
Health Care Cost Transparency Board

May 18, 2022

Health Care Cost Transparency Board Board Book

May 18, 2022
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting Materials

Meeting agenda.....	1
April meeting minutes	2
2022 CMS Actuarial Report: Summary and what it means for the Board.....	3
Grant proposal: Review and discussion	4
Hospital Cost Analysis: The Colorado Story	5
Primary care expenditures and next steps	6

Background and Topical Material

Advisory Committee on Data Issues Nominees.....	
Russ Shust	7
Chandra Hicks.....	8
Harms and healing, Milbank Memorial Fund.....	9
Grant development concept paper.....	10
Primary Care bill (SSB 5589).....	11

Agenda

TAB 1

Health Care Cost Transparency Board AGENDA

Board Members:

<input type="checkbox"/>	Susan E. Birch, Chair	<input type="checkbox"/>	Sonja Kellen	<input type="checkbox"/>	Kim Wallace
<input type="checkbox"/>	Lois C. Cook	<input type="checkbox"/>	Pam MacEwan	<input type="checkbox"/>	Carol Wilmes
<input type="checkbox"/>	John Doyle	<input type="checkbox"/>	Molly Nollette	<input type="checkbox"/>	Edwin Wong
<input type="checkbox"/>	Bianca Frogner	<input type="checkbox"/>	Mark Siegel		
<input type="checkbox"/>	Jodi Joyce	<input type="checkbox"/>	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 April meeting minutes	2	AnnaLisa Gellermann, Board Manager Health Care Authority
2:10 – 2:20 (10 min)	Discussion and appointment: Advisory Committee on Data Issues		AnnaLisa Gellermann, Board Manager Health Care Authority
2:20 -2:40 (20 min)	2022 CMS Actuarial Report: Summary and what it means for the Board	3	Michael Bailit Bailit Health
2:40 – 3:00 (20 min)	Grant proposal: Review and discussion	4	AnnaLisa Gellermann, Board Manager Health Care Authority
3:00 – 3:10 (10 min)	Public comment		Susan E. Birch, Chair, Director Health Care Authority
3:10 – 3:40 (30 min)	Hospital Cost Analysis: The Colorado Story	5	John Bartholomew and Tom Nash Consultants
3:40 – 3:55 (15 min)	Primary care expenditures and next steps	6	AnnaLisa Gellermann, Board 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.

April meeting minutes

TAB 2

Health Care Cost Transparency Board meeting minutes

April 20, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

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

Members present

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

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 March Board meeting

In March, members heard feedback from both advisory committees the plan for cost driver analyses, and possible consequences to cost growth reduction efforts. They also reviewed data on spending growth in Washington, including an analysis of trends in the commercial market created by OnPoint at the request of the Office of the Insurance Commissioner.

Based on the data presented, the Board expressed interest in learning more about the impact on cost growth of hospital spending, pharmacy spending, and the impact of shifting care from in patient to out- patient settings.



Advisory Committee feedback on impacts on criteria and strategies to support benchmark attainment

AnnaLisa Gellermann, HCA staff

Ms. Gellermann presented the Board with feedback from the Advisory Committee of Health Care Providers and Issuers on the criteria it approved for selecting strategies to support benchmark attainment. The criteria adopted by the Board were:

- 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.

The committee strongly recommended inclusion of a criterion related to access. Their concern was that consideration of decreasing services and access to services, especially among vulnerable and rural populations, is a vital consideration to the delivery system. The Board agreed that access was an important factor and that it would form an important factor in their consideration. Some Board members acknowledged the challenge in measuring the impact on access from one specific policy intervention. Staff was directed to draft language for the Board's future consideration.

The committee also reviewed the three areas identified by the Board for deeper educational dives: Market consolidation, hospital pricing strategies, and value-based payment. Members of the committee shared suggestions for finding high value targets, but no specific alternative topics were recommended.

2022 Legislative Session recap

Evan Klein, Special Assistant for Policy and Legislative Affairs
Health Care Authority

Mr. Klein presented the Board with a recap of the 2022 Legislative session, focused on health, and cost related legislation that had been introduced and/or passed during the session. The presentation included an overview of the new primary care target statute charging the Board with development of a 12% target state-wide.

Introduction to primary care expenditures

Emily Transue, Associate Medical Director
Health Care Authority

Ms. Transue provided the Board with an introductory overview of primary care in Washington, including ongoing work with stakeholders to develop a primary care definition and support and incentivize primary care providers. She reviewed Rhode Island's experience with a primary care target, and shared analytics from that state demonstrating that increased primary care spend reduced overall health care spending.



Public comment

Ms. Birch called for comments from the public. There were no comments.

Key issues in defining and measuring primary care spend

January, Angeles, Bailit Health

January Angeles of Bailit Health presented the Board with information from other states with primary care targets, and the key issues in measuring primary care spend. The major issues are identifying the data source (whether relying on claims-based spending alone or seeking other direct payments), defining primary care (including the provider and treatment types), and what to include in calculating the total spend (e.g., non-claims-based spending).

Ms. Angeles shared an overview of different state approaches.

Value based purchasing

JD Fischer, Project Manager Value Based Purchasing
Health Care Authority

Mr. Fischer shared with the Board a presentation on HCA's Value Based Purchasing program. His program was shortened due to time, and he will return at a future meeting to engage the Board on this topic again.

Adjournment

Meeting adjourned at 4:01 p.m.

Next meeting

Wednesday, May 18, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

2022 CMS Actuarial Report: Summary and what it means for the Board

TAB 3

CMS Office of the Actuary 2021-2030 Projections of National Health Expenditures

Michael Bailit
Bailit Health
May 18, 2022

Background on the CMS National Health Expenditure (NHE) Report

- ▶ Prepared by the CMS Office of the Actuary.
- ▶ Published annually since 1960, and often considered the “official” forecast of US health care spending.
- ▶ Includes data on US health care spending by type of service, source of funds, and sponsor.
- ▶ Projections are developed using actuarial and econometric modeling techniques.
 - ▶ Reflects current law and assumes the Public Health Emergency ends in 2022.

Summary of major findings

- ▶ Projects that NHE and gross domestic product (GDP) will grow 5.1 percent per year from 2021-2030.
- ▶ Near-term NHE patterns are significantly influenced by the COVID-19 pandemic.
 - ▶ The large influx of **federal dollars** for COVID-19 relief fell sharply in 2021 and will continue to do so through 2024.
 - ▶ Health care utilization should normalize through 2024.
- ▶ For 2025-2030, factors that typically drive changes in health care utilization and spending are again expected to primarily influence trends in the health care sector.

Comparison of NHE projections to Washington cost growth benchmark values (2022-24)

Category	2022	2023	2024
Average annual NHE per capita growth	4.3%	4.3%	4.2%
Washington cost growth benchmark	3.2%	3.2%	3.0%

Comparison of personal health care expenditures projections by market to WA cost growth benchmark values (2022-24)

Category	2022	2023	2024
Commercial average annual growth in per enrollee personal health care expenditures	8.3%	7.2%	5.6%
Medicare average annual growth in per enrollee personal health care expenditures	5.1%	3.3%	4.5%
Medicaid average annual growth in per enrollee health care expenditures	6.7%	6.0%	3.2%
Washington cost growth benchmark	3.2%	3.2%	3.0%

Note on PHC projections by market vs. NHE projections overall

- ▶ PHC projections per capita by market are much higher than those for NHE.
- ▶ This is due primarily to the largely negative values of the projected average annual growth rates of government public health activities.

Category	2022	2023	2024
Average annual growth in government public health activities	-11.7%	-8.1%	-9.4%

Grant proposal: Review and feedback

TAB 4

Grant Proposal: Review and Feedback

AnnaLisa Gellermann, Board Manager

Health Care Authority

May 18, 2022

Washington State context

- ▶ Washington State embraces health care innovation
 - ▶ Medicaid waiver, Cascade care, public option, all payer claims data base, accountable communities of health, direct primary care contracting, surprise billing, Health and Human Services coalition (IT priorities).
- ▶ Health Care Authority (HCA) is largest purchaser in the state.
- ▶ Sue Birch is the Director of HCA, and Chair of the Board
- ▶ New Health Care Cost Transparency Board
 - ▶ Bi-partisan, cross market purchasers. Advised by cross section of carriers, providers, and data experts.
 - ▶ Authority to call for data from all markets.
 - ▶ HCA administration provides coordination and access to state subject matter experts and data resources.
 - ▶ Charged with developing cost driver analyses and making reports to the legislature.

Grant vision

- ▶ Provide both analytic and policy development resources to reduce the cost of health care.
- ▶ Provide Washington-specific, cross-market, state-wide analysis.
- ▶ Develop partnerships and expertise to support broad-based analysis from existing public data sources.
- ▶ Develop tools to aid in effective control of health care costs while maintaining/improving population health.
- ▶ Support innovative data strategies for the public good.
- ▶ Transition from philanthropic to public funding at end of grant.

Grant Initial Focus

- ▶ Support the Board in its responsibility to make legislative recommendations to curb spending growth and achieve the benchmark target.
- ▶ Identify the key cost drivers of overall health care spend and their impact on annual growth.
 - ▶ Phase 1 analyses: changes in spending and utilization (e.g., cost driver analysis).
 - ▶ Phase 2 analyses: deeper dives into identified cost drivers.
 - ▶ Additional drivers: population growth; demographic changes, disease burden trends.
- ▶ Develop relevant and timely reports supporting legislative recommendations to curb spending growth and achieve the benchmark target.

Policy Support Unit (PSU)

▶ Capabilities:

- ▶ Distributed data management
- ▶ Deep analytic capacity: data analysis
- ▶ Computing infrastructure: storage and computing bandwidth
- ▶ Collaborative management: working with experts in agencies and organizations
- ▶ Policy awareness: from analysis to practical and implementable policy options

▶ 2-Stage Development Approach

- ▶ Incubation period – 3 years
 - Funded by catalytic philanthropy
 - Establish value measured by funding shift from philanthropy to state resources
- ▶ Sustained Operations – ongoing
 - State budgeted resources
 - Full organizational accountability
 - Well defined operational processes

Start-up: The incubation period

- ▶ Identify appropriate PSU “incubator” that accelerates access to critical capabilities.
 - ▶ Dedicated staff exclusively focused on supporting Board efforts at cost containment.
 - ▶ Candidates: Institute for Health Metrics and Evaluation (IHME) at the University of Washington, HCA, other?
- ▶ Create accountability for the PSU activities, funding use and transition.
- ▶ Establish access to necessary data sources.

