Washington State Health Care Authority

# Advisory Committee of Health Care Providers and Carriers

August 3, 2022

Washington State Health Care Authority

# Health Care Cost Transparency Board
# Board Book

**August 3, 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

# Advisory Committee of the Health Care Providers and Carriers

**August 3, 2022**
**2:00 p.m. – 4:00 p.m.**
**Zoom Meeting**

## AGENDA

| Committee Members: | | | | | |
|---|---|---|---|---|---|
| ☐ | Mark Barnhart | ☐ | Stacy Kessel | ☐ | Megan McIntyre |
| ☐ | Bob Crittenden | ☐ | Ross Laursen | ☐ | Mika Sinanan |
| ☐ | Justin Evander | ☐ | Todd Lovshin | ☐ | Dorothy Teeter |
| ☐ | Paul Fishman | ☐ | Vicki Lowe | ☐ | Wes Waters |
| ☐ | Jodi Joyce | ☐ | Mike Marsh | | |
| ☐ | Louise Kaplan | ☐ | Natalia Martinez-Kohler | | |

| Committee Facilitator: |
|---|
| AnnaLisa Gellermann |

| Time | Agenda Items | Tab | Lead |
|---|---|---|---|
| 2:00 – 2:05 (5 min) | Welcome and roll call | 1 | AnnaLisa Gellermann, Board Manager Health Care Authority |
| 2:05 – 2:10 (5 min) | Approval of June meeting minutes | 2 | AnnaLisa Gellermann, Board Manager Health Care Authority |
| 2:10 – 2:15 (5 min) | Topics we will discuss today | 3 | AnnaLisa Gellermann, Board Manager Health Care Authority |
| 2:15 – 2:35 (20 min) | Primary Care: the statute | 4 | AnnaLisa Gellermann, Board Manager Health Care Authority |
| 2:35 – 2:45 (10 min) | Public comment | | AnnaLisa Gellermann, Board Manager Health Care Authority |
| 2:45 – 3:15 (30 min) | Introduction to Primay Care Expenditures | 5 | Dr. Judy Zerzan, Medical Director Health Care Authority |
| 3:15 – 3:55 (40 min) | Primary Care Next Steps: Overview and Discussion | 6 | Dr. Judy Zerzan, Medical Director Health Care Authority |
| 3:55 – 4:00 (5 min) | Adjourn | | AnnaLisa Gellermann, Board Manager Health Care Authority |

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

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# Meeting minutes

# TAB 2

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# Advisory Committee of Health Care Providers and Carriers meeting minutes

June 2, 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

Bill Ely
Bob Crittenden
Dorothy Teeter
Jodi Joyce
Louise Kaplan
Mika Sinanan
Mike Marsh
Natalia Martinez-Kohler
Ross Laursen
Stacy Kessel
Todd Lovshin
Vicki Lowe
Wes Waters

## Members absent

Mark Barnhart
Megan McIntyre
Paul Fishman

## Agenda items

### Welcome, call to order, approval of April meeting minutes

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 9:02 a.m. Minutes from April were approved.

### Topics we will discuss today

Ms. Gellermann shared the list of topics, including reviewing Board presentations on hospital costs in Colorado, and an update on the provider reporting list for the 2022 Benchmark Data Call. Ms. Gellermann informed the committee that Dr. Zerzan was unable to attend, and that the discussion of primary care would be rescheduled.

## Hospital Costs, Price, and Profit Analysis: The Colorado Story and input for Washington's analysis

John Bartholomew and Tom Nath
PowerPoint presentation

John Bartholomew shared a presentation on hospital costs in Colorado. The committee was informed that after viewing the presentation, the Board approved an analysis of Washington hospital costs based on the same methodology. This will be presented at a future Board meeting.
Mr. Bartholomew described the Colorado issue that prompted the analysis as an unexpected increase in insurance and hospital costs of over 50% more than the national average between 2009 and 2018. In 2014 Colorado legislature established the Colorado Commission on Affordable Health Care to understand why commercial health care costs were rising so fast. One of the main findings of the Commission still in use is that hospital financial analysis is needed at the state level.
Mr. Bartholomew explained the methodology of the report. Using Medicare Cost Report data submitted by the hospitals, metrics were created on Net Patient Revenue, Hospital-Only Operating Cost, and Net Income by diving data by adjusted discharges. The results were used to identify trends across hospital types, including health systems, independents, for-profit, not-for-profit, rural, urban, and by y bed size,
Mr. Bartholomew presented summary slides from a report published in August 2021 (and available on-line) with the resultant rankings and findings. These included Colorado's ranking nationally on the metrics listed above, an aggregate income statement for all Colorado hospitals specifying two types of profit (patient services net income and other non-patient income), scatter plots charts identifying results. He also shared a chart of operating margins related to Covid, and a presentation on Consumer Benefit, both requested by the Colorado commission.
Relative to Washington, Mr. Bartholomew shared that in 2021, the state was ranked 7th in high cost per patient, and 14% higher than the national median on price per patient.
Committee members engaged in a lengthy discussion of the presentation and the sources of data used in the port, including:

- *Could the per-discharge population be more expensive if a system has an efficient ambulatory process that filters out more expensive in-patient interactions?* Mr. Bartholomew shared that he used a formula addressing the ratio of out-patient volume and in-patient discharges. He described the formula as in common use, and available for review in his appendix.
- *Is the analysis population based, in other words looking at managed care-based populations?* Mr. Bartholomew responded that the analysis was based on information submitted by hospitals in the Medicare Cost reports.
- *Is the additional federal money provided to Colorado hospitals described in the report similarly paid in Washington (e.g., the provider tax model)?* Mr. Bartholomew said he was aware of some similarities, and that he was learning about the differences. At this point, he was aware of a difference in size of the payments (Washington payments totals were lower than Colorado).
- *Adjusted discharge figures elsewhere are based on an adjusted case mix that considers the acuity level of discharges?* Mr. Nash responded that he was familiar with this type of adjustment as "equivalent discharges", and that that national case mix information was not currently available to use for national comparisons. As a result, the analysis used the more common adjusted discharge which can be determined from the Medicare Cost reports.
- *Did you conduct a per capita analysis in addition to the adjusted discharge analysis?* Mr. Bartholomew responded hospital admissions over population as a denominator created a metric that caused a lower score for states with a high admission per capita (e.g., less healthy states), and that he believed this result did not inform the purpose of the cost analysis, which is to compare relative performance between hospitals in to derive insights about what is driving cost. He shared a list to the August 2021 report.

- *Are the dollar values for charity care based on the hospital price list, or what would have been paid at Medicaid rates?* Mr. Nash reported that it was the actual cost incurred by the hospital for providing the services.
- *Was there any inclusion of the delta between cost incurred and payments made (e.g., the break*-even rate for the service)? Mr. Nash reported the results on the Charity slide were strictly charity, with no payments incurred.
- *Does this report take as a given that cost-shifting is occurring in Colorado (specifically commercial market subsidy of Medicaid rates), or conclude as a result of this analysis that is it not occurring?* Mr. Bartholomew responded that the initial argument in Colorado was that big hospitals shared that commercial pricing was a result of under-funding for Medicaid. The Colorado department had previously issued a report in January 2020, the "cost-shift myth" concluding that commercial increases far exceeded Medicaid under-payment even after Medicaid expansion. When asked if he believed this conclusion should be confined to Colorado, Mr. Bartholomew responded that he was aware of several reports and independent research that does not support the concept of const-shifting. Links to the Colorado report and one other were provided to the committee.

One committee member commented that Washington state was a very different environment (including that it is in the main a totally non-profit state) and expressed concerned that the Colorado results could create a false impression about Washington hospitals. Specifically, he pointed out that Washington margins were significantly lower, Washington Medicare contracts averaged about 175% which is significantly lower than other state reimbursements. This member suggested that the Board's report not focus on the disparity between for-profit and not-for-profit entities as potentially confusing, and that quality should be considered as an important element, especially in hospital with low discharge per thousand which likely experience higher acuity. Finally, he pointed out that the hospital system is in a period of historic crisis stemming from the Covid pandemic, staff shortages and wage rate inflation of over 20% year over year.

One committee member suggested that talking to hospital CEOs about the credibility of the adjusted discharge formula would be an important follow-up. This was supported by other committee members.

One committee member suggested that the Board needed to understand the context of hospital cost in relationship to total health care expenditures, pointing out that less than 1% of the population at any one time. She also stated it was important to understand where WA hospital costs stand related to other states. She also emphasized the importance of workforce issues. Ms. Gellermann asked if workforce was a separate topic than labor cost, and she said yes, this should be a separate topic. The member emphasized that all these topics were important to supporting sound policy recommendations.

One committee member pointed out the impact of behavioral health issues, much of which is provided by hospitals, and the lack of adequate discharge locations extending hospital stays.

Committee members also suggested that education on how to consider and evaluate hospital data are important.

One committee member stated that hospital reimbursement methodology would not be significant to the cost discussion, with the exception of how Covid and the staffing environment has shifted the cost and profit landscape. He also suggested that site of service and care patterns were important to understand.

## Input for Washington's analysis

Ms. Gellermann then asked committee members for feedback on what aspects of hospital cost would be important for the Board to have information about when considering the future Washington report including what the Board needs to know, and who should be invited to present or assist in presenting? She reported that the Board was committed to an independent analysis conducted by Mr. Bartholomew and Mr. Nash, an

explanation of the recently issued Rand report, a specific report on workforce and labor by Board member Dr. Bianca Frogner, and a presentation from the Washington State Hospital Association to the Board.
Once committee suggested information about the WA hospital landscape (e.g., for-profit vs. non-profit), labor and workforce issues, and the impact of Covid-19 and resulting anomalies in 2019 and 2020 data.
One committee member suggested that it would be important to consider differences between for-profit vs. non-profit hospitals and information about the impact of non-profits with for-profit subsidiaries. One specific topic would be to learn how funds received by non-profits are used and how they organize themselves.

## Update on provider reporting list

Ross McCool, Operations Research Specialist, HCA
PowerPoint presentation

Mr. McCool presented the committee with a draft list of provider entities that would be subject to attribution by carriers for purposes of the benchmark report. He explained that the list contained the large provider entities in Washington that would by virtue of size and composition be able to impact the total cost of care. He also shared the rationale for rolling up providers to a parent entity.
He shared the initial list (presented to the Board and both committees), and the follow up survey done by HCA staff inquiring into the existence of total cost of care contracts. Some entities were added based on survey results. Finally, he shared the post-survey draft list and requested any feedback or comments. Based on the schedule for the 2022 benchmark data call, he requested feedback be provided by June 17, 2022.
One Committee member asked how proprietary the information is and questioned the inclusion of Eastside Health Network as a contracting entity for several providers. The call was interrupted for technical difficulties, and Ms. Gellermann directed Mr. McCool to follow up individually with that committee member.
Ms. Gellermann reminded committee members that no public reporting on carriers and providers would be done in the first benchmark report.
No additional comments were shared in the meeting.

