Advisory Committee on Primary Care meeting

Washington State Health Care Authority

Washington State Health Care Authority

Advisory Committee on Primary Care
Meeting Materials

August 31, 2023
2:00 p.m. – 4:00 p.m.

(Hybrid Attendance)

Meeting materials

Tab 1

Washington State Health Care Authority

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Advisory Committee on Primary Care

August 31, 2023
2:00 p.m. – 4:00 p.m.
Hybrid Meeting

AGENDA

Committee Members:					
☐	Judy Zerzan-Thul, Chair	☐	Sharon Eloranta	☐	Mandy Stahre
☐	Kristal Albrecht	☐	Chandra Hicks	☐	Jonathan Staloff
☐	Sharon Brown	☐	Meg Jones	☐	Sarah Stokes
☐	Tony Butruille	☐	Gregory Marchand	☐	Linda Van Hoff
☐	Michele Causley	☐	Sheryll Morelli	☐	Shawn West
☐	Nancy Connolly	☐	Lan H. Nguyen	☐	Staici West
☐	Tracy Corgiat	☐	Kevin Phelan	☐	Ginny Weir
☐	David DiGiuseppe	☐	Eileen Ravella	☐	Maddy Wiley
☐	DC Dugdale	☐	Katina Rue		

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome, roll call, and agenda review	1	Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
2:05-2:10 (5 min)	Approval of July meeting summary	2	Jean Marie Dreyer, Committee Manager Washington State Health Care Authority
2:10-2:25 (15 min)	Public Comment	3	
2:25-3:10 (45 min)	Presentation: Primary care payment reform strategies	4	Summer Boslaugh, Transformation Analyst, Oregon Health Authority
3:10-3:50 (40 min)	Presentation and discussion: Primary care policy context continued	5	Shane Mofford, Center for Evidence-based Policy (CEbP)
3:50-3:55 (5 min)	Presentation: United Healthcare plan perspective on primary care target in Rhode Island		Michele Causley, Vice President of Health Plan Operations, United Healthcare
3:55-4:00 (5 min)	Wrap-up and adjournment		Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority

Tab 2

Advisory Committee on Primary Care Meeting Summary

July 25, 2023
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 committee is available on the Advisory Committee on Primary Care webpage.

Members present

Judy Zerzan-Thul
Kristal Albrecht
Sharon Brown
Tony Butruille
Michele Causley
D.C. Dugdale
Sharon Eloranta
Meg Jones
Gregory Marchand
Lan H. Nguyen
Katina Rue
Mandy Stahre
Jonathan Staloff
Linda Van Hoff
Shawn West
Staici West
Ginny Weir
Maddy Wiley

Members absent

Nancy Connolly
Tracy Corgiat
David DiGiuseppe
Chandra Hicks
Sheryl Morelli
Kevin Phelan
Eileen Ravella
Sarah Stokes

Call to order

Chair Dr. Judy Zeran-Thul called the meeting to order at 2:02 p.m.

Agenda items

Welcome, roll call, and agenda review

Dr. Judy Zerzan-Thul, Health Care Authority (HCA) announced the appointment of Jonathan Staloff as co-chair to assist with leading the committee during Dr. Zerzan-Thul's absences.

Approval of June meeting summary

The committee voted to adopt the Meeting Summary from the June 2023 meeting.

Topics for Today

The main topic was a discussion of policies to support achievement of the 12 percent primary care expenditure target.

Public Comment

Shelby Wiedmann, from the Washington State Medical Association (WSMA), commented on WSMA's keen interest in the Centers for Medicare and Medicaid (CMS') new Making Care Primary (MCP) initiative. There hasn't been much discussion on this lately and WSMA wants to know if it would be discussed at HCA's upcoming webinar on August 31 and whether this committee will be involved in the work. Dr. Zerzan-Thul confirmed that MPC will be discussed at the upcoming webinar and may be discussed in greater detail at future committee meetings.

Discussion: Policies to support achievement of the 12 percent expenditure target

Shane Mofford, Center for Evidence-based Policy (CEbP)

Shane Mofford reviewed the goals of the meeting: to review and refine draft policy recommendations to support achievement of the primary care expenditure target. The committee also reviewed the high-level definition of primary care. Policy recommendations drafted by the committee should adhere to the following principles: 1) unambiguous linkage between policy and achieving the 12 percent spending target 2) clearly defined action and actors 3) policies are feasible financially, operationally, and across competing stakeholder interests 4) and policies result in improved access and quality, not just increased expenditures.

Committee member Jonathan Staloff suggested adding equity as a goal for the fourth proposed principle.
Committee member Sharon Eloranta proposed considering budget neutrality implications. Shane Mofford noted that this would fall under financial feasibility and that neutrality is not necessarily a constraint. Somet things may cost more in the short-term and have longer term return on investment. Committee policy options are not limited to budget neutral solutions. Dr. Zerzan-Thul added that to improve the percentage spent on primary care, the total would need to remain constant, which won't happen if the denominator increases.
Committee member Meg Jones noted that there is value to referencing alignment with the health care spending growth benchmark set by the board. Dr. Zerzan-Thul responded that increasing the percent of primary care spending means more money into primary care that can decrease overall spending in other areas for better chronic disease management.
Committee member Linda Van Hoff pointed out that primary care reimbursement was cut in 2013 to certain populations of providers, e.g., nurse practitioners. When looking at increasing spending, there are already a percentage of clinicians being reimbursed at less than 100 percent of fee-for-service (FFS). Although practices are moving away from FFS, it is still a big driver. Shane Mofford responded that benchmarking to a historic level would be challenging for current day context, especially given the pandemic and innovations like telehealth. Shane altered the existing policy statement to reflect that policies should lead to sustainable levels of reimbursement for all

primary care providers in the definition and asked Linda if that change was acceptable. Linda Van Hoff preferred that it say *parity reimbursement,* but Dr. Zerzan-Thul pointed out that that would constitute a separate recommendation entirely.
Committee member Ginny Weir asked to add population health and/or quality to the principle regarding access. Committee member Mandy Stahre expressed a desire to add clearly defined measures as a principle. It should be clear whether progress is being made in policy implementation.

