Washington State Health Care Authority

Health Care Cost Transparency Board

April 20, 2022

Washington State Health Care Authority

Health Care Cost Transparency Board
Board Book

April 20, 2022
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting Materials

Washington State Health Care Authority

Agenda

TAB 1

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Washington State Health Care Authority

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

Health Care Cost Transparency Board
AGENDA

Board Members:					
☐	Susan E. Birch, Chair	☐	Sonja Kellen	☐	Kim Wallace
☐	Lois C. Cook	☐	Pam MacEwan	☐	Carol Wilmes
☐	John Doyle	☐	Molly Nollette	☐	Edwin Wong
☐	Bianca Frogner	☐	Mark Siegel		
☐	Jodi Joyce	☐	Margaret Stanley		

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome, Roll Call, and Agenda Review	1	Susan E. Birch, Chair, Director Health Care Authority
2:05 – 2:10 (5 min)	Approval of March meeting minutes	2	AnnaLisa Gellermann, Board Manager Health Care Authority
2:10 – 2:15 (5 min)	Recap of March Board meeting	3	Michael Bailit and January Angeles Bailit Health
2:15 – 2:20 (5 min)	Advisory Committee feedback on impacts on criteria and strategies to support benchmark attainment	4	AnnaLisa Gellermann Health Care Authority
2:20 -2:40 (20 min)	2022 Legislative Session recap	5	Evan Klein Special Asst., Legislative & Policy Affairs Health Care Authority
2:40 – 3:10 (30 min)	Introduction to Primary Care Expenditures	6	Emily Transue, MD ERB Medical Director Health Care Authority
3:10 – 3:20 (10 min)	Public Comment		Susan E. Birch, Chair, Director Health Care Authority
3:20 – 3:35 (15 min)	Key Issues in Defining and Measuring Primary Care Spend	7	Michael Bailit and January Angeles Bailit Health
3:35 – 3:55 (20 min)	Value-based Purchasing	8	JD Fischer Value-based Purchasing Manager Health Care Authority
3:55 – 4:00 (5 min)	Adjournment		Susan E. Birch, Chair, Director Health Care Authority

In accordance with Governor Inslee's Proclamation 20-28 et seq amending requirements of the Open Public Meeting Act (Chapter 42.30 RCW) during the COVID-19 public health emergency, and out of an abundance of caution for the health and welfare of the Board and the public, this meeting of the Health Care Cost Transparency Board meeting will be conducted virtually.

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March meeting minutes

TAB 2

Health Care Cost Transparency Board meeting minutes

March 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

Sue Birch, chair
John Doyle
Bianca Frogner
Jodi Joyce
Molly Nollette
Pam MacEwan
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

Lois Cook
Sonja Kellen
Mark Siegel

Call to order

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

Agenda items

Welcoming remarks

Ms. Birch welcomed the members.

Approval of minutes

The minutes were approved.

Recap of February board meeting

Michael Bailit and January Angeles, Bailit Health
PowerPoint presentation
Ms. Angeles reminded the Board of the areas they had selected for deeper dives: market oversight (including consolidation and setting affordability standards), hospital-based pricing strategy (including global budgets and

labor cost impact), and value-based payments. Board members also wanted to hear more about innovative approaches that other states have *not* pursued and why.
Board members approved amended criteria for selecting strategies to support cost growth benchmark attainment. The approved criteria are:

- Implementation of the strategy is likely to have a substantive impact on cost growth benchmark attainment
  Evidence supports the strategy, or if not, there is a compelling logic model for the strategy.
- The strategy is actionable for the State, payers or provider organizations.
  Approval from federal partners is not required to implement the strategy, or there is a high likelihood of obtaining required approval.
- Relevant stakeholders have the capacity to design and execute the strategy thoughtfully and successfully.

Advisory committee feedback on impacts to consider and cost growth driver analyses

AnnaLisa Gellermann, HCA
January Angeles, Bailit Health

Ms. Gellermann presented a summary of feedback from the Advisory committee of Providers and Carriers on possible consequences of transparency and cost reduction efforts, and suggestions from the committee of areas for monitoring and counter-measurement. These included unintended negative impacts on vulnerable populations, fragile health delivery systems, small practices, and primary care utilization and reimbursement, and unwanted cost-cutting. The committee agreed that the effects of the pandemic would influence benchmark results with rising labor costs, changes in utilization and required benefit changes.

Ms. Angeles presented feedback from the Advisory Committee on Data issues on the cost growth driver analysis. The committee agreed that HCA's recommendation for initial analyses of cost drivers seemed reasonable. The initial analyses are proposed as the following: Spend and trend by geography, trends in price and utilization, spend and trend by health condition, spend and trend by demographics, and monitoring of potential unintended adverse consequences. One member suggested use of the CMS Chronic Condition Warehouse for identifying and grouping conditions to analyze. Some members were interested in independent analyses of pediatric conditions.

The Board engaged in discussion about the CCW, and the availability of other data sources related to conditions and demographics. One Board member suggested selection based on current use and ease of access, another suggested considering alignment with Oregon as advantageous for participants in both states. Another suggested caution about the impact of the pandemic as potentially undercounting impacted individuals. Mr. Bailit responded that they had created a guide for states but was not aware of an empirical basis for selecting one data source over another. Ms. Gellermann indicated that the specific data sources would be the topic of future discussion with the data committee and Board as staff continued design of the cost driver analysis.

Data on spending and spending growth in Washington

Michael Bailit and January Angeles, Bailit Health
PowerPoint presentation

Mr. Bailit presented an introduction to the discussion of Washington specific data, reminding Board members that data was tool used to identify opportunities and strategies to slow cost growth. He reminded the Board that it could take notice of multiple sources and stressed that reports would vary based on the data content and methodology. He encouraged the Board to ask questions and critical thinking to conclusions presented in data.

He asked the Board to consider what the data said about where costs were rising highest and fastest, what concerns should be considered when interpreting the data, and what further analyses should be considered to better understand what is driving spending and spending growth.

Washington State Commercial Trends in Cost 2016-2019

Jane Beyer, Office of the Insurance Commissioner
Amy Kinner, OnPoint
PowerPoint presentation

Ms. Beyer introduced the OnPoint presentation by sharing the OIC's goal of having Washington specific information on trends in the commercial market that they regulate: full insured individual, large and small group health plans. The analysis requested of OnPoint was of price and utilization over a three-year period. Ms. Beyer shared that after viewing the dashboard, the office had determined that it might support their efforts to investigate and regulate mental health parity and consumer payments for ground ambulance services. Ms. Beyer also informed the Board that they would likely not be updating the tool to include data after 2019, as that work was substantially similar to the Board's legislative directive.

Ms. Kinner walked the Board through the dashboard created by the OIC. One Board member asked for clarification of the number of covered lives in the commercial market, and Ms. Beyer estimated the number at between 1.2 and 1.5 million lives. One Board member asked if there had been an attempt to determine if self-insured costs were similar. Ms. Beyer shared that the OIC did not conduct that analysis, which might require exploration of the Fair Health database or coordination with the Washington Health Alliance.

Public comment

Ms. Birch called for comments from the public.

Eric Lewis, CFO, Washington State Hospital Association
Mr. Lewis stated that the Board had important work and a big challenge to ingest data to determine and slow cost growth. He emphasized that the impact of significant changes to due Covid, inflation, labor costs and energy costs presented a challenge, and urged the Board to consider an adjustment to the benchmark to a higher number or using 2022 as a base year rather than 2021. He stated that half of hospital expenditures are spent on wages, that hospitals have been paying wage increases of over 10%. He also urged the board to consider these challenges with ad hoc reporting and attention to the context when reporting on providers who exceed the benchmark. He offered partnership in determining future cost mitigation strategies. In response to a question from the Board about accounting for federal relief money, Mr. Lewis shared that the majority of those funds were used to replace lost revenue from halting non-emergency procedures as directed by federal and state directives, and to support increase cost of procedures, with the result of stabilizing hospitals and supporting continued services.

Other data on health care cost trends in Washington

Michael Bailit and January Angeles, Bailit Health
PowerPoint presentation

Mr. Bailit presented a survey of various measures tracking spending growth from varied sources including the OIC, the Washington Health Alliance, and the Health Care Cost Institute. These showed increasing cost trends in various markets including Medicaid, PEBB, and Washington vs. national growth in service category spending. He indicated

that these types of data reports are the types that should be reviewed by the Board on a regular basis to determine cost mitigation strategies.
The Board engaged in discussion about several aspects of the presentation, asking clarifying questions about the data sources and methodology. The Board generally expressed interest in pharmacy cost generally, with correlation between new drug development and mandates to understand their impact. One member expressed an interest in understanding impacts in both cost shifting and utilization shifting (from acute inpatient to outpatient). One Board member urged the consideration of consolidation, especially acquisition of physician practices, as a significant area to understand. One Board member requested data on comparable with other states related to trend changes, and a breakdown of price utilization. Mr. Bailit shared that only limited data was available for 2020, but that a comparison could be shared in the future. He also shared that understanding the impact of price vs. volume would be important and required a measure of service mix (which would need to be based on a tool such as one developed by Milliman or HCCI). The Board also identified a priority for a deeper dive into hospital costs.

Impact of COVID 19 and rising inflation on the Cost Growth Benchmark program

Michael Bailit and January Angeles, Bailit Health
PowerPoint presentation

Ms. Angeles informed the Board about the impact of Covid on spending trends in 2019 and 2020. Minnesota and Massachusetts have both reported a decline in health care spending for that period. The trend for 2020 and 2021 is expected to be higher. She also shared information about rising costs, affected by supply chain issues, labor shortages and elevated labor costs. All these factors raise concerns about near term prospects for meeting the benchmark.
Ms. Angeles also discussed some economic indicators including a trend chart of personal consumption expenditures from 1996-2021 showing that 2019 and 2021 were very different than historic trends. Inflation and real gross domestic product are strong predictors of health care spending growth, but the impact is often delayed due to the contracting cycle.
The board was reminded of the criteria it had adopted to revisiting the cost growth benchmark and invited to engage in a discussion. Ms. Angeles shared other states have retained their benchmark values and interpret 2020 and 2021 results (at least) in the context of the pandemic and its economic impact.
The board engaged in discussion.
In general, the Board supported increased communication and feedback with stakeholders, including their advisory boards. One member suggested the Board acknowledge the comments of both WSHA and WSMA to the Board describing the challenges they are currently facing. Another member stressed the importance of continued dialog with stakeholders in the face of long-lasting stresses to the health care system.
Members generally agreed not to adjust the benchmark because that they lacked sufficient information and clarity to consider a change. Several members stressed that the challenges described by stakeholders should and would be considered when considering benchmark results. The Board determined not to adjust the benchmark, but to monitor the situation closely. Ms. Birch directed staff to work with her on acknowledgement strategies.

Adjournment

Meeting adjourned at 3:56 p.m.

Next meeting

Wednesday, March 16, 2022
Meeting to be held on Zoom

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Recap of March Board meeting

TAB 3

Recap of the March Board meeting

Recap of the March Board meeting

- Board members heard feedback from the advisory committees on:
  - Possible consequences of transparency and cost reduction efforts and how to monitor for them.
  - Plan for cost growth driver analyses.
- Board members reviewed data on spending and spending growth in Washington, including:
  - Results of an analysis commissioned by the Office of Insurance Commissioner.
  - Other publicly available data from the Washington Health Alliance, the Health Care Cost Institute and other sources.

Recap of the March Board meeting

- Based on the data presented, Board members expressed interest in better understanding:
  - Pharmacy costs and the impact of new drug development and insurance coverage mandates on costs.
  - The impact of shifting care settings from inpatient to outpatient care.
  - Hospital pricing, and the impact of labor costs.
- Board members also considered the impact of COVID-19 and rising inflation on the cost growth benchmark program.
  - The Board decided not to adjust the benchmark because it lacks sufficient information and clarity to consider a change, but agreed with the need to acknowledge these issues when considering benchmark results, and to "stay the course but stay in dialogue."

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Advisory Committee feedback on impacts

TAB 4

Advisory Committee of Providers and Health Carriers feedback

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3 Criteria for selecting strategies to support cost growth benchmark attainment

- Committee members reviewed the criteria approved by the Board
  - Implementation of the strategy is likely to have a substantive impact on cost growth benchmark attainment.
    - Evidence supports the strategy, or if not, there is a compelling logic model for the strategy.
  - The strategy is actionable for the state, payers or provider organizations
    - Approval from federal partners is not required to implement the strategy, or there is a high likelihood of obtaining required approval.
  - Relevant stakeholder have the capacity to design and execute the strategy thoughtfully and successfully.
- Strongly recommended adding a criteria related to impact on access.
- Recommended committee involvement prior to discussion and recommendations.

Strategies to support benchmark attainment

- Committee members reviewed the three areas identified by the Board for educational "deeper dives":
  - Market consolidation
  - Hospital pricing strategies
  - Value-based payment
- Members suggested that
  - industry be asked to identify "high-value targets", which may not be areas of highest cost/spend.
  - The Board should review efforts in other states that were tried and failed to reduce cost growth.
  - Pharmacy costs would present a challenge requiring granular data and assistance from both committees.
  - Impacts of Covid (including labor cost, staff shortages, and supply costs) would persist well beyond endemic status.