## Public Comment

There was no public comment

## Future Meetings: virtual vs. hybrid

Ms. Gellermann shared that Governor Inslee's amended Public Health emergency order now permitted hybrid meetings. She also shared HCA Director Sue Birch's request that meetings continue virtually only, based on concern for public health and acknowledging that virtual meetings had been successful. She invited the committee to discuss and vote on Director Birch's recommendation to continue meetings virtually only for the future.
A motion was made to continue virtually only for the foreseeable future and adopted unanimously.

## Primary Care Project overview and discussion:

Judy Zerzan, Chief Medical Director, HCA

This portion of the meeting was cancelled. It will be rescheduled for a future meeting.

## Adjourn

Meeting adjourned at 3:49 p.m.

## Next meeting

Wednesday, August 3, 2022
*Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.
**Zoom meeting is dependent on public health emergency.*

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# Topics for today

# TAB 3

# Topics for today

- Primary care statute
- Introduction to primary care expenditures
- Primary care next steps: overview and discussion

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# Primary care: the statute

# TAB 4

# Primary Care Expenditures: SSB 5589

AnnaLisa Gellermann, Board Manager
Health Care Authority
August 3, 2022

Washington State Health Care Authority

# Primary Care Expenditures:

- Added to Title 70.390 (HCCTB).
  - **Shall** measure and report on primary care expenditures and the progress toward increasing to 12% of total health care expenditures (THCE).
    - Preliminary report due December 1, 2022.
    - Annual report beginning August 1, 2023.
- Added to Title 48 (Office of the Insurance Commissioner)
  - Commissioner may include an assessment of carriers' primary care expenditures in its review of health plan form or rate filings.
    - Upcoming or for past year.
    - Must consider definition and targets established under section 1.

# Preliminary report: Recommendations

- How to define “primary care.”
  - As a proportion of total health care expenditures.
  - How definition aligns with existing definitions (OFM, Bree).
- Measurement Considerations.
  - Barriers to access and use of data.
  - How to overcome them.
- How to achieve the 12% target.
  - Annual progress needed to achieve in “reasonable time.”
  - How and who will determine if it’s being achieved.
  - Methods to incentivize achievement.
  - Specific practices to achieve the target.*

# Specific practices: Achieve target while. . .

- Improving health **outcomes** and **experience** of health care.
- Improving **value** from health care system.
  - Supporting advanced integrated primary care involving a multidisciplinary team of health and social service professionals.
  - Addressing SODH within primary care settings.
  - Leveraging innovative use of efficient interoperable HIT.
  - Increasing primary and behavioral health workforce.
  - Reinforcing to patients the value of primary care.
- Holding primary care providers accountable for improved outcomes.
- Not increasing administrative burden on primary care providers or overall health expenditures in the state.
- Taking into account differences in urban and rural delivery settings.

# Annual report (2023)

- Annual report beginning August 2023 provides:
  - Primary care expenditures with suggested breakdown by:
    - Carrier, market or payer (total expenditures and percent of THCE)
    - Physical and behavioral health
    - Provider type
    - Payment mechanism
  - Reporting barriers and recommendations to resolve them.
- OIC may access expenditures in reviewing forms and rate filings.
  - OIC to use primary care definition and targets.
  - Form and content of carrier reporting determined by OIC.

# Staff Activity

- Onboarding new resource.
- Forming HCA subject matter expert and project team.
- Development of workplan milestones and deliverables.
- Engaging with Board:  Approval of ad hoc committee June 20
- Engaging with Advisory Committee of Health Care Providers and Carriers.
- Considerations
  - Primary Care Committee formation and meeting schedule
  - Schedule of committee feedback and review within existing meetings
  - Report development and review

# Public comment

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# Introduction to primary care expenditures

# TAB 5

# Introduction to Primary Care Expenditures

Dr. Judy Zerzan-Thul

CMO, HCA

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# Overview

- Why is spending in primary care important?
- What are some of the challenges in measuring primary care expenditures?
  - Providers, services, non-claims spend
- What existing efforts can we build on?
  - OFM, Bree
- Targets
  - What does the target mean?
  - How might we get there?

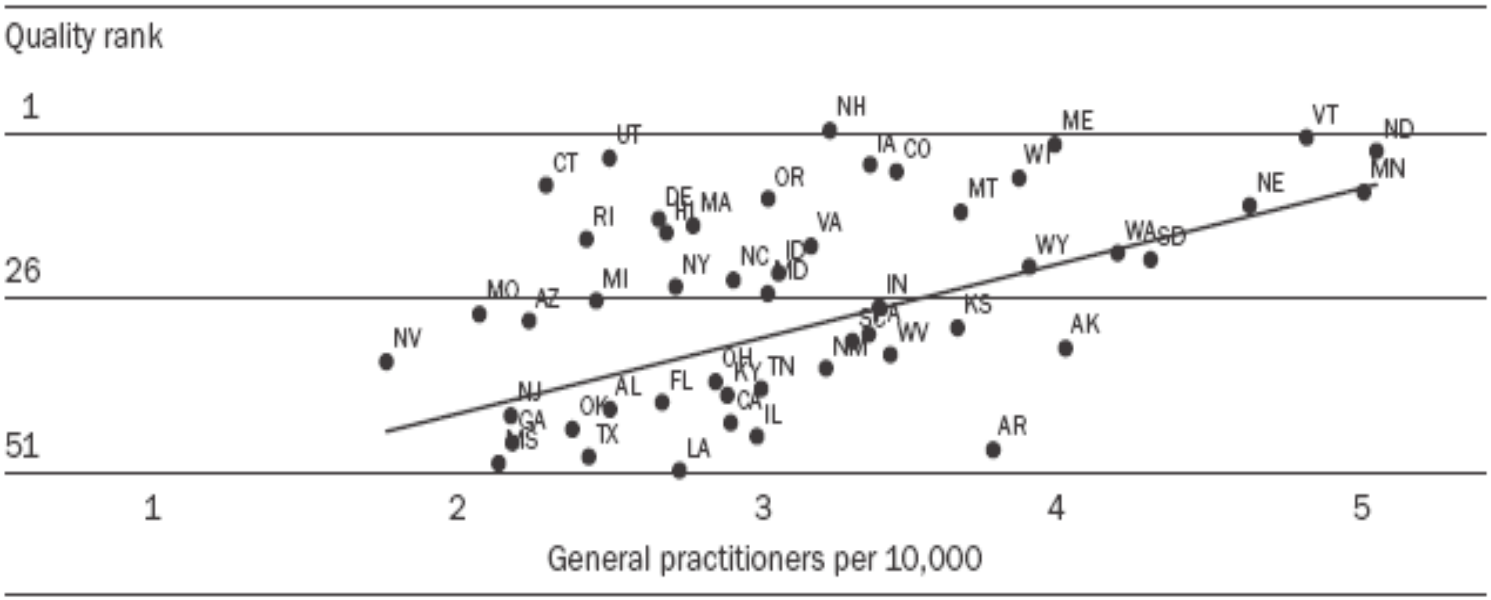
# Why does primary care spending matter?

- Over time, expectations of primary care have steadily increased
  - Quality: accountability for preventive, acute and chronic care measures
  - Expectation of proactive outreach and management, team based care, integrated behavioral health approaches, etc.
- Resources have not increased commensurate with expectations, leading to a crisis in primary care (workforce, access, etc)
- Strong evidence supports the value of resourcing primary care better

# Primary Care Associated with Higher Quality

**EXHIBIT 8**

**Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000**




**SOURCES:** Medicare claims data; and Area Resource File, 2003.

**NOTES:** For quality ranking, smaller values equal higher quality. Total physicians held constant.

Several slides adapted with permission from Chris Koller, Milbank Fund

Source: Baicker & Chandra, Health Affairs, April 7, 2004

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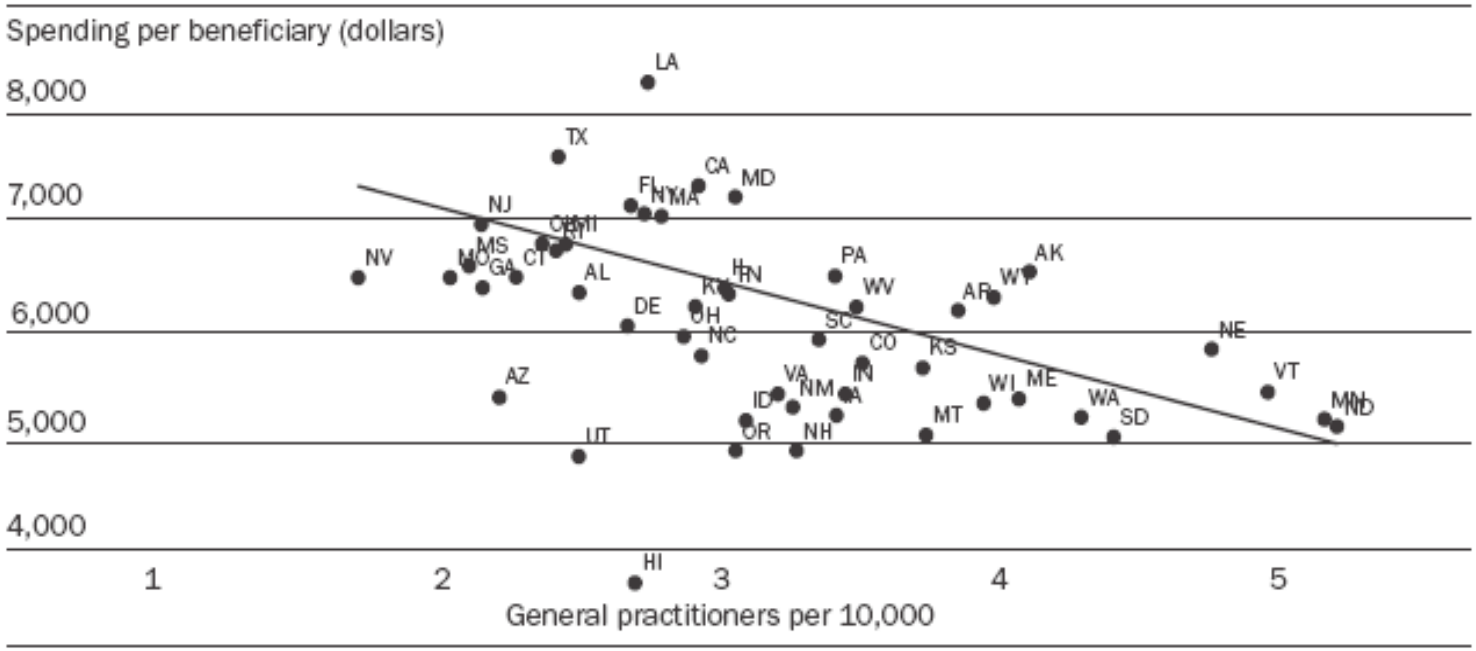
# Primary care associated with lower total costs