Discussion

- ▶ What feedback would you give to the Board about this proposal? Is it practical? Achievable?
- ▶ What are some of the challenges you see in trying to implement the proposal? Staffing? Data access? Other?
- ▶ What changes would you recommend to the proposal to improve its chances for success?

Public comment

Hospital cost, price, and profit analysis: The Colorado story

TAB 5

Hospital Costs, Price, and Profit Analysis: The Colorado Story

John Bartholomew, Presenting
Bartholomew-Nash & Associates

Health Care Cost Transparency Board
May 18, 2022

Analysis by the Colorado Department of Health Care Policy and Financing – Kim Bimestefer
Executive Director, Tom Nash, and John Bartholomew

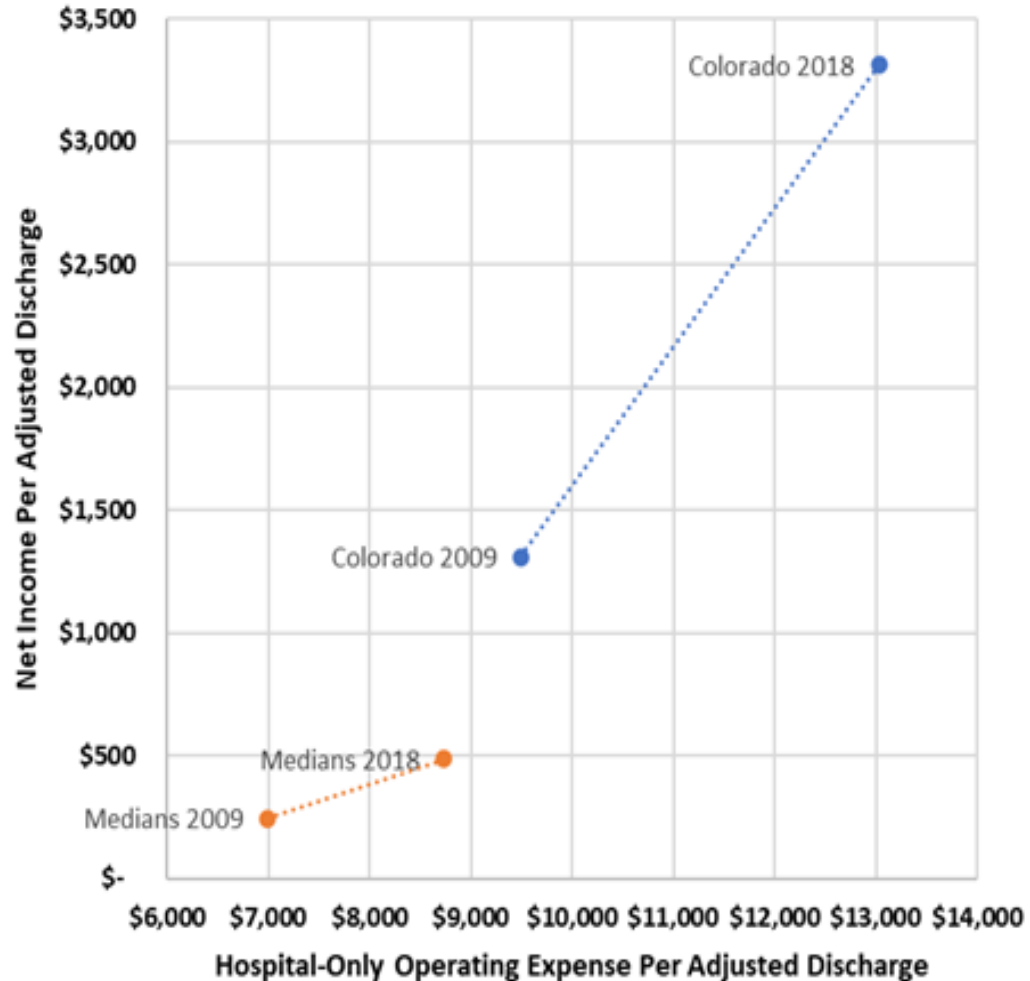
The Problem

State initiatives to improve coverage and fund hospital care in Medicaid

- 2009: Hospital provider tax that increased hospital reimbursement for Medicaid services and created state funding source for the ACA Medicaid expansion
- 2014: ACA Medicaid expansion decreased uninsured rate and cut charity care/bad debt by 50%+

Results = Rising insurance costs and hospital costs

- 2009-2018 CO hospital costs grew 50%+ more than national average
- In 2009, CO hospital profits exceeded national median by 5 times; in 2018, profits exceeded national median by 7 times



The Approach to Identify Solutions

- In 2014, the State Legislature established the Colorado Commission on Affordable Health Care to understand why commercial health care costs were rising so fast
 - The main finding still used today: hospital financial analysis is needed at the state level.
- Using Medicare Cost Report data, create metrics on Net Patient Revenue, Hospital-Only Operating Cost, and Net Income by dividing data by adjusted discharges.
 - Net Patient Revenue divided by Adjusted Discharge = **Price per Patient**
 - Hospital Only Operating Cost divided by Adjusted Discharge = **Cost per Patient**
 - Net Income divided by Adjusted Discharges = **Profit per Patient**
- Observe trends across hospital types
 - Health systems, independents, for-profit, not-for-profit, rural, urban, by bed size

Summary of the Analysis Conducted by The Colorado Department of Health Care and Financing

Report Published in August, 2021:
[Hospital Cost, Price & Profit Review](#)

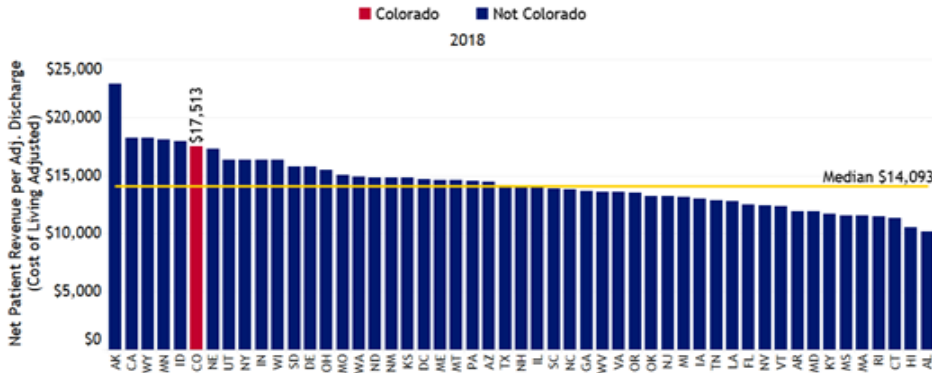
Hospital Cost, Price, Profit Analysis

- *National Rankings*
- *Data Source / Metrics*
- *Findings*
- *Community Benefit*

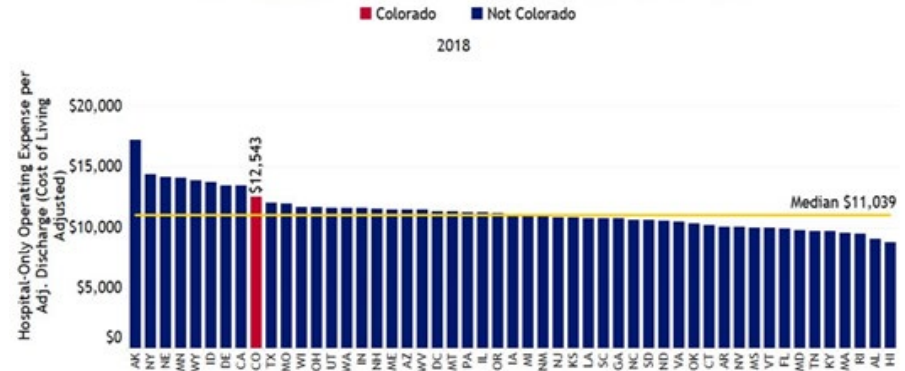
Transparency: Medicare Cost Reports, 2018

CO Rankings: 6th Price, 9th Cost, 1st Total Profit

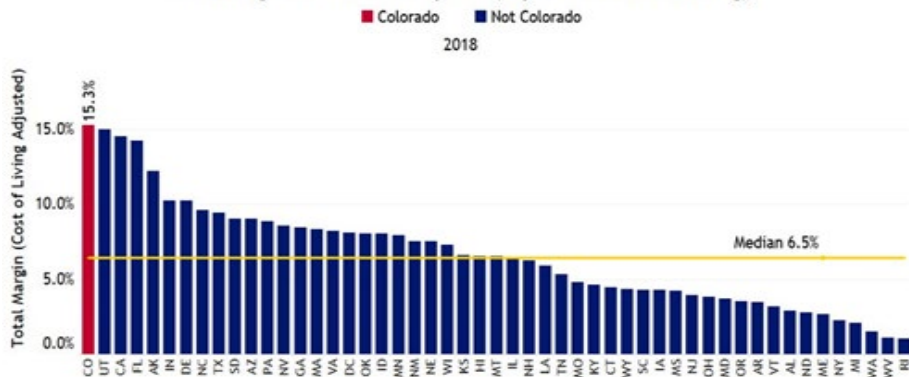
Price per Patient U.S. States Compared (Adjusted for Cost of Living)



Cost per Patient U.S. States Compared (Adjusted for Cost of Living)



