilities and an Alternative Payment Model (APM) to transform primary care
  - Collaborative model development, including:
    - Multi-payer workgroup (commercial and Medicaid plans)
    - Provider workgroup
    - Purchaser workgroup (employers, HBE)
  - PCTM defines primary care consistent with CMS guidelines, OFM, the Bree Collaborative
- Primary Care Practitioners (PCPs)
  - The defined type of practitioners that can be a PCP are fairly consistent
    - Physician (family medicine, internal medicine, geriatric medicine, pediatric medicine), Nurse Practitioner, or Physicians Assistant
    - Some minimum percentage of billed services are “primary care”
    - Messy: practitioners who practice in primary and specialty settings (behavioral health, pediatrics, mid-levels, other)
- Primary Care Services—variation amongst stakeholders and APMs. Typically defined by claims-based, and non-claims-based measurement.

Claims-Based Measurement

- Who, What and Where
- Typically defined by CPT code
- Includes office visits, preventive/wellness visits, developmental/behavioral health screenings
- May include vaccine administration, OB care, basic laboratory services
- Generally excludes procedure codes and physician-administered drugs—though common office procedures (without anesthesia) may be included
- Pharmacy claims? Physician-administered drugs? Medical devices?

What We Already Know

- OFM primary care spend using WA APCD for 2018
- Bree work on primary care
- Other states to follow

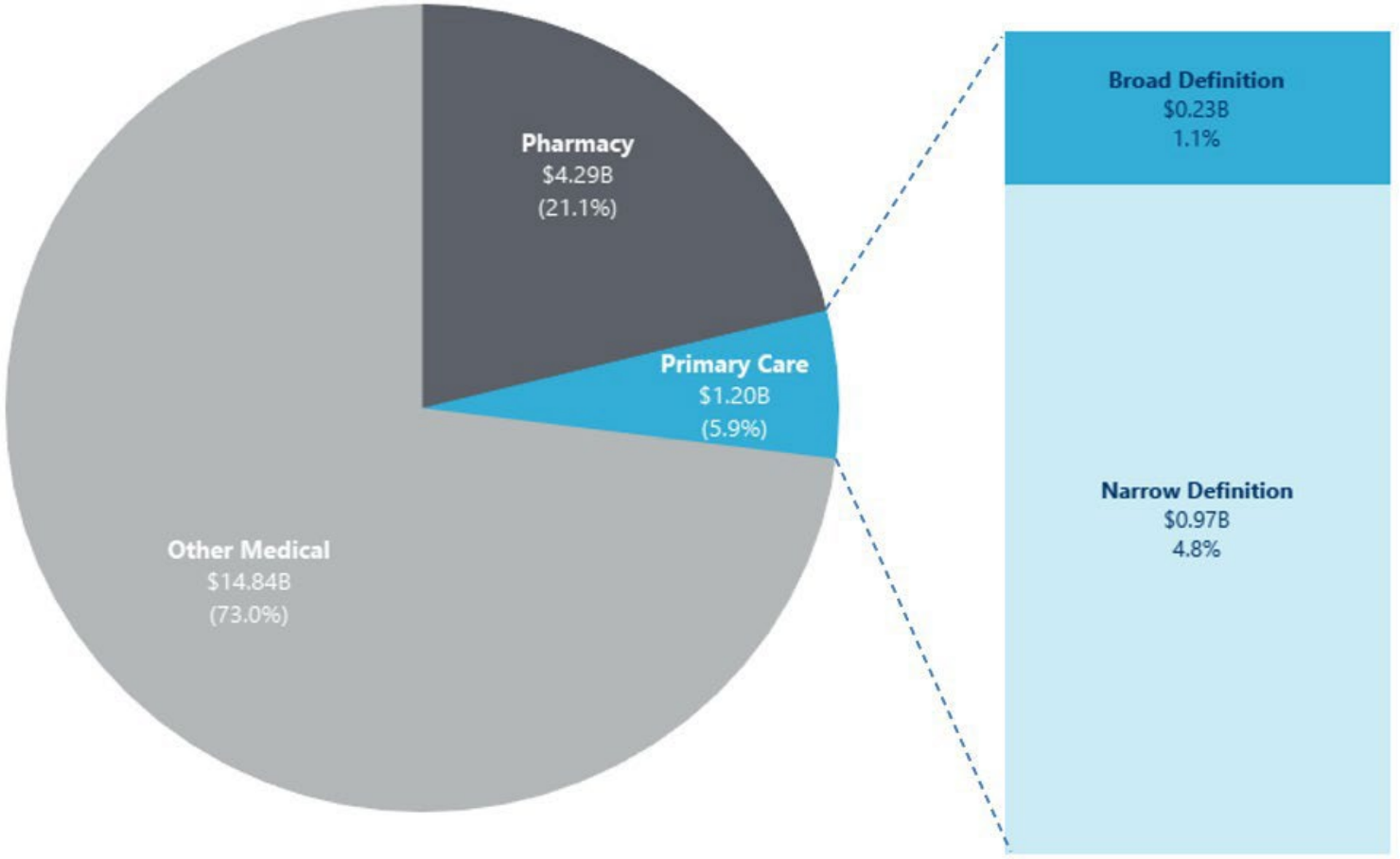
APCD Methods – Study Population

- Calendar years included
  - 2018, 2019, 2020
  - 2018 was refreshed to be consistent with changes to the WA-APCD extract and to ensure compatibility for trending
- Payer types
  - Plans included: Commercial, Medicare Advantage, Medicaid managed care, PEBB
  - Plans excluded: Medicare FFS, Medicaid FFS
- Claims limited to first service date between Jan. 1 and Dec. 31 of each year
- Pharmacy claims included
- Dental claims excluded

Methods – Identification of Primary Care

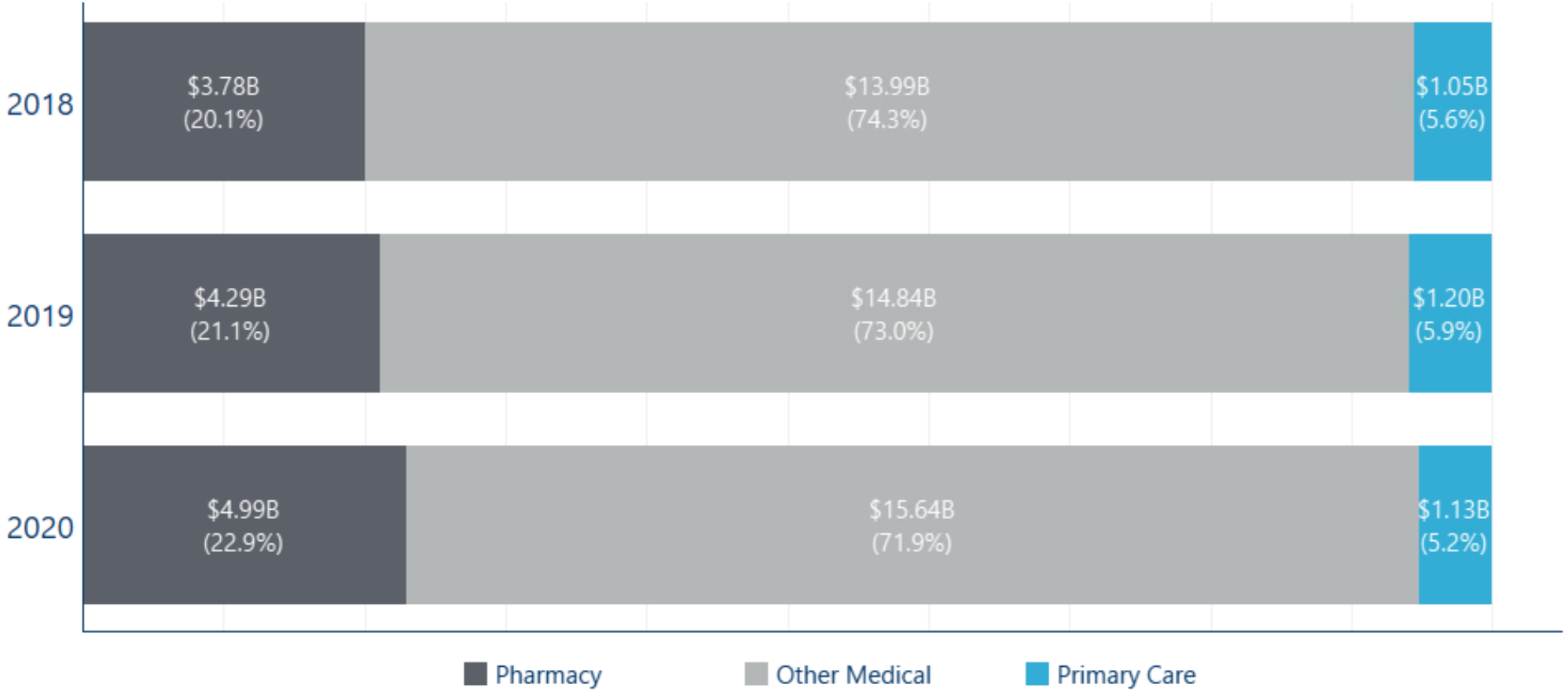
- Analysis replicated methods from 2019 OFM study (e.g., same taxonomy, CPT/HCPCS codes)
- Primary care providers
  - Identified by a set of taxonomy codes
  - Narrow and broad definition
- Primary care services
  - Identified by CPT and HCPCS procedure codes
  - Narrow and broad definition

Primary Care Spending Comprised 5.9% of Total in 2019



* Does not include Medicare FFS or Medicaid FFS plans

The % Primary Care Spending Ranged from 5.2% to 5.9% between 2018 & 2020

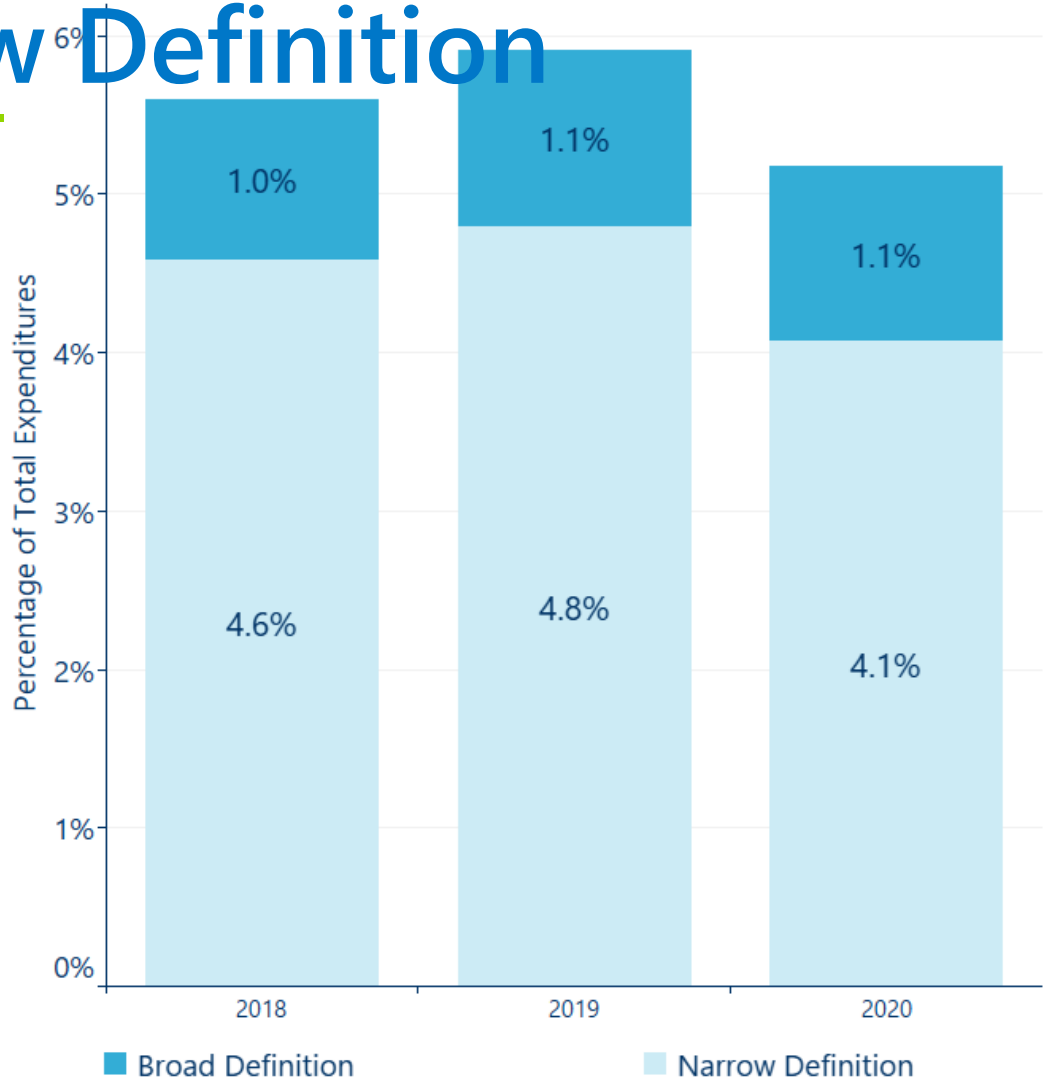


- Uptick between 2018 (5.6%) and 2019 (5.9%)
- Decline in 2020 (5.2%), likely due to COVID impacts

* Does not include Medicare FFS or Medicaid FFS plans

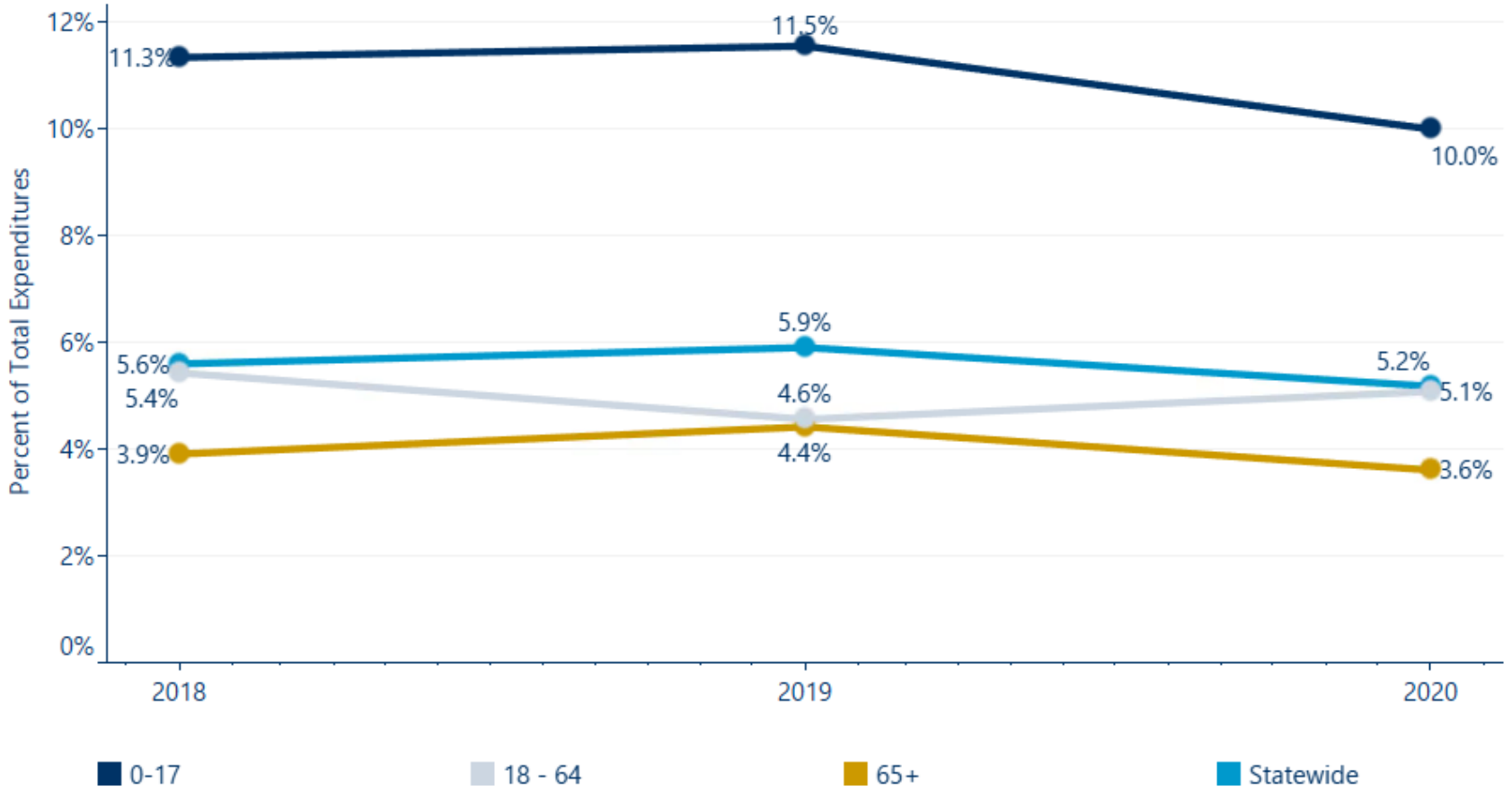
Changes in % of Primary Care Spending Primarily Driven by Narrow Definition

- Broad definition % stayed roughly the same over time, even during COVID
- Narrow definition providers/procedures dipped during COVID