**EXHIBIT 9**
**Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000**




**SOURCES:** Medicare claims data; and Area Resource File, 2003.
**NOTE:** Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004

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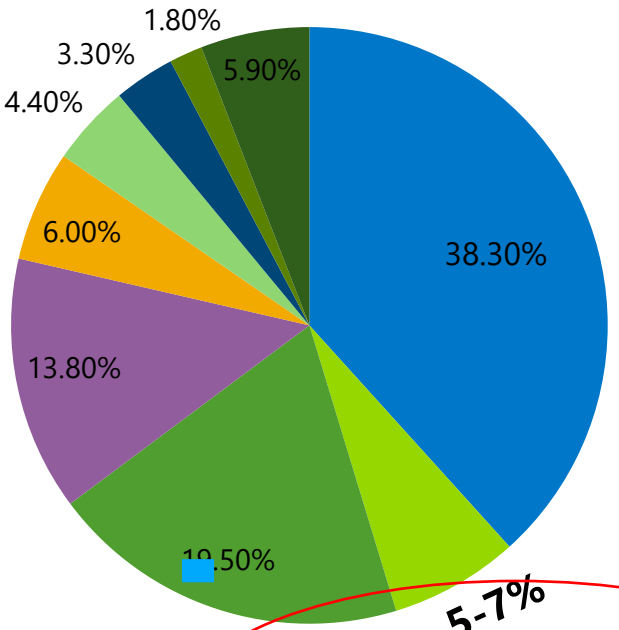
# Overall spending remains low

- Hospital Care
- All Other Physician and Professional Services
- Prescription Drugs and Other Medical Nondurables
- Nursing Home Care
- Dental Services
- Home Health Care
- Medical Durables
- Other Health, Residential, and Personal Care




5-7%

Primary Care
(estimated commercial)

Source: CMS Actuary. All Payments

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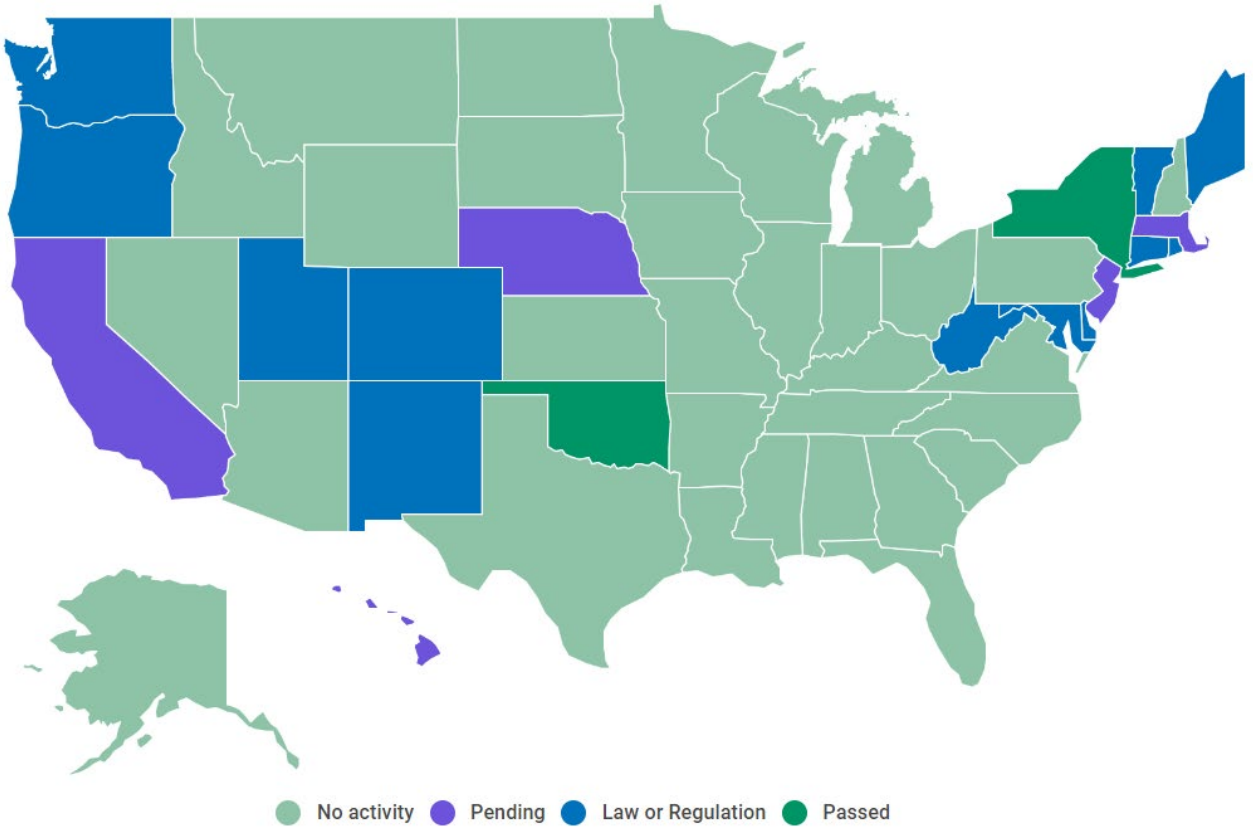
# Measuring Primary Care Spend: States with statutory or regulatory action

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# RI Affordability Standards for Commercial Insurers

- 2010: RI Office Health Insurance Commissioner:
  1. Required commercial health plans to invest in primary care, raise primary care spending by 1%/yr for 5 yrs
     - New payments had to be made through non-FFS payments
     - Could not increase overall health care spending
  2. Promoted multi-payer primary care efforts
  3. Invested in health information technology
  4. Implemented Value Based Payment models, with caps on hospital rate increases
- Standards enforced through insurance rate review process

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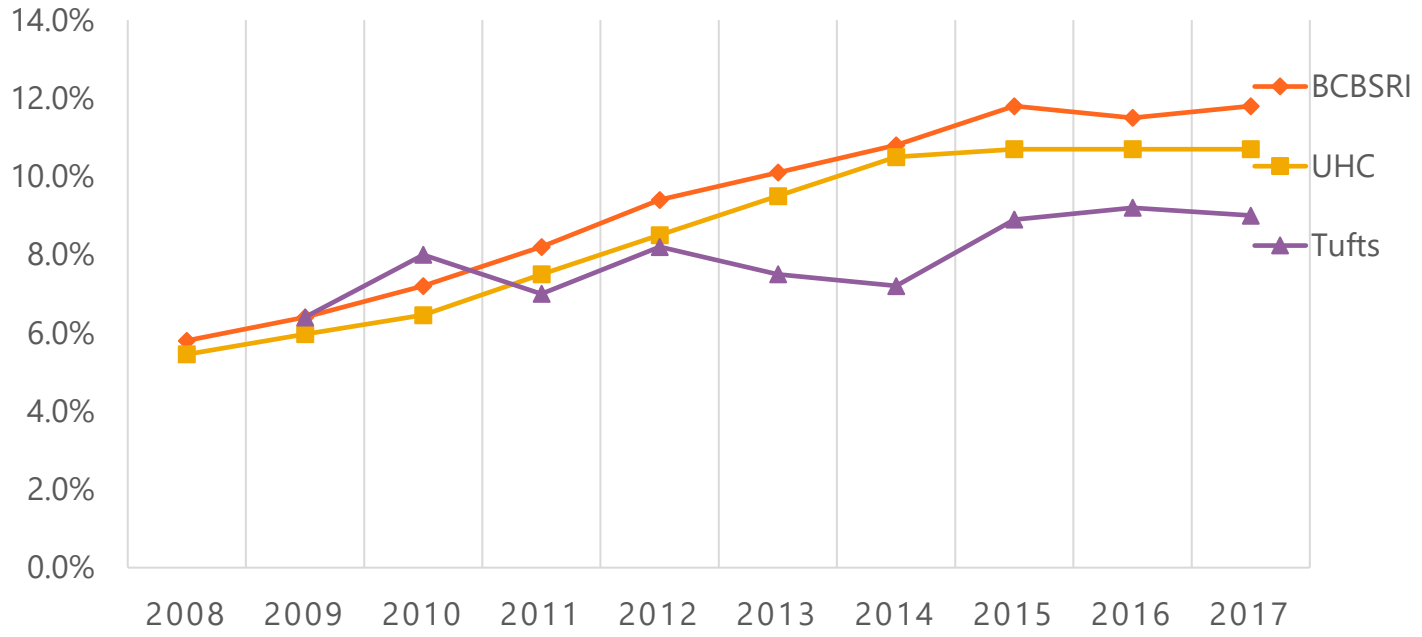
# Small Changes Make Big Impact on Payments to Primary Care

**RI primary care payments by commercial insurers on primary care increased from $47M/yr to $73M/yr (over 7yrs)**




**Primary Care Spending as Percent of Total Medical Spending Insurer (2008-2017)**
*(Self-insured plan payments not captured)*