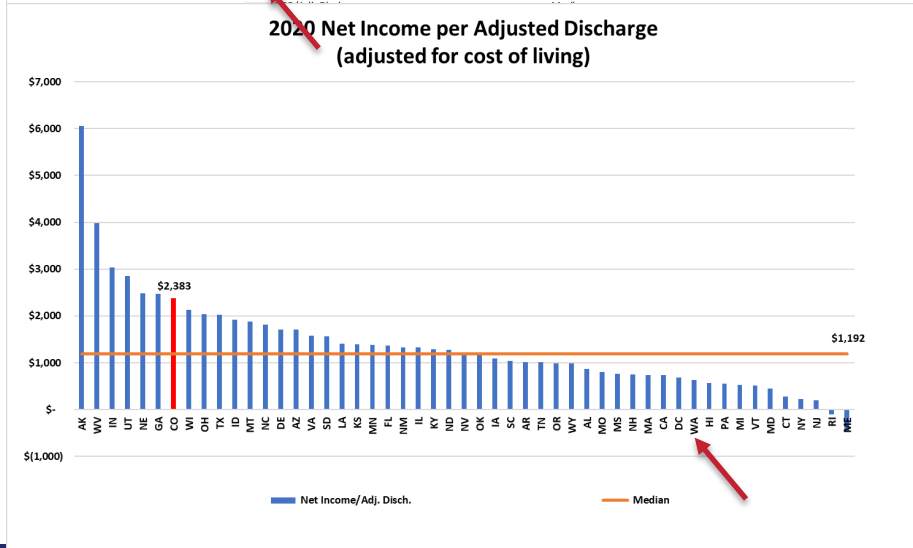
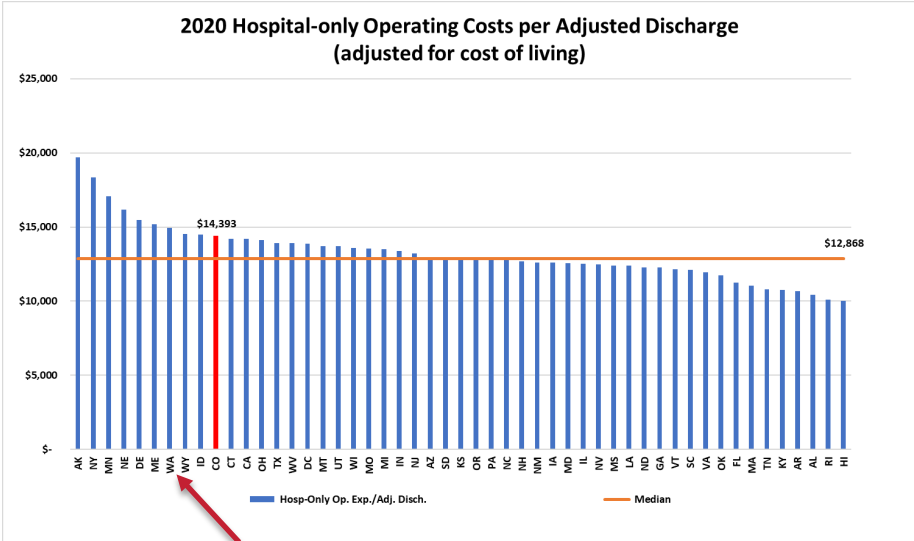
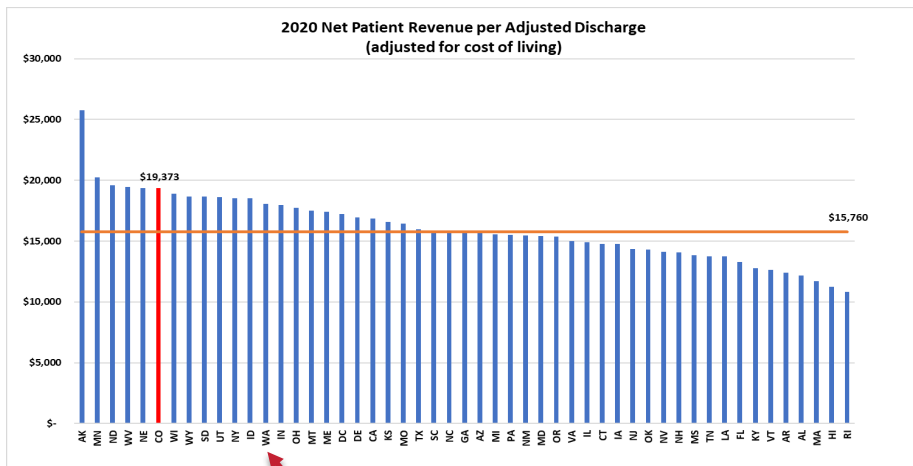
Total Margin U.S. States Compared (Adjusted for Cost of Living)



Opportunity for collaboration with hospitals to reduce prices and bring profits more in line with national median. Seeing movement: Centura, SCL, University – *but more needed!*

Transparency: Medicare Cost Reports, 2020

CO Rankings: 6th Price, 9th Cost, 1st Total Profit



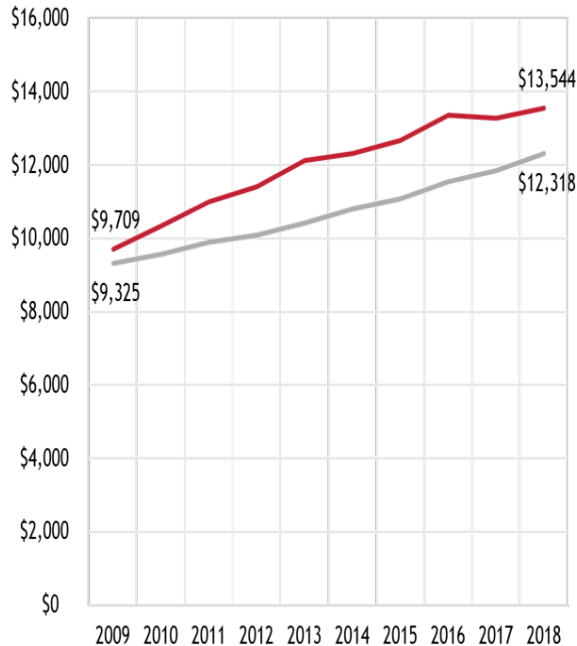
Updated data to 2020

- State of Washington identified with arrow
 - WA 14% higher than National Median on Price per patient
 - Ranked 7th highest Costs per patient

Colorado Hospital Cost, Price & Profit Trends

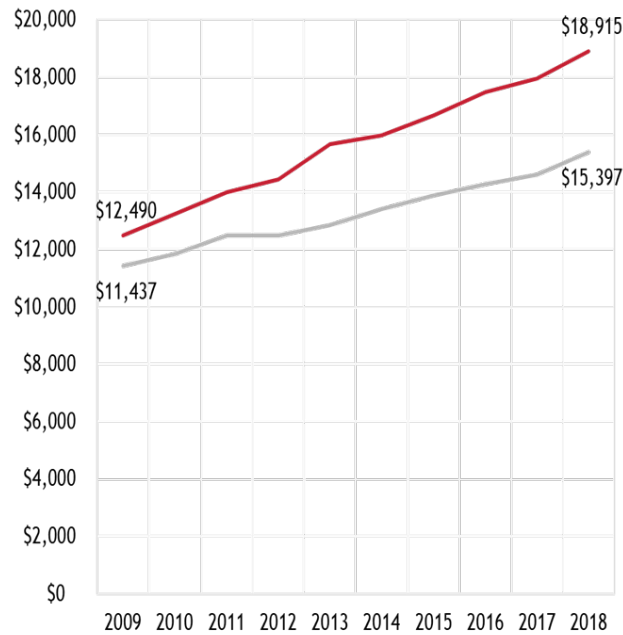
Hospital-only Operating Cost Per Adj. Discharge

— Colorado — National



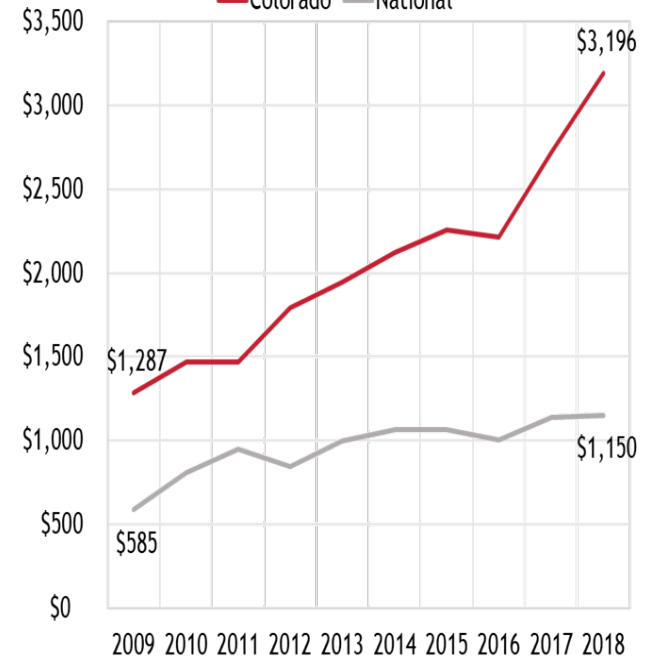
Net Patient Revenue Per Adj. Discharge

— Colorado — National



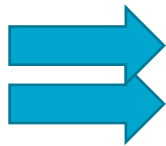
Net Income Per Adjusted Discharge

— Colorado — National



2018 Income Statement, All Colorado Hospitals; Two Types of Profit

Statement Line	Colorado
Net Patient Revenue	\$ 16,862,512,337
Hospital-Only Operating Expense	12,073,928,031
Non-Hospital Operating Expense	3,301,592,506
Total Operating Expenses	15,375,520,537
Patient Services Net Income	1,486,991,800
Plus: Other Non-Patient Income	1,371,040,633
Less: Other Non-Operating Expenses	8,546,621
Net Income	\$ 2,849,485,812
Total Margin	15.6%