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2022 Legislative Session Recap

TAB 5

2022 Legislative session recap

Evan Klein

Special Assistant, Legislative & Policy Affairs

Washington State Health Care Authority

Overview

- 2022 session background
- Policy bills
- Budget

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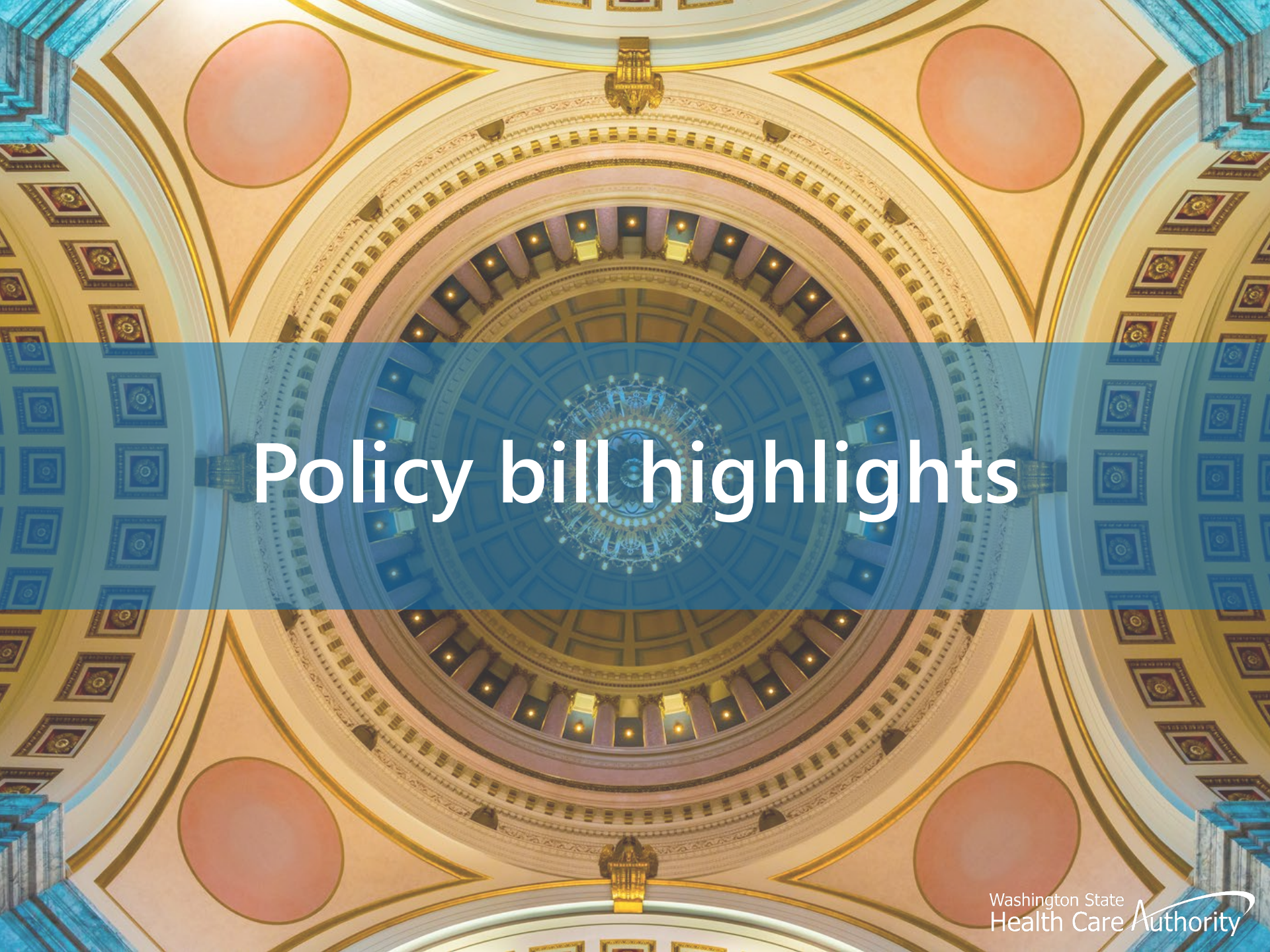
Background

- 2022 Legislative session ended March 10, 2022
- Short session – 60 days
- Supplemental budget year
  - Statewide General Fund-State (GF-S) spending increased from $59B to $64B
  - HCA budget (State + Federal) increased by ~$1.5B
- HCA analyzed over 200 bills and drafted 166 fiscal notes
- Over 55 new reporting requirements (70+ for FY 2023)



Policy bill highlights

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HCA priorities

HB 1052 – Performance measures

- Aligns insurance code with HCA requirements to engage in performance-based contracting for PEBB/SEBB

HB 1728 – Insulin Work Group

- Previously enacted in 2020 to design strategies to reduce cost of insulin
  - No initial funding to support
- Extends deadlines and adjusts membership
  - Initial report due December 1, 2022
  - Final report due July 1, 2023

Health care costs

SB 5589 – Primary care spending

SB 5610 – Prescription drug coupons

SB 5532 – Prescription Drug Affordability Board

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5589 – Primary Care Spending

- Board must measure and report on primary care spending and progress toward increasing spending to 12% of total health care expenditures
- Preliminary Report – 12/1/22
  - Define “primary care”
  - Barriers to accessing data
  - Annual progress toward 12% target
  - Methods to incentivize achieving desired levels of primary care spending

5589 – Primary Care Spending cont'd

- Annual Reports – beginning 8/1/23
  - Primary care expenditures for most recent year:
    - By Carrier, Market or Payer
    - In total and as a percentage of total health care spending
  - Evaluate annual spending by type of care, provider, and payment mechanism
  - Identify barriers to meeting reporting requirements and recommendations to resolve
- OIC authorized to assess health carriers' primary care expenditures in review of health plan form and rate filings

Supplemental budget highlights

SSB 5693 (2022)

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New programs & Coverage Mandates

- 1115 Medicaid Transformation Waiver renewal
- Apple Health coverage for uninsured immigrants
- Continuous enrollment for children
- Fertility Treatment Study
- Acupuncture & chiropractic coverage
- Health Care Cost Board
- HIV Antiviral Coverage

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Rate Increases & Provider Investments

- 2022 behavioral health provider relief funding
- 2023 behavioral health provider rate increase
- Investments in children's dental
- Opioid treatment provider rate increase
- Community health worker & behavioral health integration grants
- Home Health & Private Duty Nursing
- Mobile crisis teams

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Data & IT

- Integrated eligibility
- Community information exchange
- Electronic health records (EHR) as-a-service
- Electronic consent management

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Questions?

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Contact

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Introduction to Primary Care expenditures

TAB 6

Introduction to Primary Care Expenditures

Emily Transue, MD

ERB Medical Director

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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?

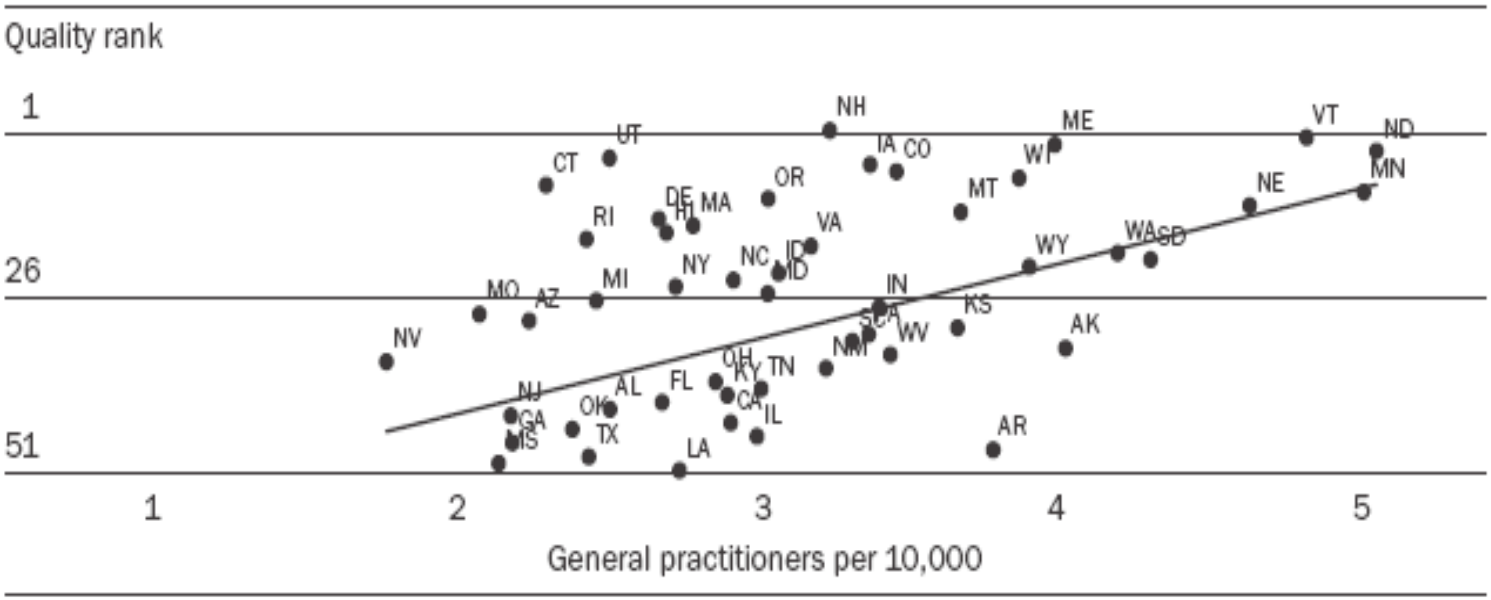
Why does primary care spending matter?

- 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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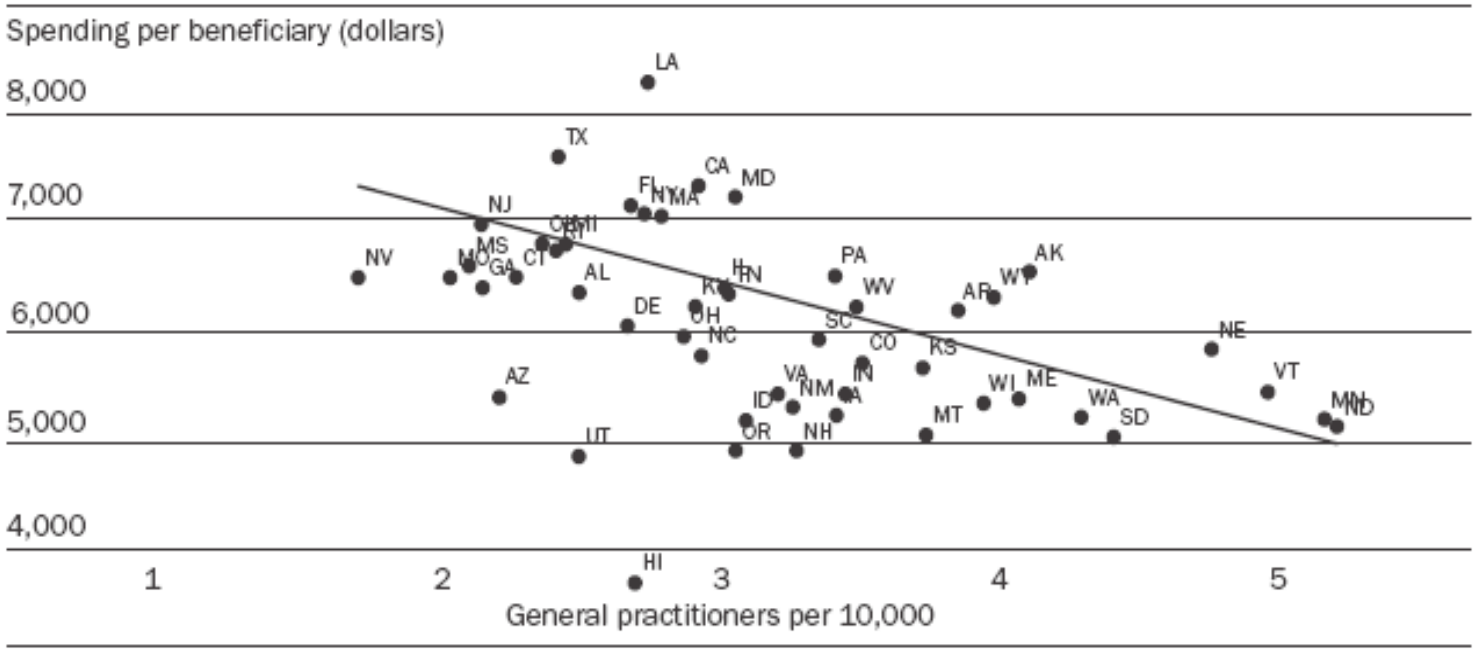
Primary care associated with lower total costs

