Advisory Committee on Primary Care meeting

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

HEALTH CARE COST TRANSPARENCY BOARD'S
Advisory Committee on Primary Care

February 29, 2024
2 – 4 p.m.
Hybrid Meeting

Meeting Agenda

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

Time	Agenda Items	Tab	Lead
2:00 - 2:05 (5 min)	Welcome, roll call, and agenda review	1	Dr. Judy Zerzan-Thul, Committee Chair, Medical Director, Health Care Authority
2:05 - 2:10 (5 min)	Approval of January 2024 meeting summary	2	Rachelle Bogue, Facilitator, Cost Transparency Manager, Health Care Authority
2:10 - 2:15 (5 min)	Public Comment	3	Rachelle Bogue, Facilitator, Cost Transparency Manager, Health Care Authority
2:15 - 2:25 (10 min)	Discussion on Workforce Development **(Committee members will be voting)**	4	Dr. Judy Zerzan-Thul, Committee Chair, Medical Director, Health Care Authority
2:25 – 3:15 (50 mins)	Presentation: Aligning Primary Care and Public Health to Advance Prevention and Whole Person Care in Washington (Patient Engagement Strategy)	5	Kyle Unland, MS, RDN, Community-Based Prevention Section Manager, Department of Health & Dr. Charles Chima, Chief of Healthcare Innovation, Department of Health Pat Justis, MA, Executive Director, Rural Health, Department of Health
3:15 – 3:35 (20 min)	Presentation: Multi-Payer Collaborative Alignment	6	Shane Mofford Center for Evidence-based Policy (CEbP)
3:35 – 3:50 (15 min)	Presentation: Multi-Payer Collaborative Alignment – Primary Care Transformation Model	7	Dr. Judy Zerzan-Thul, Committee Chair, Medical Director, Health Care Authority
3:50-3:55 (5 mins)	Wrap-up and adjournment		
3:55 – 4:00	*Additional time held for runover presentation time and discussion.*		

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board's

Advisory Committee on Primary Care meeting summary

January 23, 2023

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
2–4 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's webpage**.

Members present

Judy Zerzan-Thul, Chair
Sharon Brown
Tony Butruille
Michele Causley
Tracy Corgiat
D.C. Dugdale
Sharon Eloranta
Chandra Hicks
Meg Jones
Gregory Marchand
Sheryl Morelli
Lan Nguyen
Katina Rue
Mandy Stahre
Jonathan Staloff
Shawn West
Staici West
Ginny Weir
Maddy Wiley

Members absent

Kristal Albrecht
David DiGiuseppe
Sarah Stokes
Linda Van Hoff

Call to order

Dr. Judy Zerzan-Thul, Committee Chair, called the meeting to order at 2:03 p.m.

Washington State Health Care Authority

Agenda items

Welcoming remarks

Chair Dr. Judy Zerzan-Thul welcomed committee members, performed the role call, and provided an overview of the meeting agenda.

Meeting summary review from the previous meeting

The Members present voted by consensus to adopt the November 2023 meeting summary.

Public comment

Mandy Weeks-Green, committee facilitator, called for comments from the public. There were no public comments.

Updates on Making Care Primary

Kahlie Dufresne, Special Assistant for Health Policy and Programs, Health Care Authority

The Center for Medicare and Medicaid Innovation (CMMI), a division of the Center for Medicare and Medicaid Services (CMS), accepted applications for the new **Making Care Primary** Model through the middle of December 2023. The demonstration model seeks to drive the capacity and use of primary care through a progressive payment model. Medicare fee-for-service is utilizing this new model, and additionally, Washington received 44 applications representing 437 unique sites. Applicants are spread throughout both urban and rural areas, roughly half of which are Federally Qualified Health Centers (FQHCs), and include several multi-specialty systems. The ten-and-a-half-year timeline includes a key upcoming milestone in April 2024 when providers sign participation agreements following discussions with CMS.

Strategies to Increase and Sustain Primary Care

Chair Dr. Judy Zerzan-Thul, Chief Medical Officer, Health Care Authority

Building on prior work, the Committee will review a number of policy options that seek to increase and sustain the use of primary care, incentivizing the movement toward a minimum 12% of health care spending being used for primary care. Policy recommendations from the Committee should adhere to four principles: Unambiguous linkage between the policy and achieving the 12% goal, clearly defined action and actors, financially, operationally, and politically feasible, and must result in improved access and quality, not just expenditure. Specific policy recommendations that will be under review include:

1. Legislation mandating commercial and private providers increase primary care expenditure by 1% annually
2. Increase Medicaid reimbursement for primary care to Medicare levels
3. Multi-payer alignment
4. Focused efforts to promote primary care and preventative services
5. Workforce development
6. Work with the Cost Board to recommend levels of primary care expenditure ties to alternate payment models
7. Shift measurement of 12% primary care expenditure from aggregate to per capita

Discussion among the members touched upon the absence of recommendations regarding consolidation, that Making Care Primary does not account for pediatric care and worry regarding the speed of implementation. The definition of “preventative services” was requested to be discussed in more detail at a later meeting.

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Workforce Development and the Primary Care Spending Benchmark

Bianca K. Frogner, PhD, Professor of Family Medicine and Director of the Center for Health Workforce Studies (CHWS) at the University of Washington

Disclosure: Dr. Frogner is a member of the Cost Board but spoke as a subject matter expert on research performed at the **CHWS**. The presentation focused on studies investigating potential policies to retain a healthy, engaged health workforce at both the state and federal levels. It is important to keep in mind that containing health care spending can run counter to wage growth and the growth of the health care labor force, both of which are key aspects to maintaining workforce continuity. Higher wages help retain staff and adequate staffing levels prevent burnout, so choosing which levers to utilize when controlling costs is never simple. Of note, while the average proportion of the workforce engaged in ambulatory care is between 35-45% in the US, in Washington the figure is roughly 53%. According to licensure data, Washington has fewer physicians per capita than the national average, 228 versus 248 per 100,000, leading also to having fewer primary care physicians. The same dataset reveals that only 17.4% of registered nurses (RNs) are employed in ambulatory care of community health settings. The Medical Assistant (MA) workforce was assessed, noting that converting registered MAs to fully licensed MAs could boost the primary care workforce in Washington. In general, wages for the health workforce in Washington are higher than the national average.

Solving the challenge of meeting workforce demand requires a combination of increasing productivity, improving retention, engaging and expanding existing workers to new roles and responsibilities, and overcoming community and societal barriers. The COVID pandemic prompted more rapid rates of staff turnover across medical settings, especially among women with children. As such, support for the labor force would increase retention, including such efforts as carpool reimbursement, improved training, and better funding for childcare. Specifically studying the primary care workforce is a challenge, as specific data collection can be lacking, but the work of the Committee can support effective solutions to all these challenges.

Comments and discussions from members touched upon dealing with low-quality procedures and work that does not improve patient health. Opportunities for patient self-care could be a valuable contribution, as would hiring for technical support roles as telehealth options expand. Shifting services from medical doctors (MDs) to advanced registered nurse practitioners (ARNPs) would likely lower health care costs, but comparisons to MAs is not possible due to lack of data.

Primary Care Workforce Presentation

Renee Fullerton, Staff to the Health Workforce Council

The Health Workforce Council has been a policy development and advisory group for more than 20 years in Washington, recently focusing on behavioral health, long-term care, and dental workforces. The health care workforce is highly interconnected, with lack of staffing in one setting leading to issues in another. Advocating for improved planning data, research, and evaluation in primary care settings can lay the foundation for a stable, engaged workforce. The number of people completing Certified Medical Assistant (MA-C) training has been declining for the past ten years, which has led to strain in the health care system. While Washington is training more MDs following the opening of a third medical college in the state, the number entering family medicine has been static, prompting an increased number of doctors of osteopathy (DOs) moving to fill the gap. Expanding where and how primary care is being provided could drive its usage. Policies which seek to better understand the demographics of providers could help build a workforce best prepared to care for the populace of Washington. The **2023 Health Workforce Council report** to policymakers supported addressing educational debt, childcare, affordable housing, and transportation. Comments from committee members sought understanding of what lag might be seen between education loan forgiveness and improved workforce retention rates. Generally, the policy is more useful to entice workers toward positions more difficult to fill, such as rural clinics, but evidence of increased retention is less clear.

Adjournment

Meeting adjourned at 3:50 p.m.

Tab 3

Washington State Health Care Authority

Public comment

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Tab 4

Washington State Health Care Authority

February 29, 2024

To: Health Care Cost Transparency Board (**DRAFT for committee discussion)**

From: Health Care Cost Transparency Board's Advisory Committee on Primary Care

Re: Workforce strategy recommendations for addressing a primary care expenditure rate of 12%

The Health Care Cost Transparency Board (Board) charge for the Advisory Committee on Primary Care

SB 5589 (2022) established a state goal of spending 12% of total health care expenditures on primary care. The bill further charged the Health Care Cost and Transparency Board (Board) with defining, measuring, and reporting primary care expenditures, and proposing policies that would support movement towards the 12% goal.

The Board's Advisory Committee (Committee) on Primary Care was developed to fulfill this charge. Additionally, the Committee provides policy recommendations to the Board related to eight specific Board charges outlined in SB 5589:

1. Recommend a definition of primary care;
2. Recommend measurement methodologies to assess claims-based spending;
3. Recommend measurement methodologies to assess non-claims-based spending;
4. Report on barriers to access and use of primary care data and how to overcome them;
5. Report annual progress needed for primary care expenditures to reach 12% of total health care expenditures;
6. Track accountability for annual primary care expenditure targets;
7. Recommend methods to incentivize achievement of the 12% target; and
8. Recommend specific practices and methods of reimbursement to achieve and sustain primary care expenditure targets.

The Board will consider and create recommendations related to these goals for the Legislature in its legislative report.

This is the first policy recommendation in a series of upcoming recommendations by the Committee developed to achieve the goals outlined in SB 5589. This recommendation specifically targets numbers 7 and 8 respectively of the Committee's charge:

- *Recommend methods to incentivize achievement of the 12% target.*
- *Recommend specific practices and methods of reimbursement to achieve and sustain primary care expenditure targets.*

Background

Workforce efforts already undertaken in Washington include:

• Advanced Registered Nurse Practitioner (ARNP) residency programs through a range of partners. Health professional recruitment and retention clearinghouse (RCW 70.185.020).

• The University of Washington operates the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) rural primary care program for clinical placements in rural areas to attract medical students to practice over a longer term in rural settings.

• Medical assistants may participate in apprenticeships in selected settings, such as Community health centers and hospital outpatient departments. Apprenticeship is a workforce development tool that provides employers with skilled workers trained to the specific needs of the employer. Interest in apprenticeship is high and expanding into health care to address difficult-to-fill jobs, reduce turnover, and emphasize on-the-job learning.

• Providence Health Systems and Kaiser Permanente sponsorship of community-based physician residencies. Residents often stay within the system and the clinics where they train.

• Washington statutes (Chapter 49.62 RCW) prohibits non-compete agreements for employees with salaries less than $100,000 (subject to inflationary adjustment) annually, independent contractors with salaries of $250,000 (subject to inflationary adjustment) or less annually, and non-compete agreements more than 18 months.

• The Washington Health Corps State Health Program forgives up to $75,000 f of student loan debt or clinicians providing comprehensive primary care, including dental and behavioral health services. (Statute RCW 28B.115.130).

Examples of other states' workforce-focused policies to support primary care investment and delivery are provided below.

Non-compete policy examples:
• California: Prohibits non-compete agreements. (State code Section 16600)
• Rhode Island: Prohibits restrictive covenants on physicians (Sec. 5-37-33)
• Connecticut: Allows non-competition for physicians if limited to one year and a geographic region of more than 15 miles from the primary practice site. (Sec. 20-14p.)
• Federal: In January 2023, the U.S. Federal Trade Commission proposed a rule to ban employers from imposing non-compete clauses on their workers. The preamble to the proposed rule says that there is evidence that non-compete clauses increase prices and market concentration in the health care sector.