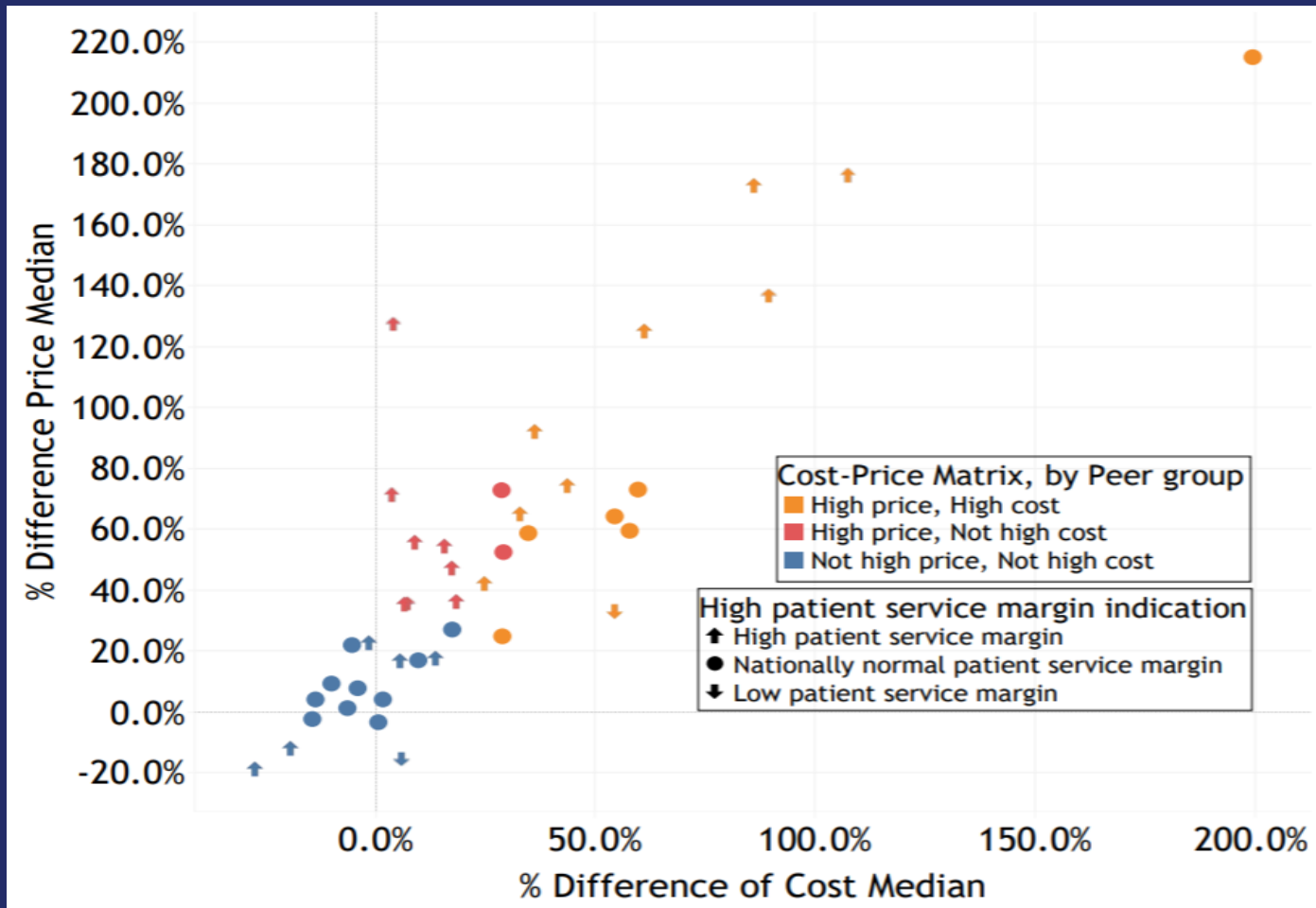
Non-Profit Hospitals Net Income: 58% of total	\$ 1,659,344,433
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Colorado Hospital Groupings

Hospital with > 25 beds

Colorado hospitals with greater than 25 beds



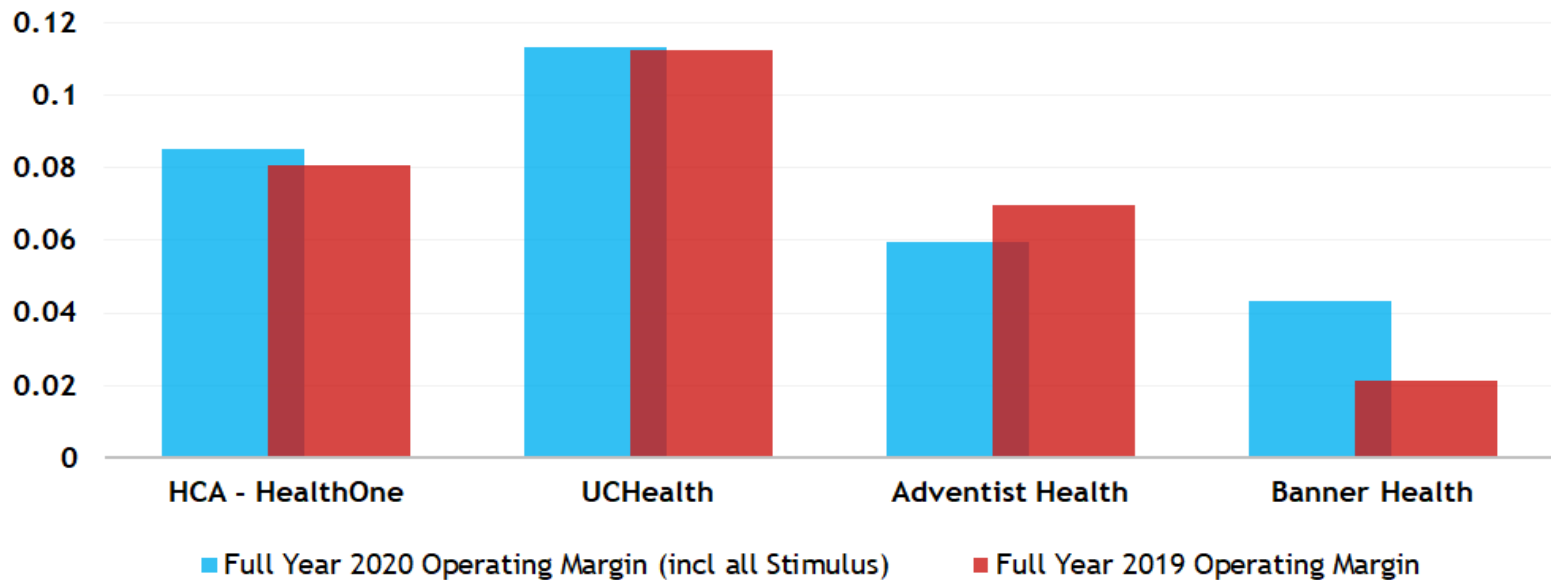


National Median Cost-Price Scatterplot of Colorado Hospitals, including Net Income/Profit

Opportunity to rein in the outliers

COVID-19 & Hospital Finances

Operating Margin, Calendar years 2020 and 2019



- HCA-HealthOne has returned their stimulus disbursements
- SCL Health Operating margin end of 2019 was 5.8% and through Sep 2020 it was 8.3%

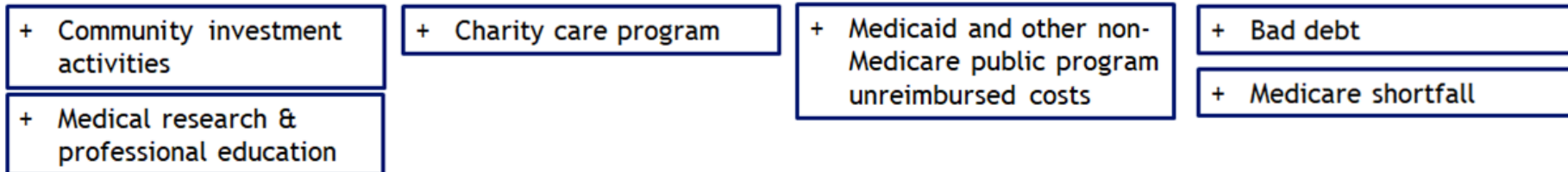
Community Benefit

Community Benefit can be Represented in Different Ways

AHA reports all benefits and uncompensated care

Reported to the IRS

Reported through HB 19-1320



*Community impact FROM
the hospital for
providing services*



*Financial impact TO
the hospital for
providing services*

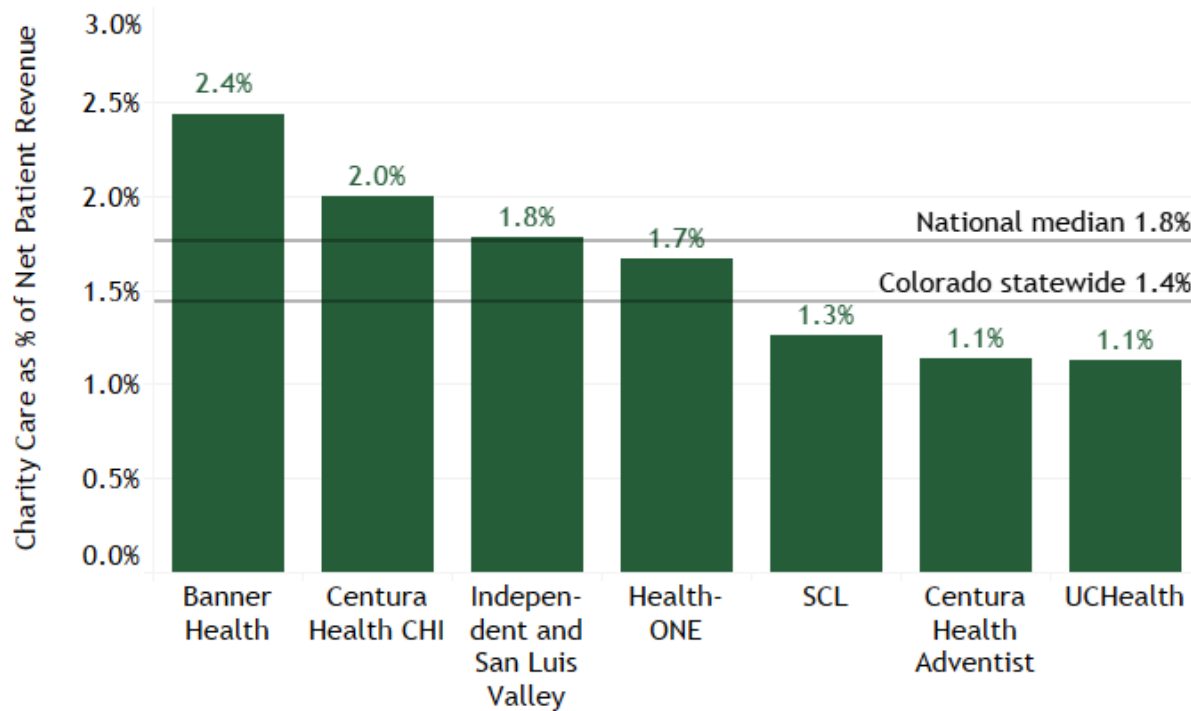
2017 Community Benefit Categories and Percent of Total Expenses

Community Benefit Category	Percent of total expense	Typical for nonprofit hospitals?	Typical for for-profit hospitals?
Financial assistance, unreimbursed Medicaid, unreimbursed costs from means-tested government programs	6.4%	✓	✓
Medicare shortfall	3.1%	✓	✓
Bad debt expense attributable to financial assistance	0.4%	✓	✓
Subtotal attributable for both nonprofit and for-profit	9.9%		
Health professions education	1.7%	✓	
Medical research	0.5%	✓	
Cash and in-kind contributions to community groups	0.3%	✓	
Community building activities	0.1%	✓	
Other (community health improvement, subsidized health)	1.7%	✓	
Total	13.8%		
Percent of total that is attributable for both nonprofit and for-profit	71.7%		

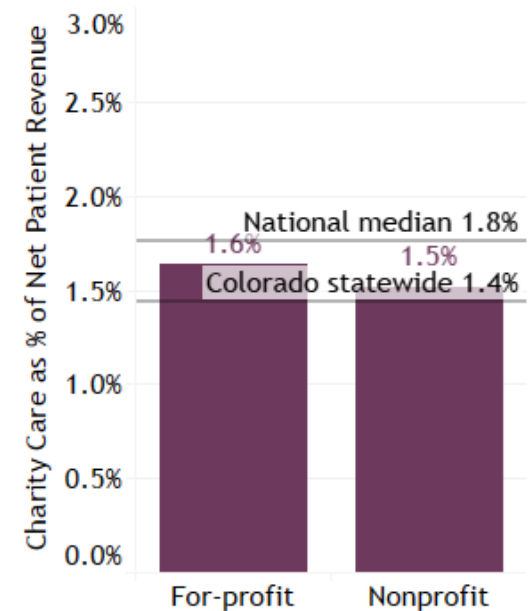
Total does not sum due to rounding.