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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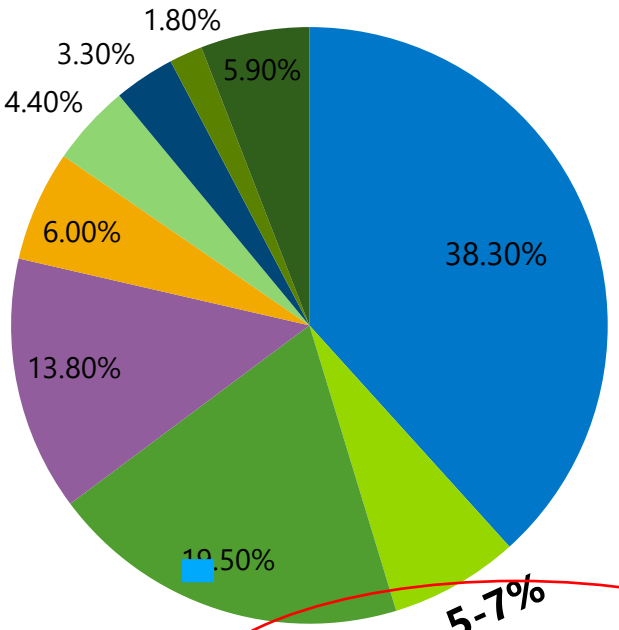
Overall spending remains low

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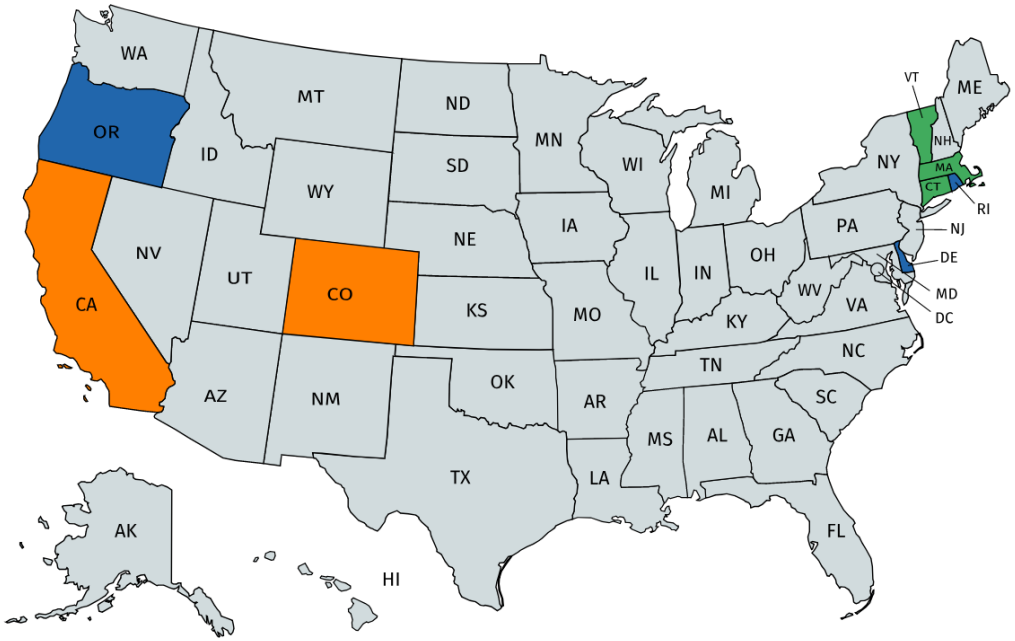
Measuring Primary Care Spend: States with statutory or regulatory action



- Statutory or regulatory action
- Proposed legislation
- Statewide measurement of primary care spending

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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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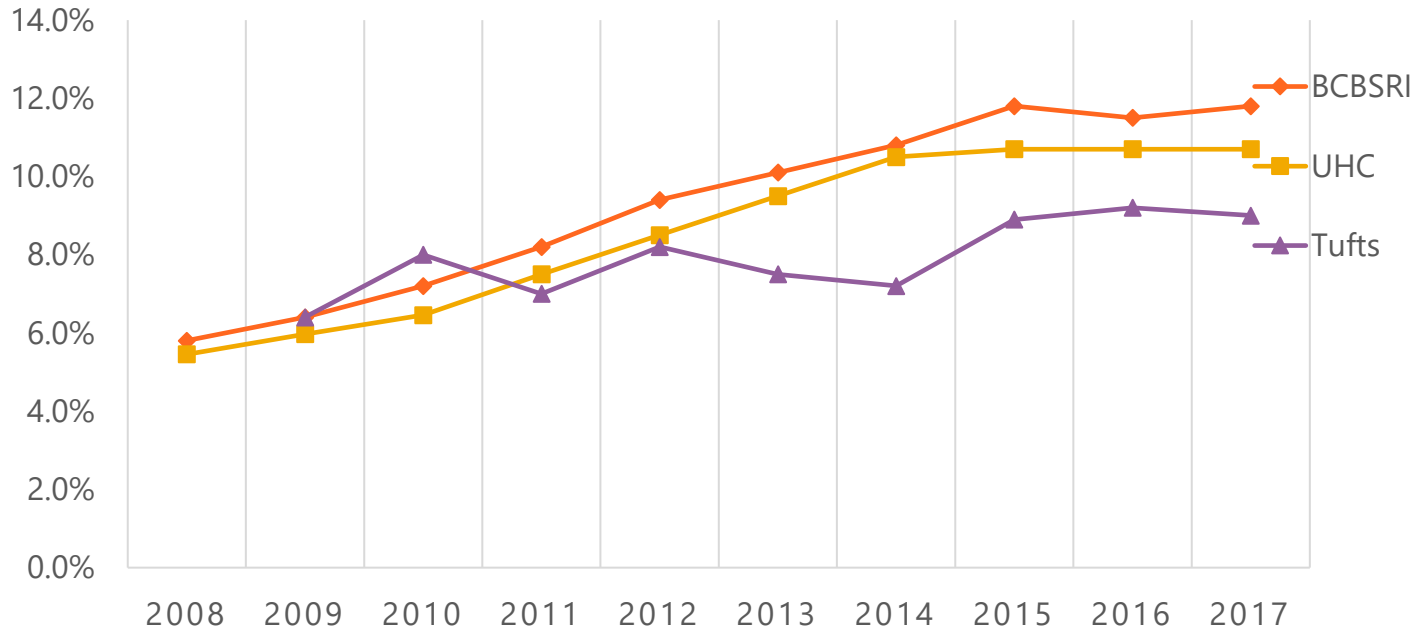
Small Changes Make Big Impact on Payments to Primary Care

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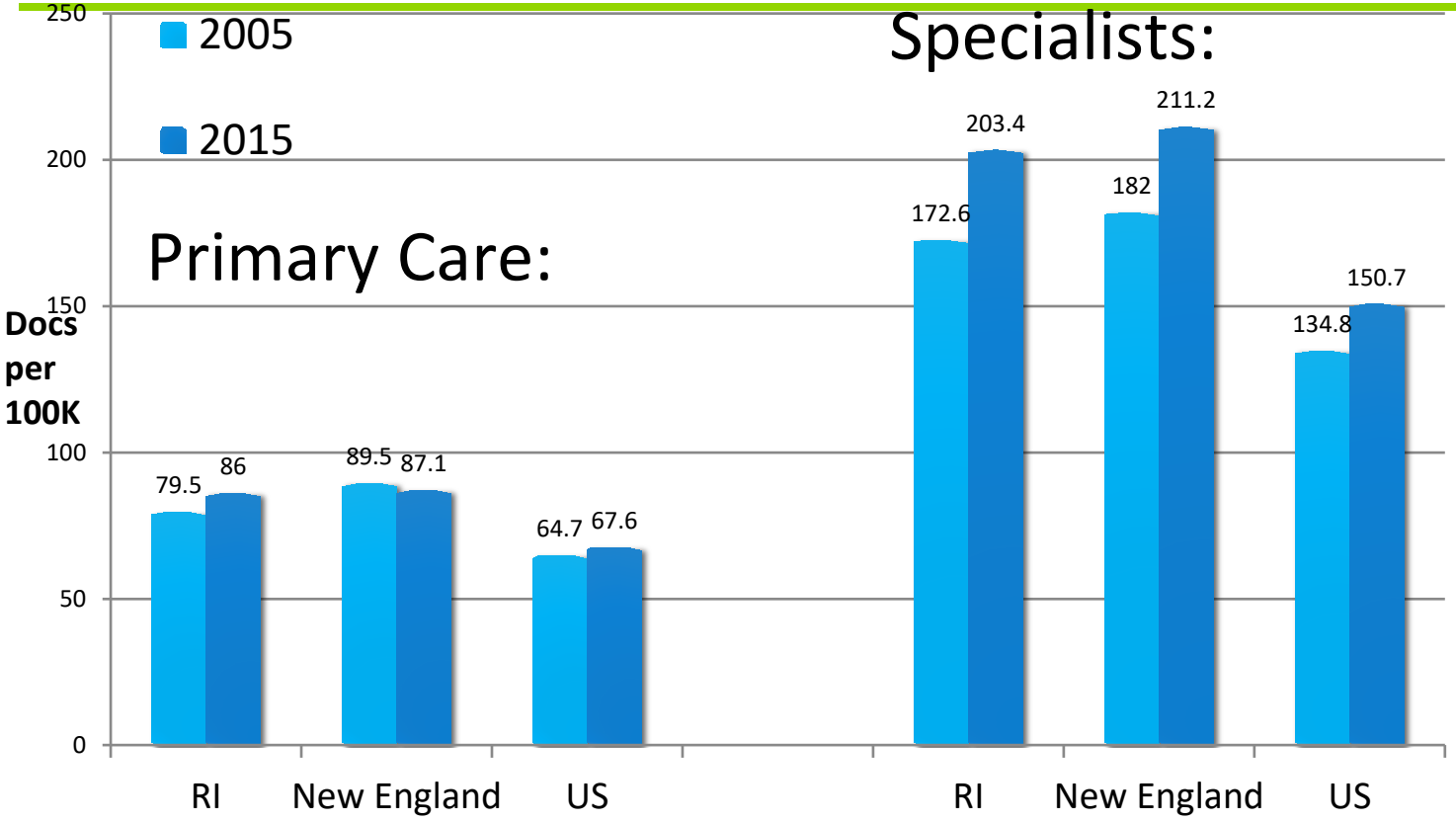
And… RI Saw Increased Primary Care Supply *(and no "Specialty Flight")*



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

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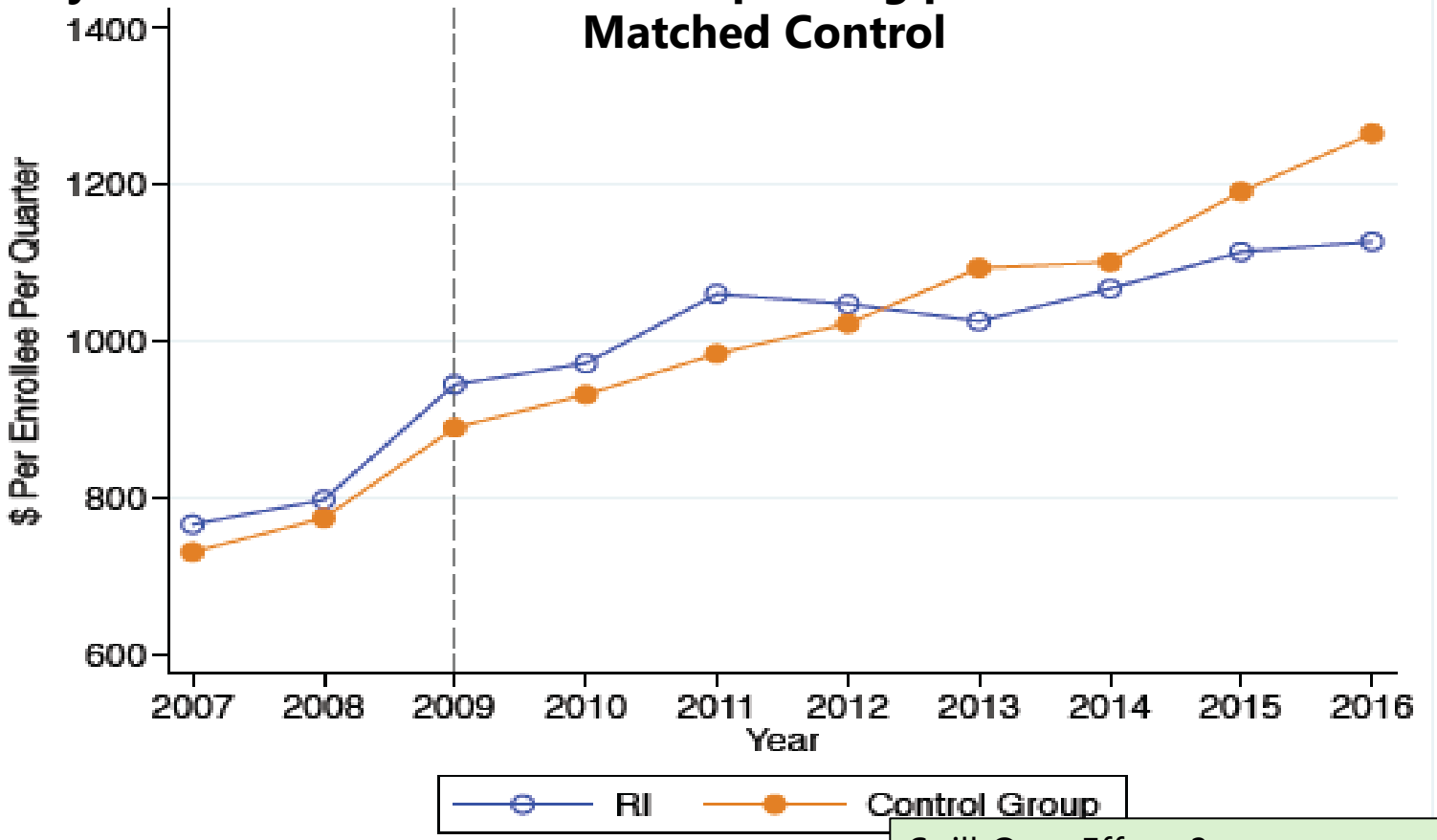
Commercial Insurance Spend: RI's Insurance Reform Interventions Bent the