Student loan forgiveness examples:
• Oregon: Primary Care Loan Forgiveness Program provides up to $35,000 per year for primary care providers working in a rural area of Oregon with a health professional shortage. (Statute: ORS 676.454. Rules: OAR 409-036-0020).[1]
• Pennsylvania: Primary Care Loan Repayment Program: Up to $80,000 per year for full-time physicians, dentists, and psychologists; up to $48,000 for other practitioners who work in an approved site in an underserved area.
• Arizona: Rural primary care provider loan repayment program for primary care providers in a shortage area. The higher the Health Professional Shortage Area Score, then the greater amount of money is provided for student loan repayment, up to $65,000 per year (Statute: ARS 36-2172). There is a separate program for providers with a rural private primary care practice in a shortage area (ARS 36-2174).

Other state workforce initiatives:

[1] Estimated to be $4 million annually.

• Oregon: Health Care Provider Incentive Program created in statute (ORS 676.454). Types of incentives to be offered per state rules (OAR 409-036-0020) include scholarships for students in health professional training programs, Community Workforce Assistance Grants to support recruitment and retention of providers, and medical malpractice insurance premium subsidies.
• Colorado: Used American Rescue Plan Act funds for home- and community-based services (HCBS) to establish a $9.5 million training fund to help direct care workers gain skills to advance within the HCBS workforce.

Committee's Additional Research into Workforce Development:

To further support workforce efforts, the Committee discussed and prioritized strategy options at its January 23, 2024, meeting. The Committee is focused on several policies to incentivize achievement of the 12% primary care expenditure target. One of the recommendations to the Legislature is to prioritize funding for state primary care workforce initiatives as collaboratively identified through the Health Workforce Council (Council).

To support the Committee's understanding of this issue in Washington, the Committee heard from Bianca Frogner, PhD from the University of Washington Center for Health Workforce Studies, and Cost Board member, joined by Renee Fullerton of the Health Workforce Council. Together they presented an overview of work already underway to address workforce issues. [2]

Dr. Frogner highlighted the connection between the health workforce and health spending. She also provided an overview of Washington's primary care workforce and shared the many challenges facing the future development of the health care workforce.

According to the Center for Health Workforce Studies, Washington has fewer physicians per capita, including primary care physicians compared to the U.S. Of those Washington physicians, only 35% work in primary care who provide direct patient care, are not federally employed, and are under the age of 75. ARNPs, registered nurses, and physician and medical assistants are essential to delivering care in response to this primary care physician shortage.

Dr. Frogner explained that solving Washington's work force issues will require a combination of more education, keeping experienced workers in jobs longer, engaging and expanding workers in new roles, and overcoming community and societal barriers for filling workforce needs with qualified health care providers. To get a sense of how these issues are impacting primary care, rural health clinics and community health centers specifically, please see the link below.

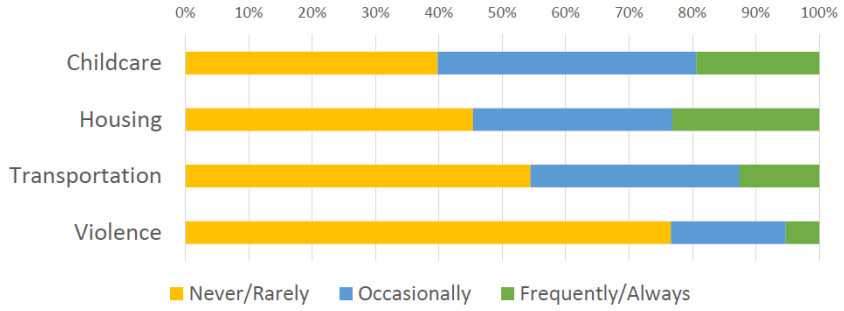
Statistics for top occupations with exceptionally long vacancies in Washington:

Primary Care: Primary Care clinics have more difficulty filling open MA positions than any other position. After that, Physician/provider positions followed by RN positions. Source: https://wa.sentinelnetwork.org/wp-content/uploads/sites/2/2024/01/WASentNet_Primary_Care_Brief_2023Fall.pdf

[2] The slides for this presentation are attached to this memo.

Speaker Renee Fullerton, Health Workforce Council (Council), presented on the Council's primary care efforts of bringing together representatives from government, labor, professional groups, educational institutions, and facilities and employers, as well as their policy development and advisory groups.

There are a large number of reasons for the current healthcare workforce shortage. Below is a chart that represents several concerns highlighted by health care providers when asked across all facility types by the Health Workforce Council: 'To what extent have the following affected your ability to recruit and train staff in the past year?'



Source: WA State Health Workforce Council.

Ms. Fullerton highlighted the interconnectedness of health care facilities, e.g., a "problem in one area quickly spills over into another." Key challenges include:

1. Patients unable to access timely primary care appointments may seek care in the emergency department. This increases costs, wait times, and burden on hospital workforce.
2. Behavioral health workforce challenges leave primary care clinics trying to serve patients with complex behavioral health needs, further burdening primary care providers.
3. Long-term care facilities lack staff required to function at full capacity. As a result, hospitals can't discharge patients in a timely manner, leading to hospitals being over capacity, diverting ambulances, and not taking patient transfers from hospitals of stabilized patients who are able to be transferred into lower level care.

Ultimately, training, recruiting, and retaining will not solve current primary care workforce challenges, nor meaningfully expand primary care. Washington must consider expanding the roles and settings where primary care is provided and ensure payment models are aligned.

Current workforce efforts underway in Washington that are recommended for Board's support.

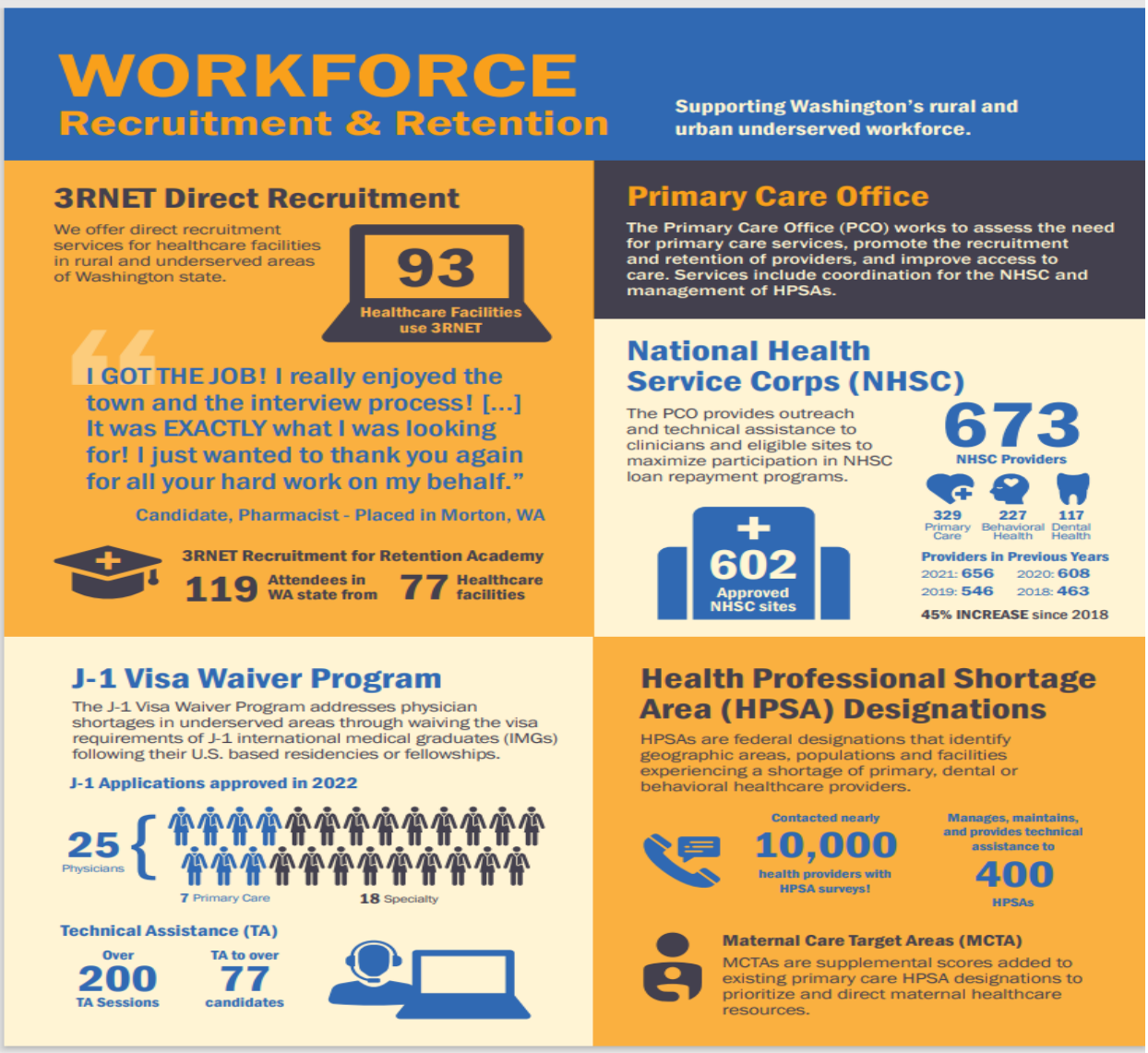
Successful investment in primary care services relies on an adequate and quality workforce to deliver and increase access to primary care. Workforce development is a key primary care investment strategy as higher utilization and expenditures on primary care can only happen when primary care practitioners in Washington have the capacity to support higher levels of access to care.

Efforts to invest in the clinician workforce pipeline through activities such as student loan forgiveness programs increases the number of physicians providing care. This then increases access, utilization, and ultimately primary care expenditures.

Washington has an array of existing efforts for workforce development underway that should be supported by the Board, but not duplicated through action by this Committee. For example, the Washington Department of Health (DOH) and The Health Workforce Council have undertaken significant efforts to increase Washington's health care workforce.
In their 2023 Annual Report, the Health Workforce Council identified several strategic priorities for increasing the health care workforce that it will focus on in 2024 for the development of further recommendations. These strategic priorities include:

- **DATA FOR PLANNING/POLICY:** Increase collection, ensure reasonable access, and resource ongoing analysis of health workforce data across multiple data sources (both qualitative and quantitative).
  • **RURAL STRATEGIES:** Generate rural-specific health workforce strategies that account for unique needs in those communities and support the adoption of those strategies.
  • **INCREASE COLLABORATION:** Use the position of the Council to drive focused policymaking that targets specific silos between the health, government, and educator sectors.
  • **SIMPLIFY THE REGULATORY ENVIRONMENT:** Systematically work to identify laws or rules that don't have a quantifiable impact on patient safety but have unintended consequences of impeding individuals' ability to enter the health workforce or move between different healthcare settings.
  • **CLARIFY CAREER PATHWAYS:** Use the position of the Council to advocate for expansion of interconnected, progression-based career pathways in health professions, including both traditional education models and "earn while you learn" models.

DOH has also focused on increasing the health care workers in Washington, particularly in rural and primary care. The graphic below provides an example of a Rural Health Infographic (wa.gov) flyer focusing on rural recruitment and retention and illustrates the unique challenges in recruiting and retaining workforce.



Conclusion and Committee's Proposal

Committee members recommend supporting DOH and the Health Workforce Council's (as a part of the Washington Workforce Board) efforts to increase workforce development which is a key primary care investment strategy.