2018 Charity Care as a Percent of Net Patient Revenues

By Hospital System



By Profit Status



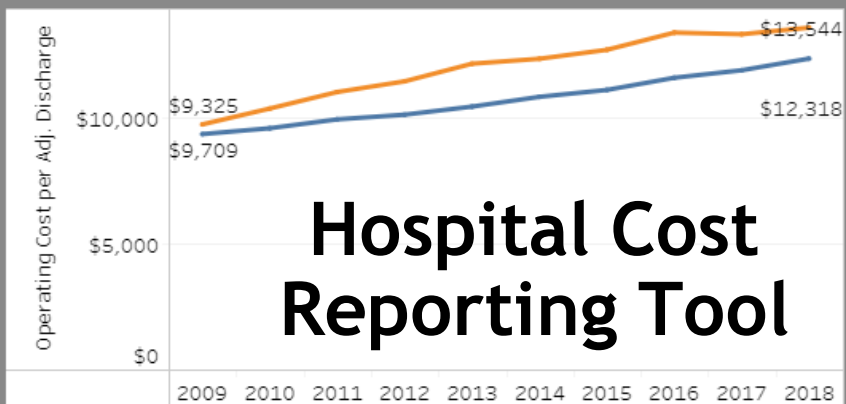
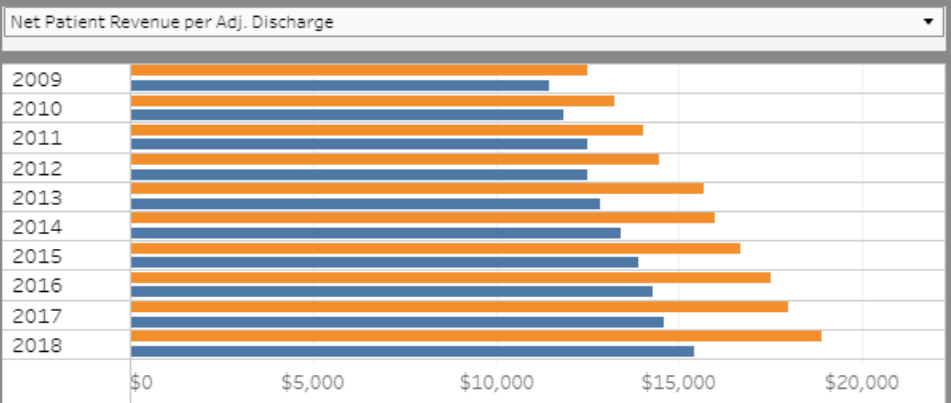
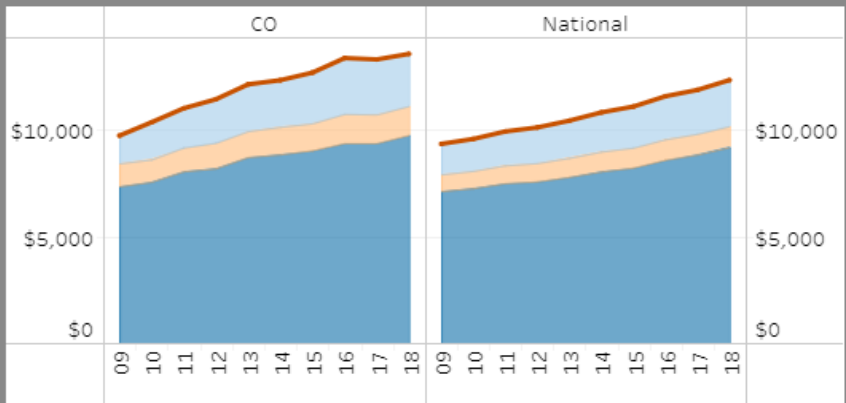


Colorado vs. National:
 Operating Cost per Adjusted Discharge, Administrative Cost per Adjusted Discharge, Capital Cost per Adjusted Discharge, Medical Cost per Adjusted Discharge, Total Margin percent, and Patient Services Margin percent

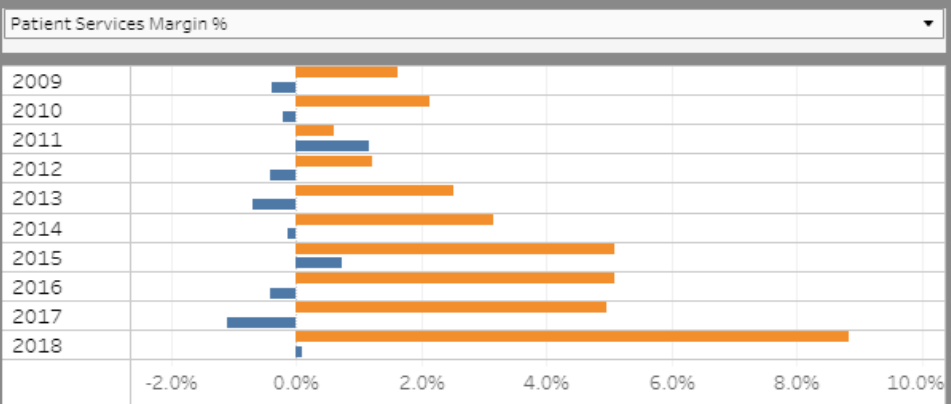


Operating Cost per Adj. Discharge Administrative Cost per Adj. Discharge Capital Cost per Adj. Discharge Medical Cost per Adj. Discharge

Region Level: CO National



Hospital Cost Reporting Tool



Questions?

Primary care expenditures

TAB 6

Primary Care Expenditures

AnnaLisa Gellermann, Board Manager

Health Care Authority

May 18, 2022

Recap-the case for primary care

- ▶ Increasing expectations with stagnant resources lead to workforce and access crisis.
- ▶ Current 5-7% on primary care (commercial estimate).
- ▶ Strong evidence supports value of higher spending to higher workforce to higher quality.
- ▶ RI Case Study: Required increased commercial plan investment by 1% a year for 5 years (non-FFS spending). Enforced through insurance rate review process. Spending increase from \$47M to \$73M over 7 years.
 - ▶ Increased primary care supply, decreased “specialty flight.”
 - ▶ 8% decrease in overall health care spending.

Primary Care Expenditures:

- ▶ Added to Title 70.390 (HCCTB).
 - ▶ Board **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.*

Preliminary Report: recommendations

- ▶ Ongoing role of the Board.
 - ▶ Guiding and overseeing the development and application of targets.
 - ▶ Implementing and evaluating strategies.
- ▶ Required activity in developing measures and reporting.
 - ▶ Consult with primary care providers and organizations.
 - ▶ Review existing work.
 - ▶ OFM, December 2019 report
 - ▶ Bree Collaborative
 - ▶ UW advancing integrated mental health center and the center for health workforce studies.
 - ▶ Milbank memorial fund
 - ▶ National Academy of sciences, engineering and medicine.
 - ▶ Health Care Authority
 - ▶ Other states

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 resources.
- ▶ Development of workplan milestones and deliverables.
- ▶ Engaging with Advisory Committee of Health Care Providers and Carriers June 2.
- ▶ Preliminary plan: June 18 Board meeting.
- ▶ Considerations
 - ▶ Stakeholder engagement
 - ▶ Ad hoc committee?
 - ▶ Approval process with existing meeting schedule
 - ▶ Report development and review

Discussion

- ▶ What should the role of the Board be in developing recommendations?
- ▶ What should staff consider in recommending a new committee?
- ▶ How will the Board consider its future role in primary care strategy development, implementation, and assessment?
- ▶ What are your priorities in carrying out this work?
- ▶ Other thoughts?

Advisory Committee on Data Issues nominee Russ Shust

TAB 7

Russ Shust

Senior Director, Medical Economics, OptumCare

Russ has over two decades of healthcare experience working with for-profit and not-for-profit companies. Having worked with Medicare, Medicaid, and ACA insurance types at different points in his career; most of his experience has been related to the Medicare Advantage insurance plan type. Russ finds true purpose in the work he does at Optum related to Population Health and using Social Determinants of Health data to work with clinicians to improve the wellness of people's lives.

Russ received a Bachelor of Science in Business Administration, with a minor in Economics, from John Brown University.

RUSS SHUST

206-228-8844 | rshust@everettclinic.com

SUMMARY

I am a healthcare professional who specializes in Medicare Advantage. My unique strengths include financial strategy, analysis, and problem solving with mathematical modeling. I have a deep knowledge and understanding of the Medicare Advantage program – particularly risk adjustment and population health. I enjoy working collaboratively with people. I have a diverse background—having worked for organizations in healthcare, social services, and manufacturing.

EXPERIENCE

OptumCare, Seattle, WA

A subsidiary of UnitedHealth Group and Optum, OptumCare is a consortium of more than 53,000 doctors and 1,450 neighborhood clinics across the country, working together to help over 19 million people live healthier lives.

Senior Director, Population Health Analytics, 2019 - present

Responsible for three areas of our company:

- Medical Economics – the analytical side of Finance; supporting Actuarial, Accounting, Financial Planning, and Contracting; as well as Clinical and Operational Leadership
- Quality Incentive Programs (QIP) – financial incentives to the providers of healthcare that reward activities that drive Population Health
- Provider Data Management (PDM) – alignment of Primary Care Providers (PCPs) to accurate Tax ID Numbers (TINs) for the purpose of Network accuracy for membership from Health Plans

Kaiser Permanente (formerly Group Health Cooperative), Seattle, WA

An integrated, nonprofit health system that provides health care and insurance coverage for over 12 million people nationally; with 600,000 people, including 90,000 Medicare Advantage lives in the State of Washington.

Senior Director, National Medicare Finance, 2017 - 2019

In addition to the responsibilities for the Washington Region (listed below) I managed the National Analytic Services Team in Oakland, CA (with 1 direct report managing a staff of 3). Responsibilities include analytics, projections, and forecasting of all KP Medicare Advantage revenue (\$16B annually) based on CMS rate action for Parts C and D.