Shane Mofford wrapped up the principles discussion and noted the further defined and prioritized policies from today's discussion would go to internal HCA staff for a further impact review and staff proposals. Subsequent proposals from HCA staff will come back to the committee for review over the course of upcoming meetings before a final vote is held.

Next, the committee reviewed the four key domains that influence primary care expenditure statistics: Direct investment, capacity growth, patient engagement, and reduced expenditure on other services.
The committee also reviewed the top 11 policies identified by members at previous meetings. These policies came from both other states' policies as well as from ideas generated by individual committee members. For this meeting, the committee looked at the first eight policies (policies that had at least 50 percent support from the group). Policies were grouped into four levels: multi-payer alignment efforts, provider payment level, workforce, and patient engagement. One area requiring more attention for vetting is workforce. Committee member Kristal Albrecht expressed an interest in care team providers like pharmacists who are not recognized as providers. Shane Mofford noted that the committee could do an inventory of policies not previously discussed at the end of today's meeting. Committee member Tony Butruille suggested that increasing care often means more team members. One of the top policies, increasing reimbursement, could incorporate building up team providers.

First, the committee reviewed the policies concerning provider payment levels, which include both increasing Medicaid payment and encouraging overall increases in primary care payments across public and private payers. This set of policies directly contributes to increasing expenditures to hit the 12 percent target. Changes to Medicaid reimbursement will require legislative authorization of funding to support increases. These policies will require approval by CMS as well as contractual changes with managed care organizations (MCOs). As of 2019, Washington Medicaid reimbursement for primary care services was at approximately 63 percent of Medicare. There are several examples of other states who have incentivized increased rates. Rhode Island required doubling of primary care spending as a percentage of overall spending over five years without increasing total spending. Rhode Island's policy was successful and was made possible through its Office of the Insurance Commissioner. Pennsylvania and Connecticut set five-year voluntary annual targets to increase primary care spending through legislative action and an executive order. Oregon required health insurance carriers and Coordinated Care Organizations (CCOs) to allocate at least 12 percent of their health expenditures to primary care through a statutory change.

Shane Mofford presented refined versions of the provider payment level policies for committee members to discuss. Payment policy one stated: The Legislature should fund increased reimbursement for primary care practices/services covered by the Medicaid program with a goal of an FFS equivalent reimbursement level (regardless of the payment mechanism) of no less than 100 percent of Medicare by 2027. Payment policy two stated: The Legislature should pass legislation mandating commercial and public payers to increase the percent of primary care expenditures by one percent annually until the 12 percent target is achieved, with the 12 percent target achieved no later than 2032; alternate – five-year ramp up, with interim goals informed by committee analysis in 2024 based on primary care expenditure measurement efforts, similar to Oregon's model.

Jon Staloff asked to make it explicit that the first policy applies to both FFS and non-FFS to achieve parity between Medicaid and Medicare. The policy could also add caring for individuals and/or populations.
Committee member D.C. Dugdale asked if the individual state approaches worked. Shane Mofford responded that Rhode Island hit their targets and are in the process of making some refinements to their policy. D.C. Dugdale asked if Rhode Island has seen improvements in public health since the policy was implemented. Shane Mofford replied that he didn't know but noted that staff are trying to get Oregon and Rhode Island to come speak to the committee.
Committee member Sheryll Morelli asked if we know how far off we are from 100 percent of Medicare. Shane Mofford noted that the current data point is four years old. Dr. Zerzan-Thul noted that Washington is closer to 100 percent of Medicare reimbursement for pediatric services with recent rate increases. Other Medicaid services are close, around 65 percent. Sheryll Morelli asked what to led to the increased rates for pediatrics? There are two classes of public insurance: public employees and Medicaid with rates that are drastically different, which is unusual for a state focused on equity. Is there an opportunity to better align these two classes? Shane Mofford noted that across other states, it is common for Medicaid to be reimbursed at lower rates than other public payers, which are closer to commercial, for a variety of reasons e.g., underlying revenue streams, employee contributions, etc. The percentages are somewhat arbitrary, and Medicare may not be the right level of reimbursement. There's a variety of providers' pay scales. Committee member Katina Rue noted that no one thinks Medicare is THE standard, but it's a known standard. An aspirational goal would be to get to other states' levels of reimbursement levels. Sheryll Morelli added that 50 percent of kids are on Medicaid. One hundred percent of Medicare doesn't cover all expenses, but it's a good place to start.
Jonathan Staloff expressed support for the payment policies, but asked for an estimate of what percentage changes to Medicaid might look like.
Tony Butruille asked how reaching the target will involve specialists. He cautioned against taking away money and focus from the work specialists perform. Shane Mofford acknowledged that this is an important tradeoff to recognize. The current payment policy proposals compete with funding spent on education and other programs.
Meg Jones expressed the need to explore available resources through Milliman who performs rate calculations so that providers see increased funding from whatever policies are enacted. The Legislature appropriated funds for behavioral health, but the rate structure caused providers to feel as though they didn't see the benefit from that appropriation. The policies need to meet the expectations of the provider community. Shane Mofford noted that there's a tool within Medicaid where the state can be directive under limited circumstances to provide for directed payment to allow the state to be more prescriptive on rates in certain situations.
Committee member Michele Causley expressed concern about the timeline for the second policy referring to commercial payers and the 12 percent. From United Healthcare's high-level information, it will be a significant lift to reach that point without adding additional costs in the system. The only way is to reduce services in other areas, e.g., hospitalizations, but that takes a long time. Are the timelines dictated by legislation? Can the committee give a proposal? Shane Mofford explained that looking at the historical analysis from the Office of Financial Management (OFM), Washington is currently looking at a seven percent shift that is close to what Rhode Island did in five years. Michele Causley suggested a year over year recommendation of working towards the goal. Committee member Lan Nguyen suggested that as the committee gathers feedback from other states, it should leave it open to pivot as long as there is value demonstrated to providers and patients. Dr. Zerzan-Thul noted that Oregon had a goal of increasing by one percent every year. Sheryll Morelli expressed the desire to have a defined target and date. Shane Mofford noted that adopting a percentage increase annually would allow the committee to define the target by whatever the target is. This would translate to 2032 if the annual increase was one percent.
Committee member Shawn West said that Wahington is at an inflection point. One percent isn't aggressive enough and the committee should aim for three percent or something more aggressive. Shane Mofford noted that one percent doesn't translate to a one percent increase in primary care. The committee can look at the prior definition