* Does not include Medicare FFS or Medicaid FFS plans

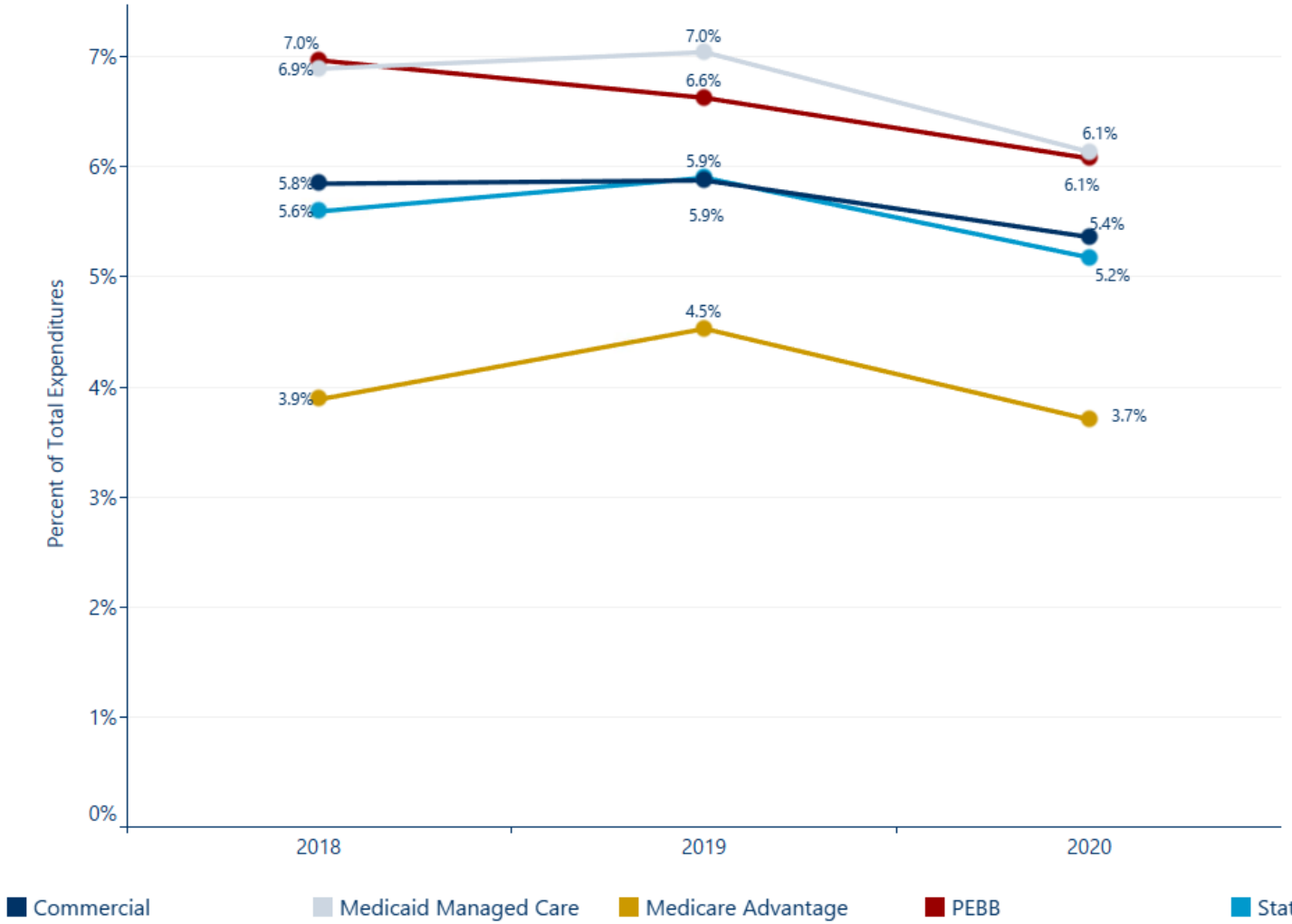
Primary Care as % of Total Expenditures by Age (in Years), 2018–2020



- Uptick between 2018 and 2019 appears to have been driven by increases among the older adult population (65+)
- Decline in 2020 was driven by pediatric (0–17) and older adult (65+) populations

* Does not include Medicare FFS or Medicaid FFS plans

% Primary Care Spending by Payer Type, 2



There was a decrease in the percentage of primary care spending in 2020 for all payer types

* Does not include Medicare FFS or Medicaid FFS plans

Summary of Claims-based Spend Findings

- Primary care spending was a small percentage of total medical and pharmacy spending (5.9%) in 2019
  - – Results were consistent with OFM's findings in their report on 2018 data
    - – Age variations were consistent with OFM report (e.g., higher percentage in pediatric population)
  - – Payer variations also consistent with OFM report
- It appears there was a small uptick in primary care spending as a percent of all spending between 2018 and 2019
  - – Driven by increases in the older adult population (65+) and Medicare Advantage
- Decrease in primary care as a percent of total in 2020
  - – Office and preventive visits decreased

Non-Claims-Based Measurement

- Billable Services and other primary care-related costs that may not appear on claims
  - Services may be paid as part of alternative payment mechanism (capitation, bundles, etc.)
  - Encounter-eligible services
  - Services that providers choose not to bill due to administrative burden (Collaborative Care codes, other)
  - Patient cost sharing
- Non-billable Services and other costs that may not appear on claims
  - Care coordination
  - Community Health Workers
  - Data management like patient registries
  - Quality incentives

Primary Care Committee Members: Considerations

- Primary Care Certification Workgroup
  - Stakeholder representation
  - Current knowledge and familiarity with topics
  - Advising on levels of primary care for multi-payer PC Transformation Model

Certification Workgroup:

Workgroup leads: Tony Butruille (American Academy of Family Physicians) and Caitlin Safford (Amerigroup)

Ann Christian – WA Council for Behavioral Health
Bruce Gray – NW Regional Primary Care Association
Carena Hopen - Molina
Courtney Ward - CHPW
Drew Oliveira - Regence
Eleanor Escafi - Regence
Elizabeth Avena –Family Medicine in Omak
Ginny Weir – Foundation for Health Care Quality
Jonathan Staloff – Family Medicine
Kate Mundell - Coordinated Care
Katina Rue - WSMA
Kristy Valdez – United
Linda Van Hoff – ARNP United
LuAnn Chen – CHPW
Matthew Hollon – American College of Physicians
Sarah Stokes – Kaiser
Sharon Brown – Greater Columbia ACH
Sharon Eloranta – WA Health Alliance
Shawn West – Embright
Sheryl Morelli – American Academy of Pediatrics
Stacey Davis - Greater Columbia ACH
Tracy Corgiat – Confluence Health
Vicki Lowe- American Indian Health Commission

Next Steps

- Select and contact Primary Care Committee members
- Present committee to the Board
- Develop meeting schedule
- Prepare agenda and materials for first meeting (Recommendation 1)

Questions, Discussion and Feedback

- What should be considered in forming the Primary Care Committee? Any considerations not listed?
- What are your initial thoughts on the recommendations we have identified?
- Do you have feedback or guidance on the process for arriving at recommendations?

Washington State Health Care Authority

Washington hospital costs, price, and profit analysis

TAB 4

Washington Hospital Costs, Price, and Profit Analysis: Review Hospitals by Bed Size Peer Groups

John Bartholomew & Tom Nash
Bartholomew-Nash & Associates

Health Care Cost Transparency Board

August 17, 2022

The Approach to Identify Outliers

- When considering data and findings regarding hospital analytics, you must consider the source.

- This analysis uses self reported 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**

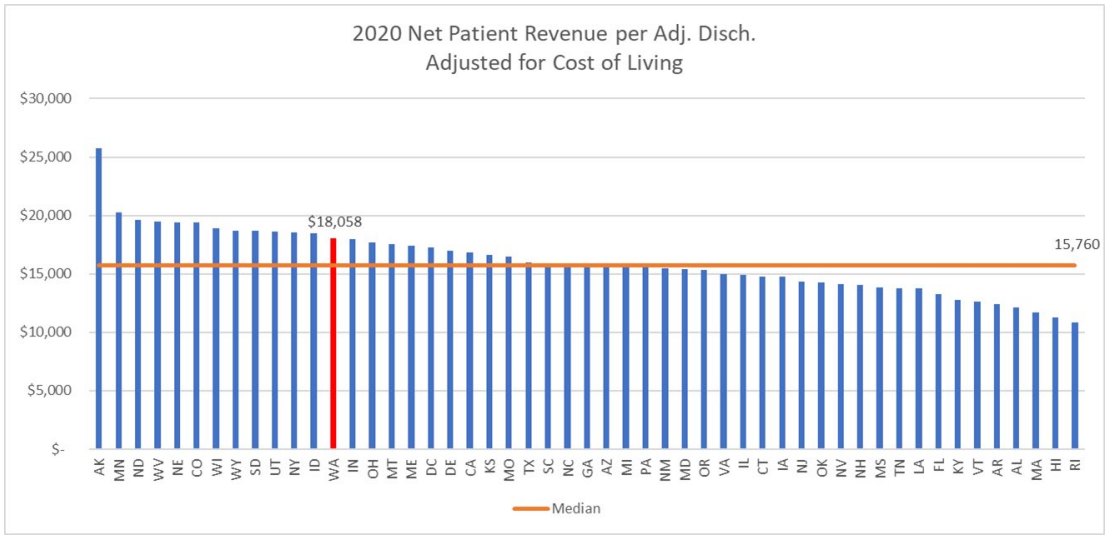
  - Hospital Only Operating Cost divided by Adjusted Discharge = **Cost per Patient**

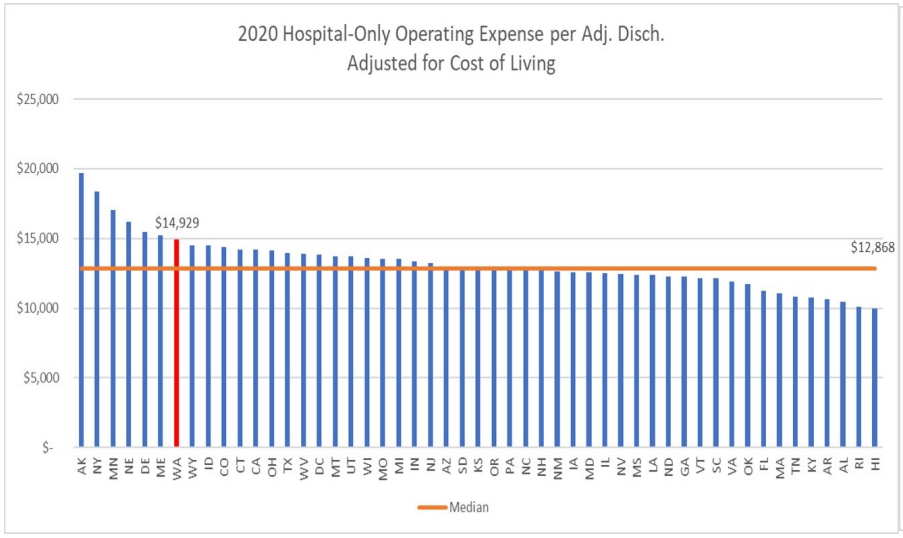
  - Net Income divided by Adjusted Discharges = **Profit per Patient**

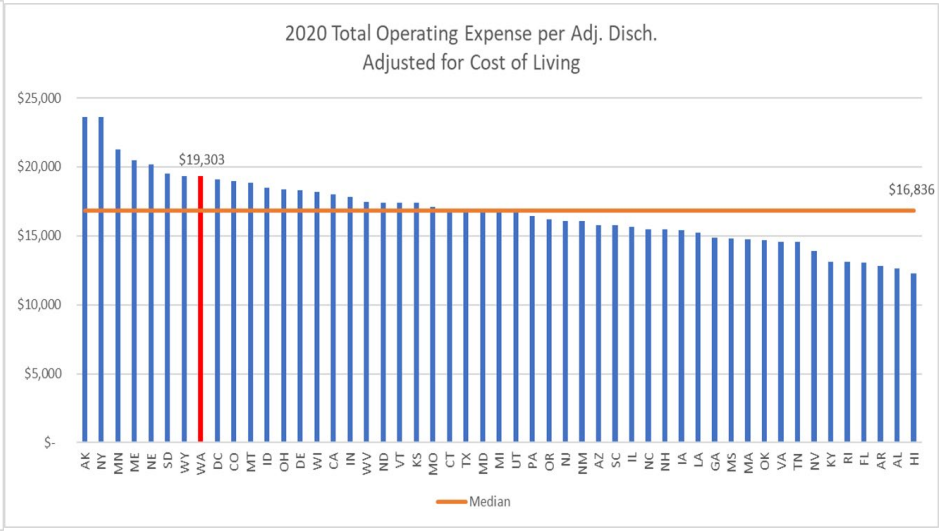
- Observe trends across hospital types and peer groups

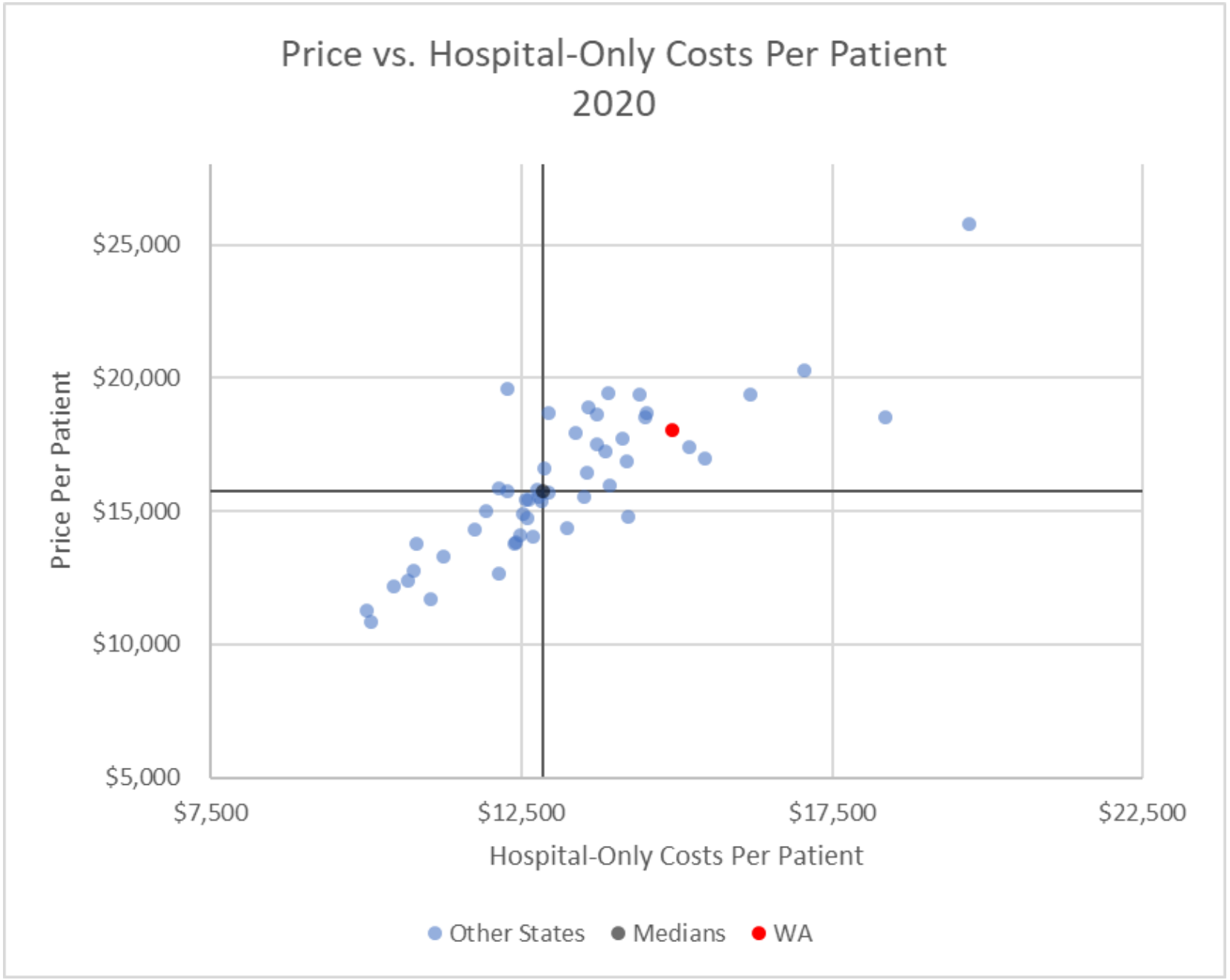
  - Health systems, independents, for-profit, not-for-profit, rural, urban, teaching, and by bed size

2020 COLA Data; WA ranked 13th Highest Price, 7th & 8th Highest Costs








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

Quick Refresh: Overall WA Hospitals in Aggregate have Higher Prices and Costs, COLA, and are lower Using Profit as a Measure*

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 are lower compared to the national median using two profit measures.

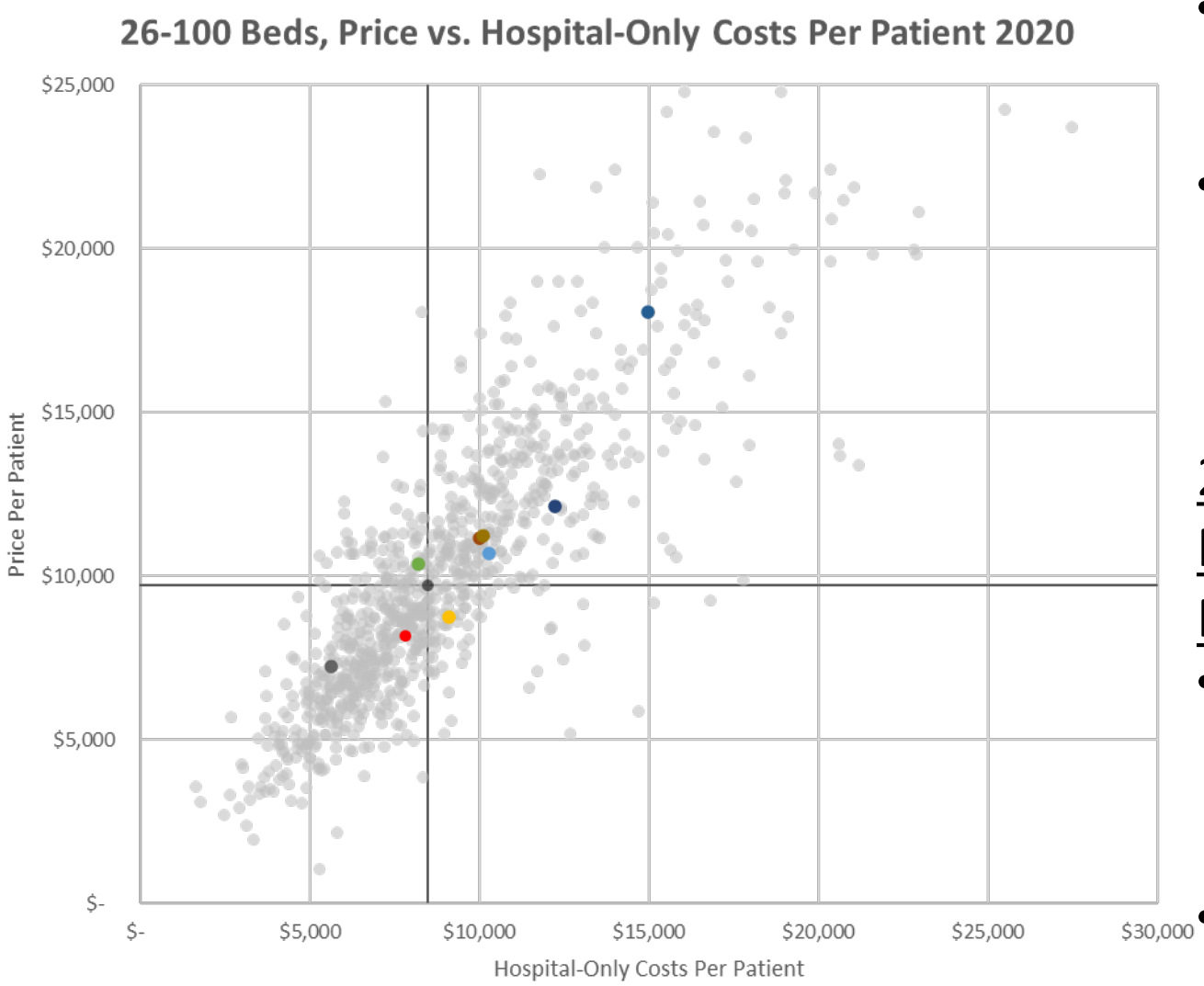
Patient Services Margin is a profit margin based solely on patient services.