Source: Office of the Health Insurance Commissioner, State of Rhode Island

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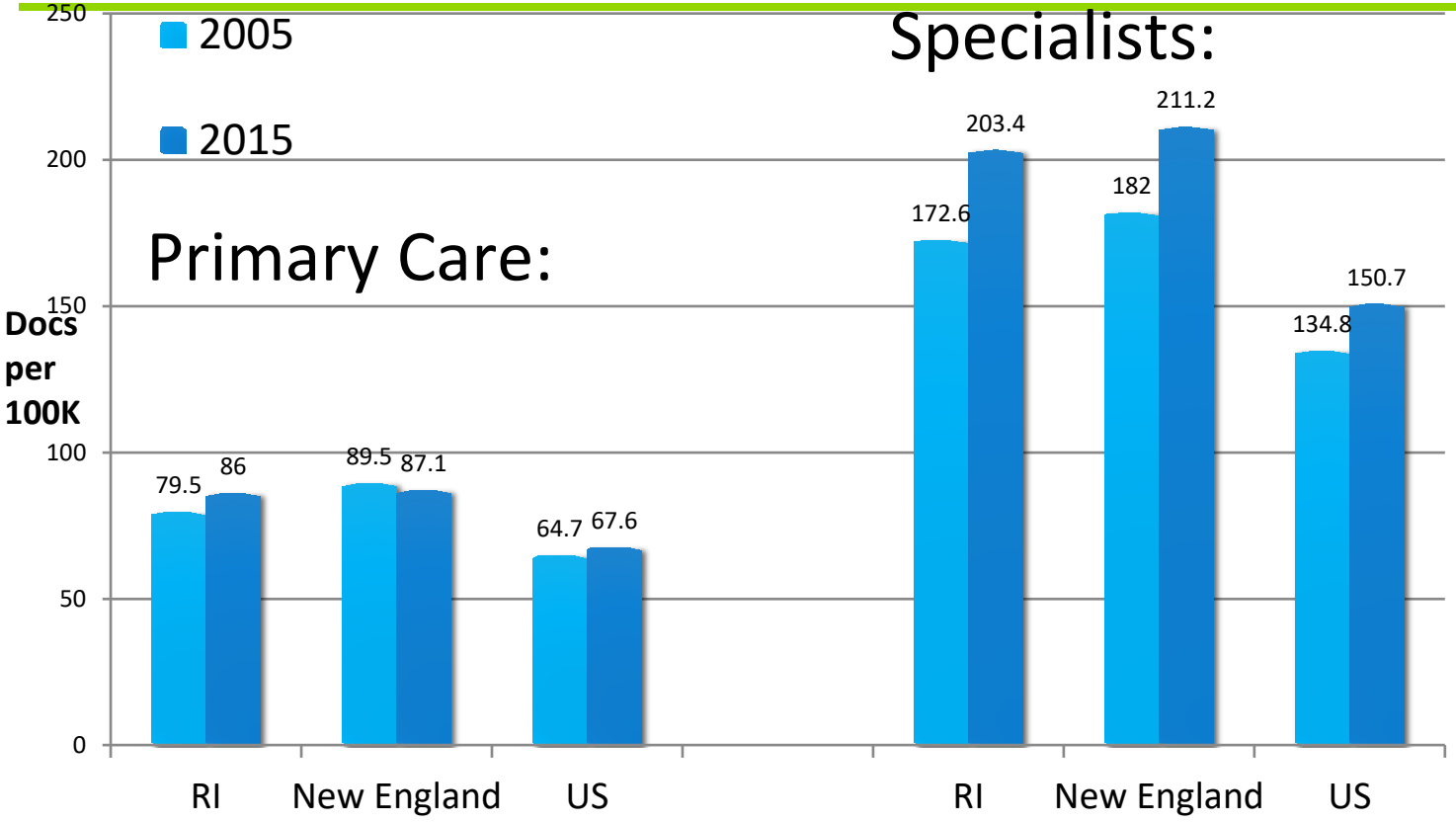
# And… RI Saw Increased Primary Care Supply *(and no "Specialty Flight")*




Notes: MDs only; Primary Care: FP, Peds, IM;
Sources: AMA Licensure and Census.Gov

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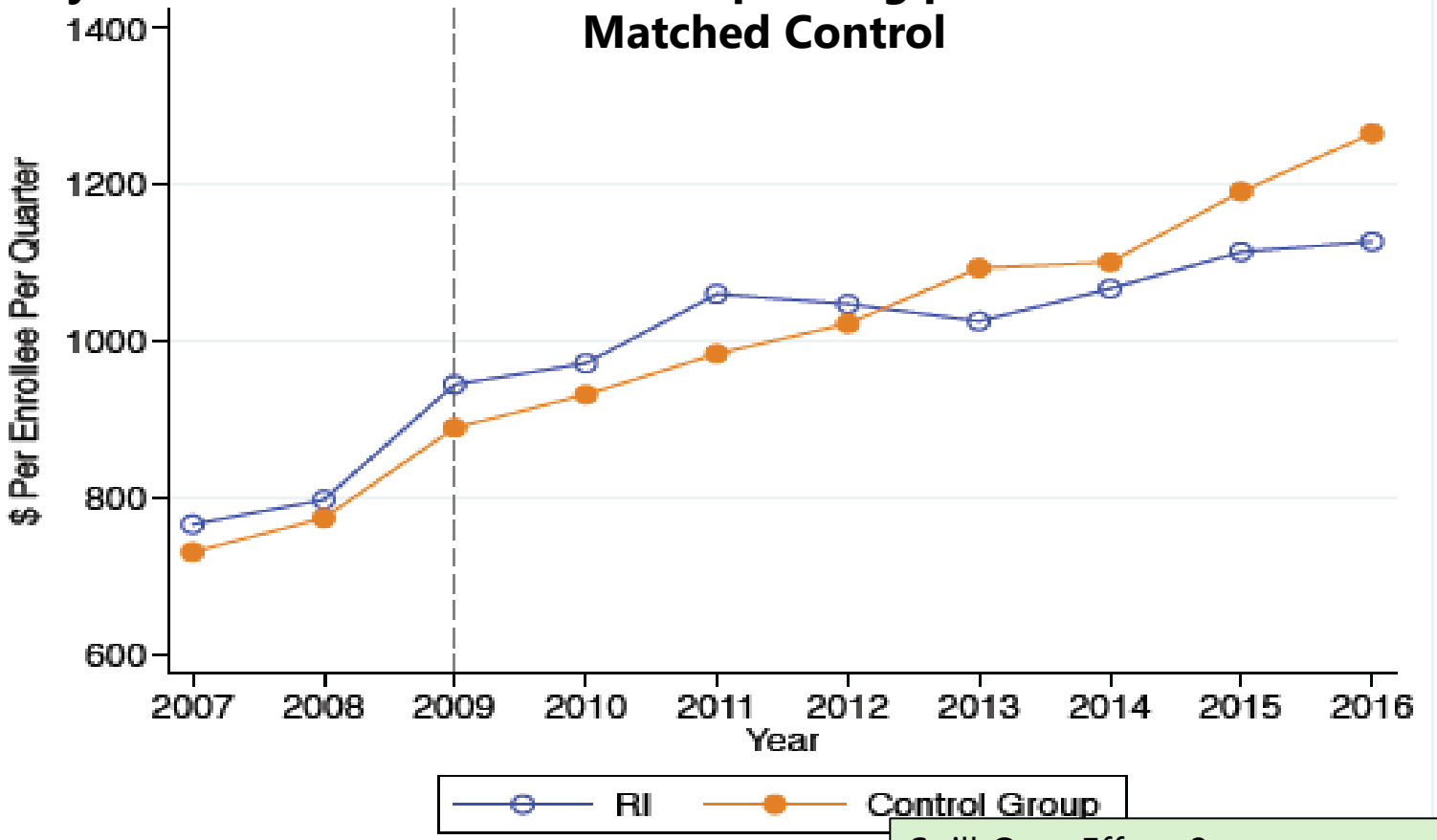
# Commercial Insurance Spend: RI's Insurance Reform Interventions Bent the

**Risk Adjusted Commercial Insurance Spending per Enrollees in Rhode Island vs. Matched Control**

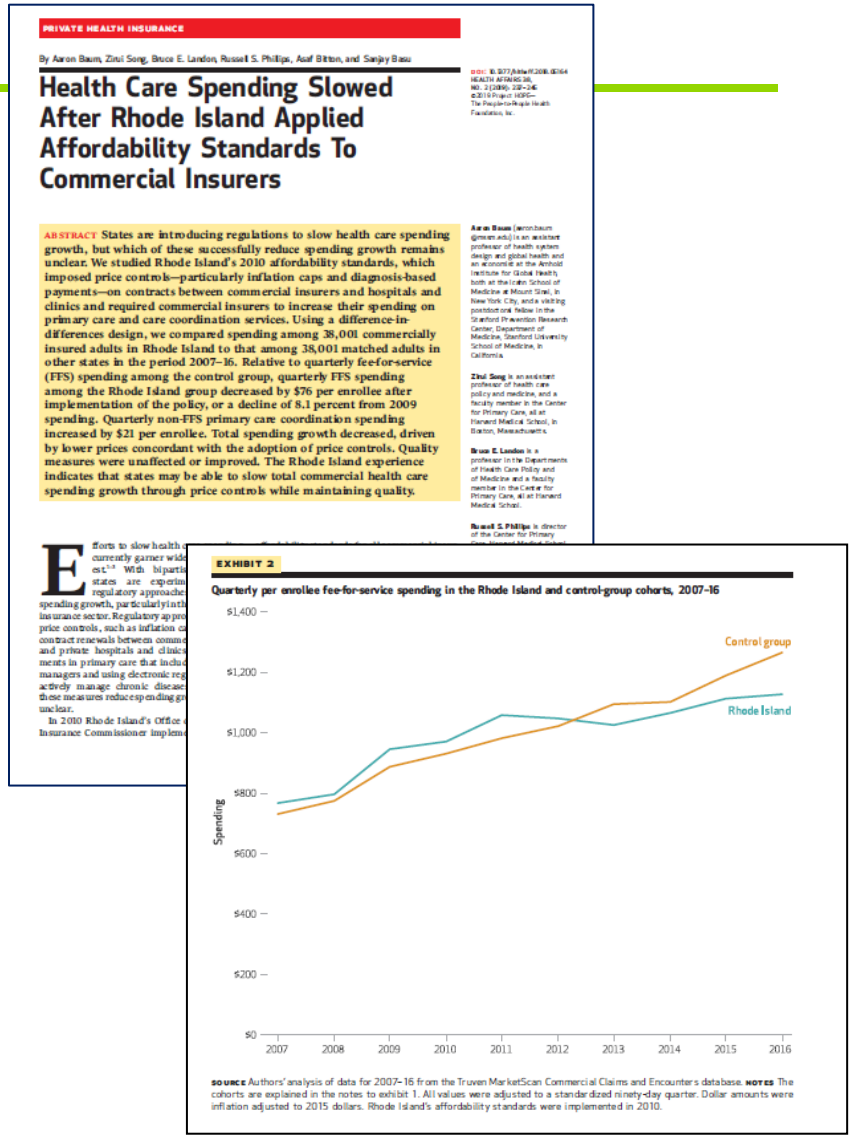



Source: Landon et al, Academy Health Annual Research Meeting, 2018

Spill Over Effects?
Per CMS Actuary, across all payers RI went from 4th to 9th most expensive state for health care (2009 to 2014)

# Impact of RI Strategy

- Analyzed trends in health care commercial plan spending in RI compared to other states over 10yr period
- Saw $21pmpm increase in non-FFS payments to primary care, along with…
- $76pmpm (8%) decrease in overall health care spending



PRIVATE HEALTH INSURANCE

By Aaron Baum, Zirui Song, Bruce E. Landon, Russell S. Phillips, Asaf Bitton, and Sanjay Basu

## Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers

ABSTRACT States are introducing regulations to slow health care spending growth, but which of these successfully reduce spending growth remains unclear. We studied Rhode Island's 2010 affordability standards, which imposed price controls—particularly inflation caps and diagnosis-based payments—on contracts between commercial insurers and hospitals and clinics and required commercial insurers to increase their spending on primary care and care coordination services. Using a difference-in-differences design, we compared spending among 38,001 commercially insured adults in Rhode Island to that among 38,001 matched adults in other states in the period 2007–16. Relative to quarterly fee-for-service (FFS) spending among the control group, quarterly FFS spending among the Rhode Island group decreased by $76 per enrollee after implementation of the policy, or a decline of 8.1 percent from 2009 spending. Quarterly non-FFS primary care coordination spending increased by $21 per enrollee. Total spending growth decreased, driven by lower prices concordant with the adoption of price controls. Quality measures were unaffected or improved. The Rhode Island experience indicates that states may be able to slow total commercial health care spending growth through price controls while maintaining quality.