Tab 5

Washington State Health Care Authority

Washington State Department of HEALTH

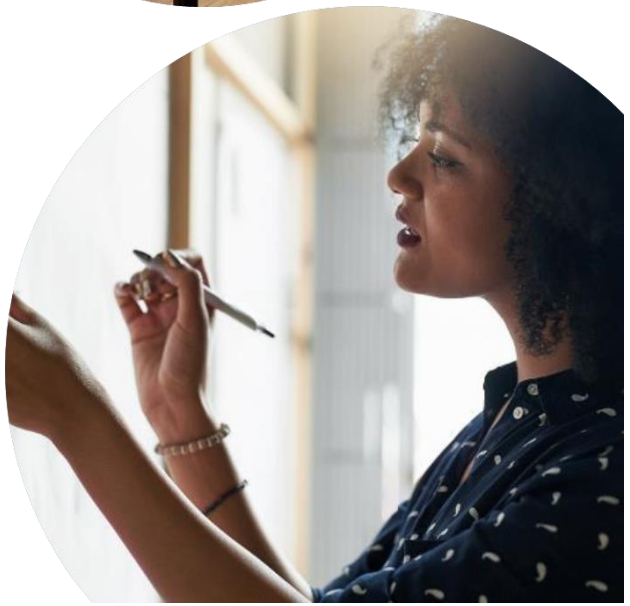
ALIGNING PRIMARY CARE AND PUBLIC HEALTH TO ADVANCE PREVENTION AND WHOLE PERSON CARE IN WASHINGTON

Presentation to the Primary Care Advisory Committee of the Health Care Cost Transparency Board 02/29/2024

BACKGROUND

About the Washington State Department of Health (DOH)

- **Vision** - Equity and optimal health for all.
- **Mission** - The Department of Health works with partners to protect and improve the health of all people in Washington state.
- **Values** – Equity, Innovation, Engagement.
- **What we do** –
  - DOH defends the public's health from various threats in a rapidly evolving world.
  - DOH's programs and services are implemented in collaboration with local health departments and state, federal, and private partners.



Preventable Illnesses are Costly

- USA spent $4.5 trillion, 17.3% of its gross domestic product (GDP) on health care in 2022.[1]
- **More than a quarter (27%) of healthcare spending was due to preventable illnesses.**
  - Investing in prevention will reduce health care spending in the long run.
- Associated risk factors include high body-mass index, high systolic blood pressure, high fasting plasma glucose, dietary risks, and tobacco smoke exposure.

1. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2023.01360

Lancet Public Health. 2020 Oct; 5(10): e513–e514.

Top 10 risk factors that drive the most death and disability in Washington state that are highly preventable

Risk Factor	Rate per 100,000	Ranking
Tobacco (use/exposure)	3,610.7	1
High body-mass index	3,200.8	2
High fasting plasma glucose	2,715.0	3
Drug use	2,196.4	4
Dietary risks	2,130.8	5
High systolic blood pressure	2,117.3	6
Alcohol use	1,563.0	7
Occupational risks	967.7	8
High LDL cholesterol	928.2	9
Kidney dysfunction	879.5	10

Data downloaded: IHME/GHDx GBD Results Tool (http://ghdx.healthdata.org/gbd-results-tool)
Global Burden of Disease Study, 2019 – Washington State Profile (https://www.healthdata.org/research-analysis/health-by-location/profiles/united-states-washington)

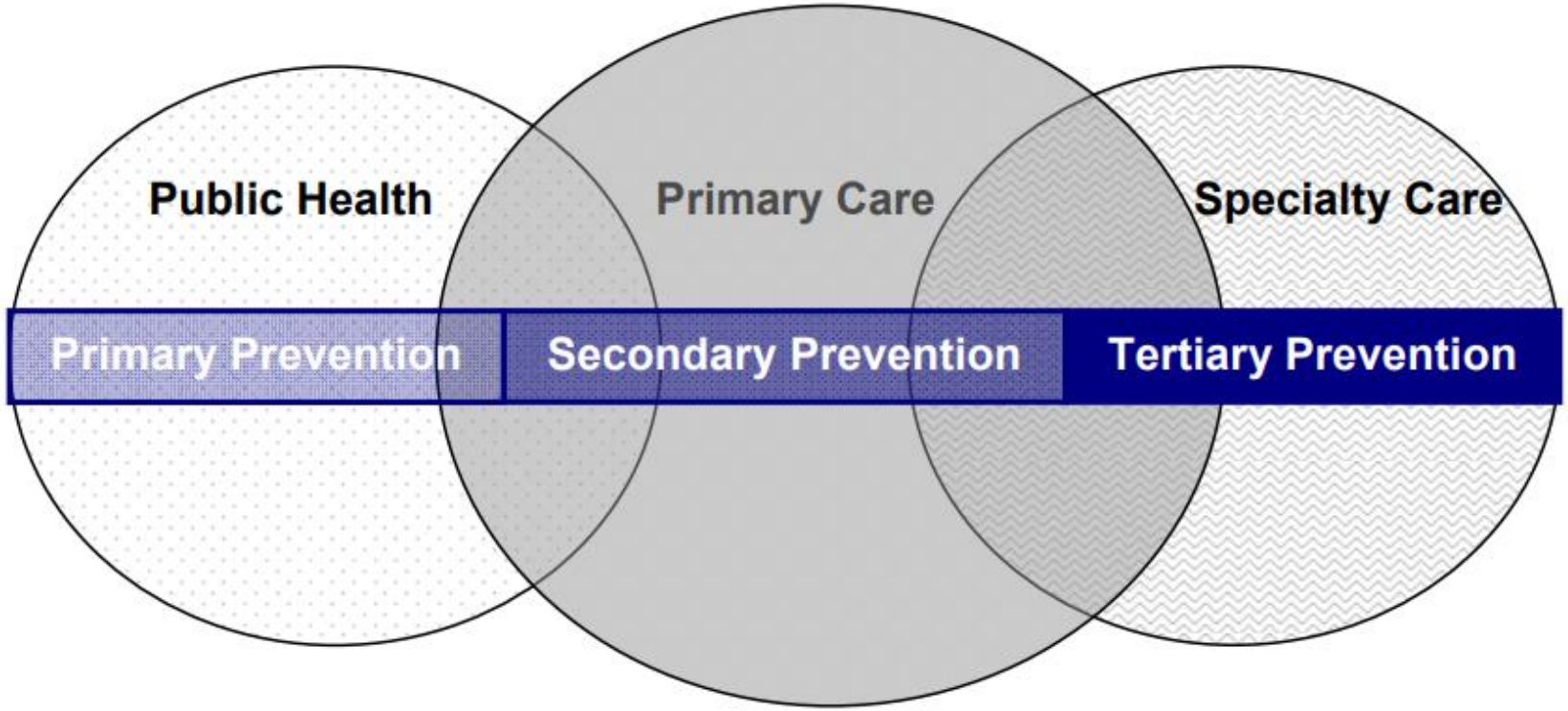
Examples of gaps in uptake of clinical preventive services in Washington

- Uptake of clinical preventive services (e.g., colon, cervical, and breast cancer screening, pneumococcal vaccination, influenza vaccination, diabetes screening, HIV testing) is lower among the uninsured, those with lower income, and those living in rural communities. (Song et al, 2021)
- COVID-19 pandemic negatively impacted risk-factor management, with 4 in 10 adults deferring the use of healthcare services for preventive, routine, and even emergency care during the pandemic. (Czeisler et al, 2020)
- Of the 36% with uncontrolled hypertension in Washington (He et al, 2024), 1/3rd are "hiding in plain sight" – neither aware of their hypertension nor taking antihypertensive medications although many have health insurance, usual source of care, or received care at least twice in the past year. (Wall et al, 2014)
- 11 percent of Washington adults report having a diagnosis of prediabetes in 2021, while nationally 38 percent have prediabetes, making it very likely that many more in the state may not know they have it. (CDC NDSR 2023, WA DOH BRFSS 2021)

Public Health and Health Care works together to prevent diseases and promote health

Source: CDC. How We Prevent Chronic Diseases and Promote Health. https://www.cdc.gov/chronicdisease/center/nccdphp/how.htm

We need both upstream and downstream interventions to prevent diseases and keep our populations healthy across their lifespan



Primary Care is an essential component of the prevention continuum, providing critical linkages to public health, social services, and specialty care to provide Whole Person Care to individuals and communities.

Source: Cusack CM, Knudson AD, Kronstadt JL, Singer RF, Brown AL. Practice-Based Population Health: Information Technology to Support Transformation to Proactive Primary Care AHRQ. July 2010.

Some of the reasons driving primary care prevention gaps

Prevention is not incentivized – the system is set up to treat sickness and not prevent it

- Higher reimbursement for procedures and interventions and less incentives for preventive and primary care.
- Provider time to address prevention-based issues is limited, resulting in incomplete care and dissatisfaction.
- Lack of reimbursement for support services needed to ensure whole person care and patient follow-up e.g. community health workers.

Data and Information gaps

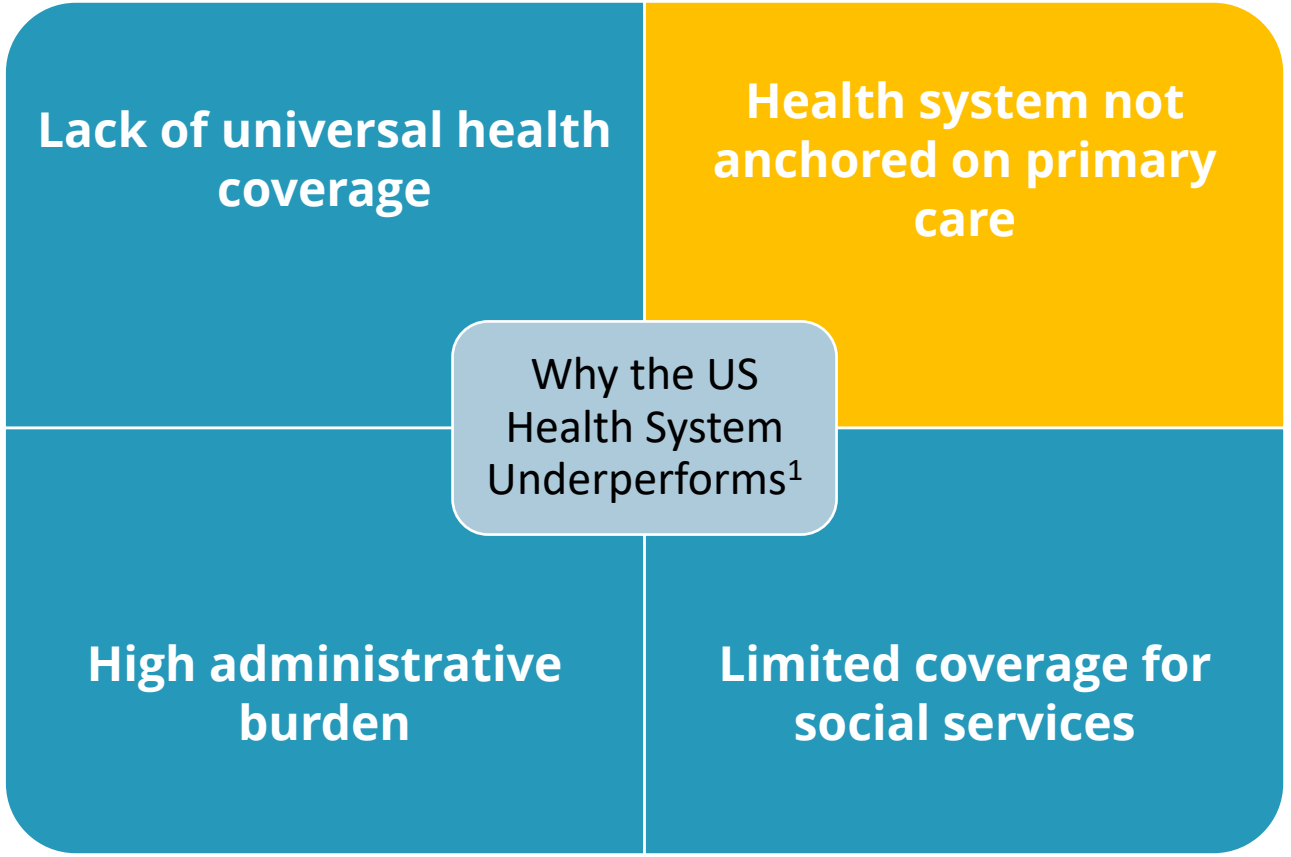
- Incomplete data in the electronic health record and limited interoperability across systems.
- Lack of real-time information to inform decision making at the point of care.