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

Review of Washington Hospital Outliers

Washington Hospital Groupings
Hospitals with > 25 Beds

Price	High price						Not high price								
	15						32								
Cost	National normal cost			High cost			National normal cost			High cost			Low cost		
	3			**12**			23			6			2		
Profit	High profit	National normal profit	Low profit	High profit	National normal profit	Low profit	High profit	National normal profit	Low profit	High profit	National normal profit	Low profit	High profit	National normal profit	Low profit
	0	2	1	2	6	4	4	11	8	0	2	4	1	1	4

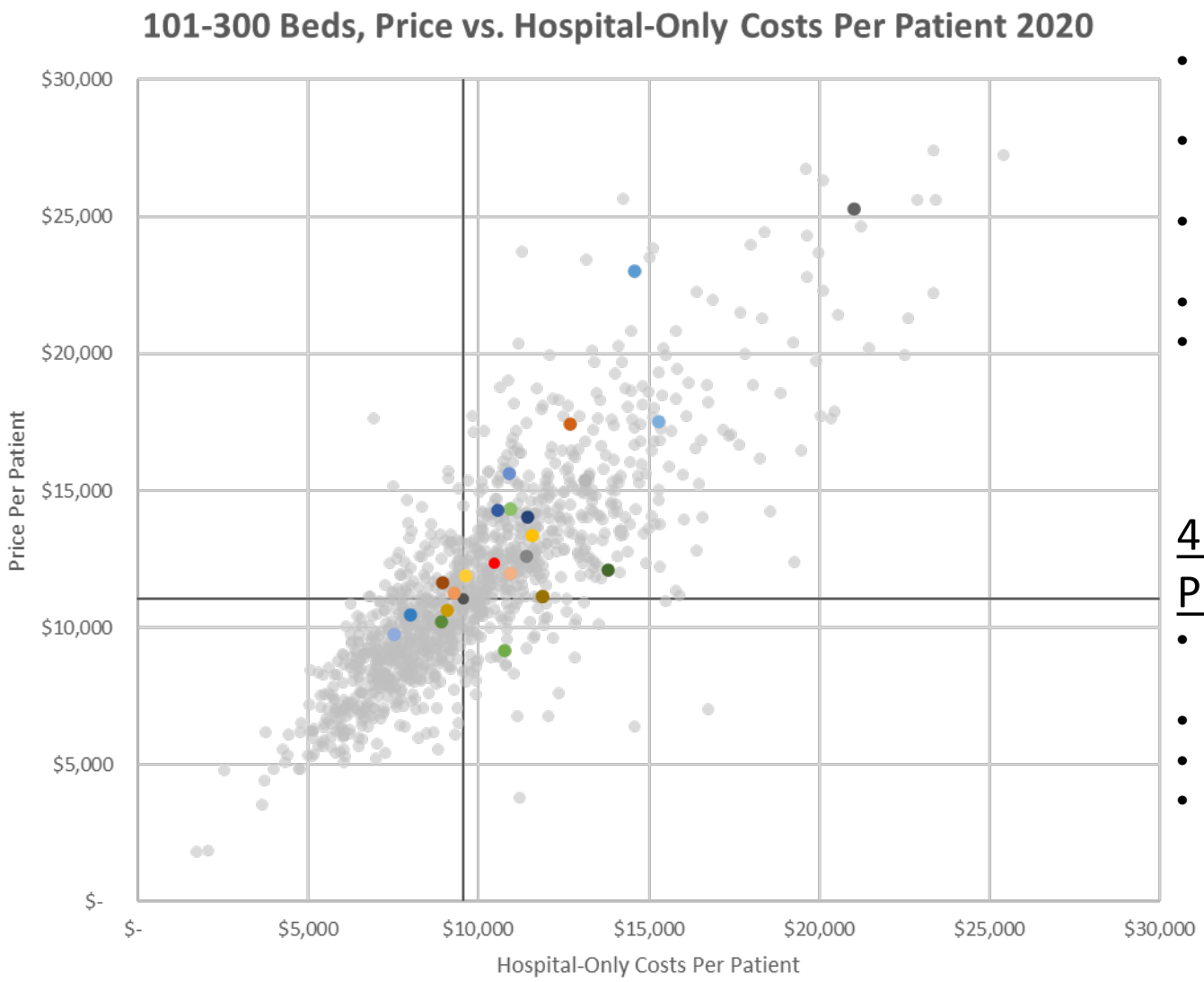


2 Price/Cost Outliers:

- Lourdes Medical Center
- Evergreen Health Monroe

2 Below Median Price/Costs:

- Multicare Covington Medical Center
- Island Hospital

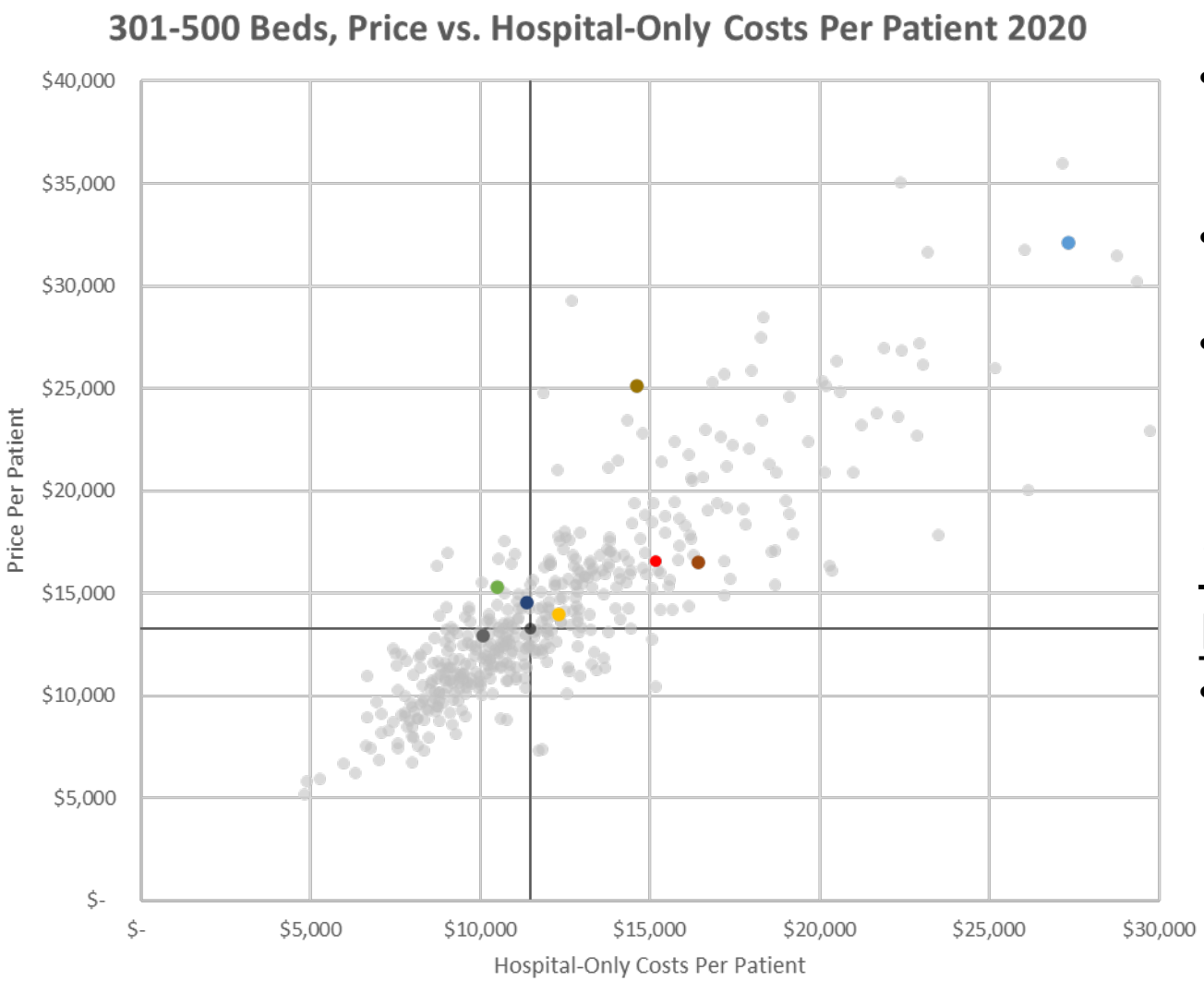


6 Price/Cost Outliers:

- Confluence Health - Central Washington Hospital
- Virginia Mason Med Center
- Deaconess Med Center
- Kadlec Regional Med Center
- Swedish Edmonds
- Peacehealth St. Joseph Med Center - Bellingham

4 Below Median Price/Costs:

- Legacy Salmon Creek Hospital
- Capital Med Center
- St. Francis Hospital
- Multicare Valley Hospital - Spokane

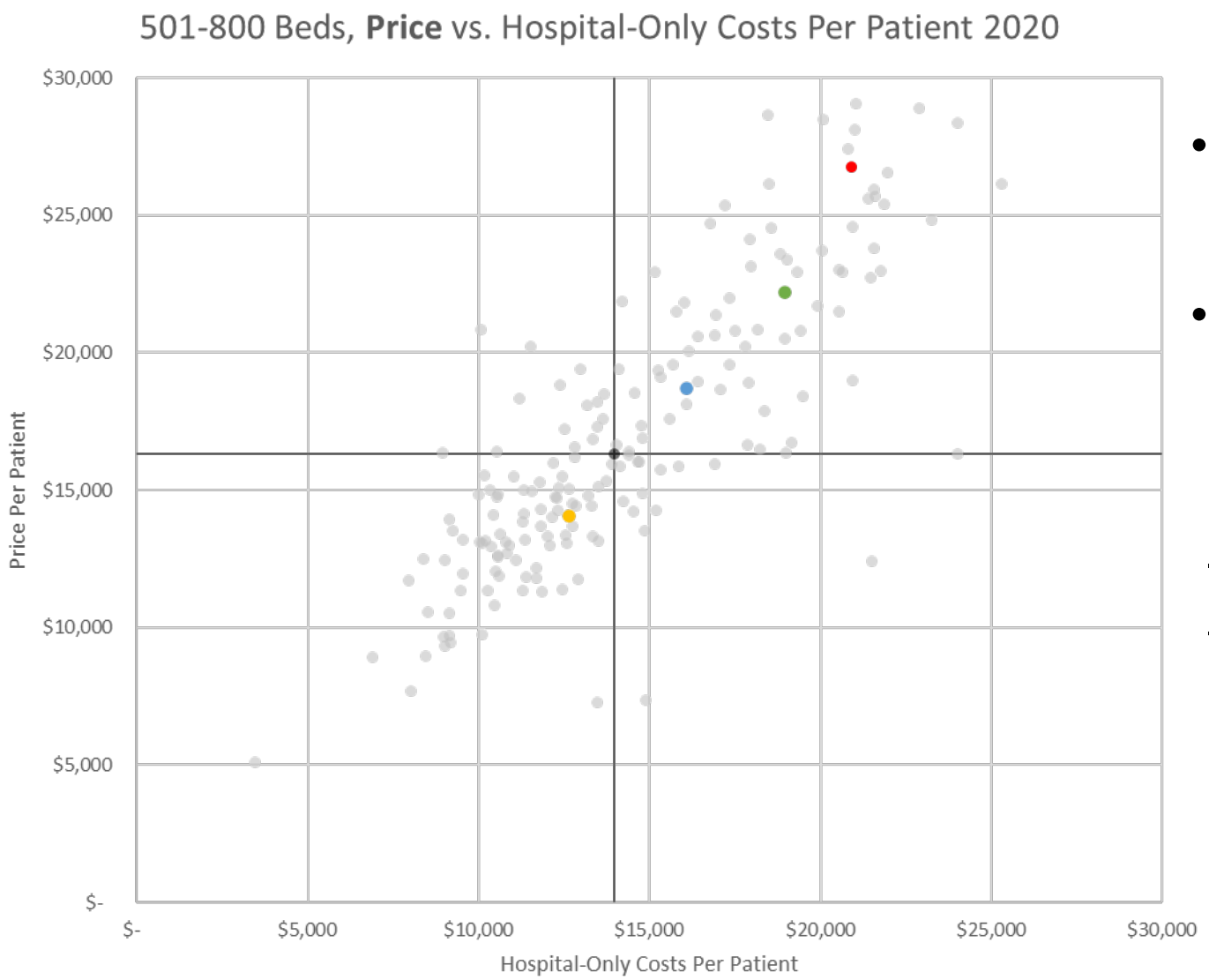


4 Price/Cost Outliers:

- Harborview Med Center
- Tacoma General Allenmore Hospital
- St. Joseph Med Center
- Providence St. Peter Hospital

1 Below Median Price/Costs:

- Evergreen Healthcare Kirkland



3 Price/Cost Outliers:

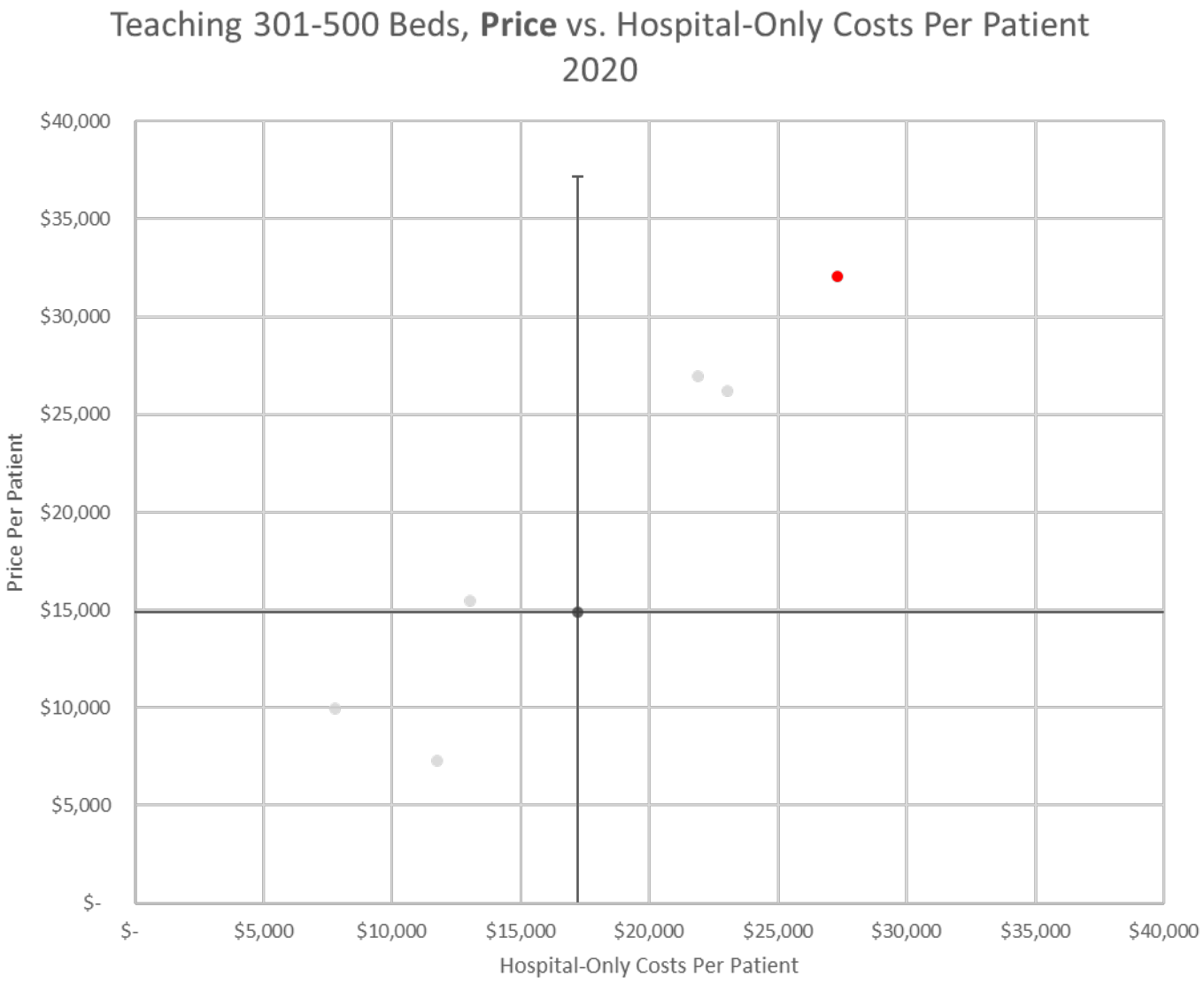
- University of Washington Med Center
- Providence Sacred Heart Med Center
- Swedish Med Center - Seattle

1 Below Median Price/Costs:

- Providence Regional Med Center Everett

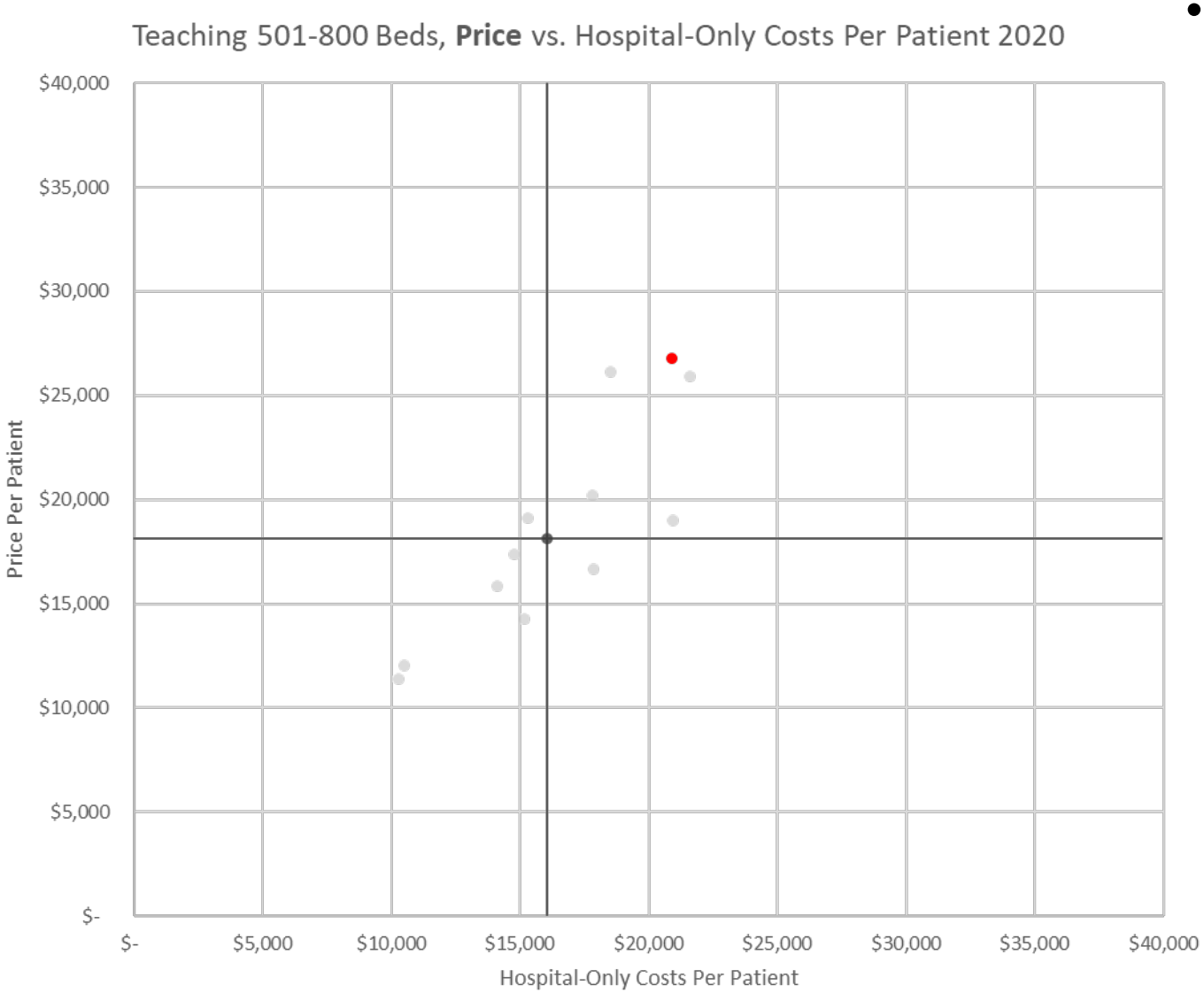
1 Price/Cost Outlier:

- Harborview Med Center



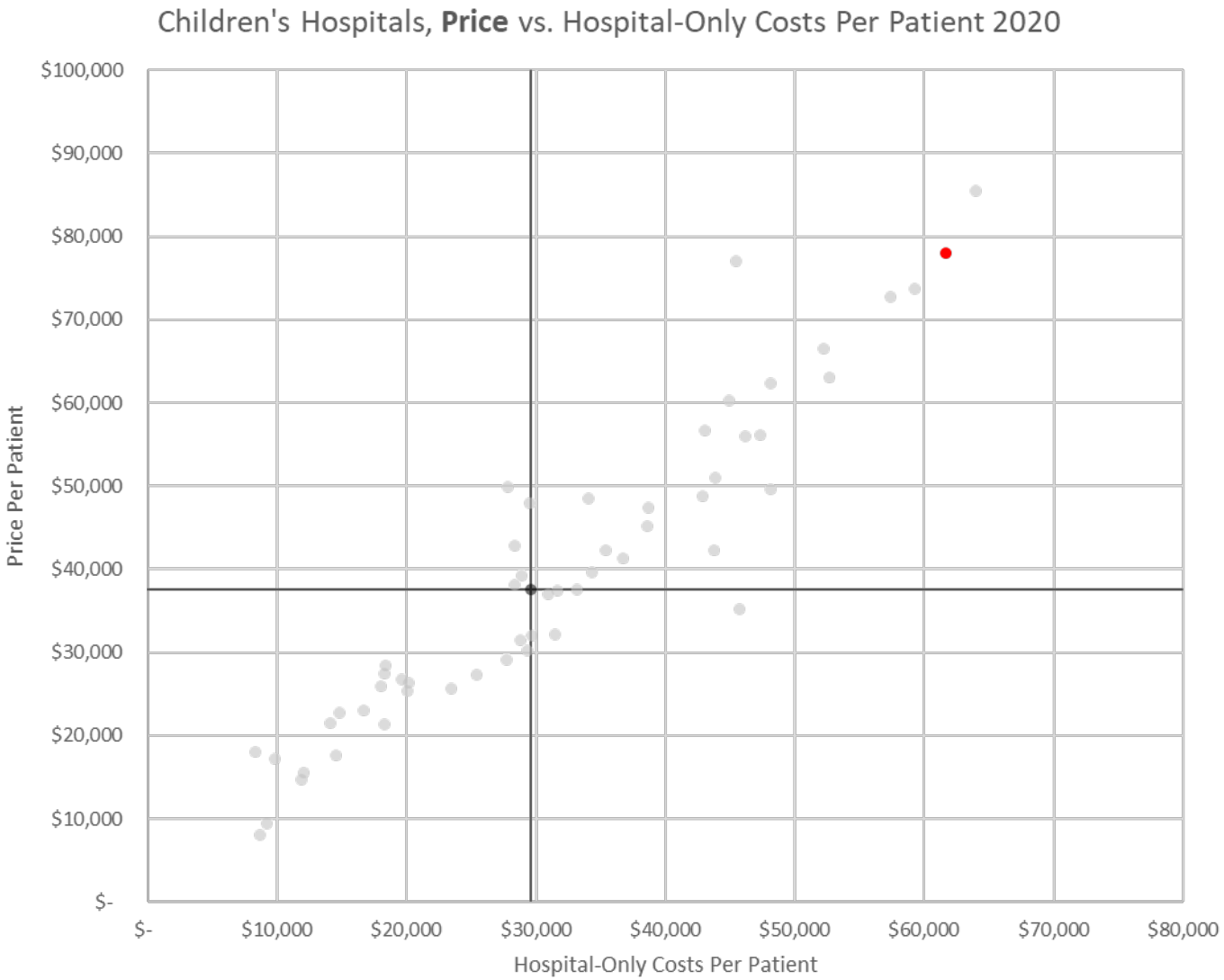
1 Price/Cost Outlier:

- University of Washington Med Center



1 Price/Cost Outlier:

- Seattle Children's Hospital



Conclusion:

- **There is more work that needs to be done.**
- **A deeper dive would be important to further understand Price, Cost, and Profit variations from the National Median over time.**
- **But also, for a fair and accurate comparison, we need to look at other measures, such as, case mix, service intensity measures, operating environment, payer mix, and other financial measures to enable better comparisons between hospitals.**
- **The goal is to adjust for service intensity, acuity, location, and other differences so the variation in price and cost is isolated to business decisions or price discrimination.**

Additional Questions/Comments?

Washington State Health Care Authority

Public comment

TAB 5

Public comment

Washington State Health Care Authority

Washington State Health Care Authority

Influence of health workforce trends on health spending growth

TAB 6

Influence of health workforce trends on health spending growth

Health Care Cost Transparency Board Meeting
August 27, 2022

Bianca K. Frogner, PhD
Professor, Department of Family Medicine
Director, Center for Health Workforce Studies
University of Washington

center for health workforce studies
UNIVERSITY of WASHINGTON

Twitter: @uwchws, @biancafrogner

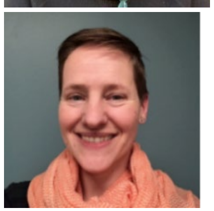
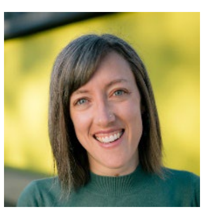
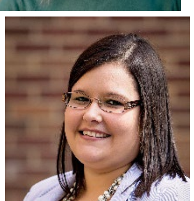
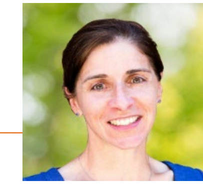




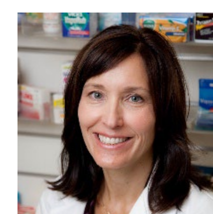



UW Center for Health Workforce Studies



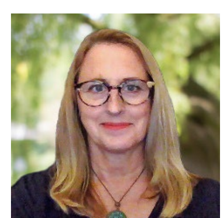










- Established in the Department of Family Medicine in School of Medicine in 1998
- Conducts health workforce research to inform health workforce planners and policy makers
- Supported by multiple grants/contracts including two center grants from the Health Resources and Services Administration with focus on:
  1) Allied health workforce
  2) Health equity & workforce diversity



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Objectives

- Defining the health workforce
- Understanding the health workforce connection to health spending
- Identifying COVID effect on health workforce
- Determining whether a workforce shortage exists
- Monitoring strategies to support the health workforce

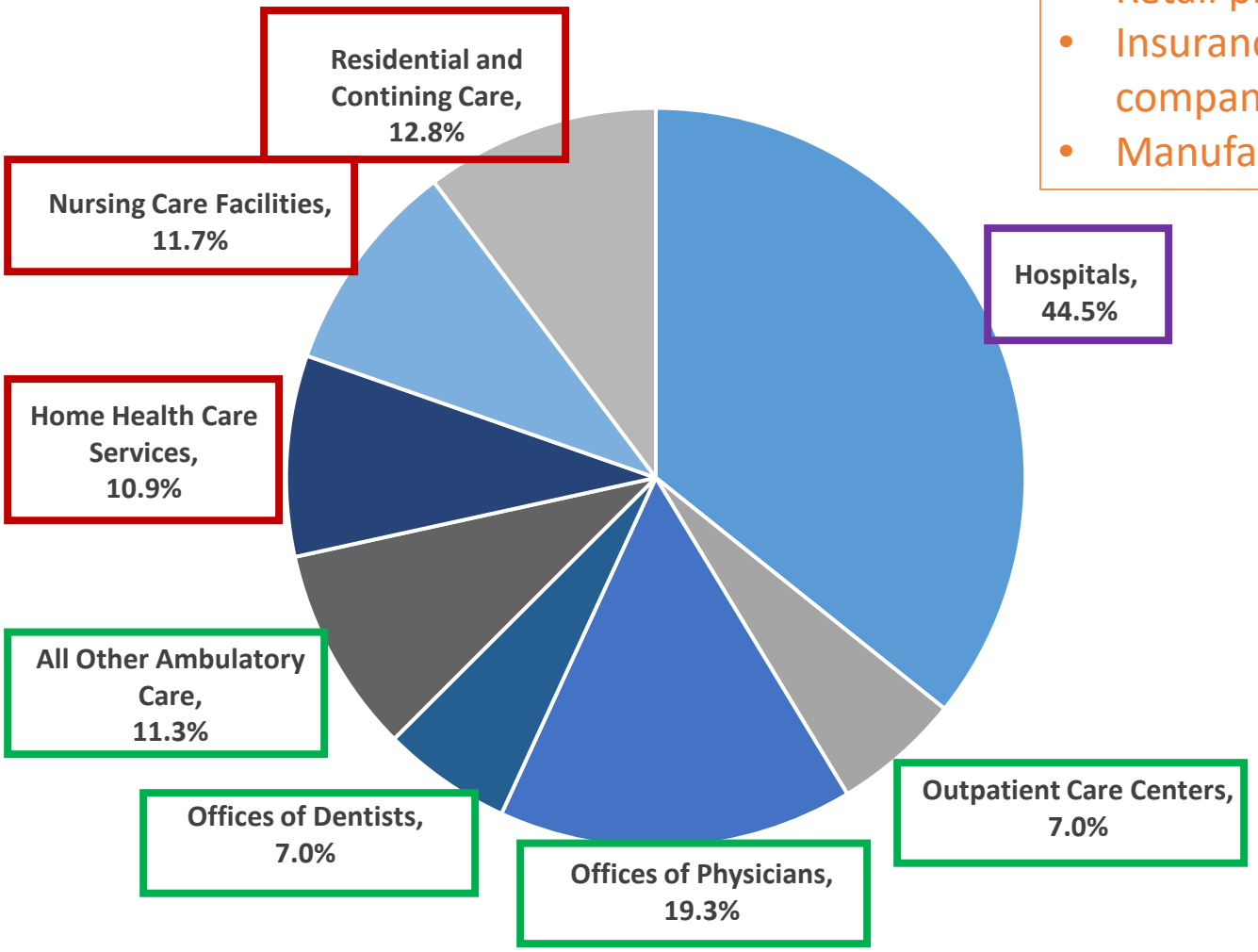
Who makes up the health workforce?

Defining Industries and Occupations

Sectors within Health Care Industry, 2019 (n=17,054,890)

Not captured:

- Retail pharmacies
- Insurance companies
- Manufacturing



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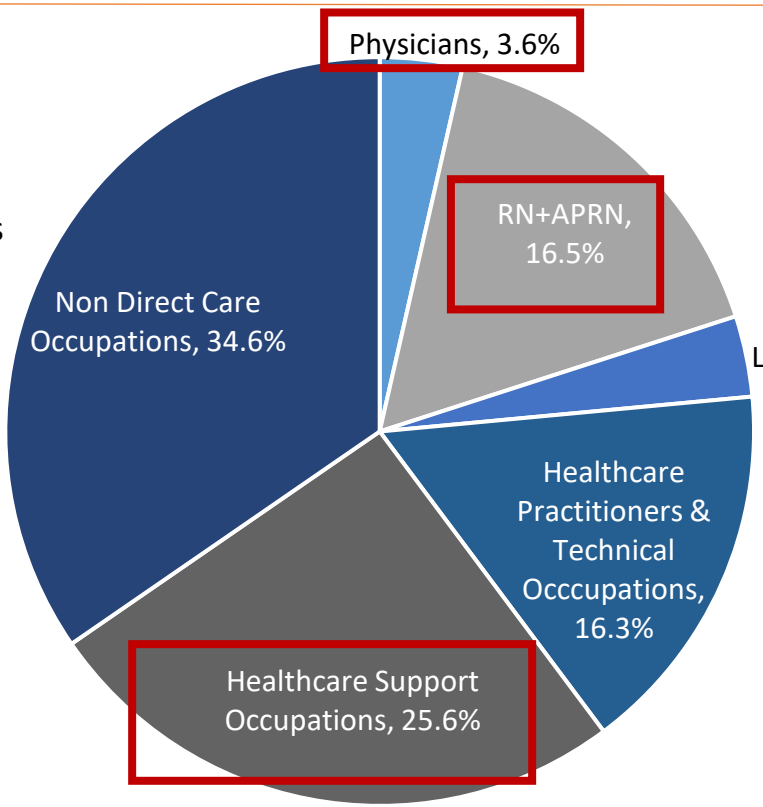
Source: Frogner calculation of Bureau of Labor Statistics, Occupational Employment & Wage Statistics, 2019

Occupations within Health Care Industry, 2019 (n=17,054,890)



Examples:
Community Health Workers
Social Workers
Administrative/Financial/ Management
Grounds/Maintenance
Food Preparation

Examples:
Dentists
Pharmacists
Therapists
Physician Assistants

Examples:
Nursing Assistants
Home Health Aides
Home/Personal Care Aides

Medical Assistants
Pharmacy Aides
Dental Assistants
OT/PT Assistants

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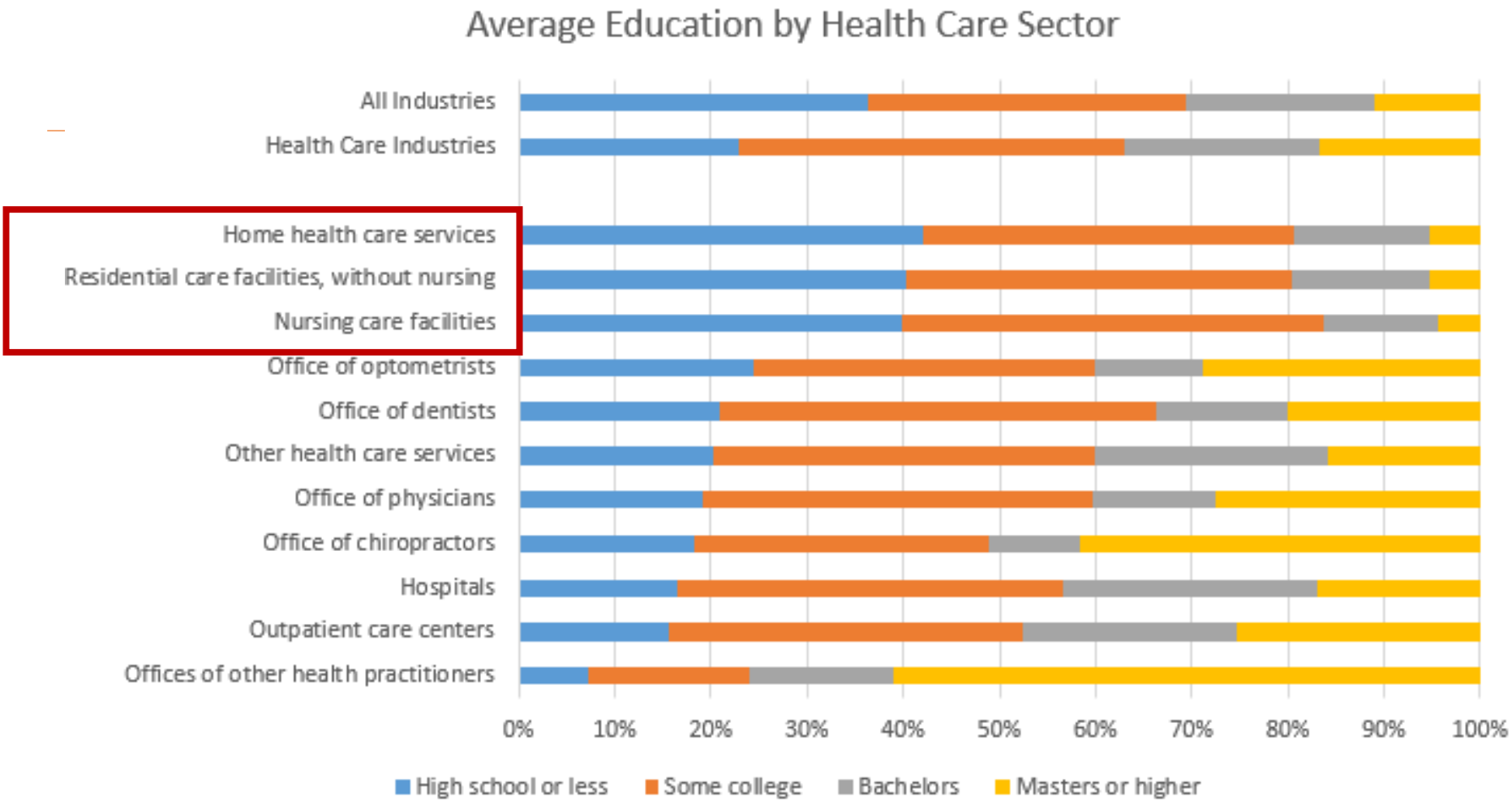
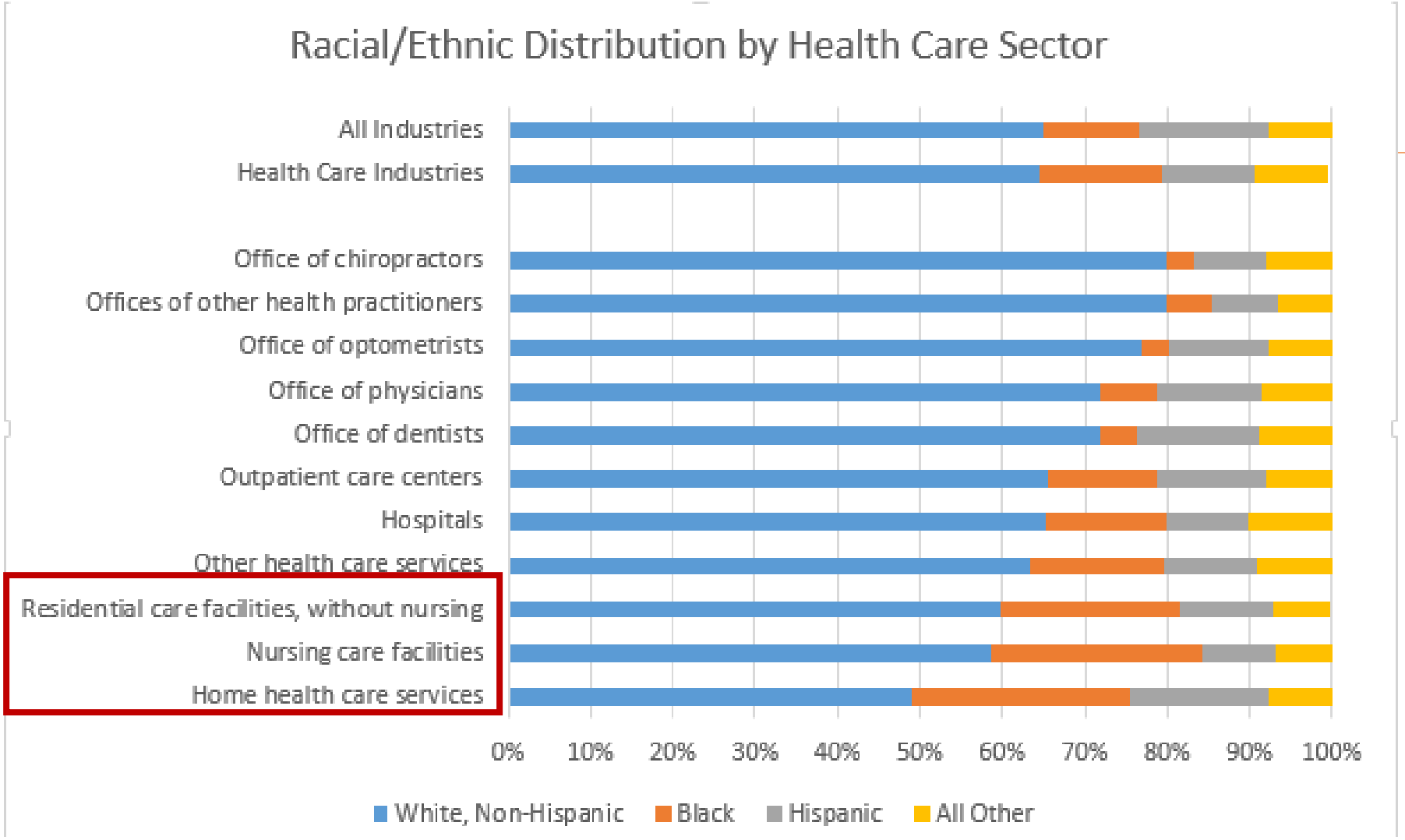
Source: Frogner calculation of Bureau of Labor Statistics, Occupational Employment & Wage Statistics, 2019



