Health Care Cost Transparency Board
Board Book

August 17, 2022
2:00 p.m. – 4:00 p.m.
(Zoom Attendance Only)

Meeting materials

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Agenda

TAB 1
# Health Care Cost Transparency Board

## AGENDA

**Board Members:**

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<thead>
<tr>
<th>Name</th>
<th>Chair</th>
<th>Vice Chair</th>
<th>Member</th>
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<td>Susan E. Birch</td>
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<td>Sonja Kellen</td>
<td>Carol Wilmes</td>
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<tr>
<th>Time</th>
<th>Agenda Items</th>
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<th>Lead</th>
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<tbody>
<tr>
<td>2:00 – 2:05 (5 min)</td>
<td>Welcome, roll call, and agenda review</td>
<td>1</td>
<td>Susan E. Birch, Chair, Director Health Care Authority</td>
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<td>2:05 – 2:10 (5 min)</td>
<td>Approval of June and July meeting minutes</td>
<td>2</td>
<td>AnnaLisa Gellermann, Board Manager Health Care Authority</td>
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<td>2:10 – 2:40 (30 min)</td>
<td>Primary Care: Overview and Next Steps</td>
<td>3</td>
<td>Dr. Judy Zerzan-Thul, Chief Medical Officer Health Care Authority</td>
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<td>2:40 – 3:15 (35 min)</td>
<td>Washington hospital costs, price, and profit analysis</td>
<td>4</td>
<td>John Bartholomew and Tom Nash</td>
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<td>3:15 – 3:25 (10 min)</td>
<td>Public comment</td>
<td>5</td>
<td>Susan E. Birch, Chair, Director Health Care Authority</td>
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<td>3:25 – 4:00 (35 min)</td>
<td>Influence of health workforce trends on health spending growth</td>
<td>6</td>
<td>Bianca K. Frogner, PhD, Professor, Dept. of Family Medicine Director, Health Workforce Studies University of Washington</td>
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<tr>
<td>4:00</td>
<td>Adjournment</td>
<td></td>
<td>Susan E. Birch, Chair, Director Health Care Authority</td>
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*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.*
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 VBP 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. 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.

Draft: Pending Board Approval
Health Care Cost Transparency Board meeting summary
7/20/2022
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 4:00 p.m.

Next meeting
Wednesday August 17, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.
Primary care: overview and next steps

TAB 3
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
Key Components of the Primary Care Transformation Model (PCTM)

### Provider Accountabilities

1. Whole person care
2. A team for every patient
3. Risk stratification
4. Behavioral health screening and follow-up
5. Patient support
6. Care coordination strategy
7. Expanded access
8. Culturally attuned care
9. Health literacy
10. Data capacity
11. Measurement of improvement

### Centralized Provider Certification

- **Level 1**: Meets minimum participation standards & working towards transformation
- **Level 2**: Making progress toward transformation
- **Level 3**: Implementing model with fidelity

### Payer Accountabilities

- **Aligned Practice Supports**
  - Aligned data sharing
  - Common attribution principles
  - Shared resources for providers

- **Shared Quality Standards**

- **Aligned Payment Model**
  - Transformation Payment
  - Prospective Comprehensive Care Payment
  - Quality Incentive Payment
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

Washington State HCA Primary Care Expenditure Study (2018–2020) * 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

Washington State HCA Primary Care Expenditure Study (2018–2020) * 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
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.
There was a decrease in the percentage of primary care spending in 2020 for all payer types.
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 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 = \textbf{Price per Patient}
  
  - Hospital Only Operating Cost divided by Adjusted Discharge = \textbf{Cost per Patient}
  
  - Net Income divided by Adjusted Discharges = \textbf{Profit per Patient}

- Observe trends across hospital types and peer groups
  
  - Health systems, independents, for-profit, not-for-profit, rural, urban, teaching, and \textbf{by bed size}
2020 COLA Data; WA ranked 13th Highest Price, 7th & 8th Highest Costs
Quick Refresh: Overall WA Hospitals in Aggregate have Higher Prices and Costs, COLA, and are lower Using Profit as a Measure*