Workforce shortage

- Lack of Primary Care Providers (PCPs) limits access and appointment availability.
- Not enough PCPs to address prevention issues.

To close gaps in our health system DOH is prioritizing **health systems and workforce transformation**

To transformation healthcare in Washington, we need to focus on why the US health system underperforms[1]



[1]Schneider EC, Shah A, Doty MM, Tikkanen R, Fields K, Williams R, II MM. Reflecting Poorly: Health Care in the US Compared to Other High-Income Countries. New York: The Commonwealth Fund. 2021 Aug 4.

Why Access to Primary Care Matters

Primary care providers offer

- **a usual source of care**
- **early detection and treatment of disease**
- **chronic disease management**
- **preventive care**

Patients with a usual source of care are more likely to receive recommended preventive services[1-3]

[1]Friedberg, M. W., Hussey, P. S., & Schneider, E. C. (2010). Primary care: A critical review of the evidence on quality and costs of health care. Health Affairs, 29(5), 766–772. doi: 10.1377/hlthaff.2010.0025This link is external to health.gov.
2.Xu, K. T. (2002). Usual source of care in preventive service use: A regular doctor versus a regular site. Health Services Research, 37(6), 1509–1529. doi: 10.1111/1475-6773.10524This link is external to health.gov.
3, Blewett, L. A., Johnson, P. J., Lee, B., & Scal, P. B. (2008). When a usual source of care and usual provider matter: Adult prevention and screening services. Journal of General Internal Medicine, 23(9), 1354–1360. doi: 10.1007/s11606-008-0659-0This link is external to health.gov.

Barriers that patients face in accessing primary care

 Financial barriers	Lack of health insurance Underinsurance Low health financial literacy
 Intra & inter- personal factors	Limited English proficiency Low health literacy Cultural norms regarding seeking care Low trust in health care
 Limited provider availability	General PCP shortage, worse for urban poor & rural populations Narrow provider networks
 Other institutional barriers & health-related social needs	Lack of transportation Limited appointment options & inconvenient hours Lack of sickness benefits/Paid Time Off

Washington State Department of HEALTH

OVERVIEW OF PREVENTIVE HEALTH, PATIENT ENGAGEMENT, AND PRIMARY CARE SYSTEMS DEVELOPMENT INITIATIVES AT DOH

CHILD HEALTH PROGRAMS

Childhood Vaccine Program

Overview

- The Childhood Vaccine Program (CVP) provides publicly purchased vaccines to participating providers for all children less than 19 years of age.
- The program supplies all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and eliminates or reduces cost barriers to receiving vaccinations.

Key Stats/ Impact

- 980 provider sites are enrolled in the Childhood Vaccine Program and provide approximately 2.6 million doses of childhood vaccine annually.

Program Needs/Plans

- Expanded provider enrollment in rural areas of the state and in areas with increased barriers to vaccine access.
- Continued collaboration with mobile health and community outreach (Care-a-Van) and pharmacy providers to increase access to routine childhood vaccines, COVID-19 Vaccine, and flu.

Early Childhood Comprehensive Systems: Health Integration Prenatal-to-Three Initiative

Overview

- Focused on strengthening the foundations of lifelong health through equitable, integrated, family-centered systems of care for young children and families.
- Requires deep partnership by the Department of Health, the Department of Children, Youth, and Families, the Health Care Authority, community organizations, managed care, early relational health programs, legislators, physicians, families, and others to meet this goal.

Key Stats/ Impact

- Our state is full of innovative, dedicated social and health providers and systems and we have collectively identified some key barriers to an integrated system.
- Enhancing integration of health care with community linkages for prenatal to three will improve health and well-being outcomes in early childhood and beyond.

Program Needs/Plans

- Plan to address top barriers identified by health care providers in promoting an integrated system – especially gaps around tangible caregiver support, meeting basic needs of families, and caregiver education.
- Key barriers for providers: lack of time, resource limits (community systems are fragmented), insufficient staff support, and lack of provider knowledge about service landscape.

School-based Health Services

Overview

- We operate the school based health center grant program, which is an integrated approach to creating access for students to medical and behavioral health services through schools. Much of this work relates to the implementation of HB1225.

Key Stats/ Impact

- Program awards grants to SBHCs that serve a high proportion (60% or more) of students furthest from educational justice due connected with poverty and inequities.
- SBHCs provide health care at low or no cost, often serving youth with no insurance, who are underinsured, or who have Medicaid.

Program Needs/Plans

- Continue to expand integrated care centers across Washington while also focusing on enhancing behavioral health services in schools not ready for a full clinic.

Strong Start - Universal Developmental Screening

Overview

- Strong Start is a free and secure data system where parents, legal guardians, and health care providers can enter and access developmental screening information in one location.
- Strong Start is an initiative supported by the Washington State legislature.

Key Stats/ Impact

- Regular screenings from ages 0 to 5 help identify areas of delay, which can help parents and providers know how to best assure that each child has tailored care to their needs.
- Developmental screening for all children is necessary to reduce health inequities in Washington.

Program Needs/Plans

- Primary care providers to partner with the department in adding screenings to the Strong Start Data System.

Well-child Visits

Overview

- Department of Health partners Health Care Authority and Medicaid Managed Care organizations to improve well child visits up to 30 months of age.
- Investments have include incentives for practices to increase their well child visit rates, developing patient-informed tips for providers to increase well-child visit rates, and creation of patient materials on multiple languages encourage well child visits.

Key Stats/ Impact

- Washington typically has around 50% of children 0-15 months who have had 6 or more well child visits, and about 60% children 15-30 months who had 2 or more well child visits.

Program Needs/Plans

- Reach out to the department's Office of Family and Community Health if you would like information and resources to improve well-child visits in your practice.

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Heart Disease, Stroke, and Diabetes Prevention Program

Overview

- Exclusively funded by CDC.
- Expected outcomes: reduce hypertension, diabetes, and related health inequities in priority populations.

Key Stats/ Impact

- Targeting 97,938 adults with cardiovascular disease and 46,245 with diabetes in four Accountable Community of Health (ACH) regions with the highest burden and unmet needs.
- Within the four ACH regions, increasing Community Health Workers' knowledge and efforts to support chronic disease self-management within the priority populations.
- With the four ACH regions, increasing the number of clinics and FQHCs that implement prevention activities to reduce hypertension and blood glucose levels.

Program Needs/Plans

- Lack of resources and funding severely limits scale of primary prevention efforts.
- Long-term goals is to support a more comprehensive approach to reducing statewide levels of heart disease, hypertension, and diabetes.

Breast, Cervical, and Colon Health Program

Overview

- Helps pay for breast, cervical and some colon cancer screenings, along with access to treatment for low-income and uninsured/underinsured adults.
- Partner with health systems and community organizations to implement evidence-based interventions for cancer screening and reduce health inequities.

Key Stats/ Impact

- From 2018-2023 the program served over 28,000 people, diagnosing over 200 cancers, and provided technical assistance to 40 clinics.
- The program has reached only about 15% of those eligible, due to funding capacity and/or community awareness.

Program Needs/Plans

- Up to date awareness of screening recommendations and resources, systems that identify and implement patient screening and HPV vaccinations for all who are eligible, and connection to resources where needed.
- Increased access for rural communities/vulnerable populations, such as mobile mammography.

Washington State Comprehensive Cancer Control Program (CCCP)

Overview

This federally funded program is an umbrella for other cancer programs in the state and ensures the programs are coordinated and aligned to reduce risk, increase early detection, identify better treatment options, and enhance survivorship.

Key Stats/ Impact

- WA CCCP was one of the first states in the nation to recommend that HPV vaccines be started at age 9 and has led to an incredible increase in the number of 9 and 10-year-olds who have received the HPV vaccine.
- Convened over 100 participants from over 40 unique organizations to provide input, recommendations, and feedback concerning the development of the state cancer plan.

Program Needs/Plans

- The program seeks to implement and sustain a more coordinated approach to cancer prevention and control in WA.
- The long-term plan is to enhance efforts that focus on cancers that have been identified as preventable, develop effective treatments for all cancers, and increase survivorship support.

COMMUNITY-BASED OUTREACH AND PATIENT ENGAGEMENT

Mobile Health Services: Care-a-Van

Overview

- Care-a-Van is a mobile health clinic that serves people across Washington. Care-a-Van currently provides glucose monitoring, blood pressure checks, naloxone distribution, routine childhood vaccines, and COVID-19 Vaccine and flu for adult and childhood populations.
- Care-a-Van works closely with community-based partners and local health jurisdictions to increase health services to priority communities.

Key Stats/ Impact

- 2,300+ Care-a-Van events have been held in Washington.
- 75% of events have been held in areas with moderate to high Social Vulnerability Index.
- 56,808 COVID-19 Vaccine doses administered, 3,840 flu doses, and 712 mpox vaccine does administered.

Program Needs/Plans

- Program plans to continue to expand health services offered, while maintaining vaccination support infrastructure to help partners address surges during respiratory virus season.
- Program is primarily funded through temporary COVID-19 grants and will need sustainable funding to maintain long-term operations.

COMMUNITY HEALTH WORKER PROGRAM

Overview

- Community Health Workers (CHWs) play a critical role in the health of their communities, linking diverse and underserved populations to health and social service systems.
- The CHW Leadership Committee is an ongoing, statewide, multi-stakeholder group representative of Washington State and our diverse communities formed to develop key priorities and guidance to inform education, training, and other aspects of the CHW workforce.

Key Stats/ Impact

- The CHW Training Program was developed as a no-cost 10-week core competency training program designed to strengthen the skills, knowledge, and abilities of community health workers. To date, **over 6,000 CHW**s across the state have completed the Core Competency training.
- The CHW Leadership Committee has contributed to upcoming revisions to the Core Competency training program to align the training program with national consensus standards.

Program Needs/Plans

- CHWs across the state both currently and in the future need sustainable and reliable funding streams for the variety of settings in which CHWs are employed.
- The CHW Leadership Committee, as well as the CHW Training Program, need increased funding to increase the capacity of both training opportunities and provide increased infrastructure to provide support and communication to the growing number of CHWs across the state.

Community Based Care Coordination: Care Connect Washington

Overview

- **Care Connect** is a statewide community health infrastructure that fosters integration of health and social services.
- It provides resources to Accountable Communities of Health to operate **Community Care Hubs** that invest in and supports a network of community-based organizations that hire trusted community-based coordinators to connect needed preventive, medical and social services to communities.

Key Stats/ Impact

- **100+ local community-based care coordinators** have assisted **130,000+ individuals/households** with various needs, including personal protective equipment for COVID, food assistance, medication deliveries, housing assistance, and childcare support.

Program Needs/Plans

- Program is evolving from a COVID response infrastructure to an important statewide community health infrastructure that links people with health related social needs to existing services.
- Sustainable funding model is needed, including reimbursement for services provides by community based health workforce.