Director, Medicare Finance, 2009 - 2017

I was responsible for the Washington Region's Medicare Advantage (MA) financial strength. I oversaw over \$1 billion per year in revenue, approximately 30% of the enterprise's total revenue. My responsibilities include:

- Annual revenue forecasting, internal rate setting, and budget creation
- Creation of the Bid Pricing Tools (BPTs) for our HMO & PPO MA bids to CMS
- Managing the relationships with vendors for purchased services
- Assisting with setting the strategic direction of the MA line of business
- Collaborating with many internal functional areas to help manage the MA line of business
- Overseeing Risk Adjustment payment methodologies
- Managing all CMS financial audits
- Overseeing monthly accounting of all MA capitated and premium revenue
- Reviewing regulatory and policy developments for financial implications
- Representing finance at meetings related to Medicare
- Overseeing two Washington teams:
 - Medicare Finance (1 direct report managing a staff of 3)
 - Risk Adjustment Services (2 direct reports who manage a staff of 10)

Medicare Analyst / Senior Medicare Analyst, 2003 - 2009

- Developed expertise in

- Medicare Part D – including capitation payments, reconciliation, Prescription Drug Events (PDEs), and Plan to Plan (P2P) components
- CMS reimbursement methods – including risk-adjustment methodologies
- Contributed to the creation of Bid Pricing Tools (BPTs) and Adjusted Community Rates (ACRs) for all GHC's bids to CMS
- Assisted in federal and State audits

United Behavioral Health, Seattle, WA

A subsidiary of United Healthcare, a national healthcare insurance company. United Behavioral Health is the mental health component of United Healthcare.

Network Contract and Compliance Administrator, 2002 - 2002

- Facilitated contracting and credentialing of all hospitals (approximately 10) and service agencies (approximately 22) in the network
- Authenticated financial transactions to all contracted providers
- Performed on-site administrative audits of all in-network providers
- Created auditing standards and tools to use on hospitals and behavioral health providers
- Monitored regulation compliance of all in-network providers

Accountant, 2001 - 2001

- Oversaw all accounting functions
- Maintained integrity of all accounting software and all G/L, A/P, and A/R functions
- Monitored contractual expenditure budgets for 22 network providers/hospitals – with approximately a \$76 million annual budget
- Facilitated the processing of all fiscal transactions
- Assisted with network management and provider relations as needed
- Assisted the reporting, documentation, and analysis for corporate finance staff
- Created policies and procedures relating to finance and provider relations

South County Senior Center, Edmonds, WA

A non-profit organization working to enrich the social, physical, and intellectual well-being of seniors in South Snohomish County.

Financial Administrator, 1998 - 2000

- Managed all fiscal operations, and created internal controls
- Prepared budgets and financial statements, fiscal reports, and summaries
- Compiled audit materials and represented the organization during all audit activities
- Performed risk management functions
- Processed licensing and regulatory documents at local, State, and federal levels
- Manage six staff and two volunteers
- Oversaw the organization's payroll

North American Companies, Tulsa, OK

A consortium of companies producing tradeshow exhibits and convention decorating, as well as manufacturing interiors for the grocery store and convenience store industries.

Controller, 1994 - 1998

- Performed strategic planning for marketing and finance
- Established a system of internal controls
- Maintained compliance with outside reporting requirements relating to financial and tax matters, as well as regulatory statements with OSHA and EPA.
- Managed cash planning
- Administered the company's payroll

EDUCATION

Bachelor of Science, 1993

John Brown University, Siloam Springs, AR
University of Oklahoma, Norman, OK

Major: Business Administration

Minor: Economics

CIVIC INVOLVEMENT

- Current Member (Former Board Member & Treasurer), Federal Bureau of Investigation (FBI) Citizens Academy Alumni Association (FBICAAA), Seattle, WA
- Former Member and President, Citizen's Patrol, Lynnwood Police Department, Lynnwood, WA
- Former Notary Public, State of Washington
- Former Member & Chairman, mayor-appointed Sales Tax Overview Committee (STOC), Tulsa, OK

Advisory Committee on Data Issues nominee Chandra Hicks

TAB 8

Chandra Hicks, FSA, MAAA

(206) 755-4289 | ChandraHicks@gmail.com

PROFILE

- 17 years of diverse health actuarial experience with increasing leadership responsibilities that includes areas of accountable care, value based care, forecasting and financial planning, provider performance measurement, provider network development, provider reimbursement analysis, and risk mitigation.
- Passionate advocate for change and innovation with an energy for situations that require creative problem solving.
- Current role managing two teams with diverse levels of experience while also working with consultants, vendors, external health plans, provider groups, external departments (DTS, Finance, provider network executives), other actuarial teams and external companies/associations to support the company's innovative provider partnership initiatives.
- Repeatedly recognized as an organized people and project manager who can work effectively across teams and departments based on abilities that include a high drive for results, perseverance in the face of obstacles and setbacks and novel approaches to finding solutions through working with stakeholders.

Professional Background

CAMBIA HEALTH SOLUTIONS (REGENCE BLUECROSS BLUESHIELD) | FEBRUARY 2005-PRESENT

Assistant Director of Delivery System Analytics | 2020-Present, Manager 2013-2020

- Actuarial leadership developing strategic provider partnerships for commercial lines of business.
- Manage two teams of 7 Actuaries and actuarial analysts whose key accountabilities are providing network analytics & network pricing, pre-contracting analytics for value based arrangements, target setting for provider incentives, forecasting savings of value based programs and system development.

Delivery System Analytics, Senior Actuary | 2011-2013

- Actuarial support in developing the company's strategic Accountable Healthcare Initiative. Provided recommendations on program methodology and contract design.
- Coordinated with several DTS and informatics areas to implement data processes, including implementation of cross-Blue plan data transfers.
- Provided actuarial expertise during operational build to support Accountable Healthcare Initiative.
- Represented Actuarial during initial provider education meetings and regularly scheduled post-contract support meetings. Responsible for presenting contracting results and explaining areas of opportunity.
- Coordinated with network executives to design Exchange networks based on target performance. Led team internally to develop factors used for Health Insurance Exchange product pricing.

Provider Network, Contract & Reimbursement | 2005-2006; 2009-2011

- Developed several methodologies to support value-based and pay-for-performance contracts.
- Contributed to development of a methodology for long-range network reimbursement management, which used underwriting principles to recommend ideal reimbursement levels and calibrate payments.
- Key contributor to development of a performance based network of healthcare providers.
- Modeled the impact of proposed hospital and professional contracts while working closely with the provider contracting department.

Corporate Forecasting | 2006-2009

- Responsible for coordinating and developing the company's budget for senior management review, as well as regular forecasting of company product lines.
- Responsible for forecasting and developing assumptions for healthcare reform impacts (Affordable Care Act), including development and modeling of company strategies to mitigate risks.
- Performed scenario modeling and sensitivity testing, including elasticity of membership impacts, RBC impacts and value-at-risk calculations for "worst-case" outcomes.
- Overhauled the projection methodology for large group forecasting through coordination with the Underwriting and Pricing departments.

Organizations And Activities

Member of the American Academy of Actuaries | 2008

Fellow of the Society of Actuaries | 2010

Member of Toastmasters International | 2009-2012

Grader, Society of Actuaries | 2011

Cambia Actuarial Internship Coordinator | 2011-2013

- Selected, interviewed and presented intern candidates to actuarial management.
- Coordinated and led weekly brown-bag sessions for interns

Formal & Continuing Education

B.S. MATHEMATICS, B.S. PHYSICS | 2003 | UNIVERSITY OF WASHINGTON

ACTUARIAL LEADERSHIP DEVELOPMENT PROGRAM | 2012 | CAMBIA

DATA SCIENCE SPECIALIZATION, COURSES 1-7, | 2017 | COURSERA, JOHNS HOPKINS UNIVERSITY

LEADERSHIP JOURNEY | 2018 | CAMBIA

SAS, SQL, R, TABLEAU, GITHUB, VBA LANGUAGES AND MS OFFICE

Harms and healing, Milbank Memorial Fund

TAB 9

Harms and Healing

APRIL 26, 2022

VIEW FROM HERE

Author:



CHRISTOPHER F. KOLLER

Related Content:

To live is to be in relationship with one another. Those relationships may be as close and personal as family or as distant and impersonal as merely inhabiting the same planet.

To be in relationship is to have the capacity to harm or heal one another. In cases of harm, the consequences require taking responsibility.

The harms of racism – discrimination based on membership in a racial or ethnic group – run deep in America. Differences in income, lifespan, medical treatment, incarceration, educational attainment – even differences in *hope* – trace back to the institution of slavery, which the framers of the American Constitution accommodated in spite of their desire to create “a more perfect union.”

These harms are so rooted in our society that many white Americans perpetuate them without intent. They have never faced the self-doubt that comes from wondering if – or knowing that – they were treated differently because of the color of their skin. They have never had to train their kids to protect themselves in the face of authority.

However, recently more white Americans, and institutions, have been exposed to the entrenched nature of these harms and have had to confront their own participation in them.

This is the case for the Milbank Memorial Fund. A constellation of events – the murder of George Floyd, the Black Lives Matter movement, and staff organizational development work on diversity, equity, and inclusion – created a moment for us to carefully examine our history. What we found was deeply disturbing and counter to our mission and values. This experience has placed us on an important journey, the very first step of which is to acknowledge our role in the United States Public Health Service Syphilis Study at Tuskegee and Macon County Alabama.

A constellation of events...created a moment for us to carefully examine our history....This experience has placed us on an important journey, the very first step of which is to acknowledge our role in the United States Public Health Service Syphilis Study at Tuskegee and Macon County Alabama.

From 1934 until 1973, the Fund paid for services associated with the burials of men who died in the course of the study. The funds included burial stipends that were used to incentivize their families to consent to autopsies. The details of the Fund’s involvement can be found in a report we commissioned from historian Susan Reverby, PhD. Although the Fund’s role is publicly documented, we have never acknowledged it openly and publicly, until now.

The study was unethical and racist. Participants were not asked for consent, were told they had “bad blood,” and were deliberately deprived of curative treatment. The study remains a particularly corrosive example of the untrustworthiness of the US health care system for Black

people and other people of color. The study was not aligned with our mission when our predecessors on the Board of Directors chose to be involved, and it is certainly not aligned with our mission now.

The Fund caused harm, and we are deeply sorry.