<table>
<thead>
<tr>
<th>Description</th>
<th>Washington</th>
<th>National Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net patient revenue</td>
<td>$ 22,031,680,843</td>
<td></td>
</tr>
<tr>
<td>Hospital-only operating expense</td>
<td>18,206,569,189</td>
<td></td>
</tr>
<tr>
<td>Other operating expense</td>
<td>5,370,712,007</td>
<td></td>
</tr>
<tr>
<td>Total operating Expense</td>
<td>23,577,281,196</td>
<td></td>
</tr>
<tr>
<td>Patient services net income</td>
<td>(1,545,600,353)</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Price</th>
<th>High price</th>
<th>Not high price</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>32</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost</th>
<th>National normal cost</th>
<th>High cost</th>
<th>National normal cost</th>
<th>High cost</th>
<th>Low cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>12</td>
<td>23</td>
<td>6</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Profit</th>
<th>High profit</th>
<th>National normal profit</th>
<th>Low profit</th>
<th>High profit</th>
<th>National normal profit</th>
<th>Low profit</th>
<th>High profit</th>
<th>National normal profit</th>
<th>Low profit</th>
<th>High profit</th>
<th>National normal profit</th>
<th>Low profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>11</td>
<td>8</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>
2 Price/Cost

Outliers:
- Lourdes Medical Center
- Evergreen Health Monroe

2 Below Median Price/Cost:
- 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
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?
Public comment

TAB 5
Public comment
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

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
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)

- Hospitals, 44.5%
- Offices of Physicians, 19.3%
- Outpatient Care Centers, 7.0%
- Offices of Dentists, 7.0%
- All Other Ambulatory Care, 11.3%
- Home Health Care Services, 10.9%
- Nursing Care Facilities, 11.7%
- Residential and Continuing Care, 12.8%

Not captured:
- Retail pharmacies
- Insurance companies
- Manufacturing

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

Average Education by Health Care Sector

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
A Simple Input-Output Model of Health Care Spending

**INPUTS**
- Labor
- Machines
  (e.g. MRI/CT, EHR)
- Disposable items
  (e.g. gowns, swabs)
- Utilities
- Buildings

**OUTPUTS**
- Health care services
  (e.g., physician office visits, hospital stays, nursing home days)

**Process**
A Simple Input-Output Model of Health Care Spending

**INPUTS**
- Labor
- Machines *(e.g. MRI/CT, EHR)*
- Disposable items *(e.g. gowns, swabs)*
- Utilities
- Buildings

**Cost of Labor & Capital Goods** *(e.g., wage, price)*

**OUTPUTS**
- Health care services *(e.g., physician office visits, hospital stays, nursing home days)*
- Price of Services *(e.g., reimbursement, premiums, out of pocket)*

**Process**

Adjusts with expected patient need/demand

What we observe as “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

Health Spending (millions)

Health Care Workers ('000s)

Average Health Care Hourly Wages

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

1.4 million health care jobs lost at 1st peak

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](https://www.bls.gov/news.release/empsit.t17.htm)
Tracking Turnover among Health Care Workers During the COVID-19 Pandemic

  - 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
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
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

<table>
<thead>
<tr>
<th></th>
<th>2021 Distribution</th>
<th>Median Hourly Wage</th>
<th>2019 Distribution</th>
<th>Median Hourly Wage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hosp</td>
<td>Amb</td>
<td>LTC</td>
<td>Hosp</td>
</tr>
<tr>
<td>N</td>
<td>7,747,840</td>
<td>6,104,540</td>
<td>3,062,530</td>
<td>7,747,840</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>0.08%</td>
<td>_NA</td>
<td>0.09%</td>
<td>$85.73</td>
</tr>
<tr>
<td>Physician</td>
<td>5.1%</td>
<td>2.9%</td>
<td>0.0%</td>
<td>&gt;$100</td>
</tr>
<tr>
<td>RN</td>
<td>7.2%</td>
<td>30.5%</td>
<td>3.6%</td>
<td>$36.88</td>
</tr>
<tr>
<td>LPN</td>
<td>2.7%</td>
<td>1.5%</td>
<td>5.1%</td>
<td>$22.92</td>
</tr>
<tr>
<td>Nursing Assistant</td>
<td>1.5%</td>
<td>6.9%</td>
<td>15.8%</td>
<td>$14.29</td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>7.2%</td>
<td>1.8%</td>
<td>0.9%</td>
<td>$17.85</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>2021 Distribution</th>
<th>Median Hourly Wage</th>
<th></th>
<th>2019 Distribution</th>
<th>Median Hourly Wage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hosp</td>
<td>Amb</td>
<td>LTC</td>
<td>Temp</td>
<td>Hosp</td>
</tr>
<tr>
<td>RN</td>
<td>557,844</td>
<td>1,861,885</td>
<td>110,251</td>
<td>66,790</td>
<td>$36.88</td>
</tr>
<tr>
<td>LPN</td>
<td>209,192</td>
<td>91,568</td>
<td>156,189</td>
<td>20,660</td>
<td>$22.92</td>
</tr>
<tr>
<td>Nursing Assistant</td>
<td>116,218</td>
<td>421,213</td>
<td>483,880</td>
<td>31,690</td>
<td>$14.29</td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>557,844</td>
<td>109,882</td>
<td>27,563</td>
<td>10,130</td>
<td>$17.85</td>
</tr>
</tbody>
</table>