to see what a one percent increase in primary care looks like for primary care reimbursement. There are other factors feeding into the calculation, but it could help ground what one percent actually looks like.
Sheryll Morelli reiterated Shawn's sense of urgency. The committee needs to better understand what a one percent increase looks like. The year 2032 is too far away and the committee should aim for five years like Rhode Island.
Committee member Madline Wiley agreed that the payment policies should occur as quickly as possible.
Michele Causley agreed to bring back the insurer perspective at the next meeting describing United Healthcare's implementation of the target in Rhode Island. Will the 12 percent target only apply to Medicaid and commercial? Shane Mofford replied that Medicare is excluded from numerator and denominator for that reason and offered to confirm.
Committee member Sharon Brown expressed the need for the Legislature to understand how dire the situation is. Rural hospitals had to close and there are residents with no services, particularly obstetric services in Yakima valley. More practices closing doors means more flooded emergency departments. Shane Mofford noted that in existing multi-payer work, there is an effort to look at how to build a case to increase investment in primary care with messaging to the Legislature. A recent report from the Washington State Health Alliance highlighted health outcomes in decline with 3.5 million Washingtonians in healthcare shortage areas. The committee could collect anecdotes to paint a picture, though there is no guarantee of action.
Jonathan Staloff noted that Rhode Island used the Health Insurance Office and rate review for enforcement. It would be helpful to have an apples-to-apples comparison of regulatory tools to see what Washington has in common with Rhode Island.
Tony Butruille noted that the Washington Legislature didn't hear enough from providers last year. Committee members need to go back to professional organizations and societies to gather feedback to bring for upcoming legislative session. For future investment, future reimbursement will be in non-FFS per-member per-month (PMPM) arrangements, which is more flexible. It is more challenging to providers to measure non-FFS, but these payment arrangements expand access. Shane Mofford noted that this is folded into the proposed multi-payer policy.
Linda Van Hoff expressed a desire to drive down the date to achieve the target. There are ways to streamline primary care delivery.

Exploration points added for further consideration included:
-Differences in reimbursement across public programs (ERB/Medicaid and Children's Health Insurance Program (CHIP))
-Strategies for assessing appropriate level of reimbursement in longer-term
-Progress toward the 12 percent target
-Ensuring that increases in primary care investment actually flows to primary care providers – part of feasibility analysis – what are realistic expectations for Medicaid rate change policy
-Sense of urgency for primary care
-Develop estimates for what a one percent increase in the ratio would translate into a provider rate increase holding all other expenditure factors constant
-Request for next meeting – understand how Rhode Island executed their primary care investment policy effectively (what was the enforcement mechanism and how does that translate to the regulator tools that are available in Washington)
-Differences in reimbursement for primary care across services across different providers (commercial)

Next, the committee moved to multi-payer alignment effort policies. There are two categories: administrative burden reduction, and payment approach alignment. Initial statements upon which the committee voted included:
1) Multi-payer collaboration to develop and implement payment models that offer greater financial flexibility and

incentives while growing access and improving quality, and 2) Payer focus on reducing administrative burden/costs for providers. These statements are connected to the 12 percent target in the following ways: multi-payer alignment combats system fragmentation and drives increased access to different models to support sustainability and access. Alignment can also drive reimbursement through alternative payment methodologies and non-claims-based payments. Washington has an existing multi-payer collaborative which developed the Primary Care Transformation Model (PCTM) focused on aligning standards, quality measures, practice supports, and payment models for primary care practices. The MCP is in the process of initiating a Learning Cohort later this year to identify collaborative opportunities to support practices' work. At the federal level, CMS has put forth the MCP initiative to align a multi-payer approach. The initiative includes federal investments to primary care practices over a 10.5-year period. The Washington collaborative is working to align the PCTM with MCP.

Shane Mofford presented the refined multi-payer policies to the committee: 1) Committee statement of support for MPC work in aligning standards, quality metrics, practice supports, and payment models 2) Committee statement of support for MPC alignment with the MCP program 3) Encourage the Legislature to identify opportunities to support and further multi-payer primary care alignment efforts.