HEALTH SYSTEMS TRANSFORMATION

Power of Providers: Supporting Providers with Patient Engagement Tools:

Overview

- **Power of Providers (POP)** is a DOH program that equips health care providers with resources to tackle challenges such as improving patient communication, combatting misinformation, and promoting access to the latest clinical guidance.

Key Stats/ Impact

- **4,500+ providers** and **436 health organizations** have joined and access learning through peer-to-peer webinars, tailored resources for providers serving patients who speak Spanish, and an Advisory Group that helps foster bi-directional feedback between a diverse group of providers and DOH.

Program Needs/Plans

- Opportunity to expand engagement topics beyond COVID-19 to other priority prevention areas.
- Grant funded with temporary COVID funds – the program needs a sustainable funding model to sustain efforts beyond COVID.

Primary Care Systems Development

Overview

- The **State Primary Care Office (PCO)** at DOH works to assess the need for primary care services, promote the recruitment and retention of providers, and improve access to care.
- Services include designating Health Professional Shortage Areas, improving uptake of the National Health Service Corps loan repayment program, facilitating J-1 work visas for foreign trained physicians to address shortages, and direct recruitment services for healthcare facilities in rural and underserved urban areas.

Key Stats/ Impact[1]

- Manages, maintains, and provides technical assistance to **400** Health Professional Shortage Areas.
- Nearly **700** providers assisted with the National Health Service Corps loan repayment program.
- **25** J-1 visas applications approved for physicians.
- **93** healthcare facilities utilized workforce recruitment services.

Program Needs/Plans

- With increased resources, the State Primary Care Office can do more to drive primary care systems development in the state, including partnering with communities, community health centers, and other healthcare organizations on primary care workforce education and other initiatives to address gaps in primary care access.

[1] 2022 Statistics

Rural Health Promotion and Systems Development

Overview

- Population Health Micro-grants enable rural primary care clinics and hospitals to engage with community organizations to use data driven approaches in their programs.
- **Grow Your Own (GYO)**is an evolving approach to support partnerships between rural health systems and education programs to create a locally driven workforce pathway.
- Use of Learning Action Networks for peer-to-peer improvements to close the gap between evidence and practice.

Key Stats/ Impact

- **58** Population Health Micro-grants awarded.
- Publishing of the GYO Toolkit after an environmental scan and follow up interviews to exemplary programs which are also featured in a new podcast, **Let's Talk Rural.**
- **19** communities engaged in a Learning Action Network to integrate palliative care into rural healthcare systems.

Program Needs/Plans

- Continue to improve the micro grant process and increase the number of awards.
- Funding needed for GYO approach to multiple roles.
- With increased funding could offer LAN approach on priority clinical or service related opportunities.

RECOMMENDATIONS

Align Primary Care, Public Health, Medicaid, and Social Services on Prevention and Whole Person Care

- Invest in initiatives that align primary care with the public health and social care system. E.g.
  - Power of Providers (POP) program: Engaging Providers and Health Systems on Clinical Prevention and Patient Communication Strategies.
  - Care-a-Van Mobile Health Services: Statewide Infrastructure for Community Outreach and Patient Engagement in Prevention and Primary Care.
  - Care Connect Washington: Enhancing Clinical-Community Linkages to Provide Whole-Person Care.
- Expand the primary care workforce to include community health workers and care coordinators, with payment reform that covers reimbursement for such critical services.

Invest in Statewide Data Initiatives to Drive Systems Transformation

- Establish a statewide Health Data Utility
  - Good quality data on chronic disease burden and gaps in primary care and clinical preventive services are needed to plan and deliver better care.
  - A health data utility is a locally governed, public-private resource providing comprehensive population health data, including robust clinical and non-clinical data, with immense benefit to state and other health care system stakeholders.[1]
  - DOH is working with the Washington Healthcare Forum and leading health systems in WA on a pilot initiative – **Transformational Repository & Analytics eXchange (TRAX)** – that can become a statewide Health Data Utility.

- Establish a statewide Health Workforce Information System
  - Inconsistent data collection has been identified as a barrier to primary care planning in Washington.
  - Without adequate supply of primary care workers, we cannot close gaps in clinical preventive services.
  - Increasing demands on primary care workers in the context of health workforce shortages leads to burnout.

[1] Source: Consortium for State and Regional Interoperability. https://thecsri.org/health-data-utility/

Invest in State Infrastructure for Primary Care Systems Development

- Increased resources for the **State Primary Care Office** and **State Office of Rural Health** at DOH will enable it to drive primary care systems development in the state.

- Growing **health services research** capability at DOH to conduct applied research and evaluation will provide insights to inform primary care transformation initiatives.

Invest in Primary Care Innovation

- Create opportunities for innovation and testing of strategies for population health with micro-funding.
- Innovative workforce solutions, such as the Grow Your Own program, can expand the toolkit for addressing primary care workforce shortages in the state.
- Complement increases in primary care expenditure with payment reform to accelerate population health management and value-based care.

Questions?

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Washington State Department of
HEALTH

Tab 6

Washington State Health Care Authority

Supporting Multi-payer Alignment in Primary Care Transformation

HCCTB Advisory Committee on Primary Care Charges

- Primary Care Definition
  - Recommend a definition of primary care
  - Recommend measurement methodologies to assess claims-based spending
  - Recommend measurement methodologies to assess non-claims-based spending

- Data Focused to support primary care
  - Report on barriers to access and use of primary care data and how to overcome them
  - Report annual progress needed for primary care expenditures to reach 12 percent of total health care expenditures
  - Track accountability for annual primary care expenditure targets

- Policies to Increase and Sustain Primary Care
  - Recommend methods to incentivize achievement of the 12 percent target
  - Recommend specific practices and methods of reimbursement to achieve and sustain primary care expenditure targets

Multi-payer Collaboration: Background

- Over the last 15 years, there have been multi-payer primary care efforts in states with federal sponsorship
- WA has not participated in these efforts to date

Model	Years	Participants
Comprehensive Primary Care Initiative (CPC)	2012-2016	442 primary care practices operating in 7 geographical regions
Multi-payer Advanced Primary Care Practice (MAPCP)	2011-2016	800+ practices in 8 states
Comprehensive Primary Care Initiative Plus (CPC+)	2017-2021	2,610 practices in 18 regions
Primary Care First	2021-2027	2,600 practices in 26 regions

Why Multi-payer Collaboration?

- Drive momentum toward a common direction with shared goals
  - Sharing of best practices and working together towards shared goals
- Reduce avoidable utilization and costs
  - Alignment of payment, quality, and data to promote larger improvements in practice performance
- Reduce burden for providers & payers
  - Use of common primary care definition, aligned requirements, coordinated supports to reduce burden
- Enact change for more than one payer's portion of patient population served by provider

Examples of Multi-payer Successes
Colorado Multi-payer Collaborative

- Supported providers participating in CPC/CPC+ through:
  - Prioritizing adoption of value-based payment systems
  - Aligning core quality measures for both adult and pediatric primary care
  - Using aligned measures as existing contracts were renewed
  - Centralizing claims aggregation and reporting
- Select accomplishments include:
  - In 2015, CO was 1 of 4 regions in the CPC program to earn shared savings by bending the cost curve while maintaining or improving key quality metrics
  - Under CPC+, CO's average performance scores exceeded those of at least 9 of 13 other participating regions for three of the five program years

Source: https://www.milbank.org/wp-content/uploads/2023/04/CO_MPC_Lessons-Learned_4.11.pdf

Examples of Multi-payer Successes
Arkansas Health Care Payment Improvement Initiative (AHCPII)

- Multi-payer statewide initiative launched in 2012 that includes multi-payer primary care home, value-based payment alignment, metric alignment, centralized data exchange and reporting
- Select accomplishments include:
  - A majority of the state's primary care providers in more than 200 practices are now participating in a patient-centered medical home (PCMH) program
  - The vast majority of PCMH providers have achieved sustained practice transformation activities, such as 24/7 access, next-day appointments, and patient engagement strategies
  - Active use of the State Health Alliance for Records Exchange (SHARE)

Source: https://achi.net/library/2019-ahcpii-tracking-report/

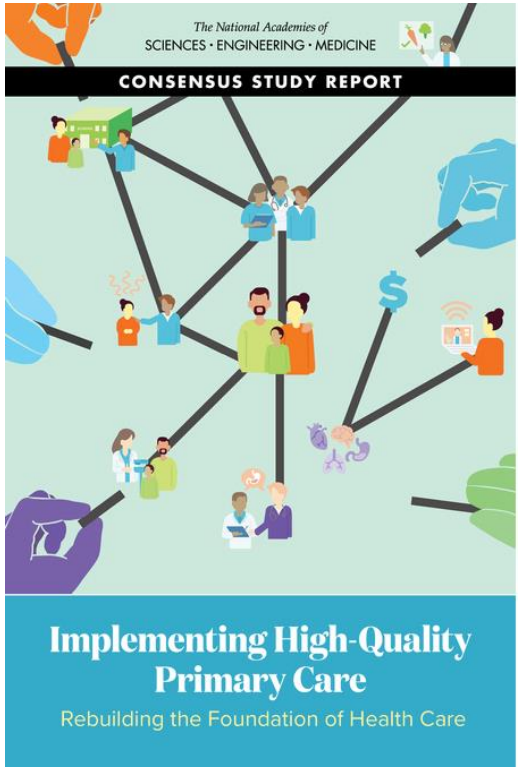
Examples of Multi-payer Successes
New York Capital District - Hudson Valley Comprehensive Primary Care Initiative

- Participating payers in CPC included commercial, Medicare Advantage, Medicaid FFS & managed care, federal employees
- Evaluation results:
  - Decline in Medicare hospital admissions
    - 6% decline for CPC group vs. comparison
    - 9% decline for high-risk CPC group vs. comparison
  - Improvements in quality-of-care measures including HbA1c testing and 14-day follow-up visits after hospital discharge
  - Total cost of care did not increase even after accounting for care management fees paid to participants in first year

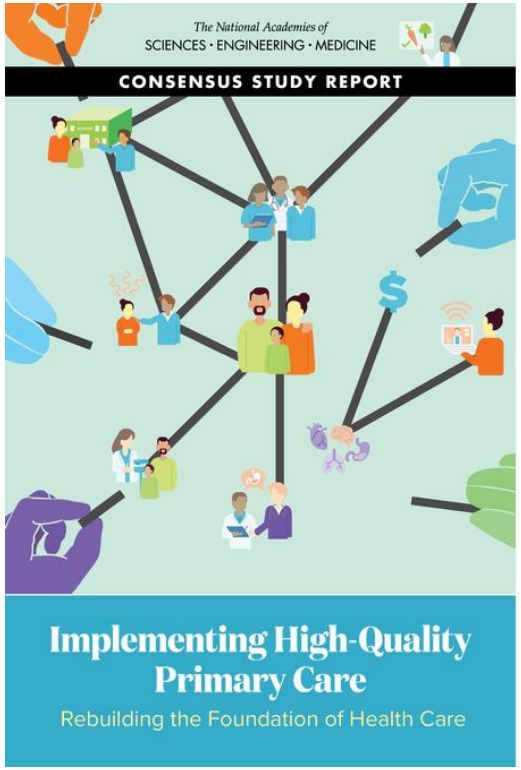
Sources: https://innovation.cms.gov/Files/reports/CPCI-EvalRpt1.pdf

Increased Calls for Multi-payer Alignment

- A 2021 report by the National Academies of Science, Engineering and Medicine, *Implementing High-Quality Primary Care* recommended states implement primary care payment reform by:
  - Using their authority to facilitate multi-payer collaboration on primary care payment and fee schedules and
  - Measuring and increasing the overall portion of health care spending in their state going to primary care.