Source: Frogner BK, Spetz J, Parente ST, and Oberlin S (2015). "The Demand for Health Care Workers Post-ACA," *International Journal of Health Economics and Management*, 15(1): 139-151.

Racial/Ethnic Distribution by Health Care Sector



Source: Frogner BK, Spetz J, Parente ST, and Oberlin S (2015). "The Demand for Health Care Workers Post-ACA," *International Journal of Health Economics and Management*, 15(1): 139-151.

Key Points

- Many different types of workers in health care
- Fairly even distribution of workers across 3 major sectors: hospitals, ambulatory care, long-term care
- Industry includes some of the most well-educated (high paid) workers, but also includes many jobs with low educational requirements with low pay *(more on wages soon…)*
  - Worth noting the high level of diversity in long-term care

Connecting the Health Workforce to Spending

Understanding Dynamic Relationships

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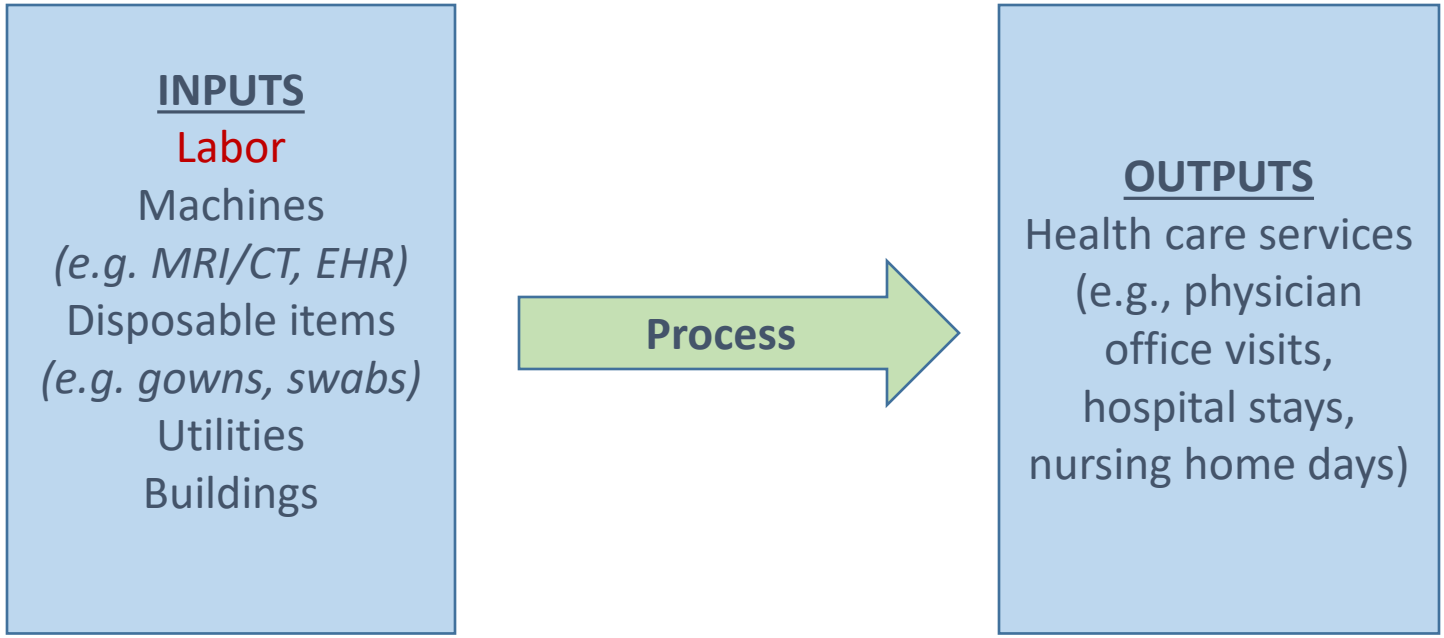
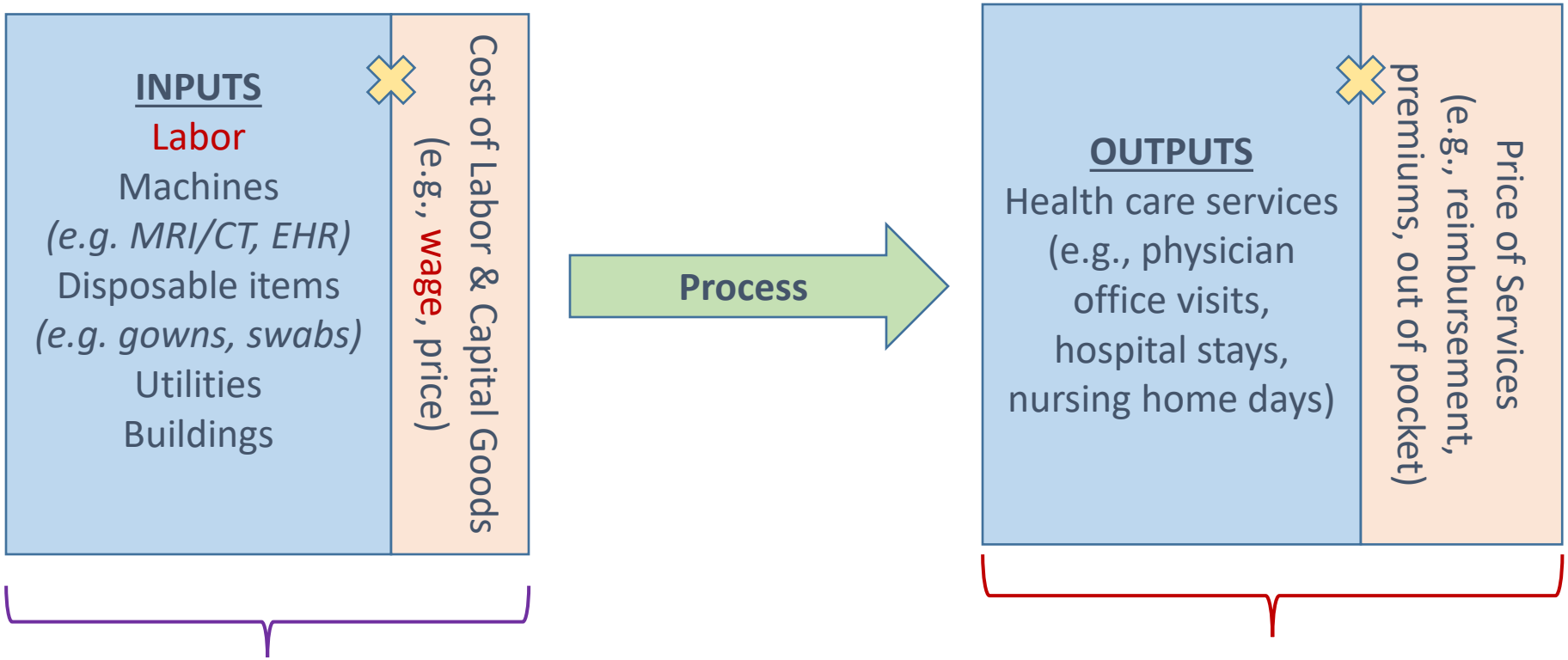
A Simple Input-Output Model of Health Care Spending

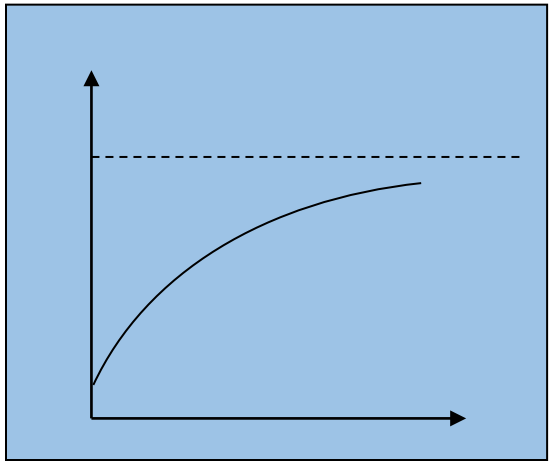


A Simple Input-Output Model of Health Care Spending

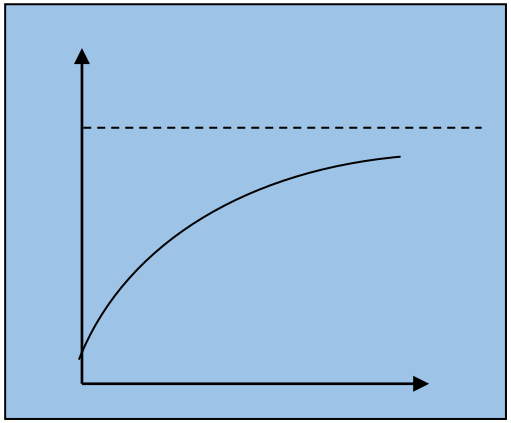


Bending the Cost Curve = Curbing Labor or Wage Growth?

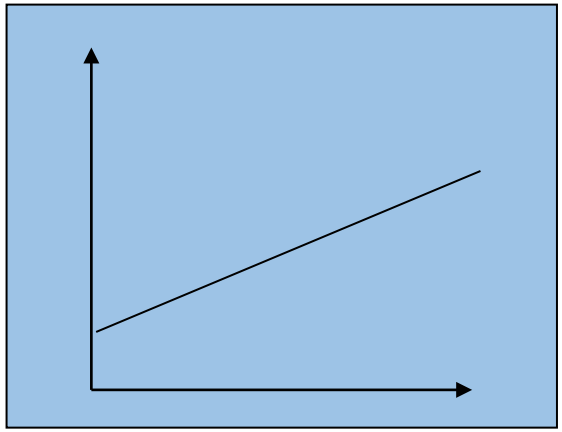
Health Spending Growth



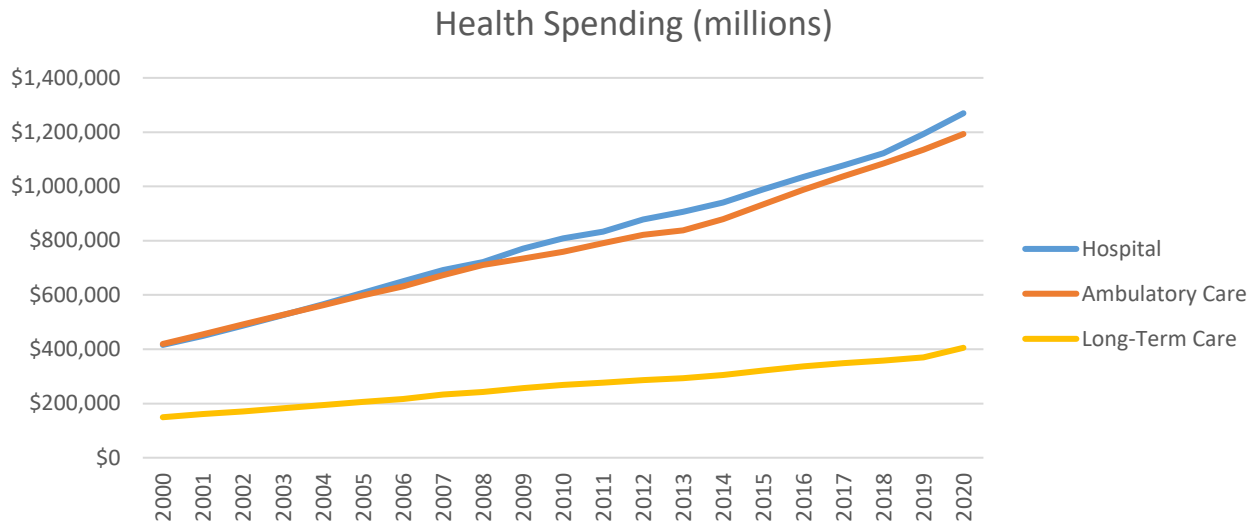
Health Care Labor Force

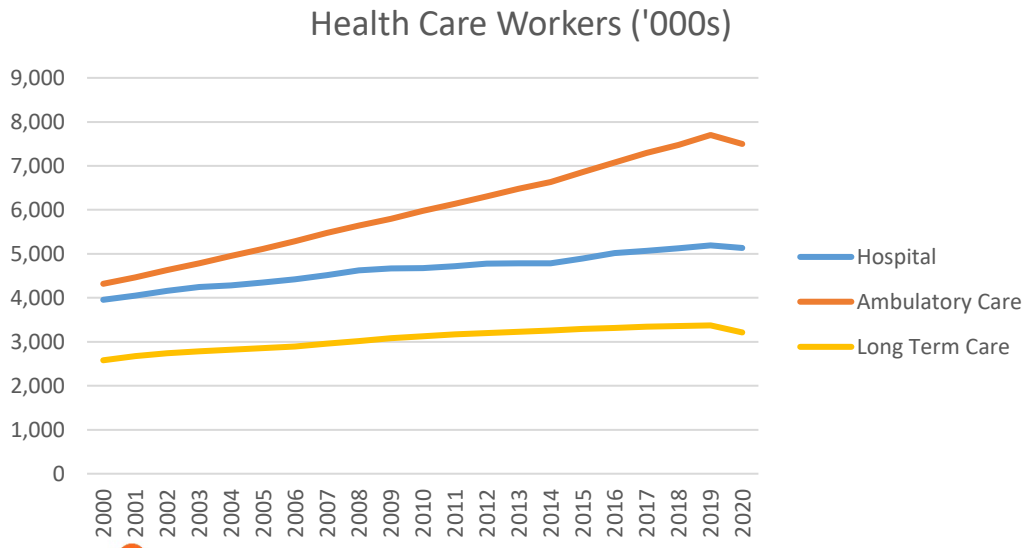


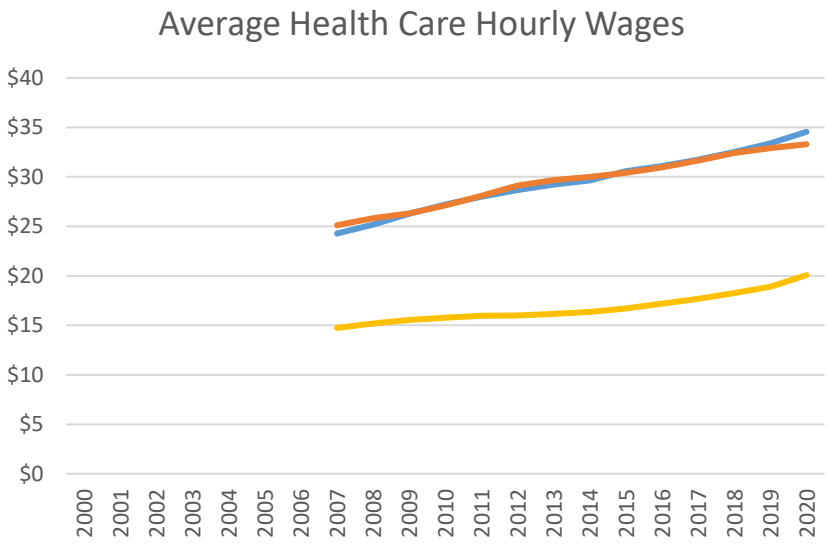
Health Care Wage Rate



National Health Spending Relative to Employment and Wage Growth







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Sources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical; https://data.bls.gov/cgi-bin/dsrv?ce

Key Points

- National health care labor and wage rates have grown fairly smooth
- Contribution of health care labor & wages relative to total health spending, including translation into prices of health care services, not well understood
  - Even less clear at the state level
- Slowing health care spending will affect total number of workers and/or wages