D.C. Dugdale expressed support for all of the policies and asked whether the committee needs to create a statement. Shane Mofford clarified that these could be further refined into more definitive statements. One option would be to suggest that additional investment in primary care could be done through this framework. Jonathan Staloff mentioned looking at the details of the MCP model and noted there are unique elements of the model that this committee could examine to support. There are three tracks in the model, one track would support upfront investment, via track one. This model integrates social and clinical complexity, and the committee could support other payers who take social complexity into account for primary care. Shane Mofford mentioned that there will be multiple provider education opportunities on MCP coming up and the insights from those meetings can be brought back to the committee. MCP will only apply to a limited number of providers in Washington due to eligibility limits. There are approximately 350 practices that would be eligible.

Exploration points added for further consideration included:
-MCP-unique characteristics
-Alignment strategy –
1) Upfront payments for track one across payers
2) Account for social complexity

Adjournment

The meeting adjourned at 4:00 p.m.

Next meeting

July 25, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Tab 3

Washington State Health Care Authority

Public comment

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Tab 4

Washington State Health Care Authority

Primary Care Payment Reform Strategies

Summer Boslaugh, MBA, MHA
Transformation Analyst, Transformation Center
OREGON HEALTH AUTHORITY
Health Policy and Analytics Division
Delivery System Innovation

HEALTH POLICY AND ANALYTICS
Delivery System Innovation Unit

Overview

- Primary care payment reform policies
- Value-based Payment Compact
- Primary care VBP model
- Lessons learned

Primary care payment reform policies (1 of 2)

Oregon Senate Bill 231 (2015)

- *Primary Care Spending in Oregon report*
  - Report health care expenditures allocated to primary care by Medicaid, public employee benefit plans and commercial health plans
  - Public report used as a tool for policy makers and other interested parties to track primary care spending by payer
- *Primary Care Payment Reform Collaborative*
  - A multi-stakeholder advisory group charged with 1) increasing investment in primary care, 2) improving payment methods, and 3) aligning payment
  - 30+ members, has convened regularly since 2016

Primary care payment reform policies (2 of 2)

Oregon Senate Bill 934 (2017)

- *Primary Care Spending in Oregon* Report
  - Requires all payers to allocate at least 12% of health care expenditures to primary care by 2023
  - Payers that do not meet the 12% target by 2023 are required to submit a plan on how they will increase the percentage of health care expenditures allocated to primary care by at least 1% each year
  - The 12% primary care spending target for the legislation was based on national research indicating that current primary care expenditure allocation was approximately 7%
- *Primary Care Payment Reform Collaborative*
  - Further defined the charge to include using VBP methods, supporting behavioral and physical health integration and aligning metrics
  - Extended the end date of the Collaborative to 2027

Oregon VBP Compact

The VBP Compact is a voluntary commitment by payers and providers across the state to increase the use of VBP to:

- Lower the rate of cost growth
- Foster health equity
- Improve quality and outcomes

The Compact will increase VBP adoption by:

Expanding innovation

Learning from early adopters

Removing barriers

Expanding knowledge and awareness

Lessons Learned

- Establish an active relationship between committee and the primary care spending report, including
  - Defining primary care in rule
  - Developing the report and implementation
- Set goal that increased primary care spending should be in VBP
- Set goal that implementation of primary care VBP model should increase primary care investment and use spending report to measure impact

For more information

***Primary Care Spending in Oregon* report**
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Primary-Care-Spending.aspx

Primary Care Payment Reform Collaborative

https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx

Thank You

Oregon Health Authority

Appendix: Details of the primary care VBP model

Primary care VBP model overview

All-payer primary care payment model, which includes the following payment model components:

- **Prospective capitated payments** for a defined set of primary care services that are widely performed by primary care practices, represent a preponderance of primary care spending, and are prone to overuse when paid fee-for-service.
- **Fee-for-service payments for all other covered services.**
- **Infrastructure payments** that include: 1) a base payment tied to PCPCH tier, and 2) additional payments for specific high-value services.
- **Performance-based incentive payments** based on an aligned quality measures set.

Participation, attribution and payment rate

- PCPCH recognition not required for initial practice participation, must be obtained within three years
- No other practice participation requirements
- Goal is all practices contracted with a payer to phasing in within three years
- All patients will be attributed or assigned, prioritizing patient choice
- Prospective payment rate set by analysis of historic PMPM spending

Risk adjustment

- Demographic risk adjustment at a minimum
- Clinical risk adjustment
  - When used, separate methodologies for adult and pediatric populations
  - Should be used in total cost of care arrangements
  - Optional for prospective capitation payment
  - Use for certain infrastructure payments
- OHA will convene a subcommittee to develop a social risk adjustment pilot model

Performance-based incentive payments

- Subgroup of the PCPRC will establish an aligned measure set with a balance of child, adolescent and adult-focused measures.
- Measures primarily derived from the Health Plan Quality Metrics Committee (HPQMC) with flexibility for the consideration of non-HPQMC measures
- Recommended total size of measure set should not exceed eight measures
- At least one equity focused measure
- Practices should be rewarded for both high performance relative to external benchmarks and for improvement over time
- Total eligible incentive payments should equal at least 10% of the value of annual projected practice service payments (capitated + fee-for-service)

Infrastructure payments

- Base payment tied to PCPCH tier
- Additional payments, as agreed upon by the payer and practice, for specific high-value services
  - Additional case management and care coordination for patients with higher levels of medical and social risk
  - Integrated behavioral health services not typically paid for by FFS
  - THW services
  - Integrated pharmacist services, such as medication consultations
  - Addressing health-related social needs (HRSN)
  - Infrastructure (technology and staff) to collect and use REALD and SOGI data
  - Innovative equity-focused services, such as funding for bus fares for patients with transportation needs