Supporting Multi-payer Collaboration



Importance of Multipayer Collaboration

- Estimated 60%+ of market needed
- Medicare needs to take leadership
- Large local payers help
- States need to help facilitate (Medicaid/ Governor)
- Neutral convener builds trust
- Provide a forum for provider learning
- Patience – returns come after >5 years
- Encourage involvement by self-insured plans

The National Academies of
SCIENCES · ENGINEERING · MEDICINE

Presentation to Rhode Island Care Transformation Collaborative, June 20, 2021

WA Multi-payer Primary Care Work Underway

- WA Multi-payer Collaborative initial efforts focused on quality measures, practice supports, and payment models for primary care practices
  - Signed initial MOU in 2020
  - Developed a WA multi-payer model in 2022
- Purchasers and providers have been engaged along the way
- The Collaborative is currently:
  - Convening a provider Learning Cohort to identify aligned opportunities to support practices
  - Seeking to align WA's model and the CMS Making Care Primary model to bring critical mass for practice transformation
  - Working toward an updated multi-payer MOU

WA Multi-payer Primary Care Framework

Provider Accountabilities

1) Whole person care
2) A team for every patient
3) Appropriate resource allocation
4) Behavioral health screening and follow-up
5) Patient support
6) Care coordination strategy
7) Expanded access
8) Culturally attuned care
9) Health literacy
10) Data-informed performance management

Terms

"Providers" = Primary Care Practices
"Payers" = Insurance Carriers, Third Party Administrators
"Purchasers" = Employers, Health Plan Sponsors

Provider Role

Participate in Provider Recognition Program

Participate in Payment Models

Leverage Practice Supports

Progress Through Provider Accountabilities Framework

State Role

Administer Provider Recognition Program

Align HCA Programs

Performance Standards
Model Participation/Financing
Practice Supports
Contract Alignment

Payer Role

Align Practice Supports

Align Quality Standards

Align Payment Models

Transformation Funding
Prospective Comprehensive Care Payment
Quality Incentives

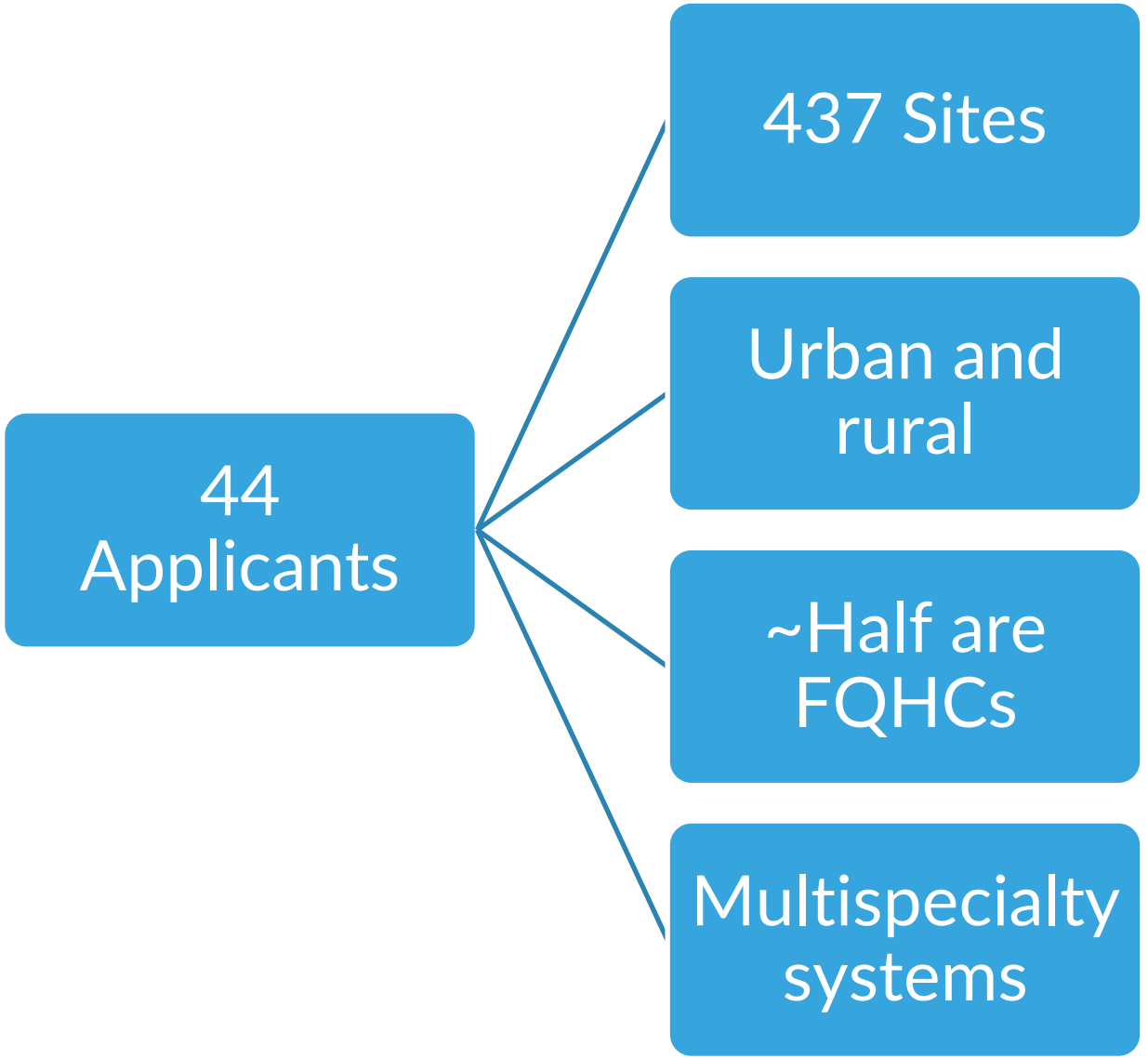
Purchaser Role

Align Contractual Expectations for Payers and/or Directly Contracted Providers

Performance Standards
Model Participation
Practice Supports
Payment Model Transformation

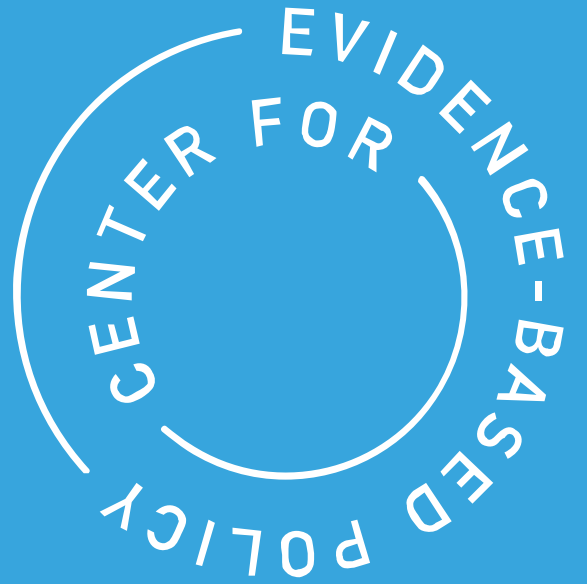
Making Care Primary

- Provider applications to CMMI for the Medicare model, Making Care Primary, were due mid-December
- HCA continuing discussions w/providers about readiness and multi-payer support



Policy Recommendations

- Committee statement of support for:
  - The WA Multi-payer Collaborative's work in aligning standards, quality metrics, practice supports, and payment models
  - The Collaborative's efforts to align WA primary care transformation efforts with the federal Making Care Primary program
  - Legislature to advance multi-payer primary care alignment efforts, particularly for state-funded plans to participate in a Making Care Primary aligned transformation model


CENTER FOR EVIDENCE-BASED POLICY

Tab 7

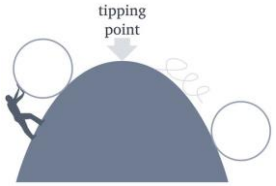
Washington State Health Care Authority

Primary Care Transformation

Washington State Health Care Authority

Benefits of Payer Partnership with CMS for MCP

Build upon existing efforts in Washington to implement an evidence-based primary care transformation model to improve primary care by providing additional Medicare resources.



Accelerate change and reach a tipping point to achieve shared goals that increase clinician incentives to improve patient outcomes, while reducing clinical and administrative burden, increasing likelihood of provider success in value-based care and realization of increased value for payer investment.

Goal-oriented and data-driven convening with other payers at the state and national level to share lessons learned and work towards increased alignment on technical model elements over time (e.g. attribution, benchmarking and risk adjustment).

Improved data provision to practices, with a long-term goal of aggregating data across payers.

Illustrate commitment to primary care investment, increasing appeal as payers to participating primary care providers.

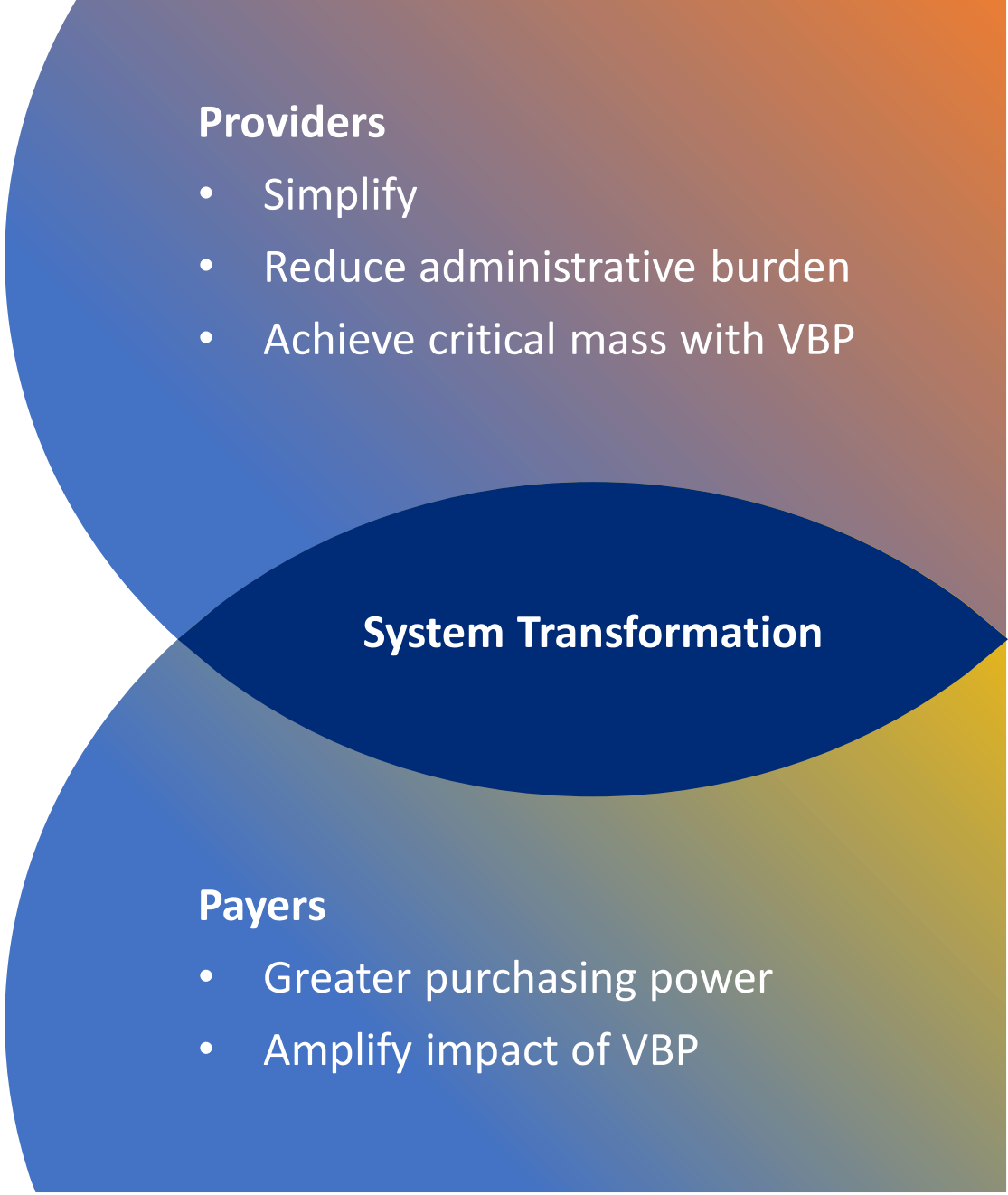
Multi-Payer Alignment

Why is this important?