Unlike the families of the men in the study and other Black people in United States, the Fund could turn its back on the harms it participated in and consign them to an unfortunate past. And we did for 50 years. This is how systemic racism is perpetuated – by neglect, distance, and accommodation.

Only when the harm is acknowledged is healing even a possibility. The Fund has embarked on this path of confession and healing. In April 2021, after the Fund's current board of directors was apprised of the Fund's role in the study, a dedicated committee called for investigation, reflection, and apology. Our Racial Equity Statement of Purpose, published today, is the next step in this process and makes clear that addressing racism is essential to achieving health equity and to authentically achieving the Fund's mission of improving population health.

The Fund's Racial Equity Statement of Purpose commits us, in part, to documenting and understanding our past. One lesson from this is the importance of having a diverse Board of Directors whose members do not have vested interests in the Fund's work. For example, the Fund's long-term affiliation with Thomas Parran, a former US Surgeon General and past technical board member of the Fund, likely contributed to our involvement in the study. As a result, we are examining and reforming our organizational and governance practices to become more diverse, equitable, and inclusive. The Fund is centering the foundational role of health equity for population health improvement in our state leadership and population health improvement programs and communications.

Hold us accountable to these commitments in one year, or five, or a generation.

But for harm to be acknowledged and healed after the passage of time, the relationship itself must be affirmed. To that end, the Fund has established a working partnership with Voices for Our Fathers Legacy Foundation (VFOFLF), an organization formed by descendants of men in the study. VFOFLF exists to honor the legacy of the men in the study and to create more trustworthy health systems by "building a bridge from mistrust to trust."

The Fund has formally apologized to members of VFOFLF. We are making a material financial contribution to the organization to endow its work and developing a longer-term partnership to support our missions.

Ms. Lillie Head is the president of VFOFLF. Her father, Freddie Lee Tyson, was a participant in the study. When his role in the study was disclosed to him, Mr. Tyson said to his daughter, "I can't do anything about what has happened to me and all of those other men, but it is up to you all to make sure nothing like this ever happens again." Today, VFOFLF offers a scholarship fund for descendants entering the health care field and is planning a Memorial and Inspirational Garden to honor the legacies of the men in the study. Recently, members of VFOFLF recorded a powerful series of public service announcements encouraging people of color to be vaccinated against COVID-19.

I first called Ms. Head, appropriately, on Yom Kippur last September, the Jewish day of atonement, when, as described in the book of Leviticus, Moses came down from Mt. Sinai to pronounce a day of atonement for the people's sins.

Subsequently, I introduced the Fund, explained my reason for calling, and voiced our sincere regret. At her request, the Milbank Memorial Fund apologized in writing and then in person with the VFOLF Board of Directors. At that meeting, each member in attendance introduced themselves by describing their family's connection to a man in the study – someone directly harmed by the Fund's actions. At her request we also extended the apology to descendants attending the Foundation's Annual Meeting in November.

After the November meeting, Ms. Head said members were receptive to the Fund's apology. "Your actions are important," she continued. "The Milbank Memorial Fund did something that was terribly wrong. You voluntarily contacted me to apologize and say that you are sorry that the organization had supported the United States Public Health Service syphilis study. I accept your apology. You will try to do better."

And so we will.

VFOLF's acceptance will be forever humbling. It is not exoneration. There are concentric circles of people harmed by the syphilis study. We at the Fund owe it to them to follow through on our commitments to learn from our errors in perpetuating systemic racism, change the way the Milbank Memorial Fund is governed and organized, and transform the work it does.

There are wide swaths of our society harmed by systemic racism. All are deserving of a fair opportunity to live healthy lives.

Injustice harms not only the victim but also the perpetrator, who lives isolated from the wholeness of a full and inclusive community. The work of admitting harm and of pursuing healing, of building a more just society – where the fundamental dignity and relationality of every human being is affirmed and where love in all its forms can grow – calls us all.

Supporting Materials

- [The Milbank Memorial Fund's Racial Equity Statement of Purpose](#)
- [The Milbank Memorial Fund Letter of Apology to Voices for Our Fathers Legacy Foundation](#)
- [A Timeline of the Milbank Memorial Fund's Involvement in the U.S. Public Health Service Syphilis Study at Tuskegee](#)
- ["An Opportunity of This Kind": The Milbank Memorial Fund and the U.S. Public Health Service Study of Untreated Syphilis in Tuskegee – A Report to the Milbank Memorial Fund by Susan M. Reverby, PhD](#)

Grant development concept paper

TAB 10

Grant Concept Paper

Overview

This document provides a brief description of the opportunity in Washington State to control healthcare costs, how a Policy Support Unit (PSU) could accelerate progress towards this goal and the anticipated short, medium and long term impact of a PSU.

Problem Statement and Opportunity

In June of 2020, Governor Inslee of Washington State, signed the Health Care Cost Transparency Board (HCCTB) into law. The goal of the HCCTB is to reduce health care cost growth and increase price transparency. The HCCTB aims to achieve this goal by 1) determining the state's total health care expenditures; 2) identifying cost trends and cost drivers in the health system; 3) setting a health care cost growth benchmark for payers and providers; and 4) reporting annually to the legislature, including providing recommendations for lowering health care costs.

The HCCTB was able to make significant progress on objectives 1 and 3 over the past two years (2020 – 2021) with support from the Peterson-Milbank Program for Sustainable Health Care Costs, a philanthropic effort that provides participating states with technical assistance to develop targets for per-capita trends as well as analyze the underlying drivers of cost.

As support from the Peterson-Milbank Program for Sustainable Healthcare Costs ends in December 2022, the HCCTB/HCA has identified limits in its analytic capability related to goal 2. Without addressing these limits, the state's efforts to control cost growth through market and regulatory interventions will not realize the full potential of the HCCTB, which should ideally progress to sophisticated interpretative analytics based on integration of abundant existing state data resources. This level of analytic capability is a critical element in the development of effective cost control strategies.

An opportunity exists to combine insightful analysis of large, complex health data within Washington with the design of a range of interventions to reduce the growth of healthcare expenditures while maintaining or improving health outcomes. A Policy Support Unit (PSU) embedded within the Health Care Authority can accelerate the use of data-informed interventions to control healthcare expenditures. The PSU will support the HCCTB and the Health Care Authority in fulfilling their responsibilities to the Washington legislature. Once the value of the PSU is established the Health Care Authority will make a legislative request to secure public funds to sustain the PSU following the initial 3 year project period.

Context – Washington State Healthcare Authority and the Cost Transparency Board

- The Washington state government has initiated several policy innovations to improve health care delivery while controlling healthcare costs:
 - A Medicaid waiver with a focus on value-based reimbursement.
 - Cascade Care: a public option for the residents of Washington state.
 - All Payer Claims Database which includes approximately 75% of the state's population
 - Accountable Health Communities that integrate healthcare, health, and SDOH priorities in defined communities.
 - Direct primary care contracting currently includes 44 practices and approximately 20,000 enrollees.
 - Transparency and surprise billing requirements that preceded federal regulations.

- Washington State health agencies have recently made progress in coordinating their IT efforts to the extent that Federal approval for matching funds have been expedited.
- The Washington State Healthcare Authority (HCA) purchases health care for more than 2.5 million Washington residents. HCA is the largest healthcare purchaser in the state. Sue Birch is the Director of the HCA and is the Chair of the Cost Transparency Board.
- In June 2020, bipartisan legislation was passed establishing the Health Care Cost Transparency Board (HCCTB), supported by the HCA. Members of the HCCTB include director level staff from HCA, the Office of the Insurance Commissioner, the Washington Health Benefits Exchange, and the Department of Labor and Industries, and 12 additional members representing different purchasing sectors. The primary responsibilities of the HCCTB are to (1) analyze annual total health care expenditures and growth in Washington state and (2) establish a health care cost growth benchmark. The HCCTB will issue annual reports that will identify providers and payers whose cost growth exceeds the benchmark. The HCCTB has been directed to submit recommendations to the legislature related to lowering health costs, focusing on both public and private sector purchasers.
- The HCCTB is empowered to conduct a state-wide data call of purchaser(s) to determine total health care expenditure. This cross-market call will include Medicaid, Medicare, commercial (both fully and self-insured), worker's compensation and Department of Corrections spending. The HCCTB has access to important cost and spending data housed within different state agencies. For example, the HCCTB can also analyze claim specific data in the All-Payer Claims database, state-collected prescription drug data, and other sources to be determined.
- The HCCTB has established 2 advisory committees to provide input and recommendations on their work. The Advisory Committee of Health Care Providers and Carriers is composed of 18 representatives from provider and health insurers doing business in Washington, including the hospital association, medical association, and every major health carrier. The Advisory Committee on Data Issues has 19 representatives with proven actuarial and data experience from every sector, including commercial carriers, government, providers and academia.
- The cost growth benchmark was established based on the historical growth of median wages in Washington and the Potential Gross State Product. The benchmark was calculated by weighting the median wage growth at 70% and the growth in PGSP at 30%.
- The HCCTB has established the following cost growth benchmarks:
 - 3.2% for 2022 – 2023
 - 3.0% for 2024-2025
 - 2.8% for 2026

If these cost growth targets are met, the HCCTB estimates \$3.8B in Medicaid savings and \$7.0B in private insurance savings. Note – these are currently the lowest benchmark targets in the US. The 20 year average growth rate in Washington State is 6.7%.

- The HCCTB is currently staffed with a Board Manager, one full time analyst, and consultant support provided through a Peterson Milbank grant.
- HCA is initiating the process of calculating the total health care expenditure (THCE). First, a data call will be made in July 2022 for baseline data (likely 2018 and 2019 to avoid the impact of the Covid pandemic). Subsequent annual data calls will take place in July of each year to provide the necessary data to establish a statewide growth trend. The sources of data will be all payers in Washington state, including state and federal government (Medicaid, Medicare, Advantage), commercial (both self-insured and fully insured),

workers' compensation (Department of Labor and Industries) and corrections health spending (Department of Corrections). Additional sources will be considered in future years including VA and Tribal spending.

- The data is high level, aggregate spending data. All analysis and reporting will be conducted by HCA staff led by the assigned HCCTB analyst. Conclusions will be presented to the HCCTB and its committees and form the central subject of an annual report to the legislature beginning in late 2022.
- The HCCTB is beginning the development of the cost driver analysis, as required by its legislative mandate. The initial analyses (Phase 1) will utilize Washington's All Payer Claims Database (APCD) to analyze spend. The current reports include variation by geographic area, by spend and utilization, by condition, and by demographics. This reporting will be included in the legislative report in late 2022. In future years, the HCCTB will determine areas for a deeper dive, likely using additional data sources (Phase 2). This initial cost driver analysis will be conducted through a contract with On Point and funded by a Milbank Memorial Fund grant allocation (\$200,000.) designated specifically for cost driver analysis. The MMF grant expires 12/31/2022.