EXHIBIT 2

Quarterly per enrollee fee-for-service spending in the Rhode Island and control-group cohorts, 2007–16



SOURCE Authors' analysis of data for 2007–16 from the Truven MarketScan Commercial Claims and Encounters database. NOTES The cohorts are explained in the notes to exhibit 1. All values were adjusted to a standardized ninety-day quarter. Dollar amounts were inflation adjusted to 2015 dollars. Rhode Island's affordability standards were implemented in 2010.

# Oregon:  SB231 (2015)

- Established Primary Care Payment Reform Collaborative
- Required state to determine percent primary care spend by payer
- Required recommendations on primary care spend targets & alternative payment models


Source: https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/SB-231-Report-2018-FINAL.PDF

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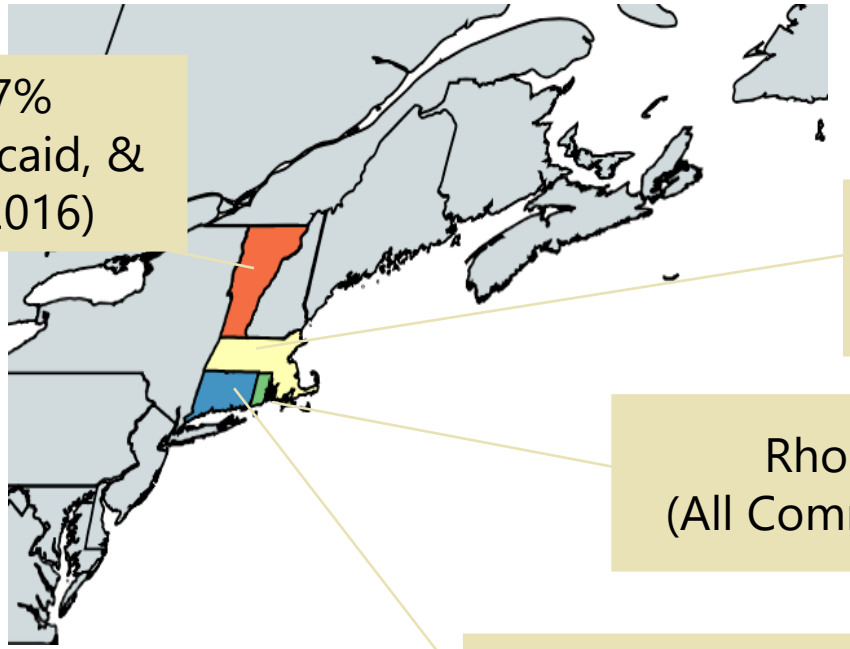
# Some baseline data (Note that definitions vary)



Vermont: 9.7% (Medicare, Medicaid, & Commercial, 2016)

Massachusetts 6.6% (Commercial Payers, 2015)

Rhode Island: 11.5% (All Commercial Payers, 2016)

Connecticut: 4.7% (State Employees, 2017)

Source: NESCSO Primary Care Workgroup Presentation, 18 October 2018

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# Primary Care Spend: Definitions and Challenges

- *Who* is primary care?
  - Which providers/provider types are included
- *What* is primary care?
  - Which services are included?
- *How* is spend measured?
  - In particular, how is non-claims spend defined and captured?

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# Who is Primary Care?

- Straightforward:
  - Family Medicine
  - Internal Medicine
  - Pediatrics
- Less straightforward:
  - OB/Gyn
  - Providers who do a mix of primary and specialty care (endocrine, sports medicine, HIV specialists, etc)
- Messy:
  - Midlevel providers (ARNP, PA)
    - Clearly play a major role in providing primary care but taxonomy often not available, or may practice in multiple settings (primary care and specialty)
  - Chiropractors, BH providers, others especially if practicing in integrated settings as part of a team

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# What services are primary care?

- Straightforward:
  - Office visits
  - Wellness visits
  - Simple procedures (vaccine administration, etc)
- Less straightforward:
  - Procedures only some PCPs do
    - Skin biopsies, sigmoidoscopies, deliveries, etc
- Messy:
  - Primary care provider type who only does specialty care (i.e., family medicine provider whose practice is exclusively vasectomies)

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# How is spend measured?

- Straightforward: Claims data
  - APCD, carrier data
- Less straightforward
  - Does patient cost share count in spend? etc
- Messy: Non-claims data
  - Alternative payment models
    - Capitation, subcapitation, bundled payments
  - Quality incentives
  - Shared savings/risk arrangements
  - Infrastructure supports (IT, etc)
  - For payments made at a system level, how is contribution to primary care assessed?

# Percentage spend

- 12% goal was likely based on Oregon goal
- Percentage requires defining both numerator (primary care spend) and denominator (total spend)
  - Inclusions and exclusions from denominator will significantly impact percentage calculation

# Existing Washington Primary Care Definitions

- Office of Financial Management (OFM) definition
  - In 2019, OFM was charged by legislature (Chapter 415) to assess primary care expenditure
  - Multistakeholder workgroup determined definitions, with a "narrow" and "broad" definition for both providers (based on taxonomy) and services (based on CPT codes)
- Bree definition
  - The Bree Collaborative convened a workgroup in 2020 on Primary Care and developed a report
  - Primary Care | Bree Collaborative (qualityhealth.org)
  - Definition based on function/role as well as taxonomy
- RCW 74.09.010
  - "General practice physician, family practitioner, internist, pediatrician, osteopathic physician, naturopath, physician assistant, osteopathic physician assistant, and advanced registered nurse practitioner"

# Existing Washington Primary Care Expenditure Reports

- OFM report
  - Report to the Legislature Primary care expenditures As required by Chapter 415, Laws of 2019 December 2019 (wa.gov)
  - Claims based, APCD data, OFM definitions
  - For 2018, PC expenditures were 4.4% ($838M) based on narrow definition and 5.6% (about $1B) based on broad definition
  - Data refresh with same definitions 2022 (not a full report)
- HCA carrier reporting
  - Contract requirement in Apple Health MCO contracts, PEBB and SEBB contracts, and Cascade Care contracts, phased in starting with 2020 payments
  - HCA has supplied template for HCA carriers to self-report
  - Claims definitions largely based in OFM report, with additional non-claims categories derived from national sources
  - Self-report percentages range from 5 to 14%
    - Note: interpretations of non-claims spend varied, and no audit of self report

# How can we approach increasing expenditures?

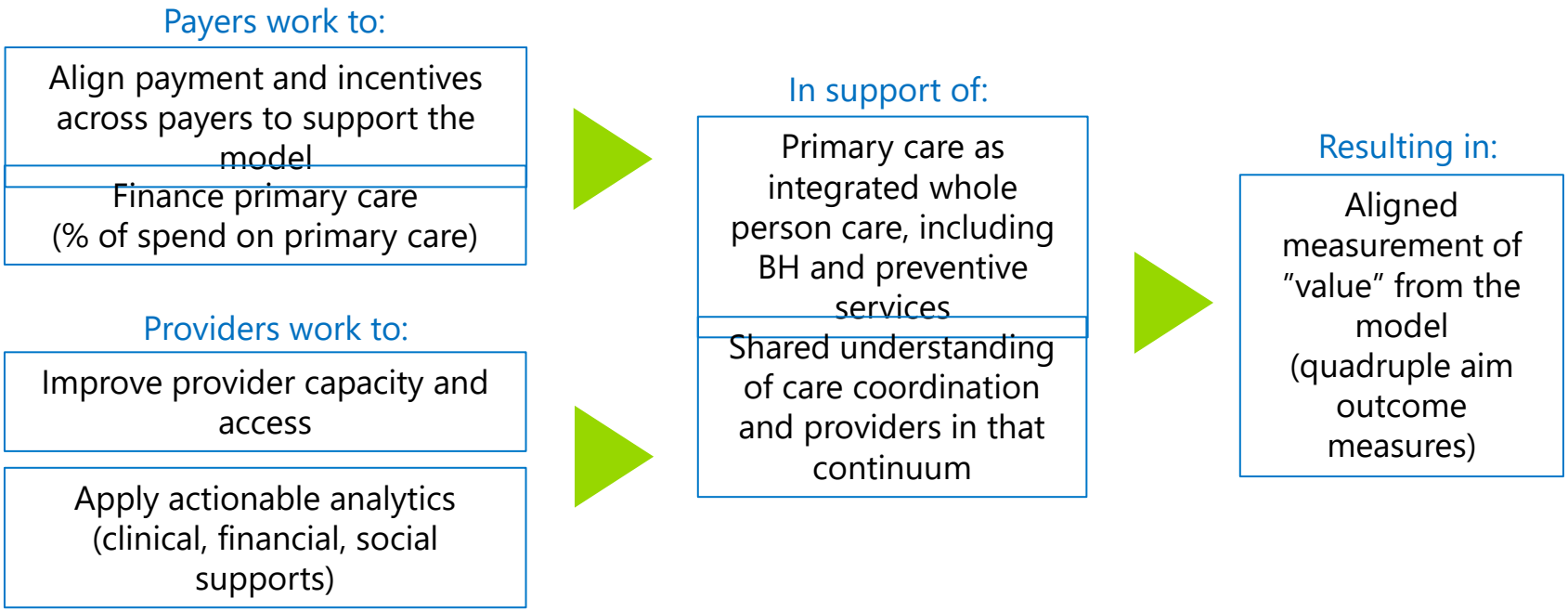
- While increased resources are necessary, they are not sufficient to achieve goals of improving quality, reducing total costs of care
- Need payment models that will ensure strengthening of primary care infrastructure, team based models, patient-centric approaches to care and access, accountability for outcomes, etc.