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

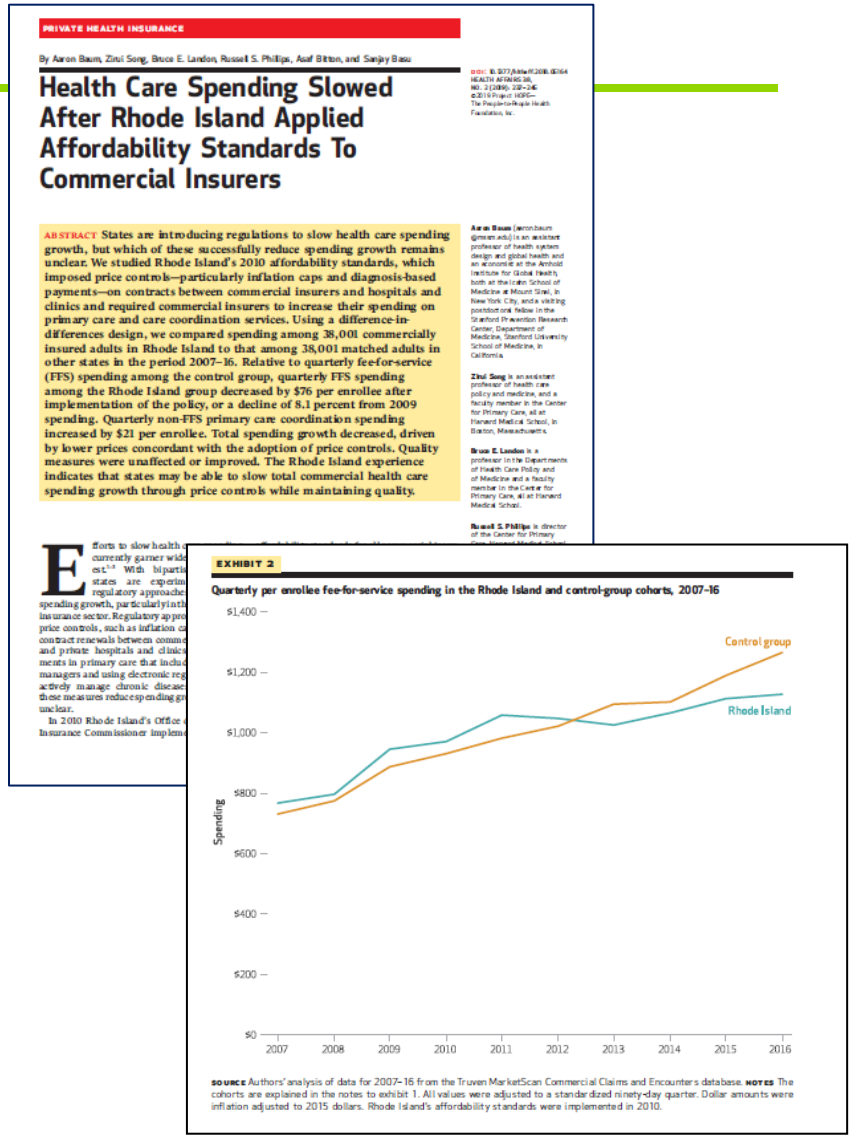


Source: Landon et al, Academy Health Annual Research Meeting, 2018

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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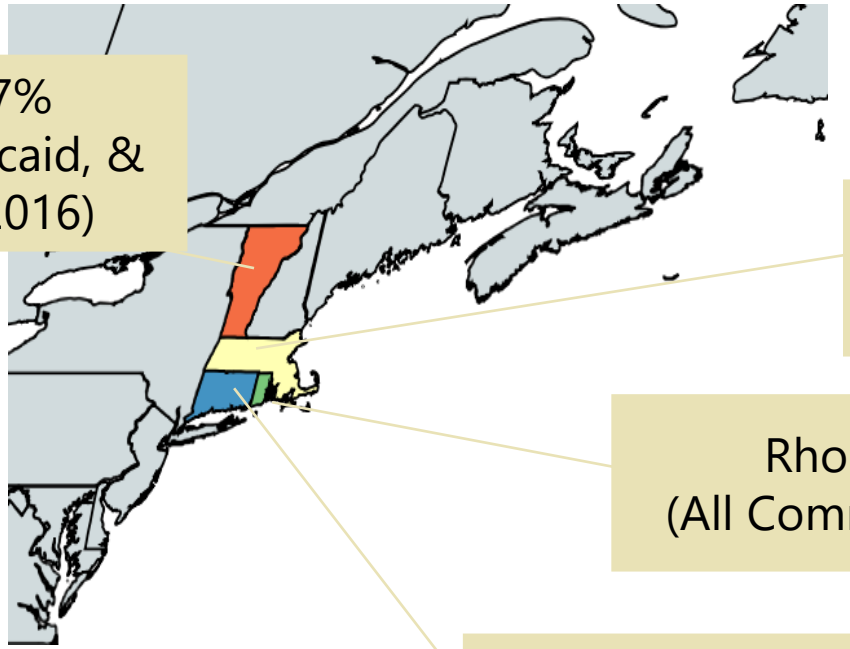
Some baseline data (Note that definitions vary)



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
  - E.g., are pharmacy costs part of total spend?

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

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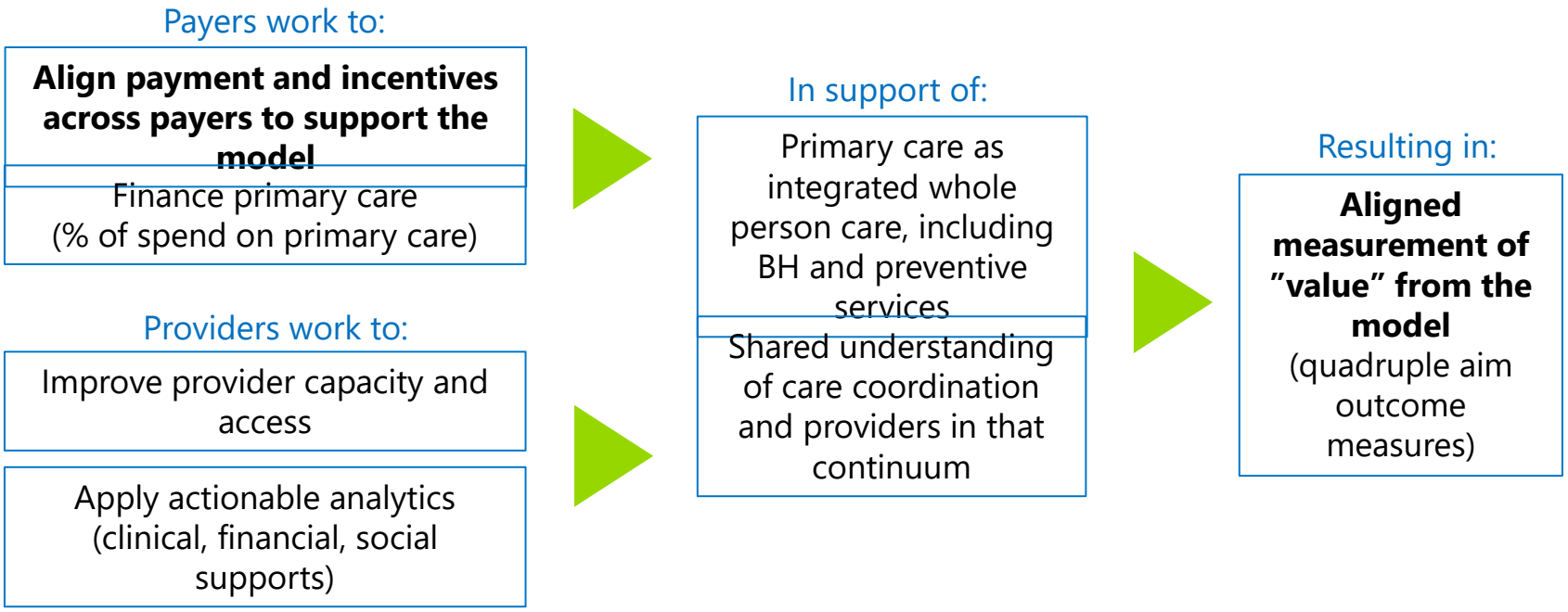
Primary Care Transformation Components



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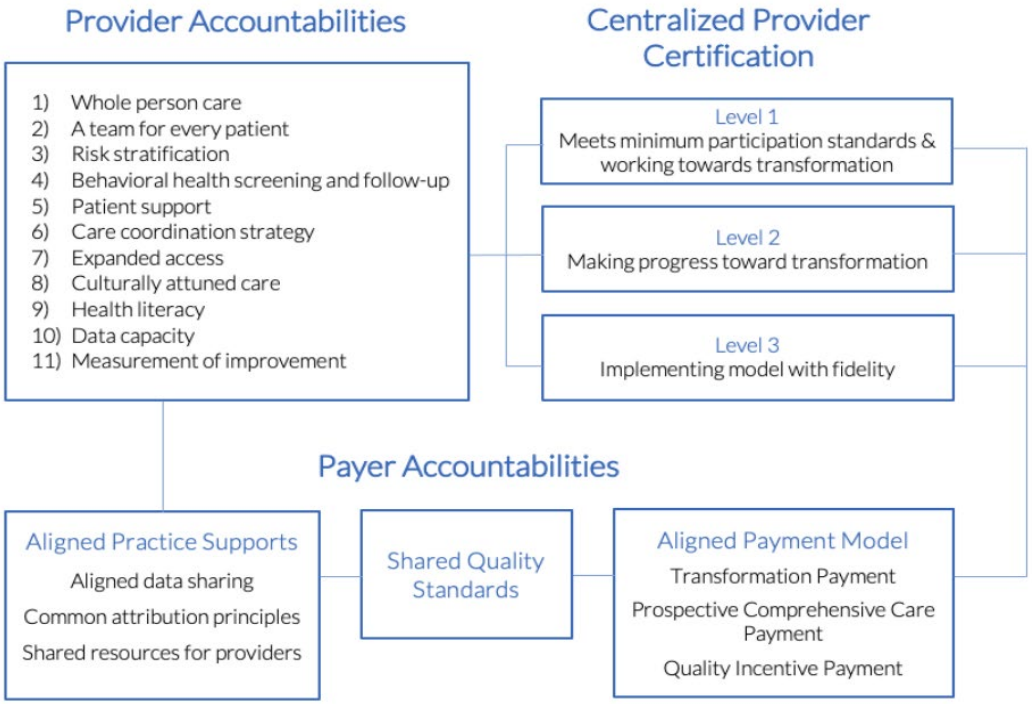
WA Multi-payer Primary Care Model
Key Implementation Elements



Proposed Payment Model

- The payment model will be comprised of three components:
  - 1) a **transformation of care fee (TCF)** paid to support the transformation to a coordinated delivery model that integrates behavioral and physical health care provided in a range of settings to ensure access;
  - 2) a prospective PMPM **comprehensive primary care payment (CPCP)** to cover costs of basic primary care services; and,
  - 3) **performance incentives** available after three years with performance measured according to a combination of quality of clinical care and utilization measures.
- To begin to receive TCFs, practices will be required to agree to make progress toward transformation as defined by specified transformation measures.
- TCF will be provided up to three years before transitioning to PIPs
  - The transition period within the three years may vary based on individual practices' progress on transformation measures