How COVID Affected Health Workforce Trends

Employment, Wages, and Competition

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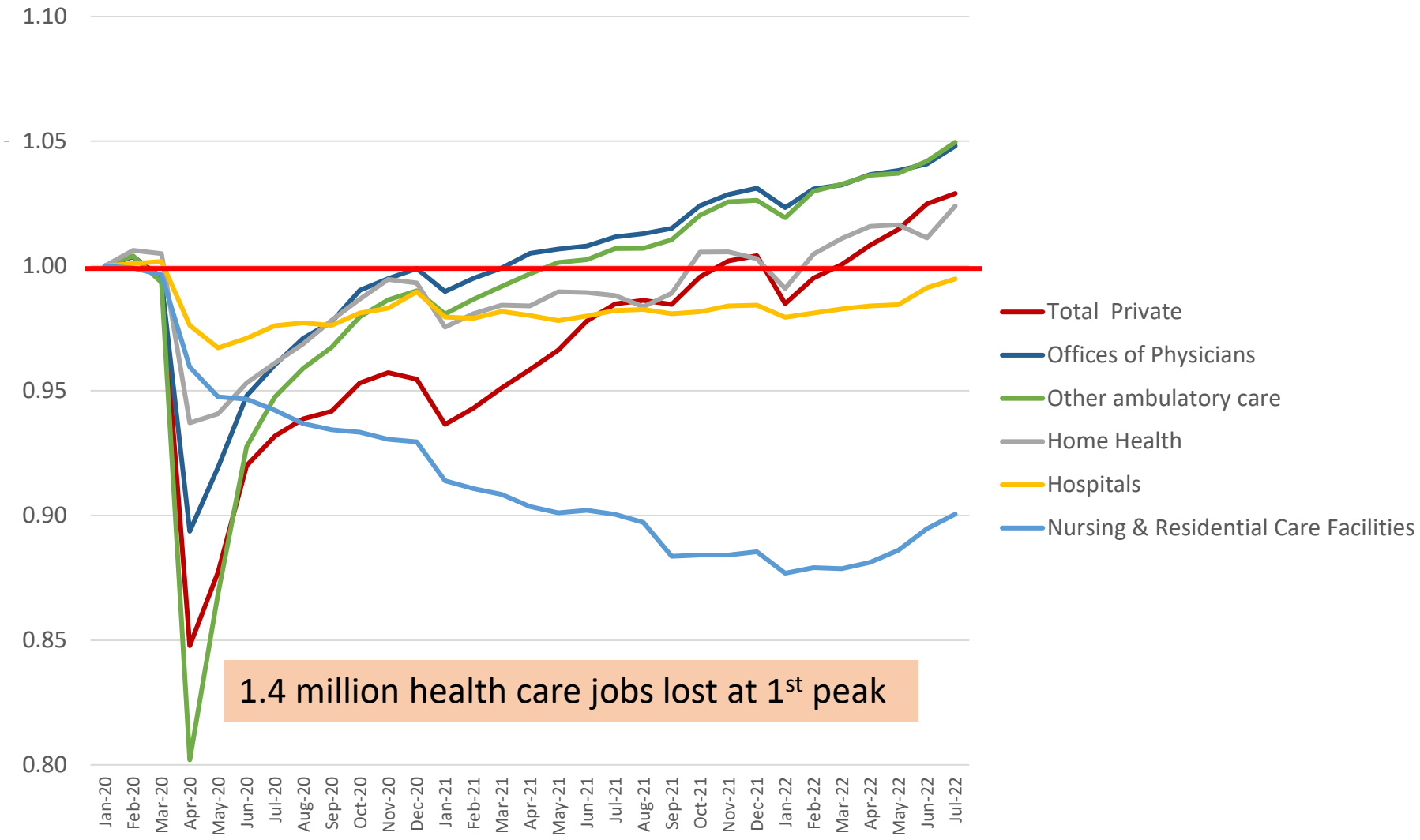
Relative Number of Employees by Sector, Jan 2020 to Jul 2022 (Jan 2020=1.00)



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Source: Author calculation of Table B-1 Employees on nonfarm payrolls by industry sector and selected industry detail, Bureau of Labor Statistics, https://www.bls.gov/news.release/empsit.t17.htm

Tracking Turnover among Health Care Workers During the COVID-19 Pandemic

- Data: Current Population Survey, Jan 2019 – Oct 2021
  - Monthly household survey collected by Bureau of Labor Statistics
  - Complex sampling frame allowing to follow individuals across months
- Sample: Health care workers
- Outcome: Turnover = employed in one month then reported as unemployed or out of the labor force in consecutive month
- Approach: Random effects logistic regression to examine leaver rates across 3 time periods:
  - Pre-Period: Jan 2019 to March 2020
  - Post-Period 1: April 2020 to December 2020
  - Post-Period 2: January 2021 to October 2021

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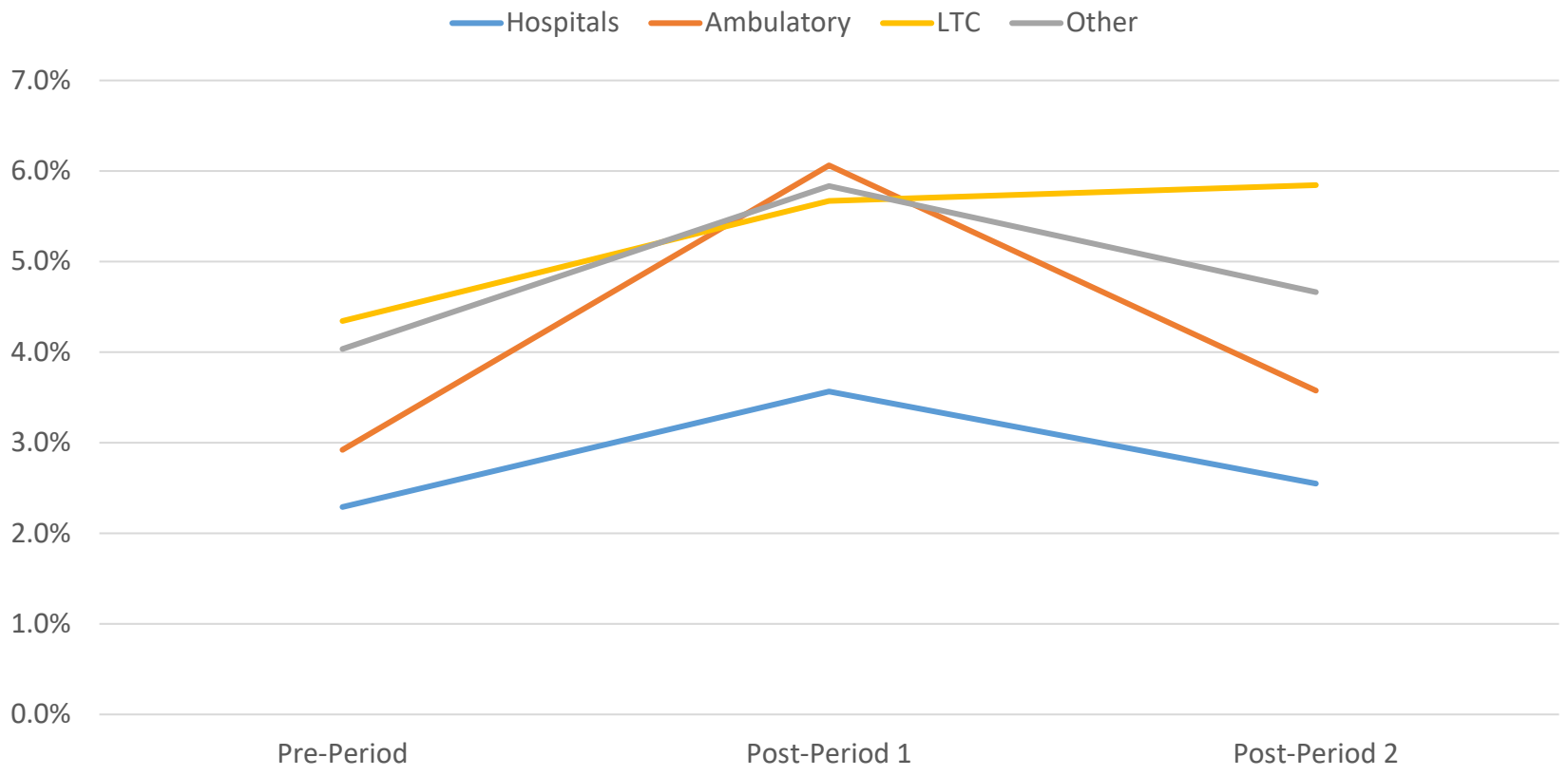
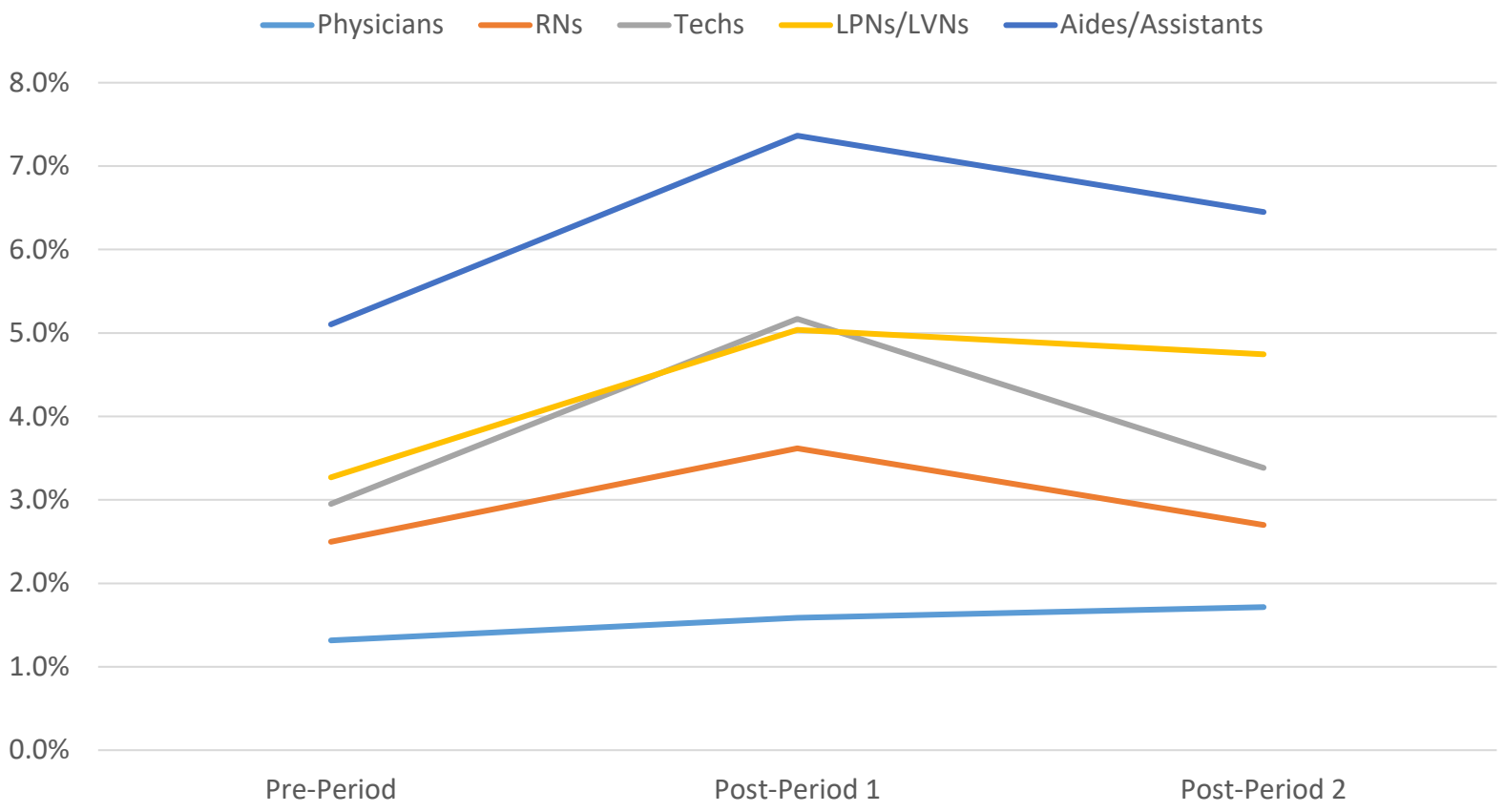
Turnover Rates by Sector and COVID Phase



LTC = long-term care; Other includes all other industries outside health care
Predicted probabilities reported controlling for gender, having child under 5 in HH, race/ethnicity, age, age sq, education, marital status, COVID cases/deaths, indicator for April 2020

Turnover Rates by Occupation and COVID Phase



RN = Registered Nurse; LPN/LVN = Licensed Practical Nurse/Licensed Vocational Nurse
Predicted probabilities reported controlling for gender, having child under 5 in HH, race/ethnicity, age, age sq, education, marital status, COVID cases/deaths, indicator for April 2020

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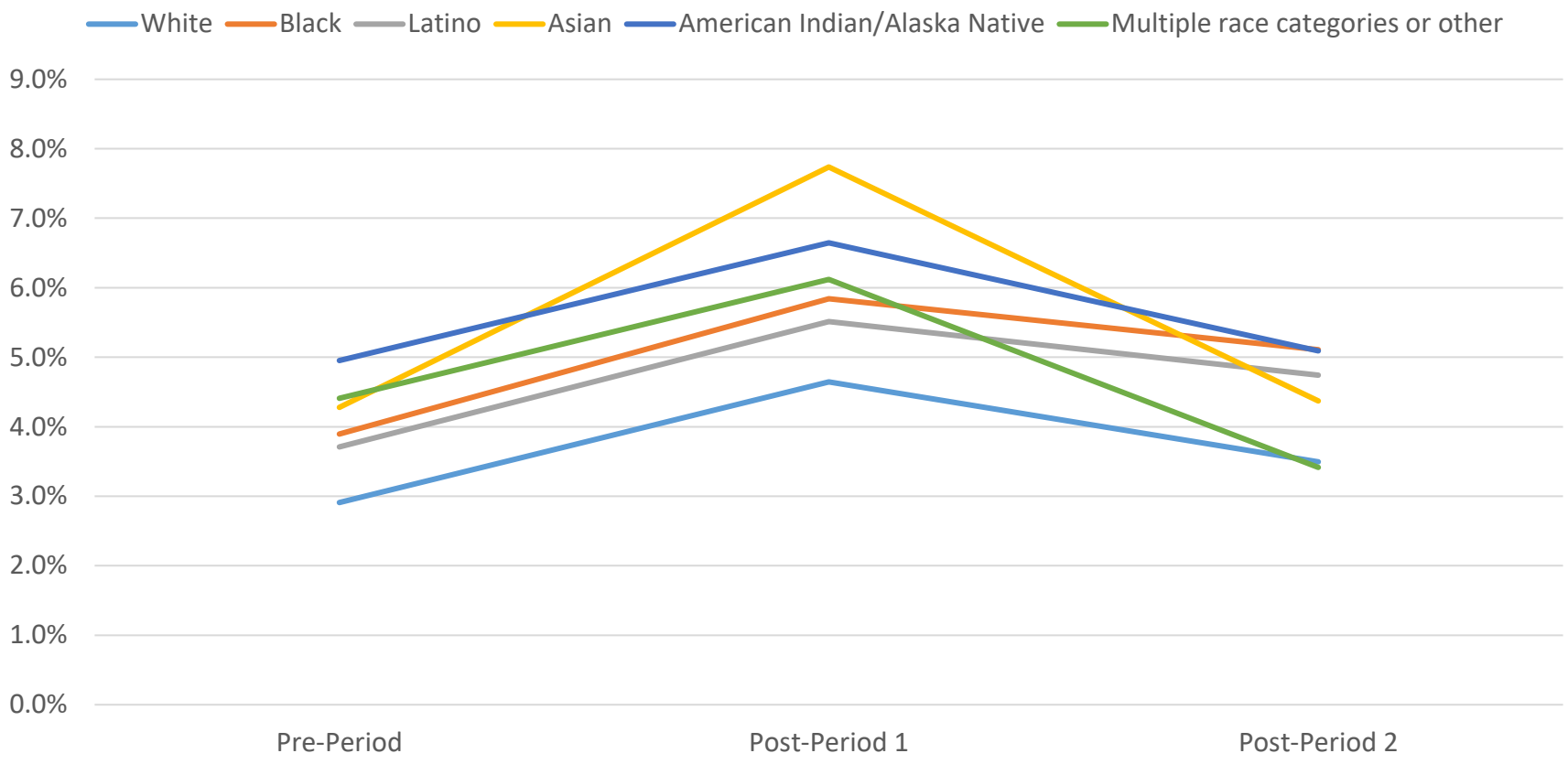
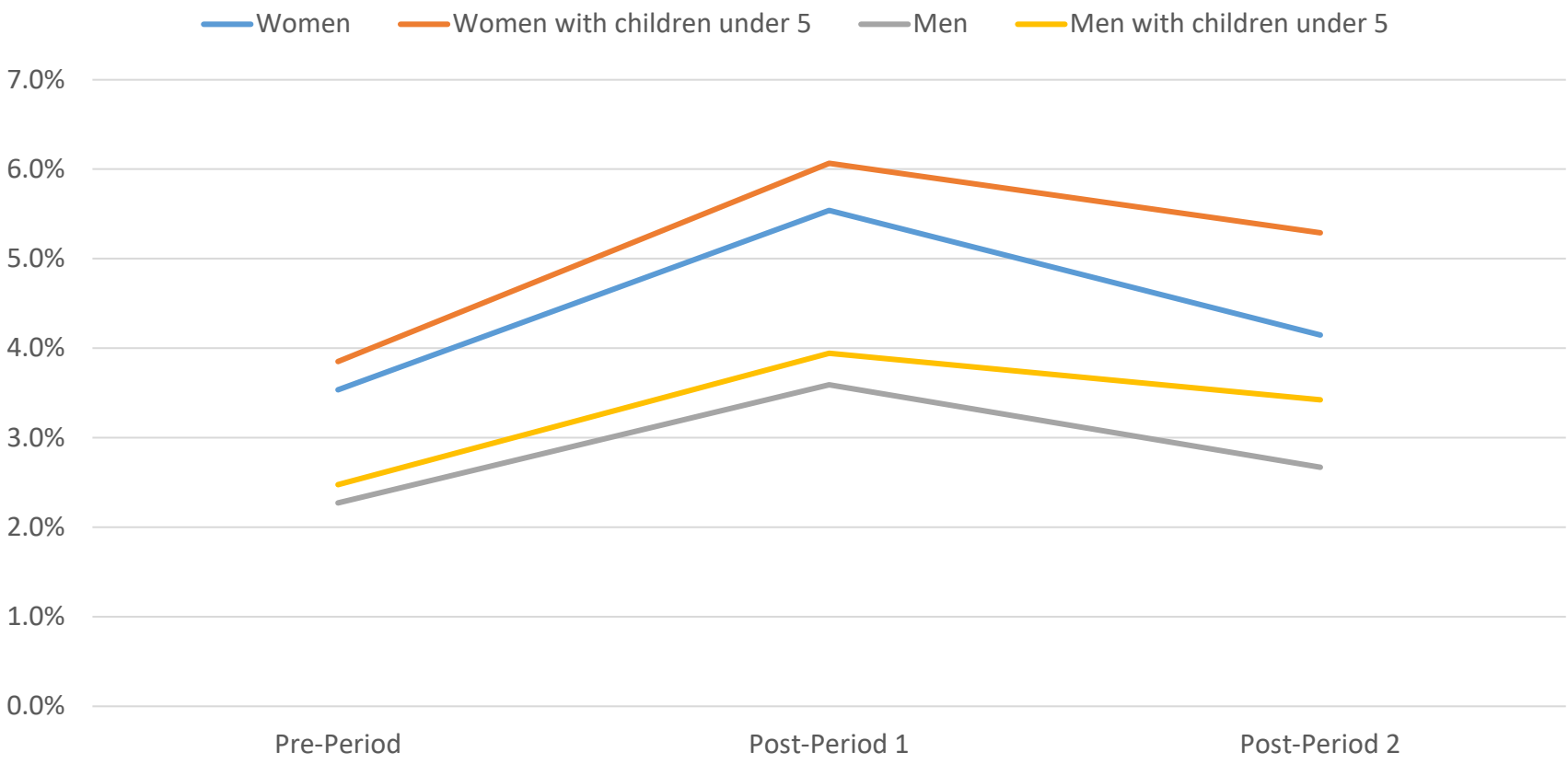
Turnover Rates by Race/Ethnicity and COVID Phase