# Washington Multi-payer Primary Care Transformation Model

- Goals:
  - Align payment, incentives, and metrics across payers and providers
  - Promote and incentivize integrated, whole-person and team-based care that includes primary care, physical and behavioral health care, and preventive services
  - Improve provider capacity and access
  - Increase primary care expenditures while decreasing total health spending
  - Work with interested public and private employers to spread and scale the model throughout Washington State
- Collaborative effort between HCA, WA payers, and primary care providers, started in 2019 and ongoing
- Multi-payer Primary Care Transformation Model | Washington State Health Care Authority

Washington State Health Care Authority

# Primary Care Transformation Components



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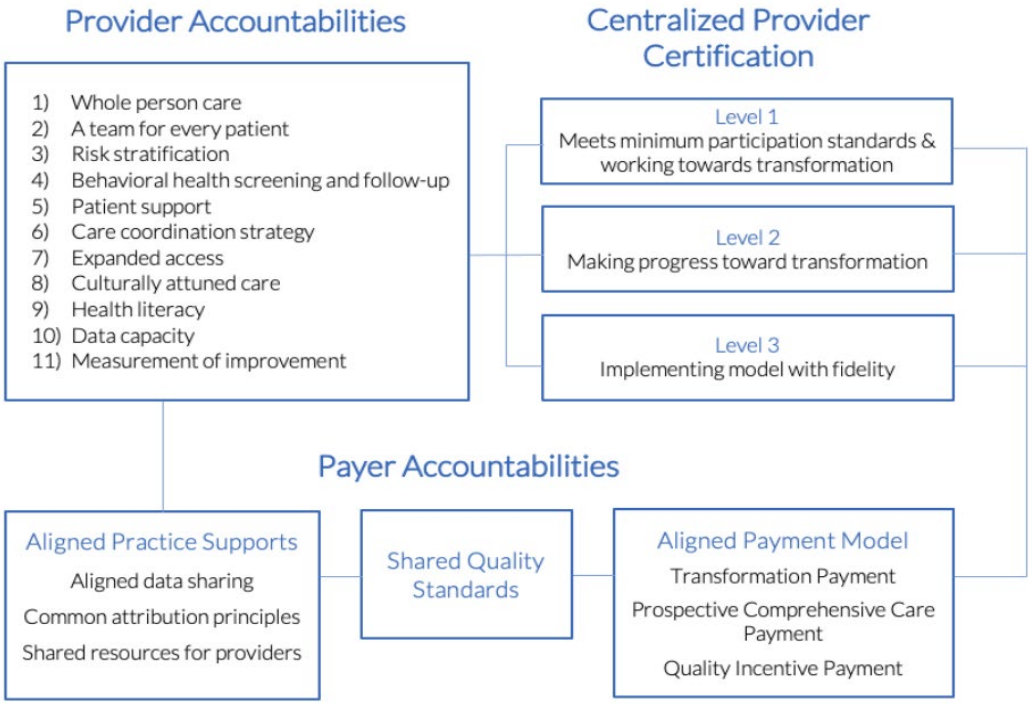
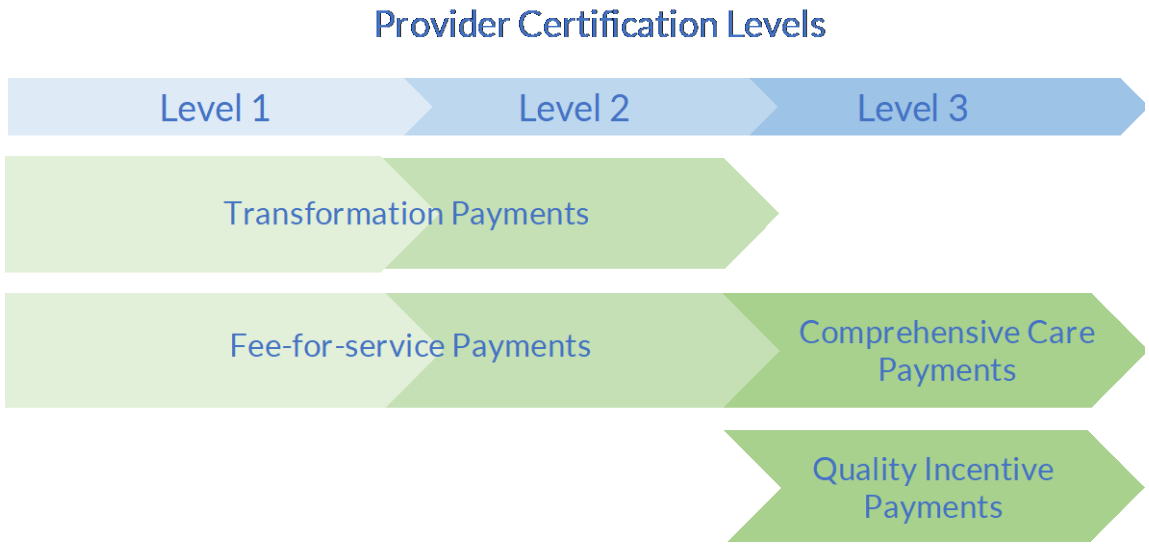
# WA Multi-payer Primary Care Model
# Key Implementation Elements



# PCTM Payment Approach

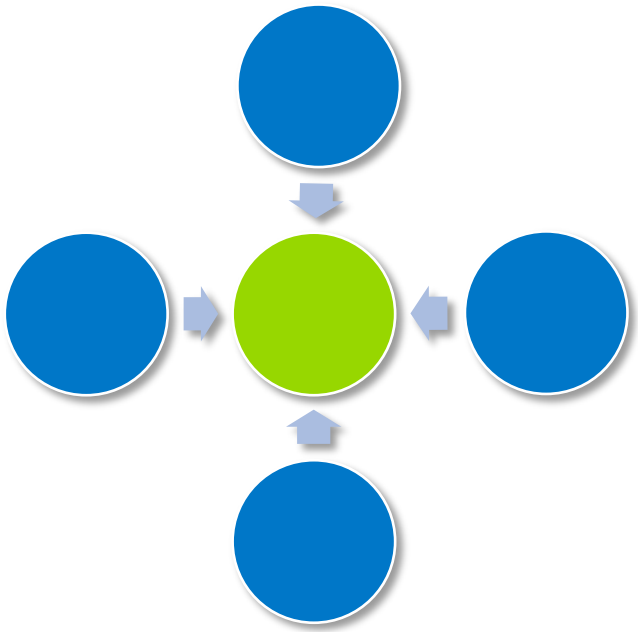


# Quality Alignment: Clinical Quality Measures

1. Child and Adolescent Well-Care Visit (WCV)
2. Childhood Immunization Status (CIS) (Combo 10)
3. Screening for Colorectal Cancer (COL)
4. Breast Cancer Screening (BCS)
5. Cervical Cancer Screening (CCS)
6. Depression Screening and Follow up for Adolescents and Adults (DSF-E): Screening submeasure only (Note: inclusion not yet finalized by PMCC)
7. Controlling High Blood Pressure (CBP)
8. Asthma Medication Ratio (AMR)
9. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (CDCN)
10. Antidepressant Medication Management (AMM)
11. Follow-up after ED visit for Alcohol and Other Drug Abuse of Dependence (FUA)
12. Ambulatory Care - Emergency Department (ED) Visits per 1,000 (AMB) (Medicaid only in HEDIS, but will adapt for use across populations)

# Centralized Provider Certification

- All plans use the same set of standards for providers
- Single process (HCA or delegate) to evaluate provider's achievement of standards (certification)
- Less burden on practices and less burden on payers
- Increases consistency/reduces different interpretation of performance across payers

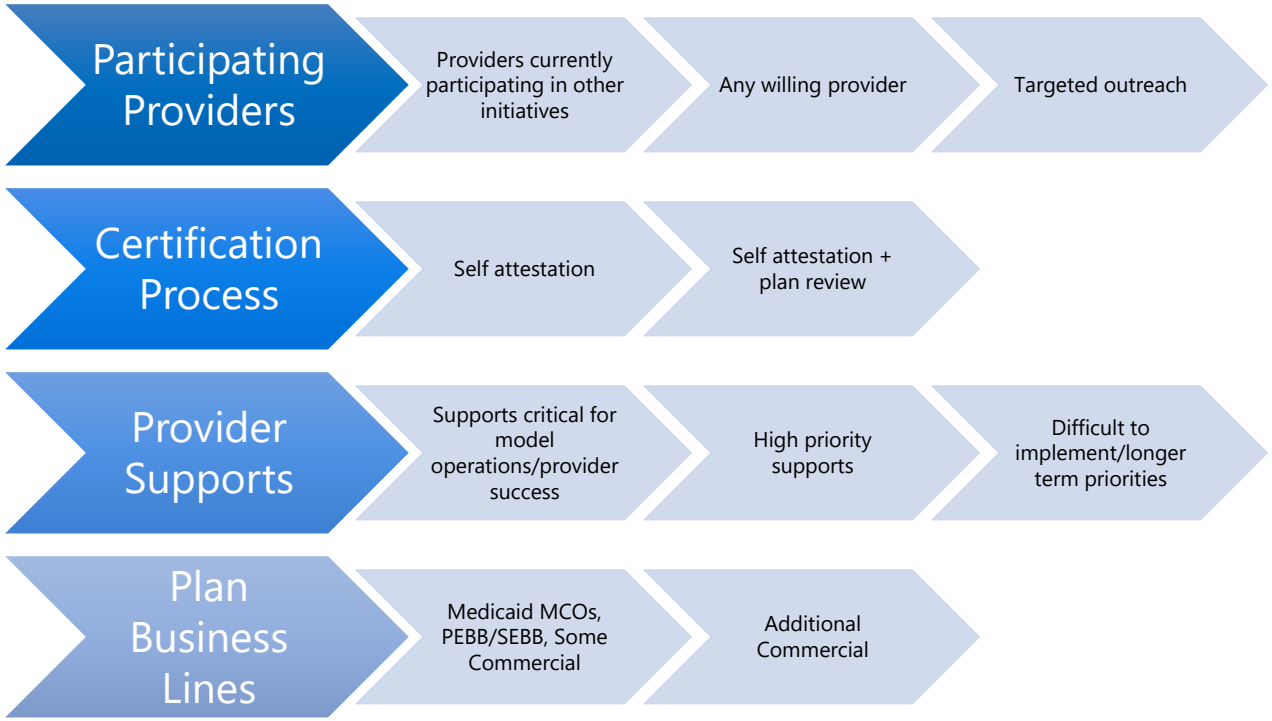


# Overview of Accountabilities

Additional definition is provided at each level. For example:

| 11. Measure improvement – use aligned metrics to measure value | | |
|---|---|---|
| **Level 1** | **Level 2** | **Level 3** |
| • Practice has a documented plan to systematically measure and track physical health outcomes as specified for the Model<br>• Practice has a documented continuous quality improvement strategy in place | • Practice has a documented plan to systematically measure and track both physical and behavioral patient outcomes as specified for the Model<br>• Systematically measures and tracks patient physical and behavioral health outcomes at individual level | • Provide timely metric data to show progress from investment<br>• Systematically measures and tracks patient physical and behavioral health outcomes at an individual and population level<br>• Practice can document measurable changes in quality and cost of care |