Provider Supports – Stakeholder Input

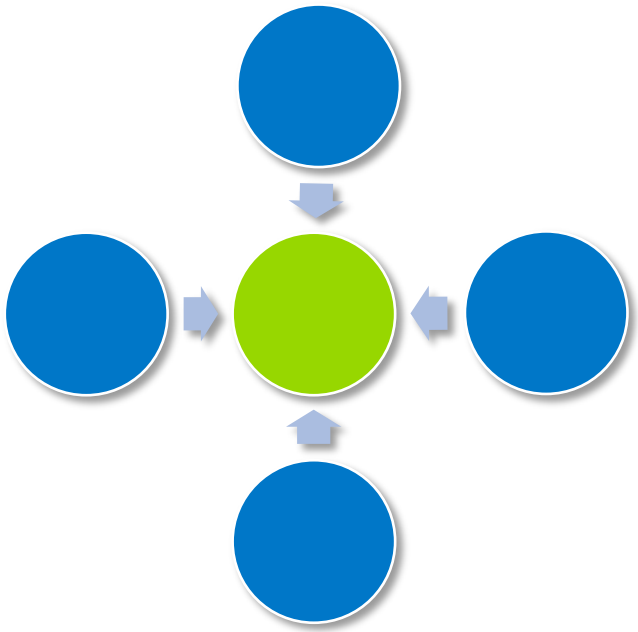
- Data & Technology
  - Regular actionable claims & utilization data for attributed patients
  - Common tool to provide patient data across payers
  - Common referral resource
  - Expanded care notification and coordination mechanisms across range of providers and settings
  - Transparent attribution process and timely accurate data
- Common Tools & Training
  - BH screening
  - Models of BH integration & coordination
  - Addressing bias & removing cultural barriers to care
  - Incorporating patient feedback, shared decision making, & patient self-management into care practices
  - Designing & implementing team-oriented care

Quality Alignment: Clinical Quality Measures

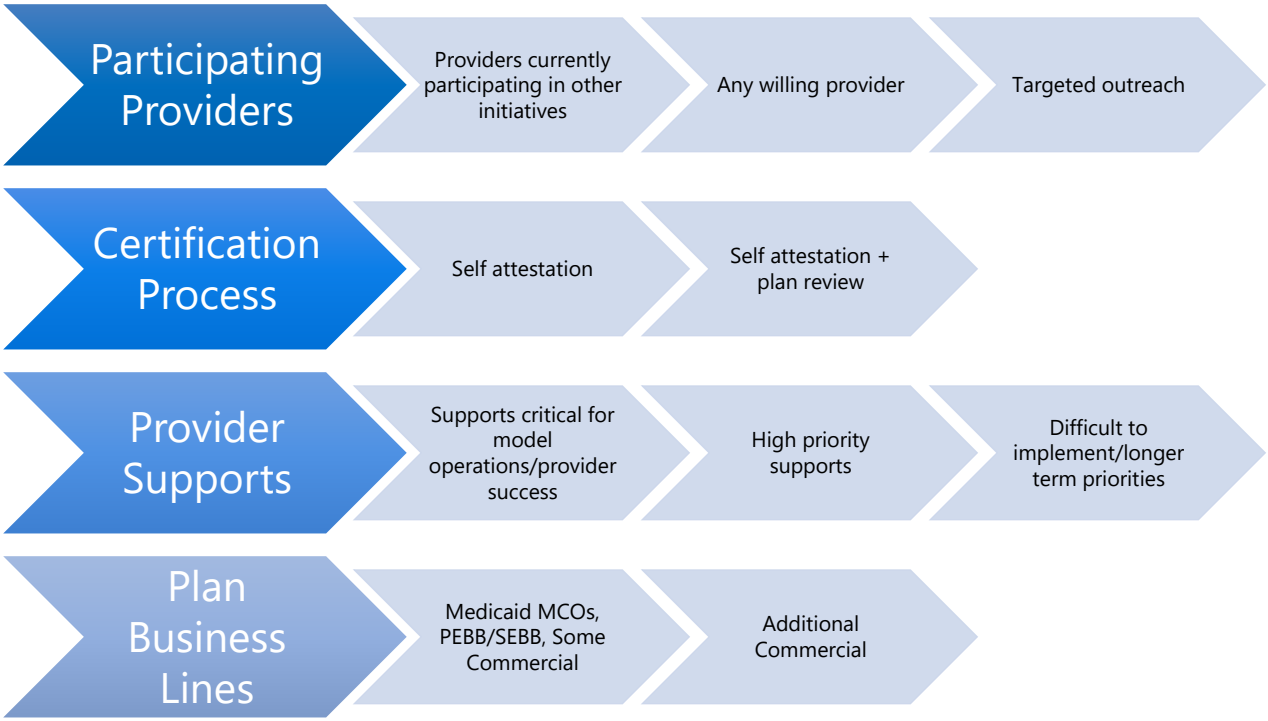
1. Child and Adolescent Well-Care Visit (WCV)
2. Childhood Immunization Status (CIS) (Combo 10)
3. Screening for Colorectal Cancer (COL)
4. Breast Cancer Screening (BCS)
5. Cervical Cancer Screening (CCS)
6. Depression Screening and Follow up for Adolescents and Adults (DSF-E): Screening submeasure only (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



Phased Implementation



Questions?

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Public comment

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Key issues in defining and measuring Primary Care Spend

TAB 7

Key Issues in Defining and Measuring Primary Care Spend

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States have established primary care spend targets through many different mechanisms

- Oregon's primary care spend requirement, established in **statute**, is targeted to commercial health insurance carriers and Medicaid coordinated care organizations.
- Rhode Island has a primary care spending obligation of insurers established through commercial health insurance **regulation**.
- Connecticut has annual all-payer primary care spend targets defined in an **Executive Order**.
  - A bill was introduced in 2022 to authorize a state agency to set the primary care spend targets.

Primary care spending targets in other states

- To date, six states have established primary care spend targets.

CO	CT	DE	OR	RI	WA
1 pct point increases in 2022 and 2023	10% by 2025 Interim: 2022: 5.3% 2023: 6.9% 2024: 8.5%	9-11% by 2025	12% by 2023	10.7%	Annual progress needed to reach 12% in a reasonable timeframe

- Legislation has been introduced in Massachusetts and Utah for primary care spend targets in 2022.

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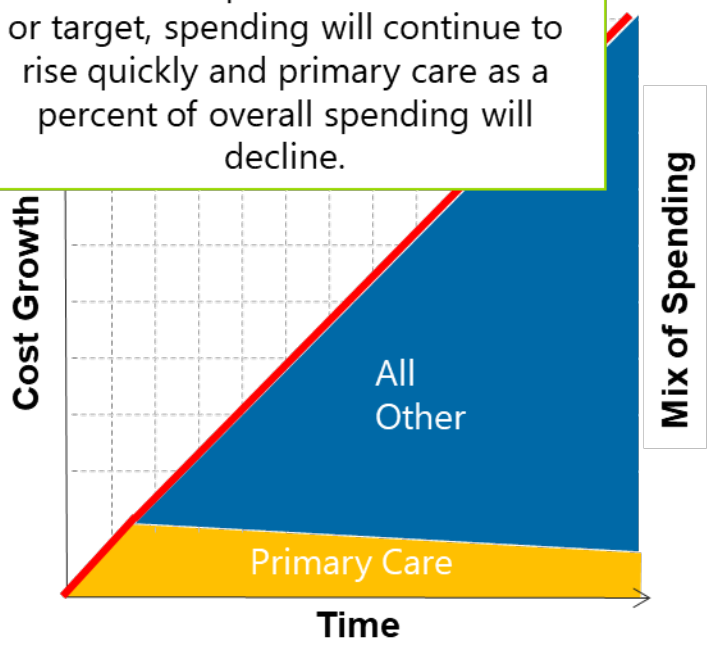
SOURCE: Primary Care Investment | Primary Care Collaborative (pcpcc.org)

How the cost growth benchmark intersects with primary care spend targets

- In some states with both a cost growth benchmark and primary care spend target, there is significant overlap in the development and implementation of the two initiatives.
  - Except for Delaware, they leverage the same governing bodies to make design decisions.
  - In Connecticut and Rhode Island, data are collected together, with total health care spending for the benchmark often used as the denominator for calculating the percent of spending on primary care.

Rebalancing of spending with a cost growth benchmark and primary care spend target

Without the impact of the benchmark or target, spending will continue to rise quickly and primary care as a percent of overall spending will decline.



The benchmark lowers the overall growth rate, while the target increases primary care spend relative to the overall spend.

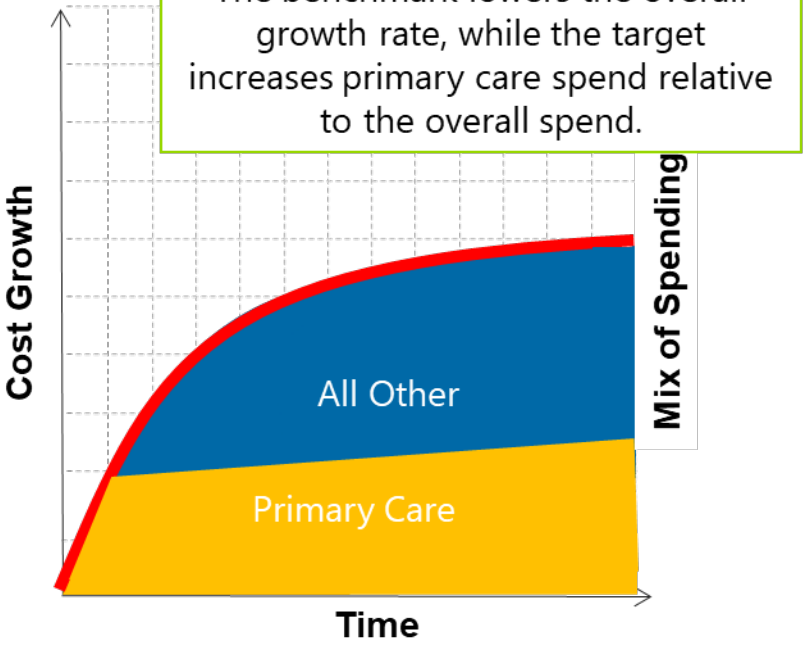
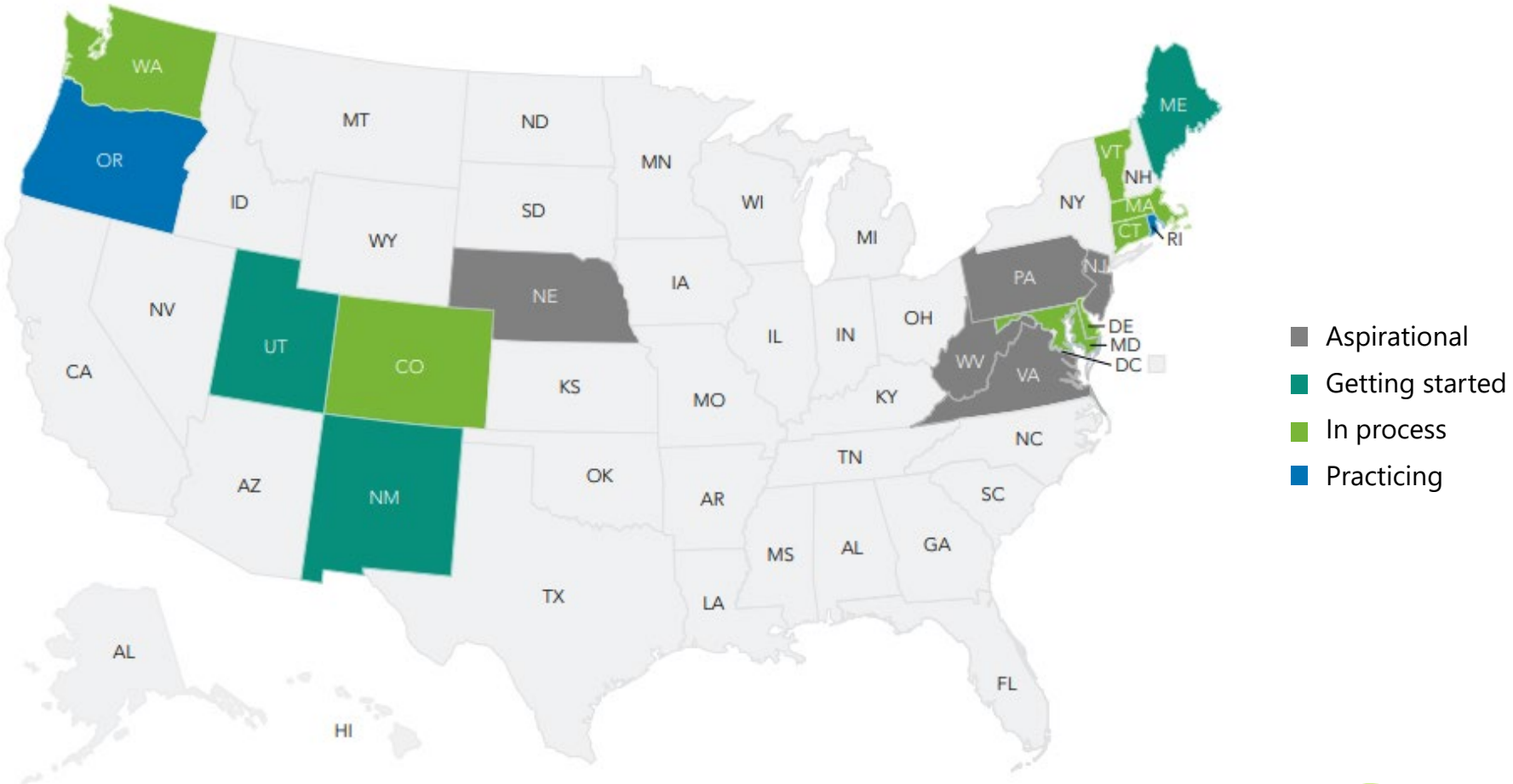


Diagram not drawn to scale.