### Wages of Select Health Care Occupations: National v. Washington

<table>
<thead>
<tr>
<th></th>
<th>2021</th>
<th>Median Hourly Wage</th>
<th>WA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hosp</td>
<td>Amb</td>
<td>LTC</td>
</tr>
<tr>
<td>RN</td>
<td>$36.88</td>
<td>$37.53</td>
<td>$30.51</td>
</tr>
<tr>
<td>LPN</td>
<td>$22.92</td>
<td>$22.60</td>
<td>$23.61</td>
</tr>
<tr>
<td>Nursing Assistant</td>
<td>$14.29</td>
<td>$17.25</td>
<td>$14.38</td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>$17.85</td>
<td>$18.17</td>
<td>$14.42</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>Median Hourly Wage</th>
<th>WA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hosp</td>
<td>Amb</td>
<td>LTC</td>
</tr>
<tr>
<td>RN</td>
<td>$33.81</td>
<td>$36.07</td>
<td>$31.85</td>
</tr>
<tr>
<td>LPN</td>
<td>$22.31</td>
<td>$21.90</td>
<td>$23.48</td>
</tr>
<tr>
<td>Nursing Assistant</td>
<td>$14.21</td>
<td>$14.96</td>
<td>$13.84</td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>$16.70</td>
<td>$17.35</td>
<td>$13.99</td>
</tr>
</tbody>
</table>

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
Very Basic Definition of a Shortage

Pool of qualified, willing, and able workers

Labor Supply

Employer Demand

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

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Growth Rate, 2019-29</th>
<th>2019 Median Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wind turbine service technicians</td>
<td>61%</td>
<td>$52,910 per year</td>
</tr>
<tr>
<td>Nurse practitioners</td>
<td>52%</td>
<td>$109,820 per year</td>
</tr>
<tr>
<td>Solar photovoltaic installers</td>
<td>51%</td>
<td>$44,890 per year</td>
</tr>
<tr>
<td>Occupational therapy assistants</td>
<td>35%</td>
<td>$61,510 per year</td>
</tr>
<tr>
<td>Statisticians</td>
<td>35%</td>
<td>$91,160 per year</td>
</tr>
<tr>
<td>Home health and personal care aides</td>
<td>34%</td>
<td>$25,280 per year</td>
</tr>
<tr>
<td>Physical therapist assistants</td>
<td>33%</td>
<td>$58,790 per year</td>
</tr>
<tr>
<td>Medical and health services managers</td>
<td>32%</td>
<td>$100,980 per year</td>
</tr>
<tr>
<td>Physician assistants</td>
<td>31%</td>
<td>$112,260 per year</td>
</tr>
<tr>
<td>Information security analysts</td>
<td>31%</td>
<td>$99,730 per year</td>
</tr>
</tbody>
</table>

Source: [https://www.bls.gov/ooh/fastest-growing.htm](https://www.bls.gov/ooh/fastest-growing.htm)
Pre-COVID Headlines on Health Workforce

**The Washington Post**

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

---

**Forbes**

The Shortage Of Home Care Workers: Worse Than You Think

---

**Home Health Care News**

Caregiver Shortage Could Mean 7.8 Million Unfilled Jobs By 2026

By Bailey Bryant | January 28, 2019
COVID Headlines on Health Workforce: 2020

NURSING HOMES

NY Nursing Homes Struggle With Severe Staffing Shortages Amid COVID Outbreaks

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?