# Phased Implementation



Washington State Health Care Authority

# Primary care next steps: overview and discussion

# TAB 6

# Primary Care Next Steps: Overview and Discussion

Dr. Judy Zerzan-Thul
Health Care Authority
August 3, 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

# 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

- 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

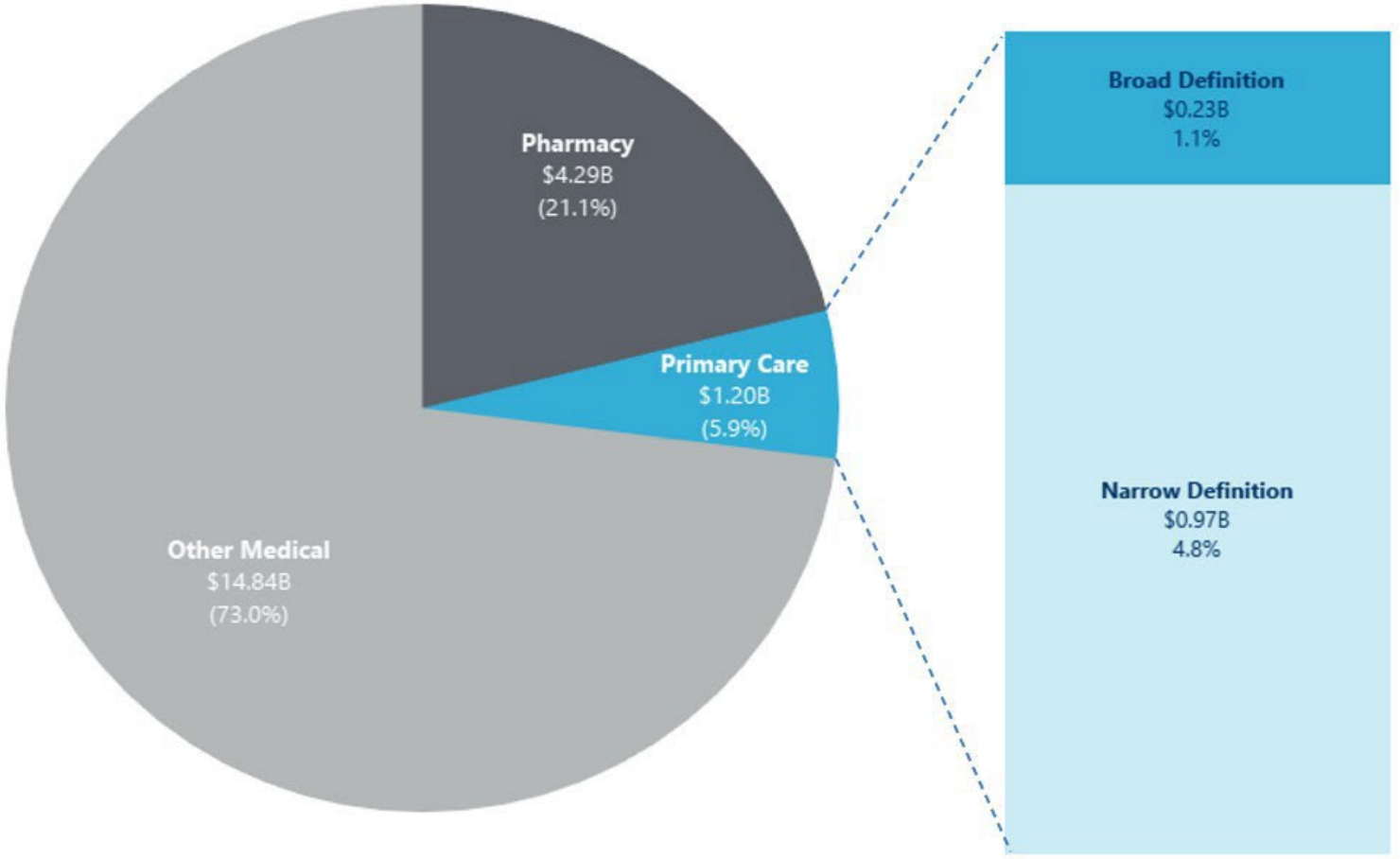
# APCD Methods – Study Population

- 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

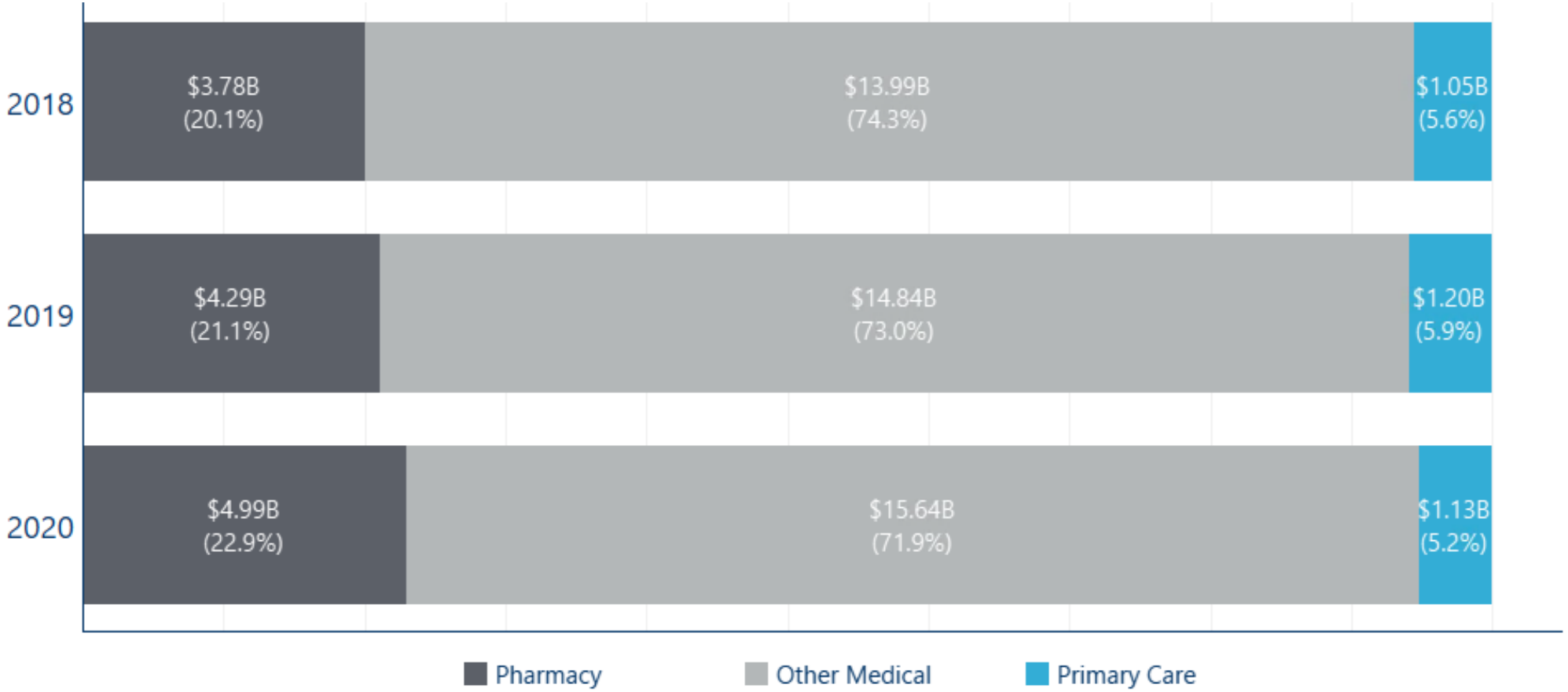
# Primary Care Spending Comprised 5.9% of Total in 2019