Promoting health equity

- Support practices to stratify quality metrics by race/ethnicity, such as with infrastructure payments
- Higher payments can be made to practices that serve patients with higher medical and social complexity
- Include one or more equity-focused measure in the measure set
- Consider using improvement targets for practices serving patients with higher medical and social complexity
- Infrastructure payments that address health-related social needs (HRSN) and/or promote health equity
- Strategies to protect against unintended adverse consequences, such as withholding or limiting care, discouraging a panel of high morbidity patients or making too many specialty, urgent care and ED referrals

Tab 5

Washington State Health Care Authority

Primary Care Policy Context Continued

Washington State Health Care Authority

Introductory Conversation Review

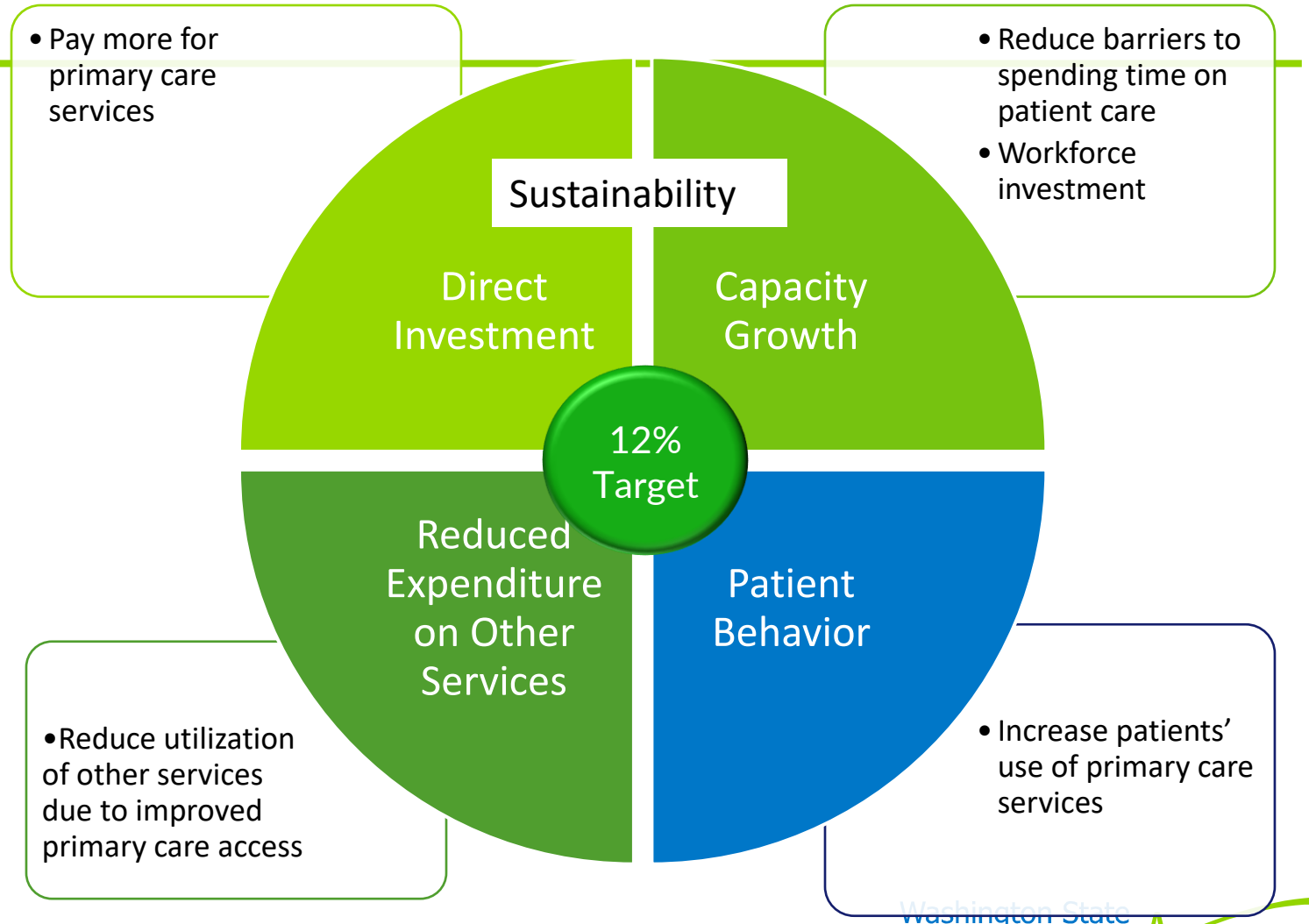
- Action is required to ensure primary care is being funded sustainably
- It will take time to achieve the 12% target
- Additional information desired to frame the reasonability of targets over time
- We will not have statewide estimates using the new primary care definition until after the 2024 data call
- Members would like to know what the outcomes were in other states that have implemented similar policies
- States used three levers to work toward their expenditure target policies:
  - Executive order
  - Legislative mandate
  - Action through Office of the Insurance Commissioner

Strategy to Advance the Discussion

- Guest speakers from Rhode Island and Oregon to share their experience
- Committee members with organizational experience in states that have implemented similar policies to share their organization's experience to the extent possible
- Illustrative examples of changes to primary care reimbursement to achieve 12% target