- Multi-payer alignment helps both provider and payers in adopting VBP and achieving system transformation

- Provider perspective:
  - Must reach critical mass in VBP (~2/3 of total patient/revenue volume) to transition to sustainable payer-agnostic, population based care models (Stowe et al., 2021; Basu et al., 2017)
  - Alignment across payers reduces administrative burden for providers (CMMI, n.d.; ASPE, 2022) and makes it easier to succeed under VBP

- Payer perspective:
  - Coordination across payers increases market power of payers, amplifies the impact of VBP, and allows for greater system-wide transformation (Crook et al., 2021; ASPE, 2022)



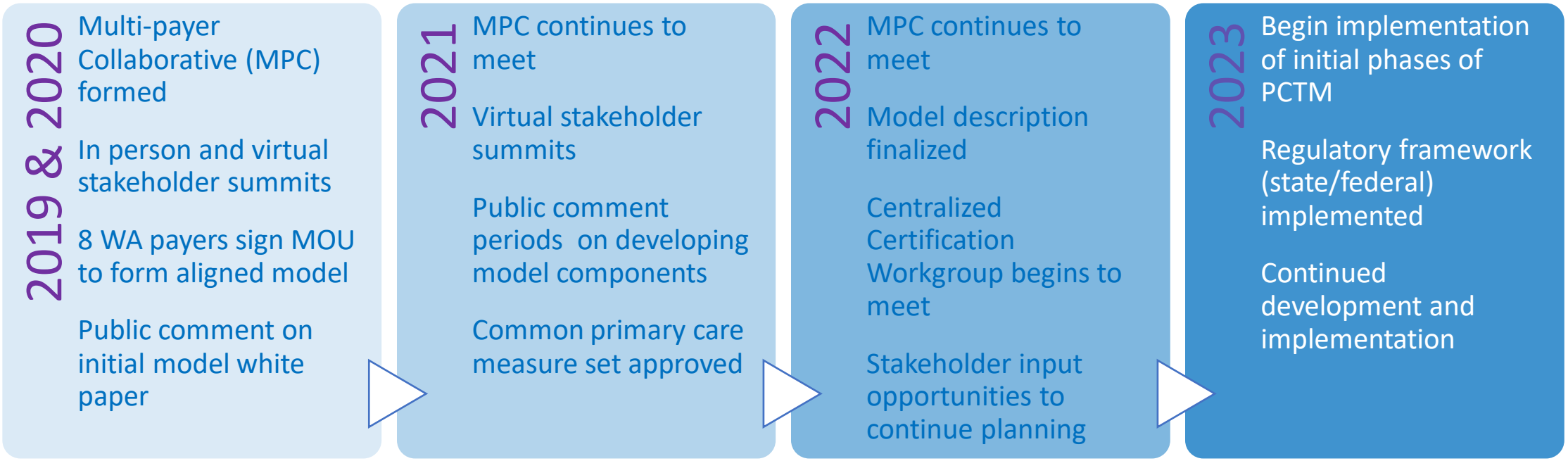
Building a new Multi-payer Primary Care Model

- Goals:
  - Align payment, incentives, and metrics across payers and providers
  - Promote and incentivize integrated, whole-person, team-based care that includes primary care, physical and behavioral health care, and preventive services

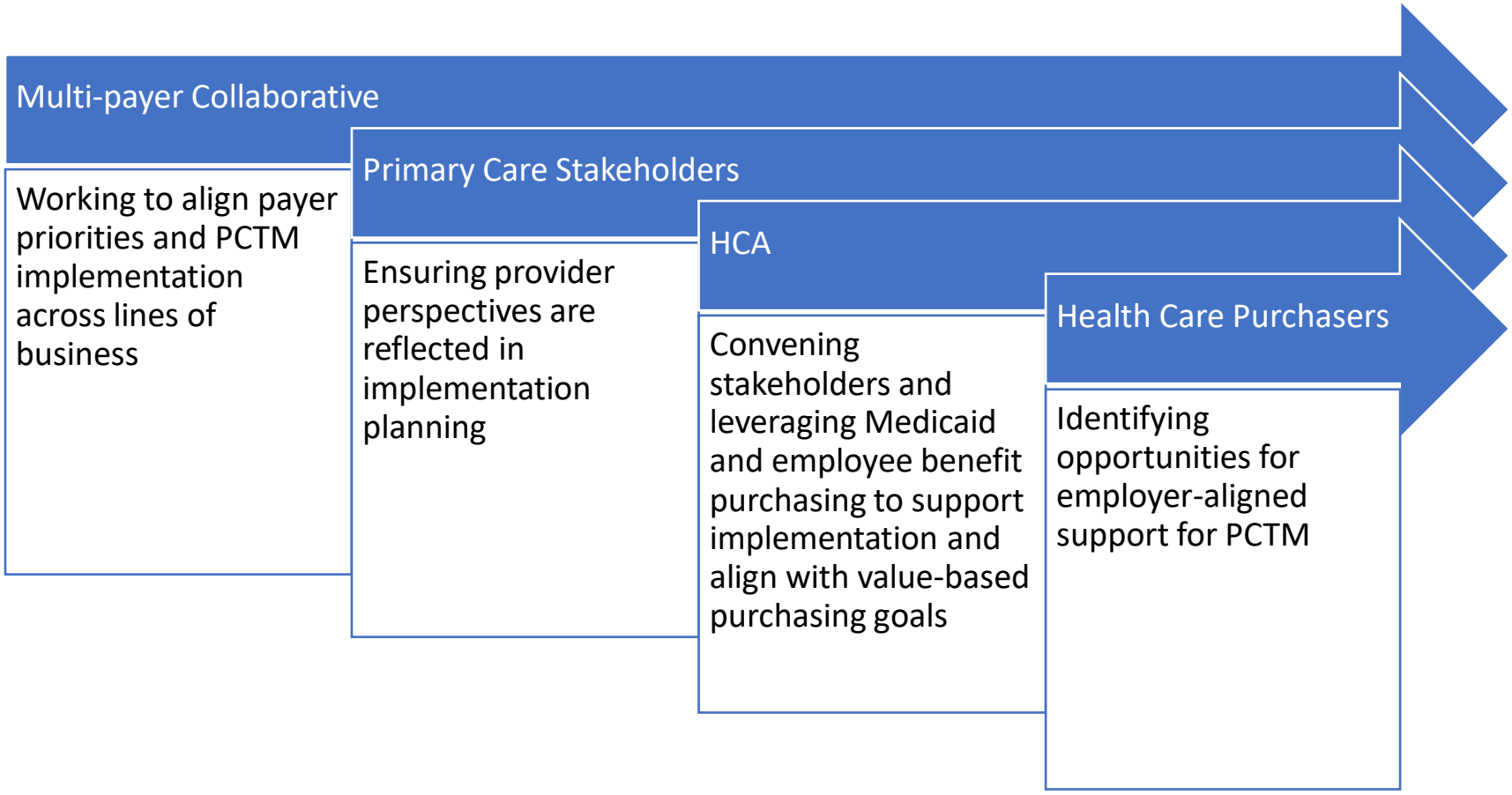
Building a new Multi-payer Primary Care Model conti.

- Goals:
  - Improve provider capacity and access
  - Increase primary care expenditures while decreasing total health spending
  - Work with public and private employers to spread and scale the model throughout Washington

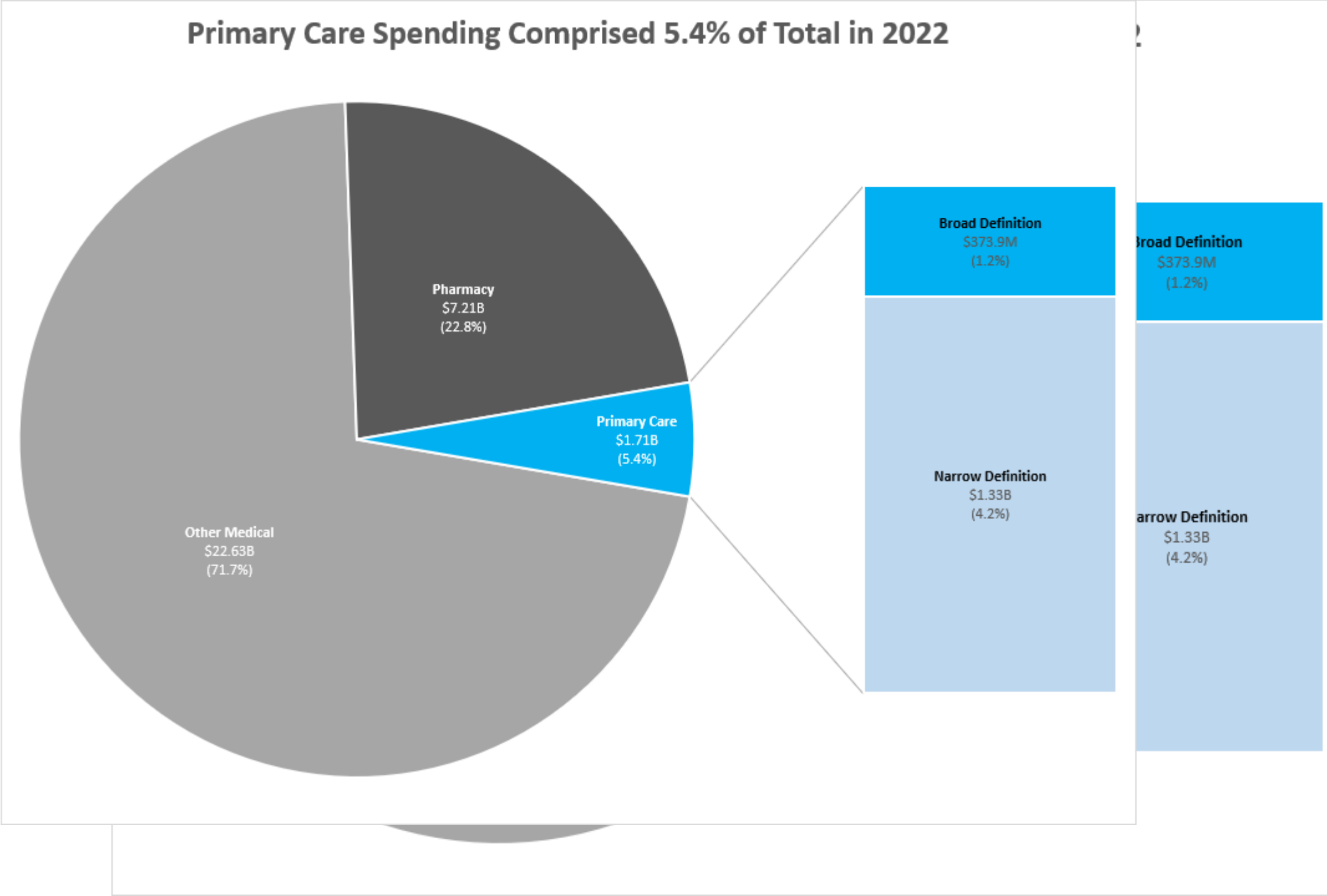
Building the WA Washington Primary Care Transformation Model (PCTM)