Nursing home workers now have the most dangerous jobs in America. They deserve better.
**COVID Headlines on Health Workforce: 2021**

- **Fortune**: Hospitals struggle to match Walmart pay as staff leave workforce due to Omicron

- **The Atlantic**: Why health-care workers are quitting in droves

- **Politico**: Health care workers are panicked as desperate hospitals ask infected staff to return
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

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

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

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)

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Registered Nurses</th>
<th>LPNs/LVNs</th>
<th>Nursing &amp; Home Health Aides</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education*</td>
<td>Education</td>
<td>Individual and family services</td>
<td>Individual and family services</td>
</tr>
<tr>
<td>Pharmacy/Drug stores</td>
<td>Public administration</td>
<td>Pharmacy/Drug stores</td>
<td>“Other” services</td>
</tr>
<tr>
<td>Finance</td>
<td>Management</td>
<td>Public administration</td>
<td>Education</td>
</tr>
</tbody>
</table>

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

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**

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 Reimagining the Future
Tipping the Scale

Pool of qualified, willing, and able workers

Labor Supply

Wages
Policies
Technology
Distribution
Available substitutes

Employer Demand

Patient Need
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

Perspective
Ensuring and Sustaining a Pandemic Workforce

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

Source: https://www.healthaffairs.org/do/10.1377/hblog20200624.983306/full/
Wa.sentinelnetwork.org

Washington’s Health Workforce
SENTINEL NETWORK

(206) 543-9797
healthworkforce@wasentinelnetwork.org

HOME  ABOUT  JOIN  FINDINGS  TEAM

Washington Healthcare Facilities Respond to COVID-19
Click here to see innovative solutions and ongoing needs.

FINDINGS DASHBOARDS
View employer needs over time
READ MORE

SHARE YOUR HEALTH WORKFORCE CHALLENGES
As a Sentinel, you will make your workforce needs known to decisionmakers and inform policy decisions in our state.
JOIN NOW

FINDINGS BRIEFS
View summarized findings for selected facility types
READ MORE

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.
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.

Nursing homes & skilled nursing facilities

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
Thank you!

Contact me with questions at:

bfrogner@uw.edu

Follow on Twitter @biancafrogner @uwichws
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# Primary Care Committee – Proposed Members