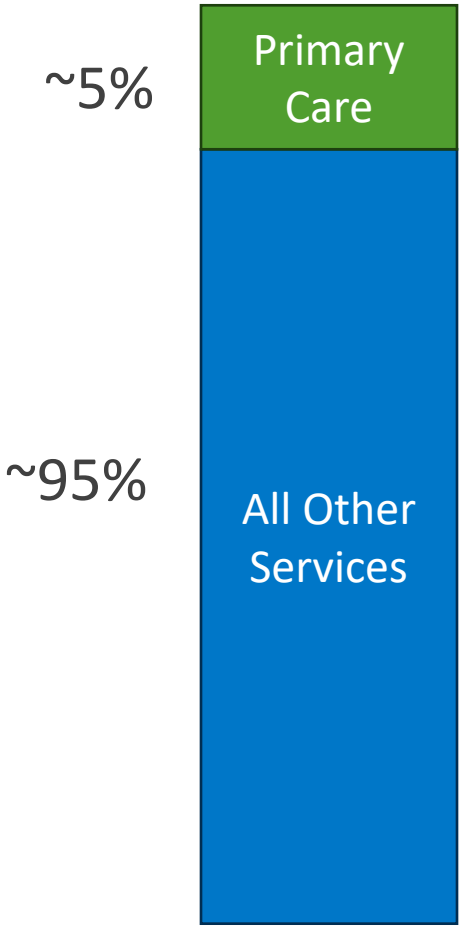
Policies to Increase & Sustain Primary Care – 12% in Context

- Four key domains that influence the primary care expenditure statistics:
  - Direct investment
  - Capacity Growth
  - Patient Behavior
  - Reduced Expenditure on Other Services



Washington State Health Care Authority

Primary Care Expenditure Thought Experiment

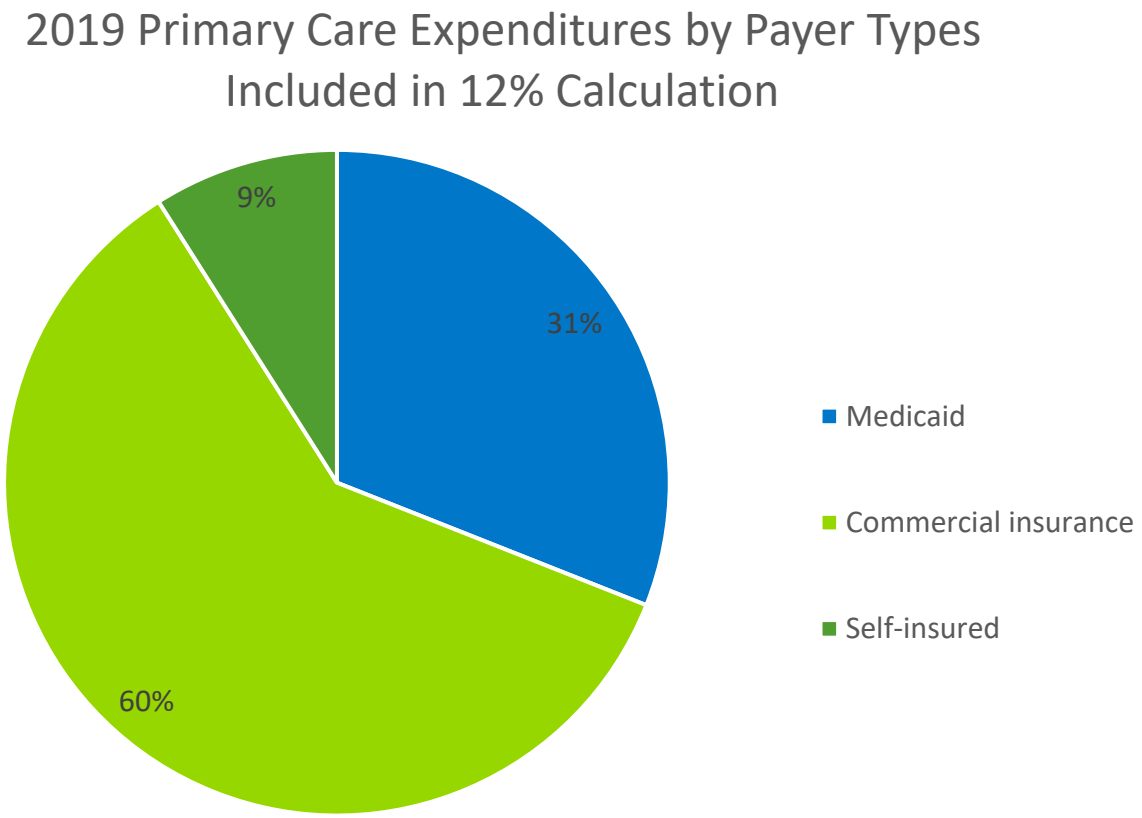


Percent of Total Expenditures	Change in Reimbursement
5%	0%
6%	20%
7%	40%
8%	60%
9%	80%
10%	100%
11%	120%
12%	140%

- **Holding total expenditure and primary care utilization constant**, increasing primary care expenditures from 5% to 12% would require a **140%** increase in primary care reimbursement rates (more than double).
- This is an **aggregate-level** perspective across all payers included in the 12% expenditure target policy. Each payer will contribute to the total differently depending on their current payment policies and utilization patterns.
- 5% is used to illustrate the concept and demonstrate differences in impact scale. The actual percentage will be definition dependent.

Washington State Health Care Authority

Payer Mix Determines Size of Impact of Policies Targeting Individual Payers



Estimates in chart are based on OFM 2019 Primary Care Expenditures Report
Report to the Legislature Primary care expenditures As required by Chapter 415, Laws of 2019 December 2019 (wa.gov)

- Policies focused on individual payer types will have proportionally smaller impacts on the aggregate expenditure totals
- Most policies will apply differently to different payer types depending on current payment levels.