Race/ethnicity groups are mutually exclusive
Predicted probabilities reported controlling for gender, having child under 5 in HH, age, age sq, education, marital status, COVID cases/deaths, indicator for April 2020

Turnover Rates by Gender/Parenthood and COVID Phase



Predicted probabilities reported controlling for race/ethnicity, age, age sq, education, marital status, COVID cases/deaths, indicator for April 2020

National Distribution and Wages of Select Health Care Occupations

2021	Distribution			Median Hourly Wage		
	Hosp	Amb	LTC	Hosp	Amb	LTC
N	7,747,840	6,104,540	3,062,530	7,747,840	6,104,540	3,062,530
Chief Executive	0.08%	-NA	0.09%	$ 85.73	>$100	-NA
Physician	5.1%	2.9%	0.0%	>$100	$ 79.98	$ 76.54
RN	7.2%	30.5%	3.6%	$ 36.88	$ 37.53	$ 30.51
LPN	2.7%	1.5%	5.1%	$ 22.92	$ 22.60	$ 23.61
Nursing Assistant	1.5%	6.9%	15.8%	$ 14.29	$ 17.25	$ 14.38
Medical Assistant	7.2%	1.8%	0.9%	$ 17.85	$ 18.17	$ 14.42
2019	**Distribution**			**Median Hourly Wage**		
	Hosp	Amb	LTC	Hosp	Amb	LTC
N	7,608,860	6,094,940	3,351,090	7,608,860	6,094,940	3,351,090
Chief Executive	0.08%	0.09%	0.07%	$ 88.87	>$100	$ 65.05
Physician	-NA	-NA	-NA	-NA	-NA	-NA
RN	7.3%	29.8%	6.1%	$ 33.81	$ 36.07	$ 31.85
LPN	2.9%	1.7%	8.2%	$ 22.31	$ 21.90	$ 23.48
Nursing Assistant	1.6%	6.7%	22.3%	$ 14.21	$ 14.96	$ 13.84
Medical Assistant	7.1%	1.8%	0.7%	$ 16.70	$ 17.35	$ 13.99

Source: Bureau of Labor Statistics. Occupation Employment and Wage Statistics: https://www.bls.gov/oes/tables.htm

National Distribution and Wages of Select Health Care Occupations: Comparing with Temporary Services

2021	Distribution				Median Hourly Wage			
	Hosp	Amb	LTC	Temp	Hosp	Amb	LTC	Temp
RN	557,844	1,861,885	110,251	66,790	$ 36.88	$ 37.53	$ 30.51	$ 31.63
LPN	209,192	91,568	156,189	20,660	$ 22.92	$ 22.60	$ 23.61	$ 27.57
Nursing Assistant	116,218	421,213	483,880	31,690	$ 14.29	$ 17.25	$ 14.38	$ 17.13
Medical Assistant	557,844	109,882	27,563	10,130	$ 17.85	$ 18.17	$ 14.42	$ 17.85
2019	**Distribution**				**Median Hourly Wage**			
	Hosp	Amb	LTC	Temp	Hosp	Amb	LTC	Temp
RN	555,447	1,816,292	204,416	47,110	$ 33.81	$ 36.07	$ 31.85	$ 33.68
LPN	220,657	103,614	274,789	17,170	$ 22.31	$ 21.90	$ 23.48	$ 23.60
Nursing Assistant	121,742	408,361	747,293	31,460	$ 14.21	$ 14.96	$ 13.84	$ 14.38
Medical Assistant	540,229	109,709	23,458	5,900	$ 16.70	$ 17.35	$ 13.99	$ 16.92

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Source: Bureau of Labor Statistics. Occupation Employment and Wage Statistics: https://www.bls.gov/oes/tables.htm

Wages of Select Health Care Occupations: National v. Washington

2021	Median Hourly Wage			WA
	Hosp	Amb	LTC	
RN	$ 36.88	$ 37.53	$ 30.51	$46.63
LPN	$ 22.92	$ 22.60	$ 23.61	$29.40
Nursing Assistant	$ 14.29	$ 17.25	$ 14.38	$17.86
Medical Assistant	$ 17.85	$ 18.17	$ 14.42	$22.82

2019	Median Hourly Wage			WA
	Hosp	Amb	LTC	
RN	$ 33.81	$ 36.07	$ 31.85	$40.14
LPN	$ 22.31	$ 21.90	$ 23.48	$27.80
Nursing Assistant	$ 14.21	$ 14.96	$ 13.84	$15.97
Medical Assistant	$ 16.70	$ 17.35	$ 13.99	$20.90

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Source: Bureau of Labor Statistics. Occupation Employment and Wage Statistics: https://www.bls.gov/oes/tables.htm

Key Points

- COVID has had largest effect on long-term care, particularly SNF, employment
  - Disproportionate burden on low wage workers, women with young children and workers of color
  - Turnover in low wage jobs and SNF may have ripple effects on the entire system
- Wage rates have increased since start of COVID, appearing to be faster in WA
  - Poor data for highly paid workers in national datasets
- How many work as travelers, as well as their pay, is hard to identify
  - Relatively small number of workers
  - Pain may be temporary (more on this soon)

Are we facing a health workforce shortage?

Speculating on the Future

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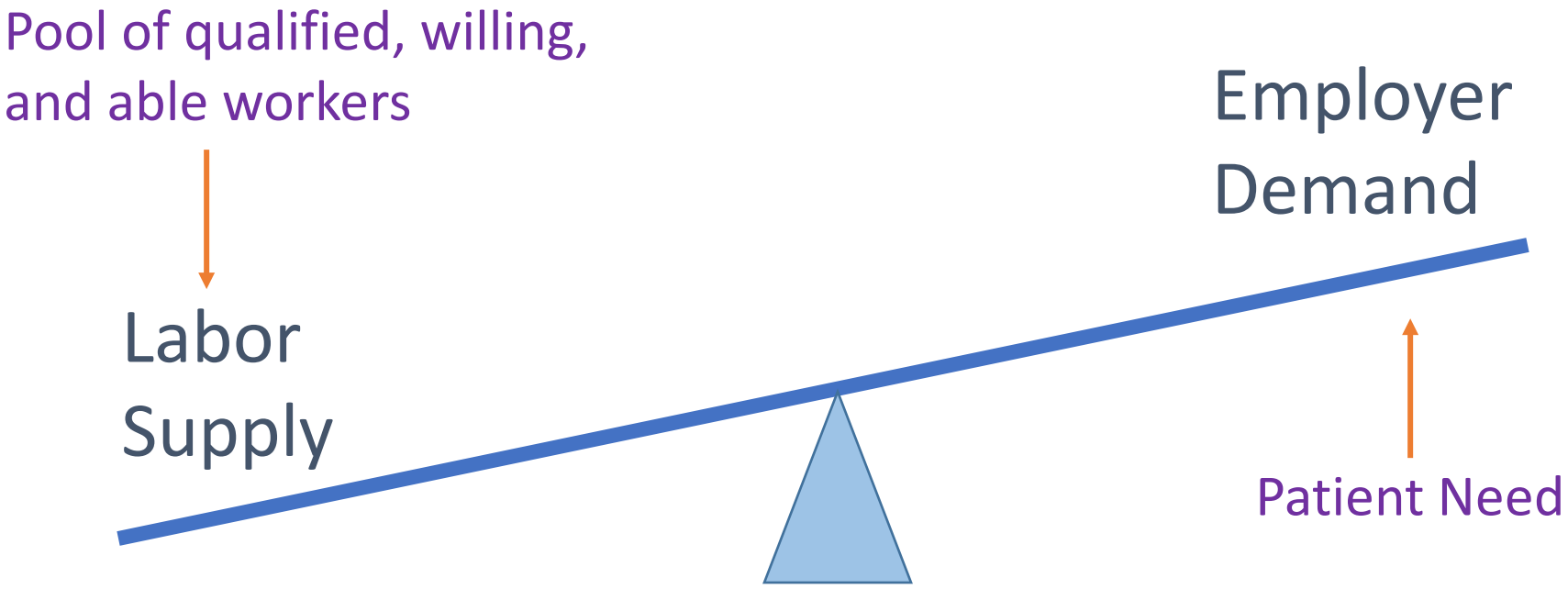
Very Basic Definition of a Shortage



Pre-COVID: Long-Term Care Jobs Projected as Fastest Growing, 2019 to 2029

OCCUPATION	GROWTH RATE, 2019-29	2019 MEDIAN PAY
Wind turbine service technicians	61%	$52,910 per year
Nurse practitioners	52%	$109,820 per year
Solar photovoltaic installers	51%	$44,890 per year
Occupational therapy assistants	35%	$61,510 per year
Statisticians	35%	$91,160 per year
Home health and personal care aides	34%	$25,280 per year
Physical therapist assistants	33%	$58,790 per year
Medical and health services managers	32%	$100,980 per year
Physician assistants	31%	$112,260 per year
Information security analysts	31%	$99,730 per year

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Source: https://www.bls.gov/ooh/fastest-growing.htm

Pre-COVID Headlines on Health Workforce

Health & Science

The disabled and the elderly are facing a big problem: Not enough aides

The Washington Post
Democracy Dies in Darkness

Forbes

7,265 views | Apr 18, 2018, 02:05pm

The Shortage Of Home Care Workers: Worse Than You Think

Home Health Care News

STAFFING

Caregiver Shortage Could Mean 7.8 Million Unfilled Jobs By 2026

By **Bailey Bryant** | January 28, 2019

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COVID Headlines on Health Workforce: 2020

NURSING HOMES

NY Nursing Homes Struggle With Severe Staffing Shortages Amid COVID Outbreaks

4 NEW YORK

At least 1,700 residents with COVID-19 have died in nursing homes since Dec. 1, according to a state count that likely understates the number of fatalities, and federal records show at least 13 staff members at the state's 600 nursing homes have died in that same time as a result of the virus

Published January 26, 2021 • Updated on January 27, 2021 at 1:36 am

The New York Times

A Parallel Pandemic Hits Health Care Workers: Trauma and Exhaustion

Vaccines may be on the way, but many on the front-lines are burned out. Has the government done enough to help alleviate their stress?

The Washington Post
Democracy Dies in Darkness

Nursing home workers now have the most dangerous jobs in America. They deserve better.

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COVID Headlines on Health Workforce: 2021

FORTUNE

HEALTH · HOSPITALS

Hospitals struggle to match Walmart pay as staff leave workforce due to Omicron

BY JOHN TOZZI AND BLOOMBERG
January 7, 2022 9:11 AM PST

wbur CONSIDER THIS

Consider This: Hospital staffing crisis sends demand for travel nurses to all-time high

11:21

February 01, 2022

The Atlantic

HEALTH

WHY HEALTH-CARE WORKERS ARE QUITTING IN DROVES

About one in five health-care workers has left their job since the pandemic started. This is their story—and the story of those left behind.

By Ed Yong

POLITICO

HEALTH CARE

Health care workers are panicked as desperate hospitals ask infected staff to return

While most health workers are vaccinated, many are still falling sick, exacerbating a staff shortage as more Americans seek hospital care.

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Current Contributors to Low Labor Supply

Pool not available to work because:

- Directly affected by COVID illness (sickness and death)
- Childcare and other caregiving responsibilities

Pool not willing to work:

- Burnout/moral distress/moral injury
- Safety concerns

Lack of qualified applicants

- Training unavailable, slow and expensive to complete
- Restrictive practice policies

Interactive Data on Job Leavers across Sectors

https://usafacts.org/projects/jobs/who-leaves?utm_source=Mailchimp&utm_medium=Email&utm_campaign=Aug-8-reconciliation&utm_content=leaving-jobs-viz-text

Ten Most Common Prior Year Industry for Entrants and Current Year Industry for Leavers of the Health Care Industry Between 2003 and 2013

Entrants' Prior Year Industry (N=15,742,141)		Leavers' Current Year Industry (N=23,729,493)	
Not in the labor force or unemployed (excluding in school)	13.0%	Not in the labor force	34.7%
Leisure and hospitality	11.0	Unemployed	18.6
Retail trade (excluding pharmacies and drug stores)	8.8	Educational services	5.6
Educational services	8.4	Leisure and hospitality	4.6
In school	6.9	Professional, scientific and technical services	4.3
Professional, scientific and technical services	6.3	Retail trade (excluding pharmacies and drug stores)	4.0
Public Administration	6.0	Public Administration	3.9
Management, administrative and support, and other services	5.7	Management, administrative and support, and other services	3.8
Finance and Insurance	5.1	Social Assistance	3.2
Social Assistance	5.0	Finance and Insurance	2.9

Source: Frogner BK. (2017) "The Health Care Job Engine: Where Do They Come From and What Do They Say About Our Future?" *Medical Care Research and Review*, DOI: 10.1177/1077558716688156

Among those who continued to work yet made a job change, common non-health care sectors to which health care workers moved (as of March 2021)

Physicians	Registered Nurses	LPNs/LVNs	Nursing & Home Health Aides
Education*	Education	Individual and family services	Individual and family services
Pharmacy/ Drug stores	Public administration	Pharmacy/ Drug stores	"Other" services
Finance	Management	Public administration	Education

Of those that made change in last year, LPNs/LVNs and nursing/home health aides experienced high attrition (75-80%) from their occupation:

- ~25% of LPNs who left went on to become a registered nurse
- ~25% of nursing and home health aides became a personal care aide

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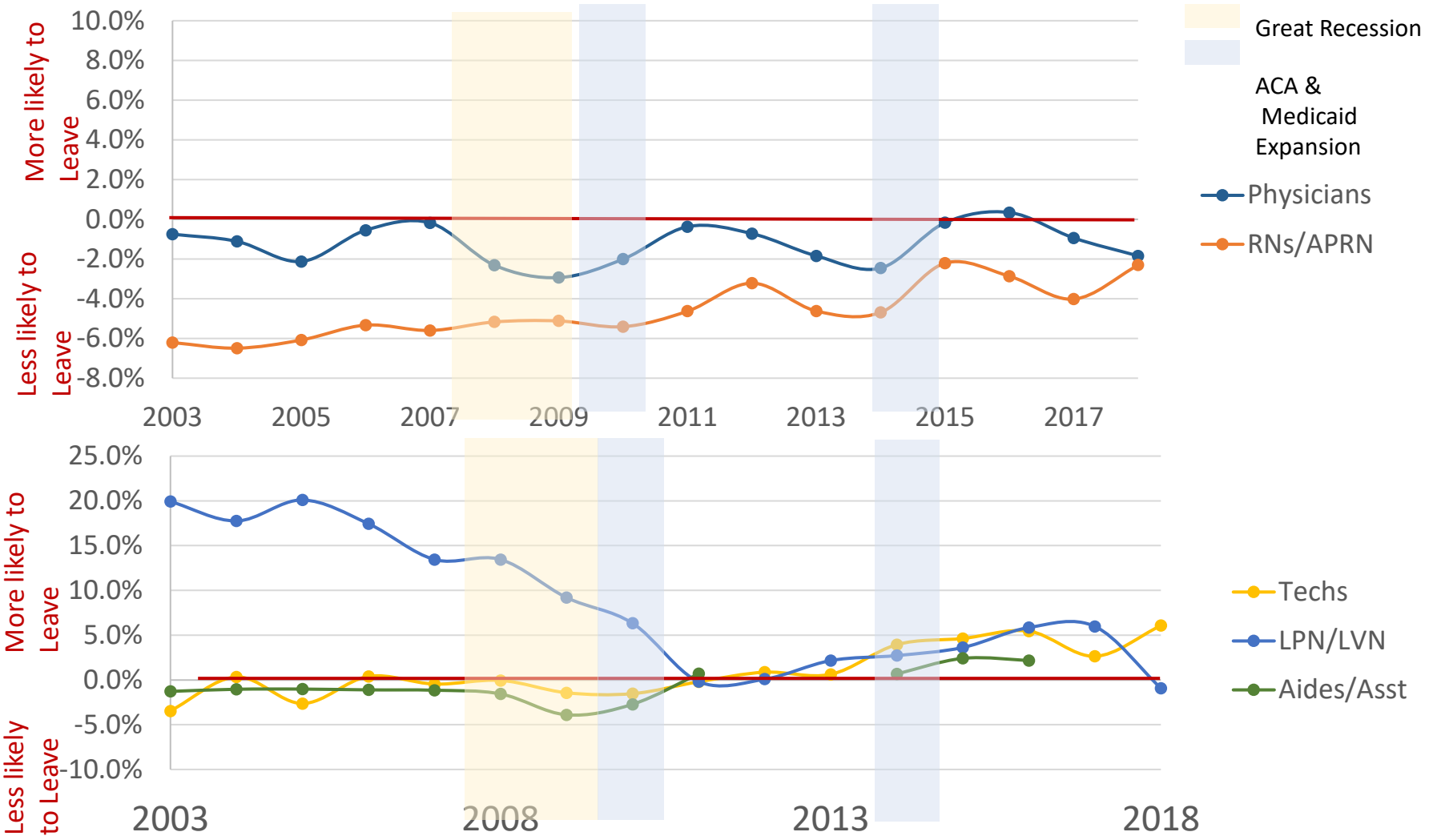
Note: Unpublished results – do not cite; Results based on Frogner's calculation based on data from March 2021 CPS supplement; Compared job/industry in current year with prior year.
*Education does not mean going back to school but rather working in the education sector (e.g., teacher)

Brief Look at Leaver Trends During Recessions



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Source: Frogner, Is Health Care a Desirable Place to Work? Examining Trends in Competition for Health Care Labor. Work in Progress

Key Points

- Health care jobs have long been in high demand
- Competition within health care as well as outside health care, particularly for low wage with low educational requirements workers
- Recessions generally have been “good” for health care labor

How do we address these problems?