Many other states have interest in increasing primary care investment



SOURCE: Investing in Primary Care: Lessons from State-Based Efforts (chcf.org)

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Key decision points for measuring primary care spending

- To increase primary care investment, one must measure primary care spending. Key decision points for measuring primary care spending include:
  1. What is the data source(s)?
  2. What services comprise primary care?
  3. Who is a primary care provider?
  4. Should spending be calculated on a paid or allowed basis?
  5. What non-claims-based payments should be included in the calculation?
  6. How should total health care expenditures be defined?

1. Identifying the data source(s)

- Data availability strongly influences how to operationally define primary care.
- There are three options for data, each with its own set of advantages and disadvantages:
  - **All-Payer Claims Database** – is easier to collect but does not include self-insured and non-claims payment data
  - **Direct payer reporting** – allows customization but involves additional effort and expense and could be difficult to validate.
  - **A combination of the two** – allows for a more comprehensive definition of primary care but requires additional effort, expense and validation.
- CA and RI have also collected data from provider organizations to understand the distribution of non-claims-based payments.

2. Defining what services constitute primary care services

- Office-based visits comprise most of a primary care practice's revenue, but there are many other services that may be delivered depending on scope of practice. For example:
  - Should home visits for newborn care be included?
  - Should preventive dental services for children be included?

3. Defining who is a primary care provider

- Beyond traditional primary care specialties, there are specialists that deliver some primary care services. For example:
  - How should services delivered by behavioral health clinicians in an integrated setting be treated?
  - Should primary care services rendered by OB/GYN providers be included?
  - Should primary care delivered in urgent care centers and retail clinics be included?
  - Should services provided by a standalone telehealth provider be considered primary care?

4. Calculating spending on a paid or allowed basis

- The paid amount is the actual payment to a provider while the allowed amount also includes copays and other cost-sharing.
- Opinions vary on the degree to which the measure is being used to determine insurer accountability or to assess overall spend level. For example:
  - Rhode Island uses **paid** amounts based on the rationale that health plans have the ability to only control paid amounts. Oregon uses the same definition to focus on plan investments in primary care.
  - The New England States Consortium Systems Organization (NESCSO) uses **allowed** amounts based on preferences expressed by New England states.

5. Inclusion of non-claims-based payments

- Non-claims-based payments, such as incentive payments and care management infrastructure payments can represent a sizeable portion of primary care practice revenue.
- There is currently no standard practice for capturing and reporting non-claims-based payments.
  - A 2021 Milbank paper proposes a standard definition and measurement methodology.
- Also, capitated payments to provider organizations present a particular challenge because of the difficulties in identifying what percentage of payments can be attributed to primary care.

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SOURCE: https://www.milbank.org/wp-content/uploads/2021/04/Measuring_Non-Claims_7-1.pdf

6. Defining total payments

- Total payments constitutes the denominator for the primary care spending target calculation.
- States vary somewhat in their inclusion of certain spending categories in the denominator, such as prescription drugs or long-term care.
- Including more categories produces a more comprehensive estimate of total medical spending, but a narrower definition that includes categories that are applicable across multiple markets may be more equitable across payers.

State approaches to primary care spend measurement

- States have used various (and inconsistent) approaches to measurement.

	PRACTICING		IN PROCESS							GETTING STARTED		
PRIMARY CARE DEFINITION	OR	RI	CO	CT	DE	MA	MD	VT	WA	ME	UT	CA/IHA
Services and Expenses												
▸ Office visits/preventive visits/vaccine administration	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
▸ Behavioral health	✔		✔			✔	✔	✔				
▸ Care coordination and/or management	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
▸ Health information exchange/other infrastructure	✔	✔	✔	✔		✔		✔				
▸ Maternity	✔§		✔§					✔				
▸ Primary care incentive payments		✔	✔	✔	✔	✔		✔				

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SOURCE: Investing in Primary Care: Lessons from State-Based Efforts (chcf.org)

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Value-based purchasing

TAB 8

Value-based Purchasing (VBP)

Health Care Cost Transparency Board
April 20, 2022

Washington State Health Care Authority

Agenda

1. What is VBP, why is it important, and how are we doing it?
2. Does VBP work and what do we know about its impact?
3. What is next for VBP?
4. Discussion

1. What is VBP, why is it important, and how are we doing it?

Lingo

- Value-based Purchasing

- Value-based Payments & Alternative Payment Models (APMs)

- Value-based Care

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What is value-based purchasing? (VBP)

- VBP is the concept of **paying for quality rather than quantity** of health care.
- In traditional fee-for-service (FFS) payment, each service (exam, procedure, test) has a set price.
  - This creates a system that rewards providing a lot of expensive services, whether they improve patient health.
- Shifting to value-based payment means creating a system where **patients get the care they need, when they need it**…
  - …and *don't* get a lot of expensive, unnecessary care.

What is VBP?

Fee-for-service

When a health care provider is paid for each service they provide, regardless of the quality or patient's need for that service.

Value-based Payment

When a health care provider is paid for providing high-quality and high-value care to their patients.

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Alignment with the HCP-LAN Alternative Payment Models (APM) Framework

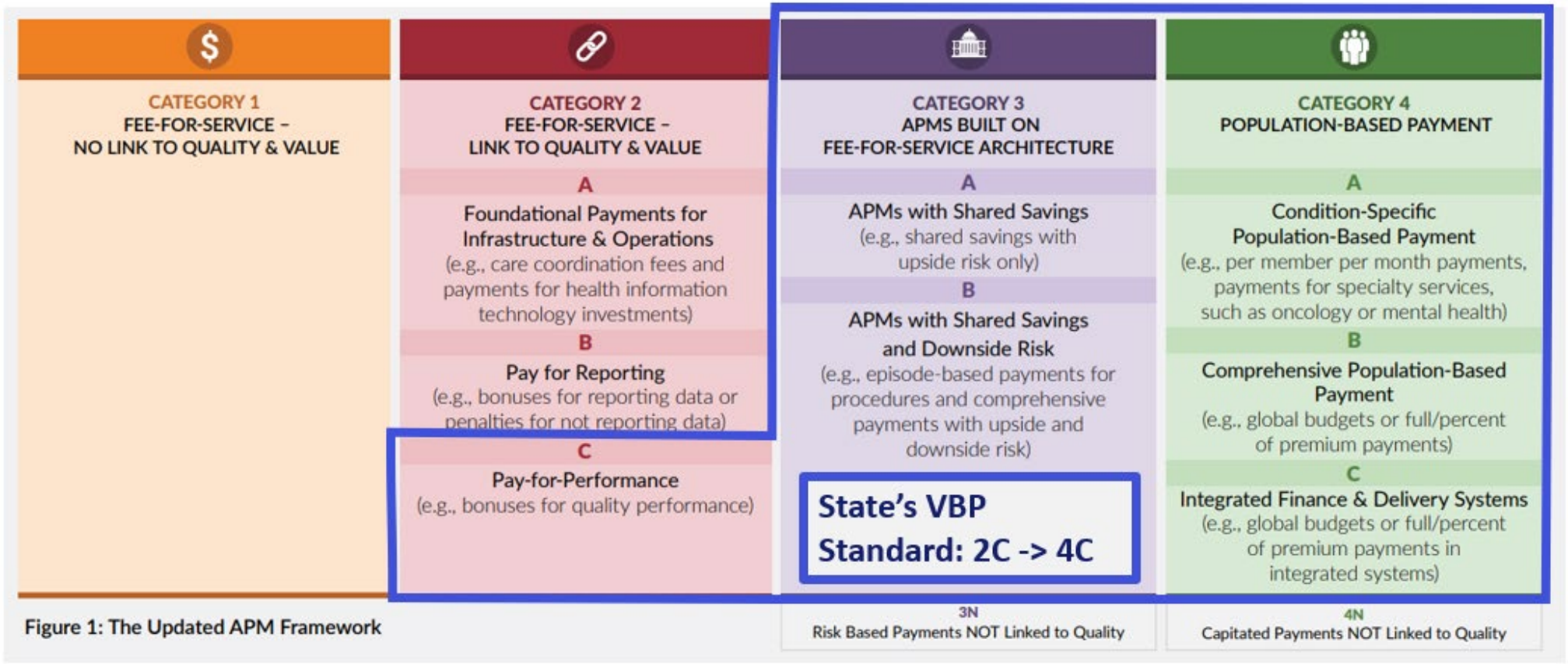

Figure 1: The Updated APM Framework

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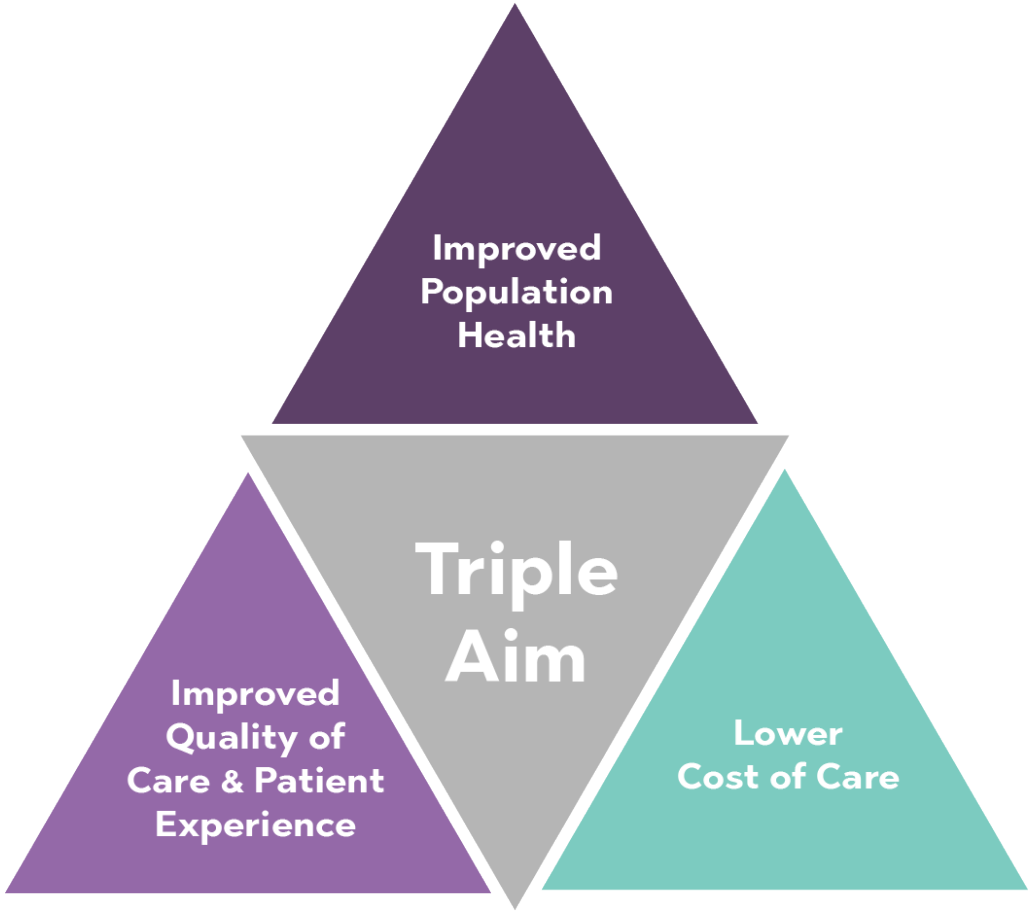
Q: Why VBP?
A: Payment drives transformation

VBP should achieve the triple aim by:

- Reducing unnecessary and low-value health care (lower cost)
- Rewarding preventive and whole-person care (better health)
- Rewarding the delivery of high-quality care (better quality and experience)