Example: If Medicaid is reimbursing at 65% of Medicare (in aggregate across all primary care services) and increases reimbursement to 100% of Medicare, because Medicaid is estimated to be 31% of total primary care expenditures the 54% increase in reimbursement would result in only a relative ~17% increase in total primary care reimbursement in aggregate (5% to 5.85%).

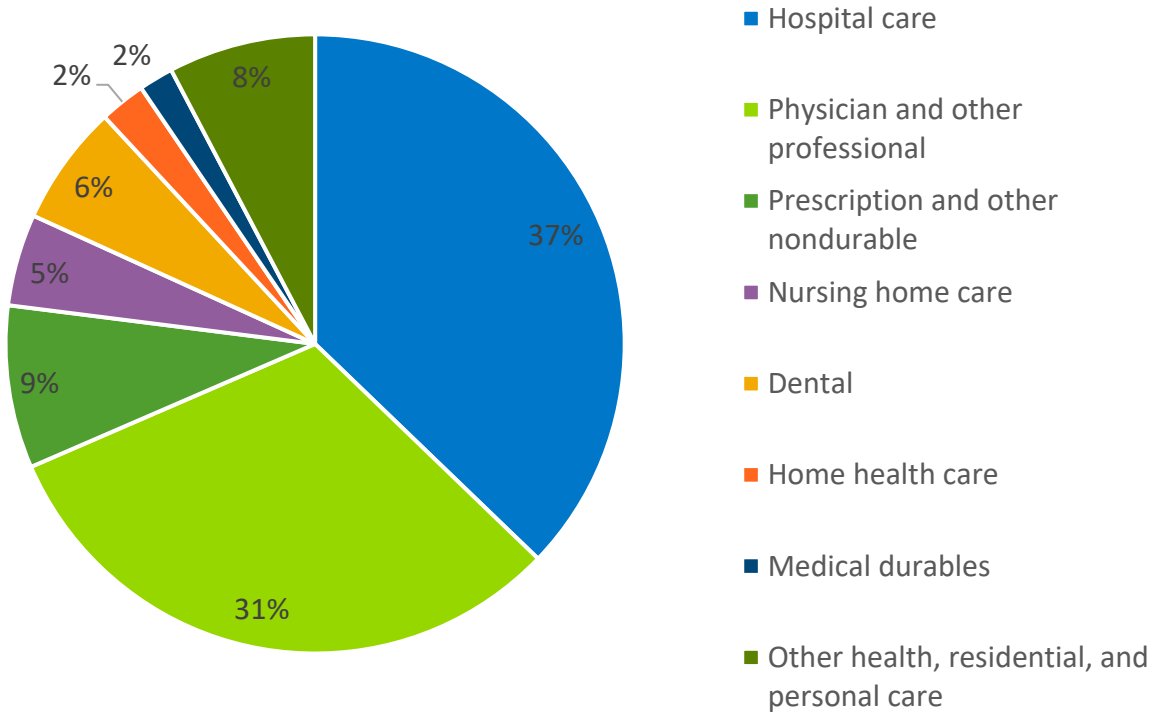
Washington State Health Care Authority

Expenditures and Trends Across Categories

National Expenditure (Utilization and Price) Growth Rates by Category of Service

Service Category	2019	2020	2021
Inpatient	4.4%	6.2%	4.4%
Outpatient	5.8%	6.6%	Not available
Pharmacy	5.7%	3.7%	7.8%
Physician and Clinical Services	4.2%	7.0%	5.6%

Percent of Expenditures by Service Category



Source: 2021 National Health Expenditures Highlights Report

Washington State Health Care Authority

Primary Care Expenditure - Context

Holding expenditures constant is useful for illustrating the general magnitude of reimbursement increases, but the reality is more challenging. We must consider three factors:

- **What are the natural underlying patterns of utilization change over time for both primary care and other services?**
  - Increases in primary care utilization compared to other services could reduce the magnitude of needed reimbursement increases to hit the expenditure ratio target.
- **What is the natural underlying rate of price changes for other services?**
  - Faster growth in prices for other services would require even greater primary care investment to 'keep up'.
- **What are policy driven expected changes to utilization of primary care services and other service?**
  - Increases in primary care utilization compared to other services could reduce the magnitude of needed reimbursement increases to hit the expenditure ratio target.

Key Takeaways

- Small increases in percent of total spend require significant increases in primary care reimbursement when holding utilization and total expenditures constant
- Total expenditures include many moving pieces.
- Ideally:
  - Increasing primary care reimbursement would increase utilization of primary care services
  - Increasing primary care access would decrease utilization of other service categories (e.g., emergency, inpatient)
  - Dynamic interactions impact primary care percentage of total expenditure
- Implementation of payment changes will vary by payer.

Primary Care Policy Context Continued

Washington State Health Care Authority

Broad vs. Narrow Primary Care Definition

The Committee will need to select either the broad or narrow definition when finalizing the expenditure target policy recommendations.

1. To achieve the 12% target under a narrower definition, investments would be focused on the narrower set of providers – fewer providers would see increased reimbursement.
2. The magnitude of investment directed to a narrower set of providers would have to be greater to move the aggregate statistics.