Ongoing Efforts and Reimaging the Future

Tipping the Scale

Pool of qualified, willing, and able workers

Labor Supply

Employer Demand

Patient Need

Wages
Policies
Technology
Distribution
Available substitutes

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Contributors to Low Labor Supply Need to Be Addressed

Pool not available to work because:

- Directly affected by COVID illness → paid sick leave
- Childcare and other caregiving responsibilities → childcare/dependent benefits

Pool not willing to work:

- Burnout/moral distress/moral injury → address workplace culture
- Safety concerns → adequate PPE, vaccine education/availability

Lack of qualified applicants

- Training unavailable, slow and expensive to complete → invest in education/training programs
- Restrictive practice policies → relax training requirements, scope of practice regulations

Re-examine general scope of practice rules

HealthAffairs

PERSPECTIVE | HEALTH PROFESSIONALS

HEALTH AFFAIRS > VOL. 41, NO. 8: SPENDING, PAYMENT & MORE

PERSPECTIVE

Patients Receive Flexible And Accessible Care When State Workforce Barriers Are Removed

Bianca K. Frogner

AFFILIATIONS

PUBLISHED: AUGUST 2022 Full Access https://doi.org/10.1377/hlthaff.2022.00759

Perspective

Ensuring and Sustaining a Pandemic Workforce

Erin P. Fraher, Ph.D., M.P.P., Patricia Pittman, Ph.D., Bianca K. Frogner, Ph.D., Joanne Spetz, Ph.D., Jean Moore, Dr.P.H., Angela J. Beck, Ph.D., M.P.H., David Armstrong, Ph.D., and Peter I. Buerhaus, Ph.D., R.N.

The NEW ENGLAND JOURNAL of MEDICINE

Article Figures/Media Metrics

4 References 4 Citing Articles

CURRENT EFFORTS TO fight the Covid-19 pandemic aim to slow viral spread and increase testing, protect health care workers from infection, and obtain ventilators and other equipment to prepare for a surge of critically ill

Audio Interview

Interview with Dr. Erin Fraher on opportunities for expanding health workforce capacity during the Covid-19 pandemic. (13:32)

Download

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Source: https://www.healthaffairs.org/do/10.1377/hblog20200624.983306/full/; https://www.nejm.org/doi/full/10.1056/NEJMp2006376

wa.sentinelnetwork.org

What is the Health Workforce Sentinel Network?

How is the Health Workforce Sentinel Network used?

The Sentinel Network is an initiative of Washington's Health Workforce Council, conducted collaboratively by Washington's Workforce Board and the University of Washington's Center for Health Workforce Studies. Funding to initiate the Sentinel Network came from the Healthier Washington initiative, with ongoing support from Governor Inslee's office and the Washington State Legislature.

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Workforce Training & Education Coordinating Board

Nursing homes & skilled nursing facilities

To what extent has your organization used recruitment incentives like sign-on bonuses during the pandemic? What recruitment strategies have been most successful?

Most respondents reported using bonuses, but with very limited success. Other strategies were often more effective.

We have implemented a $15K/$5K sign-on bonus for majority of staff. Implementing CMA and NAR to CNA career path. Working on an LPN apprenticeship program. Working with Next Step as a feeder pool for trained CNAs.

Sign on bonuses have shown to be inadequate. People would rather have higher hourly wages than a sign on bonus.

Small hospitals

What are your top workforce needs that could be alleviated by policy, regulatory, and/or payment changes?

- *More funding for the training programs.*
- *Better reimbursement rates.*

Primary care offices

Have you implemented new retention strategies during the pandemic? Please describe.

Many strategies were reported, with pay increases less commonly mentioned than we heard from other settings.

Improving our medical benefit offerings and reducing the cost of care to our employees and the practice

Staff care and team building and supports. Weekly compliments/prizes, workplace wellness.

Final thoughts

- Availability of health care workers has significantly fluctuated over the pandemic and has not yet returned to pre-pandemic levels.
  - Hard to predict long-term changes to health care delivery due to COVID that may influence demand for health care workers, but trajectory suggests that most sectors are on path to recovery.
  - Skilled nursing facilities are struggling and without recovery, ripple effects may be seen across health system.
- As economy recovers, we will see competition rise from other industries – health care sectors are also competing with each other. [1]
  - Particularly true for aides/assistants who have low barriers to entry.
  - Critical to focus on aides/assistants who provide much needed support to health care teams, but also need to consider support for physicians
- Strategies to retain health care workers exist and if deployed effectively, may be able to prevent severe shortage.
  - Raise wages, but also address disparities in wages. [2]
  - Yet wages often limited by insurance structure and not easy to pass on costs to consumers, but fortunately not the only solution.

1. Frogner, The Health Care Job Engine: Where Do They Come From and What Do They Say About Our Future? Medical Care Research and Review, 2018
2. Frogner BK, Schwartz M. Examining Wage Disparities By Race And Ethnicity Of Health Care Workers. Medical Care. Oct 2021 Volume 59 - Issue - p S471-S478

Thank you!

Contact me with questions at:

bfrogner@uw.edu

Follow on Twitter @biancafrogner @uwchws

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Washington State Health Care Authority

INDEX

Primary Care Committee – Proposed Members

Washington State Health Care Authority

Name	Title	Place of Business
Tony Butruille	Family Medicine Doctor	Cascade Medical Center
Caitlin Safford	Chief of Staff	Amerigroup
Ann Christian	Chief Executve Officer	WA Council for Behavioral Health
Bruce Gray	Chief Executive Officer	NW Regional Primary Care Association
Carena Hopen	Family Medicine Doctor	MyHealth Everett/Molina Healthcare
Courtney Ward	Health Program Manager, Health System Innovation	Community Health Plan of Washington
Drew Oliveira	Senior Executive Medical Director	Regence (recently retired)
Eleanor Escafi	Director of Network Innovation	Cambia Health Solutions/Regence
Elizabeth Avena	Family Medicine Doctor	Confluence Health Omak Clinic
Ginny Weir	Chief Executive Officer	Foundation for Health Care Quality (Bree)
Jonathan Staloff	Family Medicine Doctor, Fellow	UW Medicine
Kate Mundell	Senior Director of Network Management	Coordinated Care Health
Katina Rue	Family Medicine Doctor, President-Elect	Washington State Medical Association
Kristy Valdez	Director, Value-Based Programs and Provider Payment	United Health Group
Laura Morano	Care Transformation Consultant	Seattle Children's
Linda Van Hoff	Primary Care Nurse Practitioner (NP), President ARNP United	ARNP United (NP organization), Overlake Clinic
LuAnn Chen	Senior Medical Director	Community Health Plan of Washington
Matthew Hollon	Internal Medicine Doctor, President ACP	American College of Physicians (internist organization), Multicare Family Medicine
Sarah Stokes	Associate Director of Network Operations	Kaiser Permanente
Sharon Brown	Executive Director	Greater Columbia Accountable Community of Health
Sharon Eloranta	Medical Director	Washington Health Alliance
Shawn West	Chief Medical Officer	Embright
Sheryl Morelli	Chief Medical Officer	Seattle Children's
Tracy Corgiat	Vice President Primary Care	Confluence Health
Vicki Lowe	Executive Director	American Indian Health Commission

Advisory Committee on Primary Care Feedback on Proposed Members

Washington State Health Care Authority

Name	Title	Place of Business
Bob Crittenden	Freddy Chen	Currently serves as Chief Health and Science Officer for the American Medical Association (AMA). Recently left UW (scientific side). Served as chief of FM at Harborview and ran the FM WAMI residency network, worked for Regence as medical director, and worked nationally to establish the teaching community health center
Jodi Joyce	Mary Bartolo (COO of SeaMar), Paul Minardi (President and Exec Med Director of KP Washington), Yakima Valley Farmworkers	SeaMar is a large (17th largest by visit volume in the U.S.), multi-site FQHC that would speak well to definitions, challenges, realities, and opportunities of primary care. YVFW is 16th largest FQHC nationally.
Mika N. Sinanan	Vicki Fang, MD	UW Medicine system
Mika N. Sinanan	FQHCs e.g., SeaMar, Yakima Valley Farmworkers	Service-oriented clinicians
Mika N. Sinanan	Kaiser Permanente clinicians	Service-oriented clinicians
Mika N. Sinanan	Teresa Girolami, MD	Solo-practitioner with primary care practice, member of King County Medical Society, with a focus on legislative and policy issues
Mika N. Sinanan	DC Dugdale	Internist, primary care provider, and UW Medicine Medical Director for Value-Based Care
Dorothy Teeter		Providers and primary care members who currently practice in primary care models of accountable care
Ross Laursen		Members with expertise in code definitions/criteria and familiarity with VBP methodologies for primary care design
Wes Waters	Kevin Phelan	Over 25 years of network management and contracting experience, with 18 years focused on Medicaid, Medicare, and other programs. Developed statewide networks in several markets for procurement opportunities and managed national and local market network teams. Related to primary care transformation, can provide a perspective on other states' and payors' efforts.

August 10, 2022

Chair Sue Birch
Health Care Cost Transparency Board
Submitted via email to: hcahcctboard@hca.wa.gov

Re: Request for Board Focus on Impact of High Health Care Prices for WA Residents

Dear Chair Birch and Members of the Health Care Cost Transparency Board:

Thank you for your work to implement a statewide health care cost growth benchmark. As the Board moves into the substantive work of parsing trends that impact cost growth, we write to **request your concerted attention on the most important trend: the impact of high and ever-increasing health care costs on families, workers, and small businesses in Washington.**

The undersigned organizations represent Washington residents who do not have a seat at the table in health care cost discussions. We are not big payers, providers, or purchasers – we represent *people* whose paychecks are increasingly eaten up by premiums, deductibles, and other out-of-pocket costs. We worked to help pass the Health Care Cost Transparency Board's enabling legislation, over the objections of other stakeholders who now aim to serve as the Board's primary source of information and insight. We write now to highlight the need for the Board to include consumer-oriented perspectives in two ways:

1. Center patient access as the end goal in price conversations, not relative profit/revenue.

At the July 20th Board meeting, the Board heard a presentation from the Washington State Hospital Association which emphasized hospitals' concerns about their profit/revenue margins. Similarly, Board consultants Bartholomew-Nash & Associates described hospital finances in terms of "underperformance on profit" compared to national averages. While we applaud Mr. Bartholomew and Mr. Nash for their efforts to analyze hospital finances with granularity, we are concerned that focusing on local profit margins compared to egregious hospital practices in other parts of the country is an inappropriate measure of success for our Washington State hospitals, the vast majority of which are intended to be not-for-profit or public entities. We appreciated the remarks of Boardmember Hole-Marshall, who questioned the focus on profit margin as a metric. We recommend that further inquiry into health care industry finances focus primarily on metrics related to solvency and break-even needed to maintain consumer access to essential health care services.

2. Create opportunities to hear from WA residents about the impact of health care prices.

As Washington State consumers have raised in public testimony at the last two Board meetings, the Board has not yet focused on the patient and consumer experience of high health care prices in detail.

The experience of WA residents should be a critical component of the Board's inquiry. Just as the Board is interested in hearing from health care industry representatives about their finances and stability, the Board should seek information from Washington patients, workers, and small businesses about the impact of growing health care prices on their economic stability and ability to access care. Alongside information about hospital quarterly revenue, the Board should hear about the financial cliff hundreds of thousands of Washington residents[1] will face later this year when pandemic coverage protections are slated to end, leaving residents at the mercy of premium rate increases that may be as high as 16% in the individual market.[2] Discussions about inflation in the health care industry should be coupled with information about how Washington residents are already bearing the burden of inflation.

We ask the Board to thoughtfully structure opportunities to hear this consumer-focused perspective. We are aware that the Board has two named consumer representatives, one of whom recently exited the Board due to conflicts with the health care industry and one of whom will cycle off the Board this December. We suggest that this is not enough, given the outsized opportunity for industry stakeholders to weigh in via the Board's two Advisory Committees. We respectfully recommend that the Board consider at least two initial steps to rebalance its information sources:

- Establish regular opportunities for consumer representatives and directly impacted consumers to present to the Board about the impact of health care prices on WA residents. We suggest that the Board could begin with an invitation for consumer groups to present this fall. In the future, the Board should consider regular presentations on consumer impact, as other states with similar health transparency entities have done.[3]

- Consider whether the current Board membership and advisory committee structure offers Boardmembers sufficient input from Washington patients, families, workers, and small businesses who suffer most from unregulated health care prices. We hope Chair Birch will work with the Governor's Office to fill the two consumer seats and an open Taft-Hartley seat on the Board with individuals who can speak to the experience of Washington residents struggling with the impact of high health care prices.

We offer the undersigned organizations as resources as the Board considers these recommendations. Please let us know how we can be helpful in supporting you - contact Emily Brice (emily@nohla.org) or Sam Hatzenbeler (sam@opportunityinstitute.org). Thank you for the opportunity to comment.

Sincerely,

---

[1] Testimony of Health Care Authority and Health Benefit Exchange staff at a 7/20/22 Senate Health & Long Term Care Committee Work Session: https://app.leg.wa.gov/committeeschedules/Home/Documents/30049?//HLTC/////year

[2] Information on proposed premium rate increases from the Health Benefit Exchange 6/30/22 meeting: www.wahbexchange.org/content/dam/wahbe-assets/events/exchange-board/EB_202206_AffordabilityPreview.pdf

[3] *See, e.g.*, Massachusetts' annual health care cost trend hearing, at which consumer representatives testify: https://www.mass.gov/service-details/annual-health-care-cost-trends-hearings.

AFT Washington (Karen Strickland, President) & AFT-WA Retirees Chapter (Jim Howe, Director)

Economic Opportunity Institute (Sam Hatzenbeler, Senior Health Policy Associate)

Health Care for All - WA (Ronnie Shure, President)

Health Care is a Human Right - WA (David Loud, Nathan Rodke, Claude Burfect Co-Chairs)

Northwest Health Law Advocates (Emily Brice, Senior Attorney & Policy Advisor)

Patient Coalition of Washington (Jim Freeburg, Executive Director)

Milbank Memorial Fund
Using evidence to improve population health

Three Federal Actions to Support State Efforts to Make Health Care More Affordable

JULY 18, 2022
BLOG POST

Author:

RACHEL BLOCK

Related Content:

Addressing health care cost growth requires a systemic view of our health system and its performance. However, gaps in health care spending data and limited capacity for measurement and analysis make it difficult to understand and act on what's driving a growing affordability crisis in US health care.

States leading health care cost growth initiatives, including California and the six states supported by Peterson-Milbank Program for Sustainable Health Care Costs (as well as Massachusetts and Delaware) seek to address this challenge by better understanding health care cost growth. Their initiatives are designed to establish statewide health care cost growth targets, require payers to submit their health care spending data and meet the target, and then identify and implement solutions for addressing rising health care costs. However, US health policy operates through a federal, state, and private partnership, and further federal support is critical for states to build a sustained, holistic, and effective approach. In this blog post, we recommend three specific federal actions that can advance state-led initiatives to bend the health care cost curve.

1. Data policy: Require ERISA plans to submit standardized health spending data

States can collect *aggregate* data from health plans, including self-insured plans covered under the federal Employee Retirement Income Security Act (ERISA), to monitor their health care cost target performance. However, as a result of the U.S. Supreme Court's 2015 *Gobeille vs. Liberty Mutual* decision, states may not require submission of *individual claim* data by self-insured plans to state claims databases. In many states, these plans cover more than 60% of the state's commercial/employer-covered populations, and this segment is growing. Without this information, states do not have a complete picture of health care spending drivers. It is also important to engage these self-funded plans in the state's policy process around containing cost growth, and contributing data is an important step in that engagement.

Recent federal legislation focused on standardizing state claims data collection to encourage more ERISA plan participation, but it stopped short of requiring that these plans do so. The U.S. Department of Labor (DOL) should require ERISA plans to submit de-identified claims and non-claims-based payment data. Using the common standard recently recommended to DOL, the plans should submit data to state all-payer claims databases (APCDs) or, for states that do not have them, alternative federal and state data collection systems.

2. Policy and data analysis support: Provide a permanent source of funding for health care data infrastructure

The Peterson-Milbank program provides technical assistance to states that complements often significant state-funded investments in cost-containment data infrastructure. Cost growth target programs provide market-wide insight into spending and new tools for holding accountable payers and providers, including providers that serve Medicare and Medicaid enrollees. A dedicated federal source of funding could help ensure the sustainability of these programs.

State cost growth programs have used Medicaid-enhanced administrative matching funds as one source of support for data systems development and implementation. To facilitate requests, the Centers for Medicare and Medicaid Services (CMS) should issue guidance on designing and using statewide health data infrastructure that supports cost growth target programs and APCDs. (This type of guidance was provided previously in support of statewide health information exchange programs.) While investment of these funds must be proportionate to the extent of Medicaid data participation, these databases have clear benefits to Medicaid in gauging cost growth over time, identifying high-cost areas that are susceptible to intervention, and examining Medicaid performance as compared to that of private payers. Philanthropy can support these efforts, but the federal government should promote the use of matching funds in any state that commits to a systemwide health care cost growth target process.

3. Payment policy: Increase federal participation in all-payer value-based payment models

Cost growth targets and their associated data analytics and reporting are important means of providing insight and transparency around health care spending. Value-based payment (VBP) programs can build on these efforts by creating a consistent set of measures and incentives across payers to get traction on controlling cost growth and making investments in cost-effective services like primary care. Many states and regions have implemented *multipayer* programs involving commercial and Medicaid plans, but there are few ways to bring in Medicare to create *all-payer* models. Greater federal participation in VBP programs would support health system transformation and attract more interest from other market segments.

CMS and state experience with multipayer VBP models illustrates both the galvanizing impact of federal participation and having more dollars go toward improved population health. The Comprehensive Primary Care Initiative and the Comprehensive Primary Care Plus models generated interest from large and diverse groups of payers (including states) and practices. Broad payer participation, including Medicare-supported shared technical assistance and upfront care management fees, incentivized practices to meet quality metrics to receive enhanced payments. While these models have had mixed success in achieving cost savings, there have been demonstrable improvements in several participating regions. One well-established state-led program — the hospital all-payer rate-setting system in Maryland — has proven to be successful in controlling cost growth. These models show how federal participation can increase the participation of other payers and providers for greater scale and allow states to pursue broad payment strategies such as hospital global budgets.

Health care cost growth targets provide key insights into systemwide health care spending trends. These state-led programs are essential to provide the public and policymakers with a common foundation of data that can be used to explain cost trends and motivate actions to address them. But state efforts need federal support to realize their full potential and, as described here, there are practical steps that can be taken to forge a strong federal-state partnership to pursue coordinated health care cost containment strategies.

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