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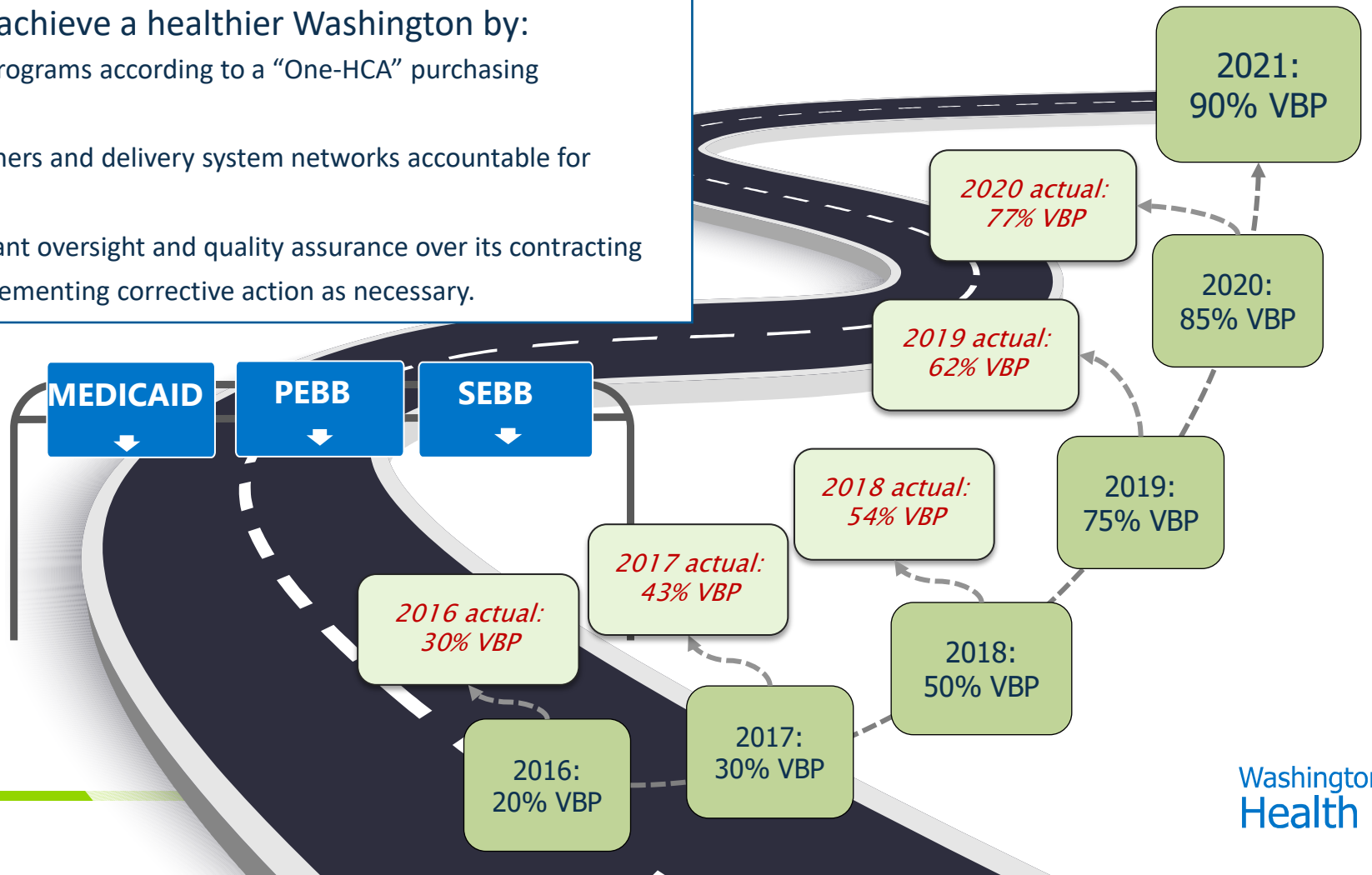
HCA's VBP Roadmap

HCA's vision is to achieve a healthier Washington by:

- Aligning all HCA programs according to a "One-HCA" purchasing philosophy.
- Holding plan partners and delivery system networks accountable for quality and value.
- Exercising significant oversight and quality assurance over its contracting partners and implementing corrective action as necessary.



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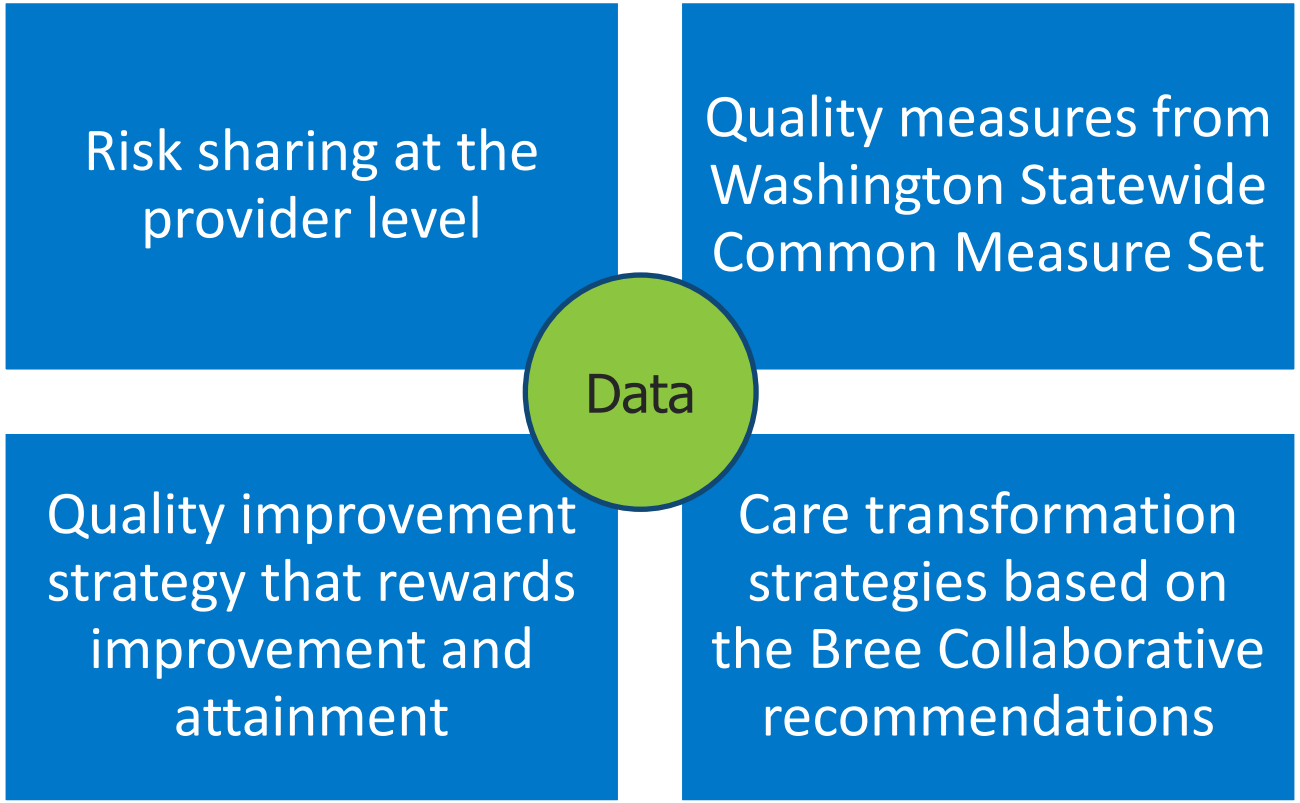
Driving common elements in all HCA's new payment models



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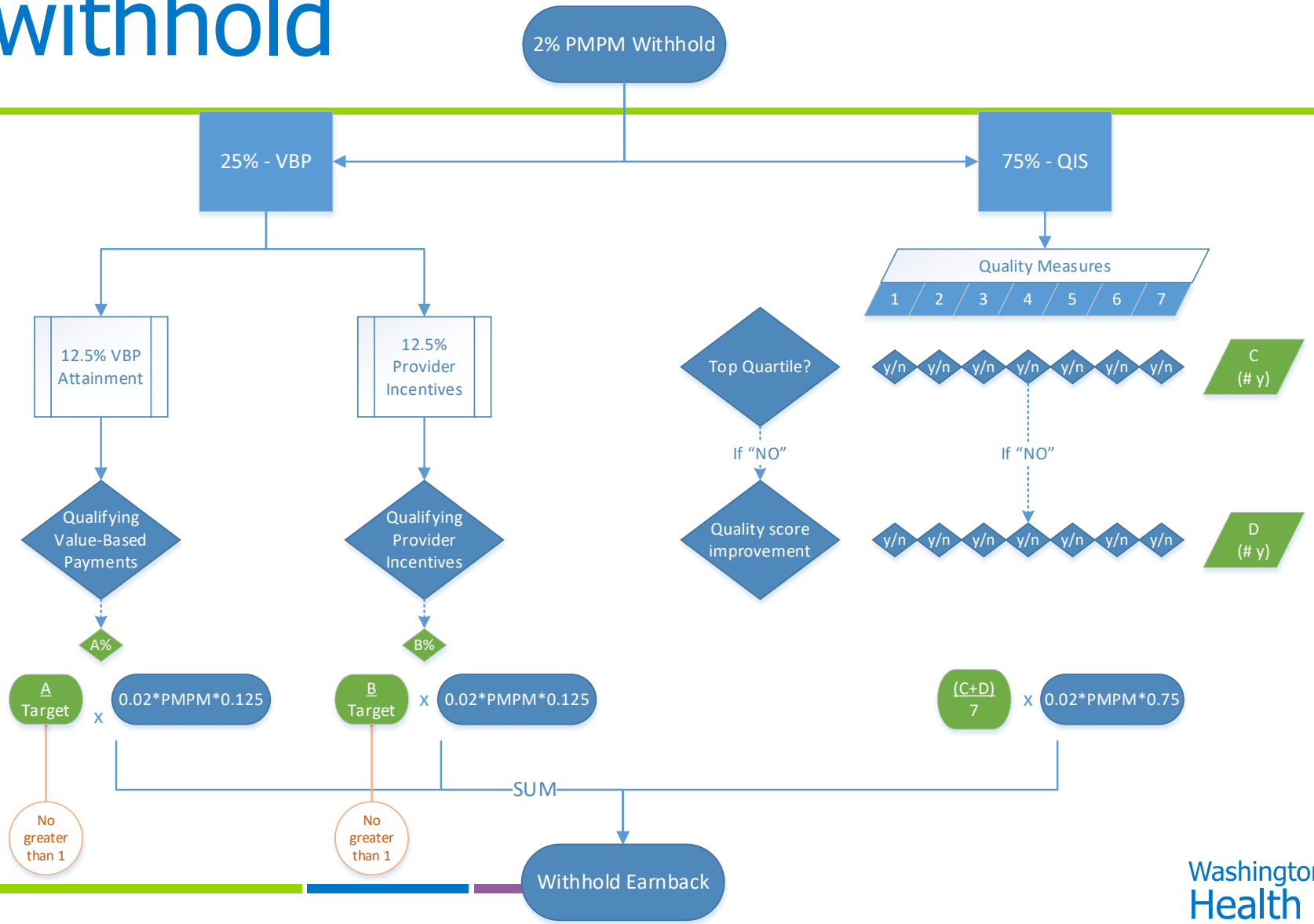
Examples

Public and School Employee Benefits	Apple Health (Medicaid)
• Accountable Care Program, ACO model with upside and downside risk to incentivize clinical and quality accountability • Total Joint Replacement and Spine Fusion and Centers of Excellence • New self-insured TPA contract requires Regence to offer substantially similar ACO program to book of business (risk sharing and care transformation approaches) to spread VBP in the marketplace • MLR tied to VBP attainment for SEBB fully-insured health plans	• 2% MCO premium withhold based on quality and provider VBP arrangements • Behavioral and physical (financial) health integration • Medicaid Transformation regional VBP goals tied to incentive payments to Accountable Communities of Health (ACHs) and MCOs • Alternative Payment Model 4 for FQHCs moves clinics away from encounter-based system • Developing a multi-payer primary care APM and aligned child primary health services APM • Developing a Medicaid APM for CHART

MCO withhold



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2. Does VBP work and what do we know about its impact?