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<tr>
<th>Name</th>
<th>Title</th>
<th>Place of Business</th>
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<tbody>
<tr>
<td>Tony Butruille</td>
<td>Family Medicine Doctor</td>
<td>Cascade Medical Center</td>
</tr>
<tr>
<td>Caitlin Safford</td>
<td>Chief of Staff</td>
<td>Amerigroup</td>
</tr>
<tr>
<td>Ann Christian</td>
<td>Chief Executive Officer</td>
<td>WA Council for Behavioral Health</td>
</tr>
<tr>
<td>Bruce Gray</td>
<td>Chief Executive Officer</td>
<td>NW Regional Primary Care Association</td>
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<tr>
<td>Carena Hopen</td>
<td>Family Medicine Doctor</td>
<td>MyHealth Everett/Molina Healthcare</td>
</tr>
<tr>
<td>Courtney Ward</td>
<td>Health Program Manager, Health System Innovation</td>
<td>Community Health Plan of Washington</td>
</tr>
<tr>
<td>Drew Oliveira</td>
<td>Senior Executive Medical Director</td>
<td>Regence (recently retired)</td>
</tr>
<tr>
<td>Eleanor Escafi</td>
<td>Director of Network Innovation</td>
<td>Cambia Health Solutions/Regence</td>
</tr>
<tr>
<td>Elizabeth Avena</td>
<td>Family Medicine Doctor</td>
<td>MyHealth Everett/Molina Healthcare</td>
</tr>
<tr>
<td>Ginny Weir</td>
<td>Chief Executive Officer</td>
<td>Foundation for Health Care Quality (Bree)</td>
</tr>
<tr>
<td>Jonathan Staloff</td>
<td>Family Medicine Doctor, Fellow</td>
<td>UW Medicine</td>
</tr>
<tr>
<td>Kate Mundell</td>
<td>Senior Director of Network Management</td>
<td>Coordinated Care Health</td>
</tr>
<tr>
<td>Katina Rue</td>
<td>Family Medicine Doctor, President-Elect</td>
<td>Washington State Medical Association</td>
</tr>
<tr>
<td>Kristy Valdez</td>
<td>Director, Value-Based Programs and Provider Payment</td>
<td>United Health Group</td>
</tr>
<tr>
<td>Laura Morano</td>
<td>Care Transformation Consultant</td>
<td>Seattle Children's</td>
</tr>
<tr>
<td>Linda Van Hoff</td>
<td>Primary Care Nurse Practitioner (NP), President ARNP United</td>
<td>ARNP United (NP organization), Overlake Clinic</td>
</tr>
<tr>
<td>LuAnn Chen</td>
<td>Senior Medical Director</td>
<td>Community Health Plan of Washington</td>
</tr>
<tr>
<td>Matthew Hollon</td>
<td>Internal Medicine Doctor, President ACP</td>
<td>American College of Physicians (internist organization), Multicare Family Medicine</td>
</tr>
<tr>
<td>Sarah Stokes</td>
<td>Associate Director of Network Operations</td>
<td>Kaiser Permanente</td>
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<tr>
<td>Sharon Brown</td>
<td>Executive Director</td>
<td>Greater Columbia Accountable Community of Health</td>
</tr>
<tr>
<td>Sharon Eloranta</td>
<td>Medical Director</td>
<td>Washington Health Alliance</td>
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<tr>
<td>Shawn West</td>
<td>Chief Medical Officer</td>
<td>Embright</td>
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<tr>
<td>Sheryl Morelli</td>
<td>Chief Medical Officer</td>
<td>Seattle Children's</td>
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<tr>
<td>Tracy Corgiat</td>
<td>Vice President Primary Care</td>
<td>Confluence Health</td>
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<tr>
<td>Vicki Lowe</td>
<td>Executive Director</td>
<td>American Indian Health Commission</td>
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August 5, 2022
## Advisory Committee on Primary Care
### Feedback on Proposed Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Place of Business</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bob Crittenden</td>
<td>Freddy Chen</td>
<td>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.</td>
</tr>
<tr>
<td>Jodi Joyce</td>
<td>Mary Bartolo (COO of SeaMar), Paul Minardi (President and Exec Med Director of KP Washington), Yakima Valley Farmworkers</td>
<td>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.</td>
</tr>
<tr>
<td>Mika N. Sinanan</td>
<td>Vicki Fang, MD</td>
<td>UW Medicine system</td>
</tr>
<tr>
<td>Mika N. Sinanan</td>
<td>FQHCs e.g., SeaMar, Yakima Valley Farmworkers</td>
<td>Service-oriented clinicians</td>
</tr>
<tr>
<td>Mika N. Sinanan</td>
<td>Kaiser Permanente clinicians</td>
<td>Service-oriented clinicians</td>
</tr>
<tr>
<td></td>
<td>Teresa Girolami, MD</td>
<td>Solo-practitioner with primary care practice, member of King County Medical Society, with a focus on legislative and policy issues.</td>
</tr>
<tr>
<td>Mika N. Sinanan</td>
<td>DC Dugdale</td>
<td>Internist, primary care provider, and UW Medicine Medical Director for Value-Based Care</td>
</tr>
<tr>
<td>Dorothy Teeter</td>
<td></td>
<td>Providers and primary care members who currently practice in primary care models of accountable care.</td>
</tr>
<tr>
<td>Ross Laursen</td>
<td></td>
<td>Members with expertise in code definitions/criteria and familiarity with VBP methodologies for primary care design.</td>
</tr>
<tr>
<td>Wes Waters</td>
<td>Kevin Phelan</td>
<td>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.</td>
</tr>
</tbody>
</table>
August 10, 2022

Chair Sue Birch  
Health Care Cost Transparency Board  
Submitted via email to: hcahctboard@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)
Three Federal Actions to Support State Efforts to Make Health Care More Affordable

JULY 18, 2022
BLOG POST

Author:

RACHEL BLOCK

Related Content:

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 a 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.