* Does not include Medicare FFS or Medicaid FFS plans

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



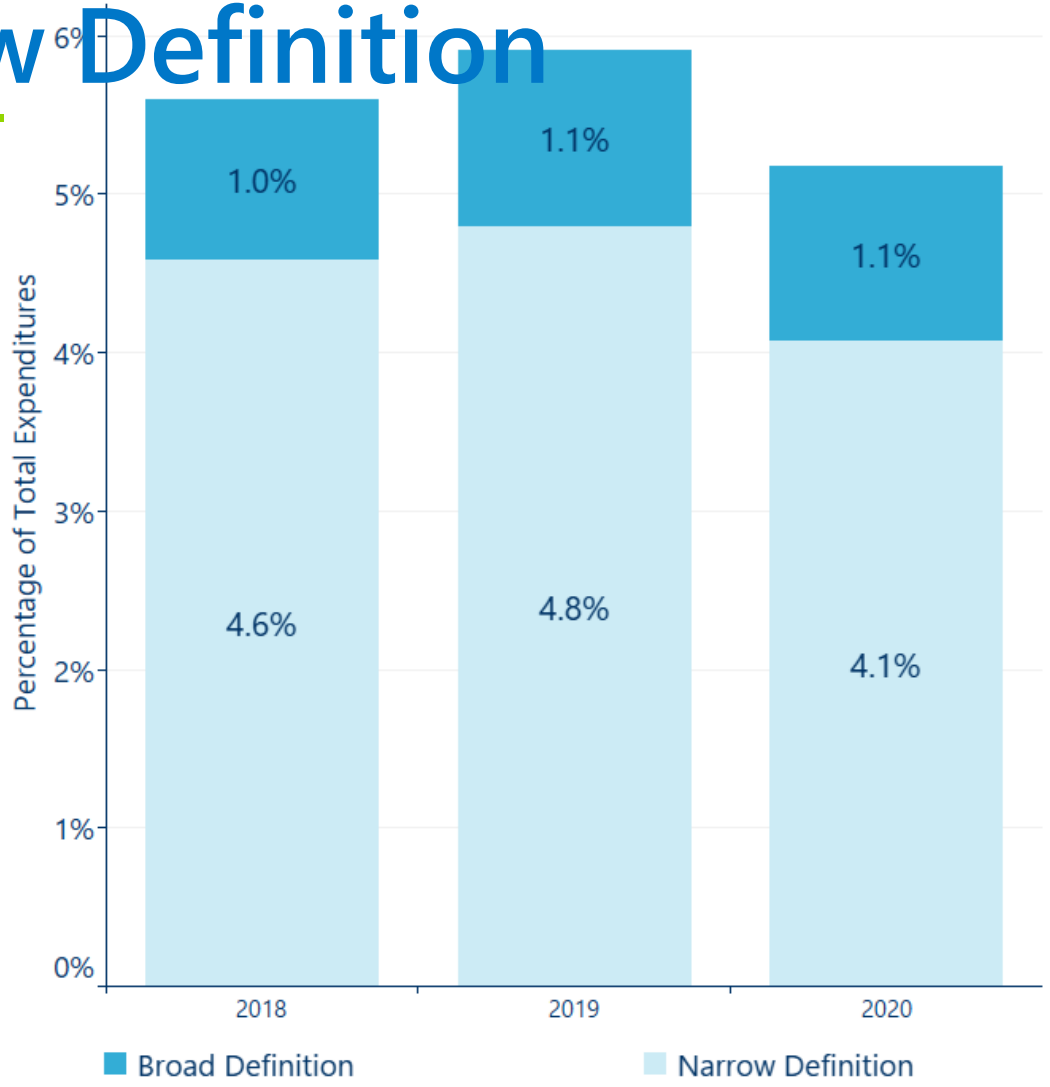

- Uptick between 2018 (5.6%) and 2019 (5.9%)
- Decline in 2020 (5.2%), likely due to COVID impacts



* Does not include Medicare FFS or Medicaid FFS plans

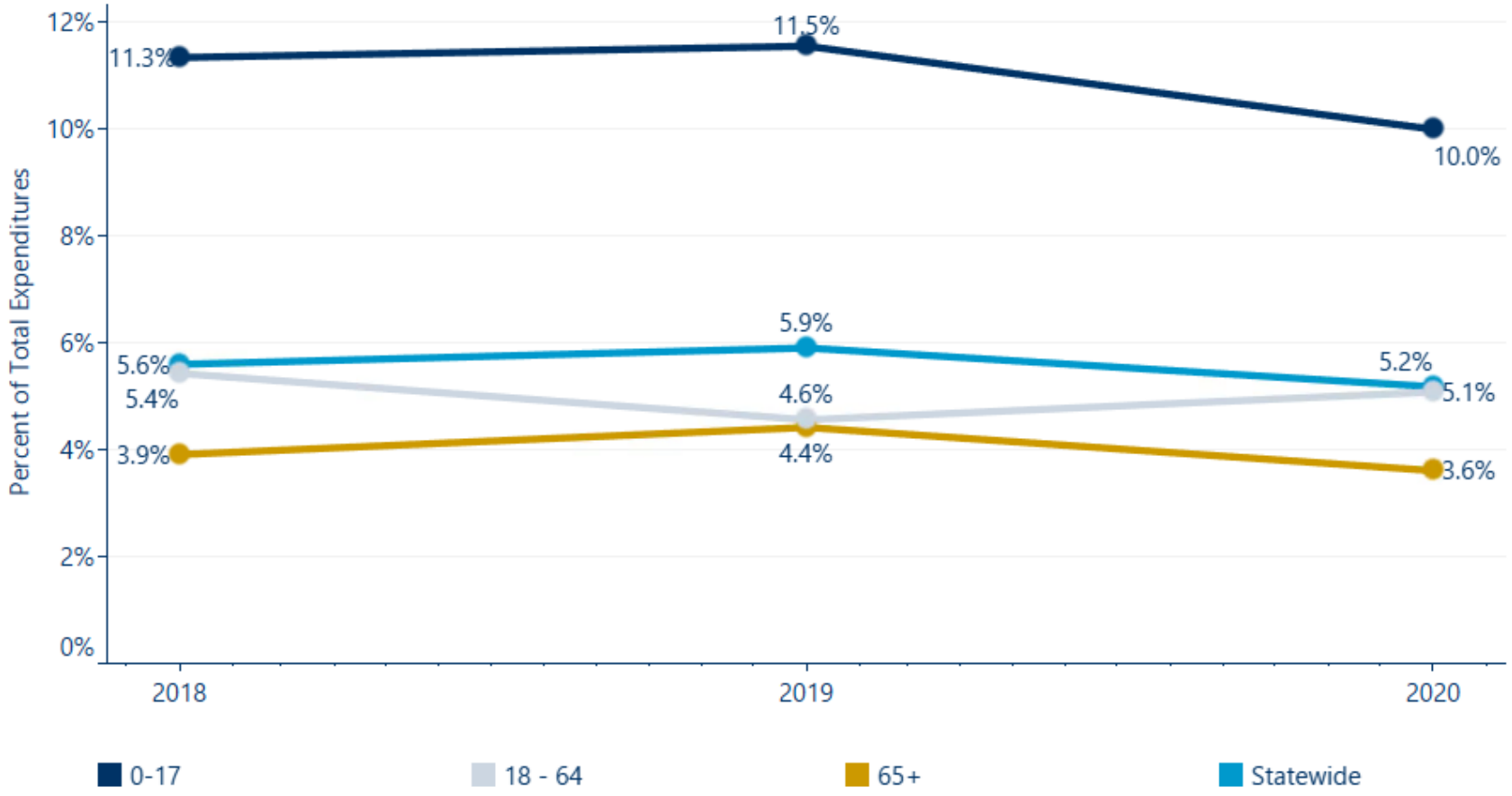
# Changes in % of Primary Care Spending Primarily Driven by Narrow Definition

- 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

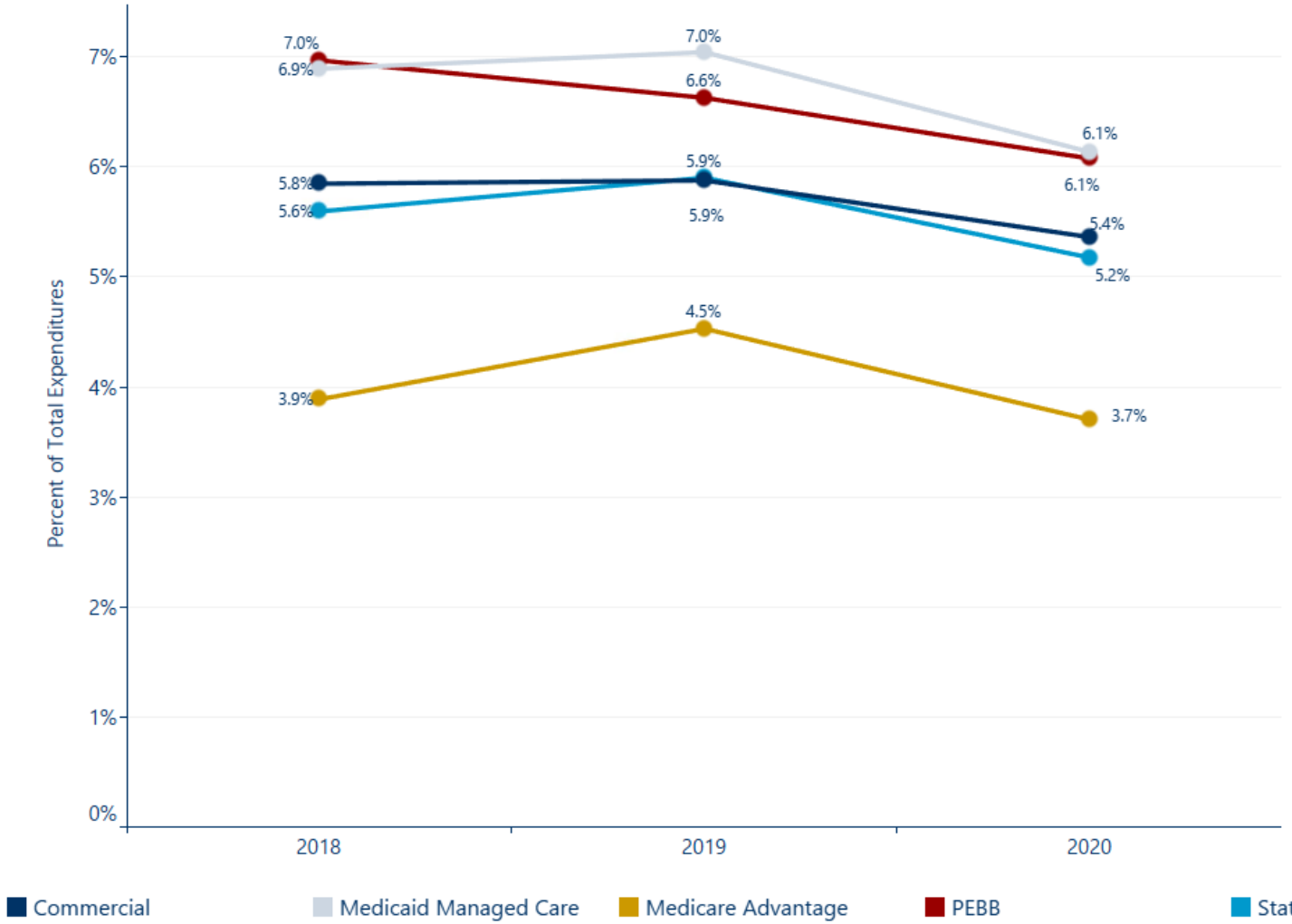



- Uptick between 2018 and 2019 appears to have been driven by increases among the older adult population (65+)
- Decline in 2020 was driven by pediatric (0–17) and older adult (65+) populations



* 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, 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)**

Bruce Gray – NW Regional Primary Care Association
Carena Hopen - Molina
Courtney Ward - CHPW
Drew Oliveira - Regence
Ece Sonmez - NW Regional Primary Care Association
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
Laura Morano - Seattle Children's
Linda Van Hoff - ARNP United
LuAnn Chen – CHPW
Matthew Hollon – American College of Physicians
Ann Christian – WA Council for Behavioral Health,
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?