Policy Support Unit Capabilities

- A Policy Support Unit (PSU) can provide analytic and policy development resources to initially support the HCCTB's cost driver analysis, benefitting market participants, the legislature, and HCA and other state agencies integral to developing effective control of healthcare costs while maintaining and/or improving population health.
- Critical capabilities of the PSU include:
 - Distributed Data management: HCA has secured access to different data sources which are distributed across multiple state agencies. Each agency will have different architecture that must be bridged, and regulations that must be followed to access these data.
 - Deep analytic capacity: a wide variety of approaches will likely be necessary to identify opportunities for reducing costs and maintaining or improving health outcomes. The ability to disaggregate and analyze the data by patients, providers, geography, health condition, type of service, and demographic segments are an initial set of analyses.
 - Stakeholder/partner management: The PSU will need to work with experts in other state agencies, research centers and the private sector who may provide data for analysis, recommend use cases and/or provide insight to build better analytics and interventions. For example, the PSU may need to work with employers to help with benefit plan design or purchasing interventions. Building confidence in both the agencies which are providing data and public/private stakeholders who may be impacted by the analyses developed by the PSU will be critical for establishing and maintaining credibility.
 - Computing infrastructure: significant data storage and computing bandwidth will likely be required to enable the data management and analysis. Understanding the cost and performance trade-offs for using cloud-based or local solutions will be important for cost effective use of resources.
 - Healthcare business expertise: An understanding of the business strategies and tactics employed by healthcare providers, pharmaceutical payments and reimbursements, and insurers is critical to creating insight and developing potential interventions to control healthcare costs.
 - Embedded resources: PSU resources will work side by side with HCA staff. Embedding with the HCA will enable a constant flow of information and perspectives to inform the analyses and recommendations developed by the PSU.

- Use case development: developing alternative approaches to inquiry to identify high leverage opportunities to reduce cost without compromising quality or access. Build capability to know what questions to ask, how to develop the analytical capability to provide answers, and translating resultant insights into actionable options.
- Intervention and Analytics co-development: Translating analysis into practical, implementable interventions requires a dynamic interplay between analytics and intervention design. Creating an environment where these two areas of expertise converge will be critical for interventions to realize their potential to control healthcare costs.
- A PSU Steering Committee will be established to ensure alignment with the primary state agency that serves as the PSUs primary focus (likely the Washington State Healthcare Authority) and the principal philanthropic donors (Petersen Center on Health Care and Gates Ventures). The primary sponsor of the PSU's work should likely be the chair of the HCCTB (Sue Birch) and the initial deployment of the PSU would be to serve the HCCTB in their analysis of cost drivers of health in Washington State.
- The incubator will strive to develop a "self-contained unit" exclusively focused on supporting the Washington state cost containment effort. A dedicated full-time staff will be recruited and brought on-board within the first twelve months of the grant award and will be incubated over a 3 year period. It is the intent of the Healthcare Authority to request on-going funding from the legislature to sustain the operations of the PSU. For public funding to be available at the end of the grant, the legislative request will be made at the grant's midpoint (18 months). Once public funding is made available, the PSU will be transferred to the appropriate state agency and continue to provide analytic and policy development support to the Healthcare Authority and other agencies as recommended by the Steering Committee.

Policy Support Unit Outputs and Outcomes

- Outputs are deliverables created by the PSU. This list is not exhaustive but describes some of the key outputs that will establish the value of the PSU.
 - Data strategy documenting data sources, compliance with data use regulations, and processes for incorporating new data sources.
 - Data access agreements to enable access and processes to incorporate each data source.
 - Analytic framework to describe and ensure data is comprehensively integrated into the cost driver analysis.
 - Annual cost driver analyses based on the prioritized areas defined by the HCCTB.
 - Annual recommendations for additional data to improve the cost driver analyses.
 - By Year 2, an operating budget to inform a request for state budget allocation to support ongoing PSU operations.
- Outcomes are the results achieved by the PSU. Outputs are often used to help achieve outcomes. Outcomes for the PSU are described in short-, medium- and long-term timeframes.
 - *Short Term: (3 months -1.5 years) Knowledge & Awareness*
 - Increase in HCCTB and HCA members' ability to define WA data use strategy, including cost driver analytic framework
 - Increase in HCCTB understanding of the drivers of cost in WA
 - Increase in HCCTB understanding of political feasibility of specific interventions
 - *Medium Term: (1.5-3 years) Behavioral*
 - Increase in cost mitigation recommendations supported by cost driver analyses

- Improved sustainability of WA's cost growth benchmarking efforts through legislative allocation of funds to PSU staffing & technical assistance
- Increase in cost mitigation recommendations implemented in public-private sector
- *Long Term: (3-7 years) Environmental*
 - Improved sustainability of PSU through transition and integration into appropriate state agency
 - Increased understanding by PCH and GV around key elements (required skill sets, level of funding and infrastructure) necessary to support long term sustainability of cost growth benchmarking initiatives.
 - Improved policy dialogue and healthcare interventions by the state of Washington resulting from data-informed decision-making
 - Increased affordability of healthcare for Washingtonians

DRAFT

Primary care bill (SSB 5589)

TAB 11

CERTIFICATION OF ENROLLMENT

SUBSTITUTE SENATE BILL 5589

Chapter 155, Laws of 2022

67th Legislature
2022 Regular Session

HEALTH CARE—PRIMARY CARE EXPENDITURES

EFFECTIVE DATE: June 9, 2022

Passed by the Senate February 8, 2022
Yeas 48 Nays 1

DENNY HECK

President of the Senate

Passed by the House March 3, 2022
Yeas 96 Nays 1

LAURIE JINKINS

**Speaker of the House of
Representatives**

Approved March 24, 2022 9:14 AM

JAY INSLEE

Governor of the State of Washington

CERTIFICATE

I, Sarah Bannister, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SUBSTITUTE SENATE BILL 5589** as passed by the Senate and the House of Representatives on the dates hereon set forth.

SARAH BANNISTER

Secretary

FILED

March 24, 2022

**Secretary of State
State of Washington**

SUBSTITUTE SENATE BILL 5589

Passed Legislature - 2022 Regular Session

State of Washington

67th Legislature

2022 Regular Session

By Senate Health & Long Term Care (originally sponsored by Senators Robinson, Cleveland, Frockt, and Randall)

READ FIRST TIME 01/27/22.

1 AN ACT Relating to statewide spending on primary care; adding a
2 new section to chapter 70.390 RCW; and adding a new section to
3 chapter 48.43 RCW.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 NEW SECTION. **Sec. 1.** A new section is added to chapter 70.390
6 RCW to read as follows:

7 (1) The board shall measure and report on primary care
8 expenditures in Washington and the progress towards increasing it to
9 12 percent of total health care expenditures.

10 (2) By December 1, 2022, the board shall submit a preliminary
11 report to the governor and relevant committees of the legislature
12 addressing primary care expenditures in Washington. The report must
13 include:

14 (a) How to define "primary care" for purposes of calculating
15 primary care expenditures as a proportion of total health care
16 expenditures, and how the definition aligns with existing definitions
17 already implemented in Washington, including the previous report from
18 the office of financial management and the Bree collaborative's
19 recommendations;

20 (b) Barriers to the access and use of the data needed to
21 calculate primary care expenditures, and how to overcome them;

1 (c) The annual progress needed for primary care expenditures to
2 reach 12 percent of total health care expenditures in a reasonable
3 amount of time;

4 (d) How and by whom it should annually be determined whether
5 desired levels of primary care expenditures are being achieved;

6 (e) Methods to incentivize the achievement of desired levels of
7 primary care expenditures;

8 (f)(i) Specific practices and methods of reimbursement to achieve
9 and sustain desired levels of primary care expenditures while
10 achieving improvements in health outcomes, experience of health care,
11 and value from the health care system, including but not limited to:
12 Supporting advanced, integrated primary care involving a
13 multidisciplinary team of health and social service professionals;
14 addressing social determinants of health within the primary care
15 setting; leveraging innovative uses of efficient, interoperable
16 health information technology; increasing the primary care and
17 behavioral health workforce; and reinforcing to patients the value of
18 primary care, and eliminating any barriers to access.

19 (ii) As much as possible, the practices and methods specified
20 must hold primary care providers accountable for improved health
21 outcomes, not increase the administrative burden on primary care
22 providers or overall health care expenditures in the state, strive
23 for alignment across payers, and take into account differences in
24 urban and rural delivery settings; and

25 (g) The ongoing role of the board in guiding and overseeing the
26 development and application of primary care expenditure targets, and
27 the implementation and evaluation of strategies to achieve them.

28 (3) Beginning August 1, 2023, the board shall annually submit
29 reports to the governor and relevant committees of the legislature.
30 To the extent possible, the reports must:

31 (a) Include annual primary care expenditures for the most recent
32 year for which data is available by insurance carrier, by market or
33 payer, in total and as a percentage of total health care expenditure;

34 (b) Break down annual primary care expenditures by relevant
35 characteristics such as whether expenditures were for physical or
36 behavioral health, by type of provider and by payment mechanism; and

37 (c) If necessary, identify any barriers to the reporting
38 requirements and propose recommendations for how to overcome them.

39 (4) In developing the measures and reporting, the board shall
40 consult with primary care providers and organizations representing

1 primary care providers and review existing work in this and other
2 states regarding primary care, including but not limited to the
3 December 2019 report by the office of financial management, the work
4 of the Bree collaborative, the work of the advancing integrated
5 mental health center and the center for health workforce studies at
6 the University of Washington, the work of the Milbank memorial fund,
7 the work of the national academy of sciences, engineering, and
8 medicine, and the work of the authority to strengthen primary care
9 within state purchased health care.

10 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43
11 RCW to read as follows:

12 The commissioner may include an assessment of carriers' primary
13 care expenditures in the previous plan year or anticipated for the
14 upcoming plan year in its reviews of health plan form or rate
15 filings. In conducting the review, the commissioner must consider any
16 definition of primary care expenditures and any primary care
17 expenditure targets established under section 1 of this act. The
18 commissioner may determine the form and content of carrier primary
19 care expenditure reporting.

Passed by the Senate February 8, 2022.

Passed by the House March 3, 2022.

Approved by the Governor March 24, 2022.

Filed in Office of Secretary of State March 24, 2022.

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