Recall: VBP changes the incentive structure

- Incentivizes providers to provide person-centered, coordinated care
- Directly ties payment to performance on quality
- Emphasizes prevention, theoretically reducing long-term costs and preventable utilization

- Challenges to evaluation:
  - Time and resource intensive
  - Short-term vs. long-term
  - Correlation vs. causation and confounders

Evaluating the impact

- What we can “easily” measure:
  - Health plan quality performance
  - Health plan provider contracting
    - Breadth: total dollars in APMs
    - Depth: total dollars ‘at risk’ or as ‘incentive payments’
  - Member experience for specific models (e.g., COE program)

- HCA currently evaluates:
  - Plan performance on quality and VBP elements
  - HCA’s overall VBP progress
  - Plan and provider experience with VBP (annual Paying for Value Survey)
- State Innovation Model evaluation
  - University of Washington evaluation (including evaluating the Accountable Care Program)

UW evaluation of the ACP

- Assessed the impact of the ACP on utilization, cost, and quality after one year
  - Evaluation funded through the State Innovation Model grant
  - Findings:
    - Small decrease in outpatient hospital visits
    - Members increased primary care utilization
    - No significant decrease in spending, although without price data, evaluators were unable to assess possible cost savings
    - Limited practice transformation
  - As expected, change takes time, and this is not a quick-fix APM strategy

Evaluating patient experience: HCA's Centers of Excellence

- Centers of Excellence for knee and hip replacement and spine care
- Member satisfaction with the knee and hip COE was high in 217 and 2018 :

Feedback question	Rating
My case manager was courteous and helpful	9.8
I felt ready for my surgery	9.6
The travel arrangement met my needs	9.3
My recovery went well	9.3
If I have another joint replacement, I would choose to use this program	9.7
I would recommend this program to family and friends	9.8
Overall satisfaction with your total experience	9.5

- Members saved an average of $988.46 through the knee and hip COE

https://www.hca.wa.gov/about-hca/uniform-medical-plan-ump/centers-excellence#coe-results

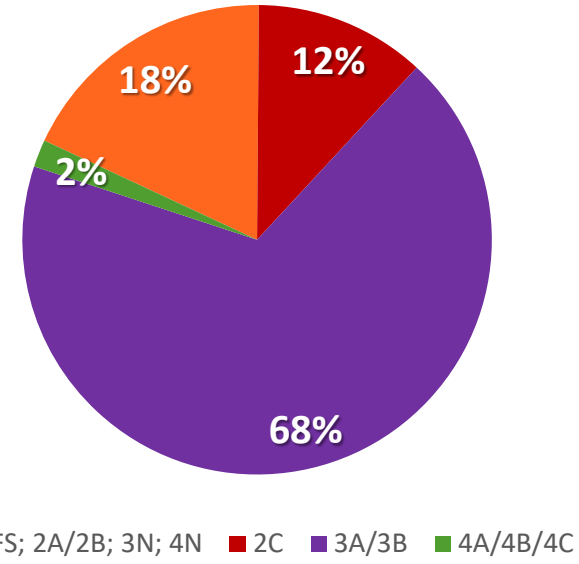
MCO quality performance

Key: ✓ Criteria Met No Criteria Not Met NA Not applicable/Not contracted

Value-Based Payment Measure		Amerigroup Washington	Coordinated Care of Washington	Community Health Plan of Washington	Molina Healthcare of Washington	UnitedHealthcare Community Plan
Total Percent Achieved		60%	83%	83%	58%	75%
Washington Apple Health Integrated Managed Care (AH-IMC) Shared Measures - *Four shared measures reported by all MCOs*						
Antidepressant Medication Management (AMM)	Effective Acute Phase Treatment	No	✓	✓	✓	✓
	Effective Continuation Phase Treatment	No	✓	✓	✓	✓
Mental Health Treatment (Service) Penetration, Age 6-64, all MCO, excluding BHSO		No	No	✓	No	No
Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care	✓	✓	✓	No	No
	Postpartum Care	✓	✓	✓	✓	✓
Asthma Medication Ratio (AMR), Total		✓	✓	✓	✓	✓
Washington Apple Health Integrated Managed Care (AH-IMC) Plan-Specific Measures - Three quality focus performance measures specific to each MCO						
Substance Use Disorder Treatment Penetration, Age 12-64, all MCO, excluding BHSO		✓	✓	✓	✓	✓
Well Child Visits (WCV), Age 3-11		Data not available				
Follow Up Care for Children Prescribed ADHD Medication (ADD), Initiation Phase		NA	✓	No	NA	NA
Comprehensive Diabetes Care (CDC), Poor HbA1c Control (>9%)		NA	NA	NA	No	✓
Comprehensive Diabetes Care (CDC), Medical Attention for Nephropathy		Data not available	NA	NA	NA	NA

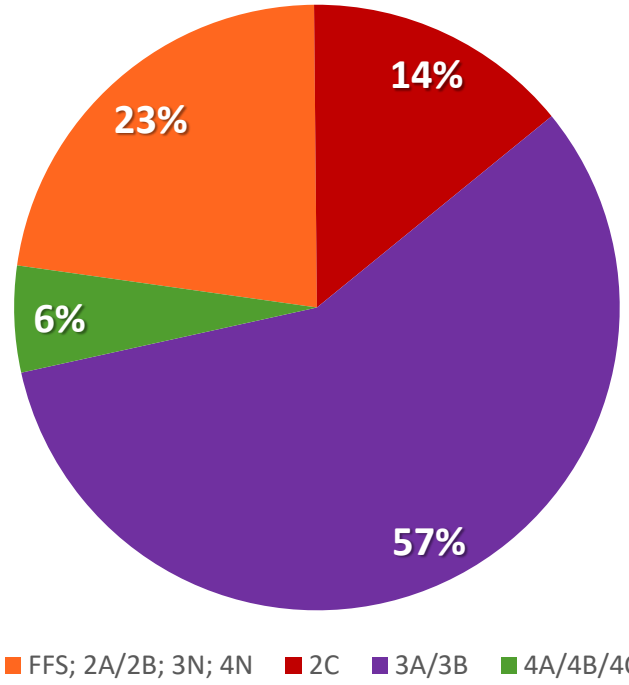
Measuring VBP adoption ('breadth'): CY2020

Medicaid Managed Care



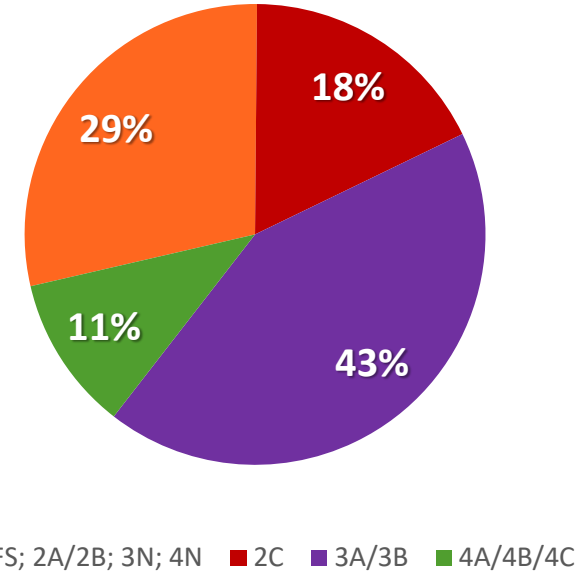
$ 4,561,989,886

HCA TOTAL



$ 7,880,535,034

PEBB & SEBB



$ 3,318,545,148

2020 state-financed VBP = 77%

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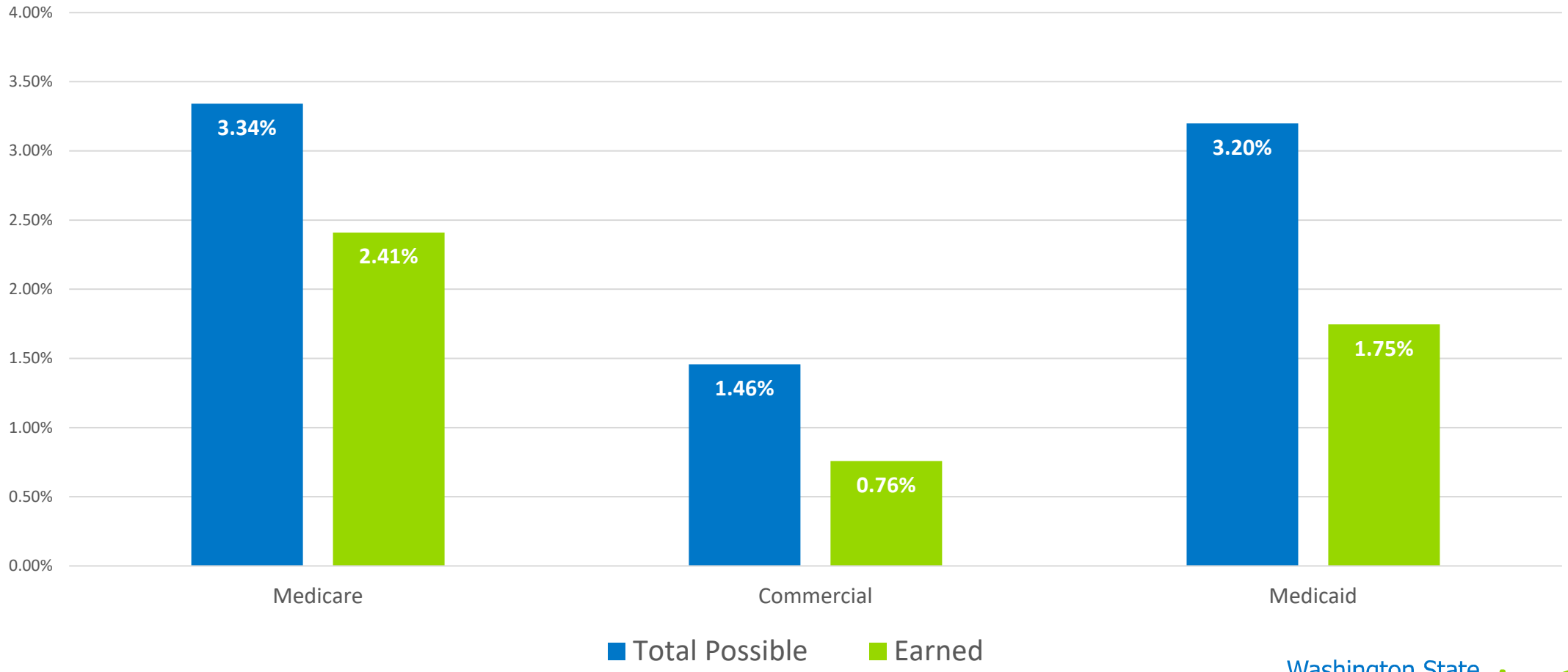
Measuring provider incentives ('depth')



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3. What is next for VBP?

National context: HCP-LAN APM goals

- Goal statement: “Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk APMs.” i.e., APM Framework categories 3B and up

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%

HCA 2022-25 strategic plan

hca.wa.gov/about-hca/
our-mission-vision-and-values

**Refreshed VBP goals in development*

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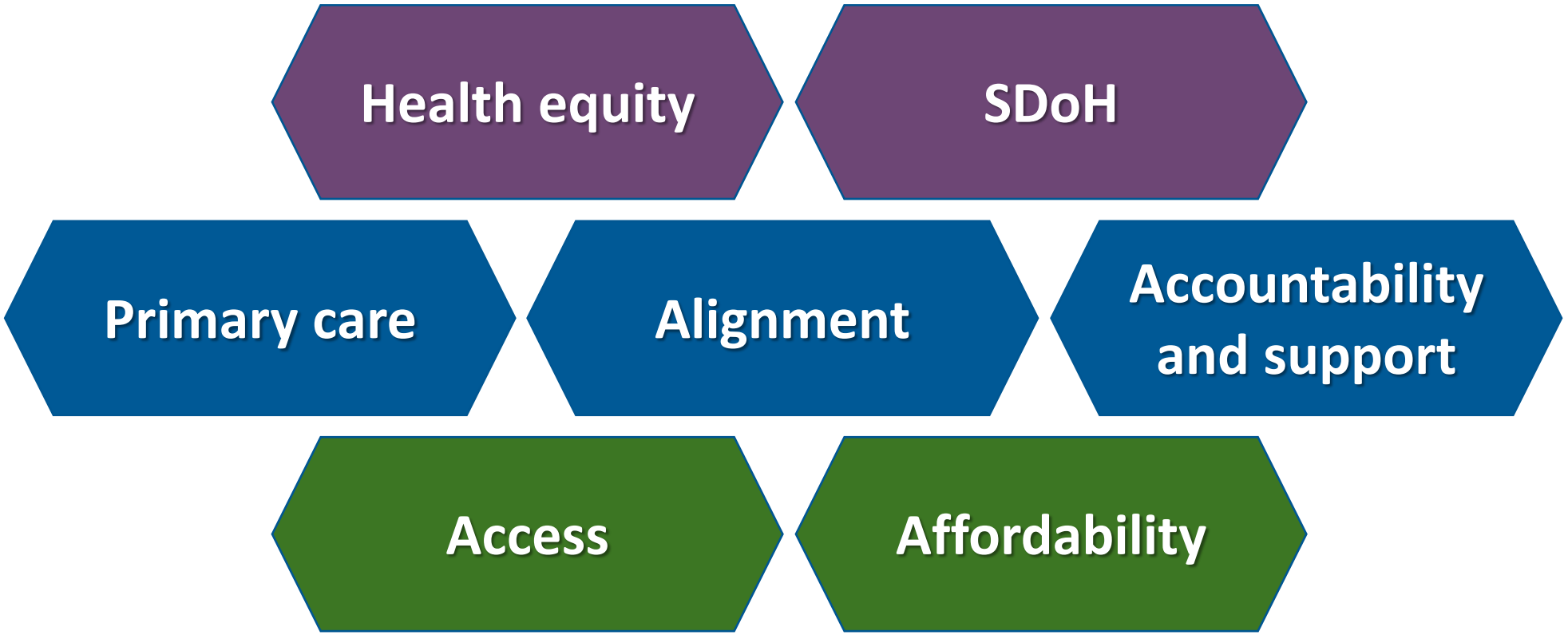
Continue refining and developing APMs

- Multi-payer primary care transformation model
- Community Health Access and Rural Transformation (CHART) Medicaid and Aligned Payer APM
- Medicaid Transformation renewal will continue community-based care and delivery system transformation
- Applying an equity lens to purchasing
- In development: consolidating and enhancing our measurement and evaluation of VBP efforts

VBP Roadmap: priorities



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Questions?

More information:
https://www.hca.wa.gov/about-hca/value-based-purchasing-vbp

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