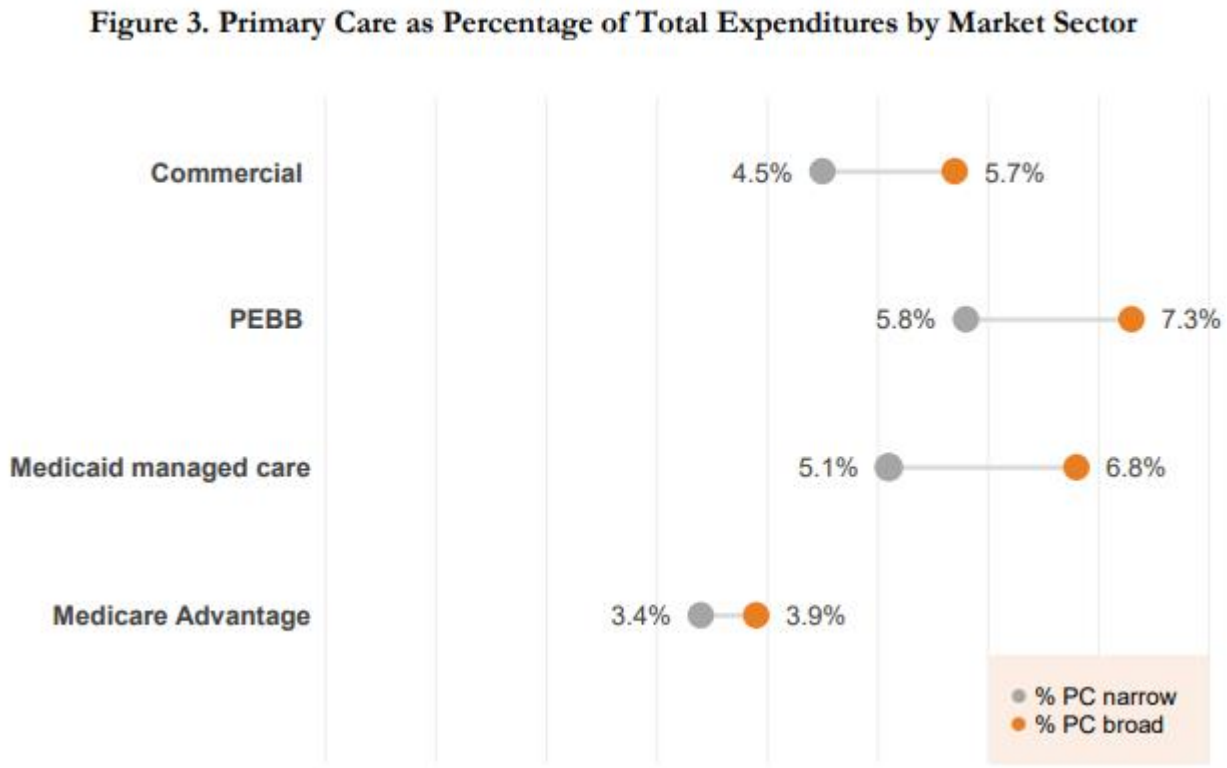
This comes down to how you want to concentrate/dilute resource investment in primary care. For example, how does the policy support movement toward team-based care?

Narrow vs. Broad General Differences

Provider types included in the broad definition that are not included in the narrow definition

- Advanced Practice Midwife
- Advanced Practice Registered Nurse
  - Psychiatric Mental Health
- Counselors
  - Addiction (Substance Use Disorder)
  - Mental Health
- Family Medicine
  - Addiction Medicine
  - Bariatric Medicine
  - Hospice and Palliative Care
- Internal Medicine
  - Addiction Medicine
  - Bariatric Medicine
- Marriage and Family Therapist
- OBGYN
- Physician Assistant
  - Psychiatric Mental Health
- Psychologist
  - Addiction (Substance Use Disorder)
  - Clinical
  - Adult Development and Aging
  - Etc.
- Registered Nurse
- Social Worker
  - Clinical
  - School

Variation In Distance to Target



Results will change with the updated primary care definition and with inclusion of non-claims-based expenditures.

Source: OFM 2019 Primary Care Expenditures Report
Report to the Legislature Primary care expenditures As required by Chapter 415, Laws of 2019 December 2019 (wa.gov)

Washington State Health Care Authority

Key Considerations

- The primary care definition will directly impact investment strategies if a 12% expenditure target is adopted.
  - This impact could vary depending on whether the payment model is fee-for-service or an alternative payment methodology (APM).
    - Under a blanket fee-schedule increase, providers outside of primary care may benefit from the increase
    - Under and APM, investments could be targeted to primary care while capturing the entire care team.
- We do not know how far apart the two definitions will be.
  - Prior measurement efforts may be a reasonable proxy, but they did not include non claims-based expenditures or the same provider types
- No decision today, we can discuss this further when we talk about this further after our set of guest speakers the next couple of months.

Making Care Primary Reminder

Washington State Health Care Authority

Making Care Primary (MCP)

- New Medicare primary care model in 8 states, including WA
- The program runs for a 10.5 year period (2024-2034), with the same cohort of providers maintained for the duration of the program
- To be apart of the cohort, eligible providers must apply
- Programmatic focus on improving care management, coordination, and integration
- Supports value-based payments and equitable access through additional investments in primary care
- Aligns public and private payers. Washington payers are exploring how to align current efforts with the MCP program.

MCP Provider Application

On August 14th, CMS issued the provider application for Making Care Primary. They are accepting applications from **September 4, 2023 through November 30, 2023**. There is a **one-time onboarding** to this program.

The application can be found here:
https://innovation.cms.gov/media/document/mcp-rfa

Thank you for attending the Advisory Committee on Primary Care meeting!

Washington State Health Care Authority