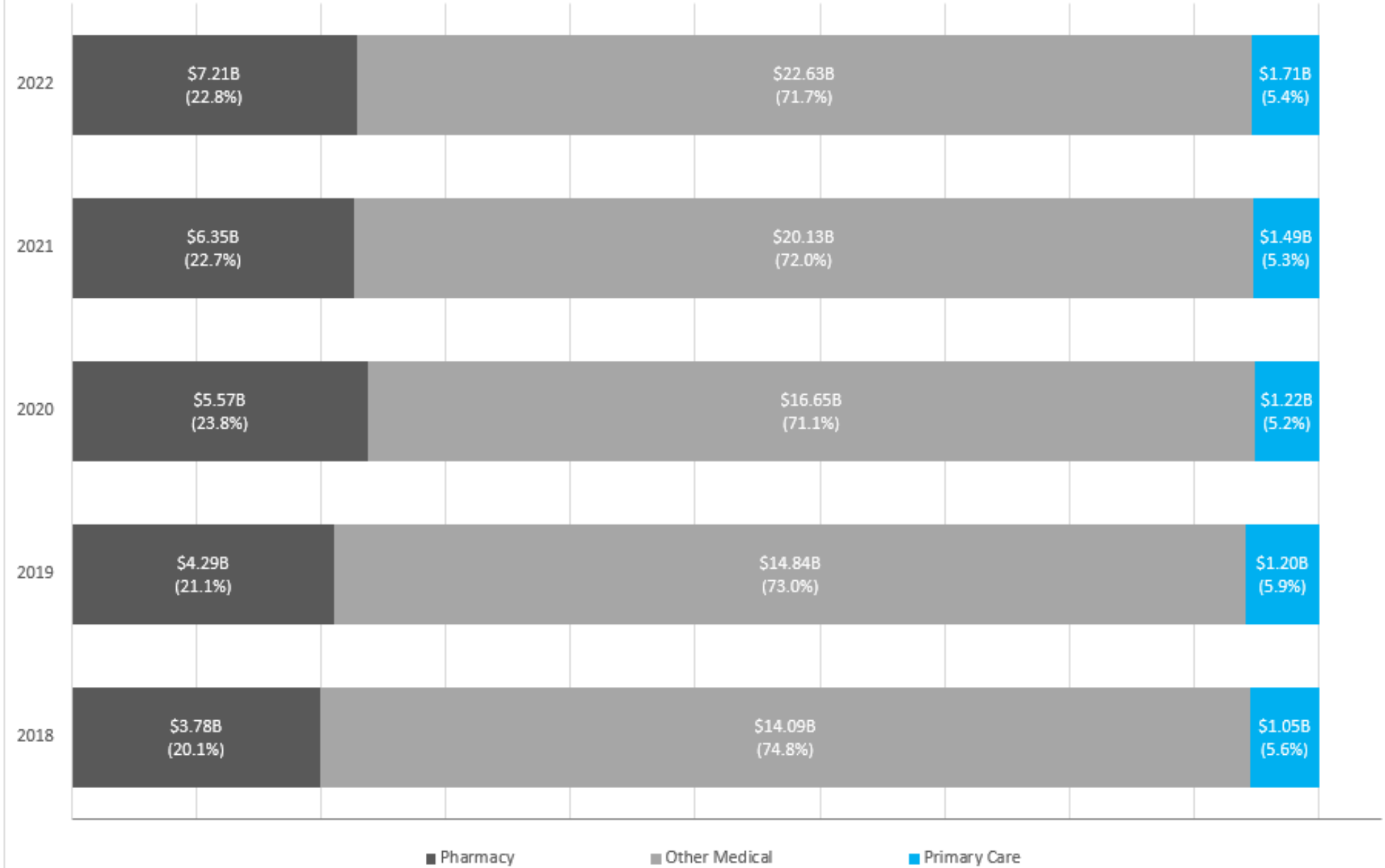
Aligned Efforts

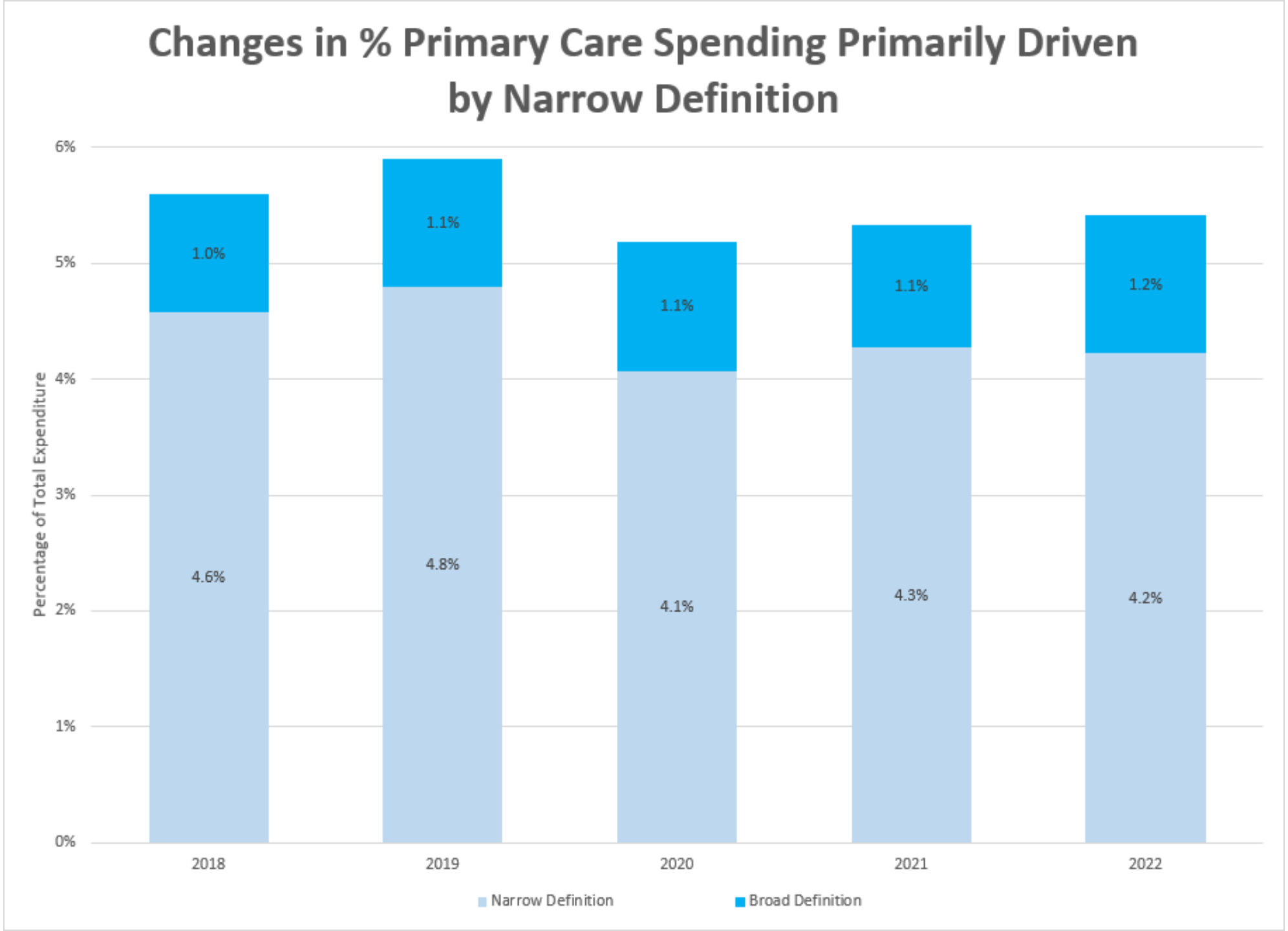


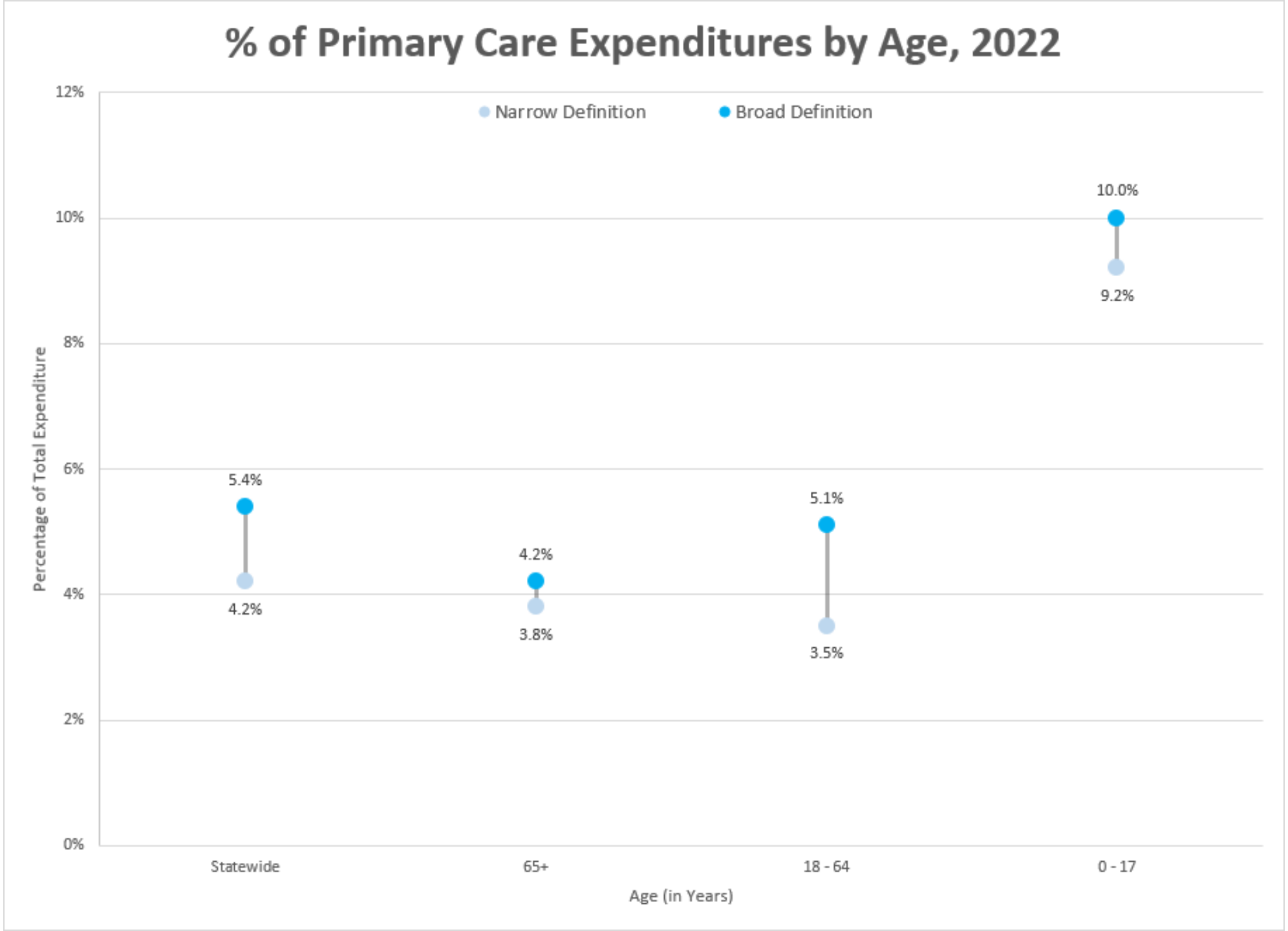
Partnership and alignment leading to successful PCTM implementation

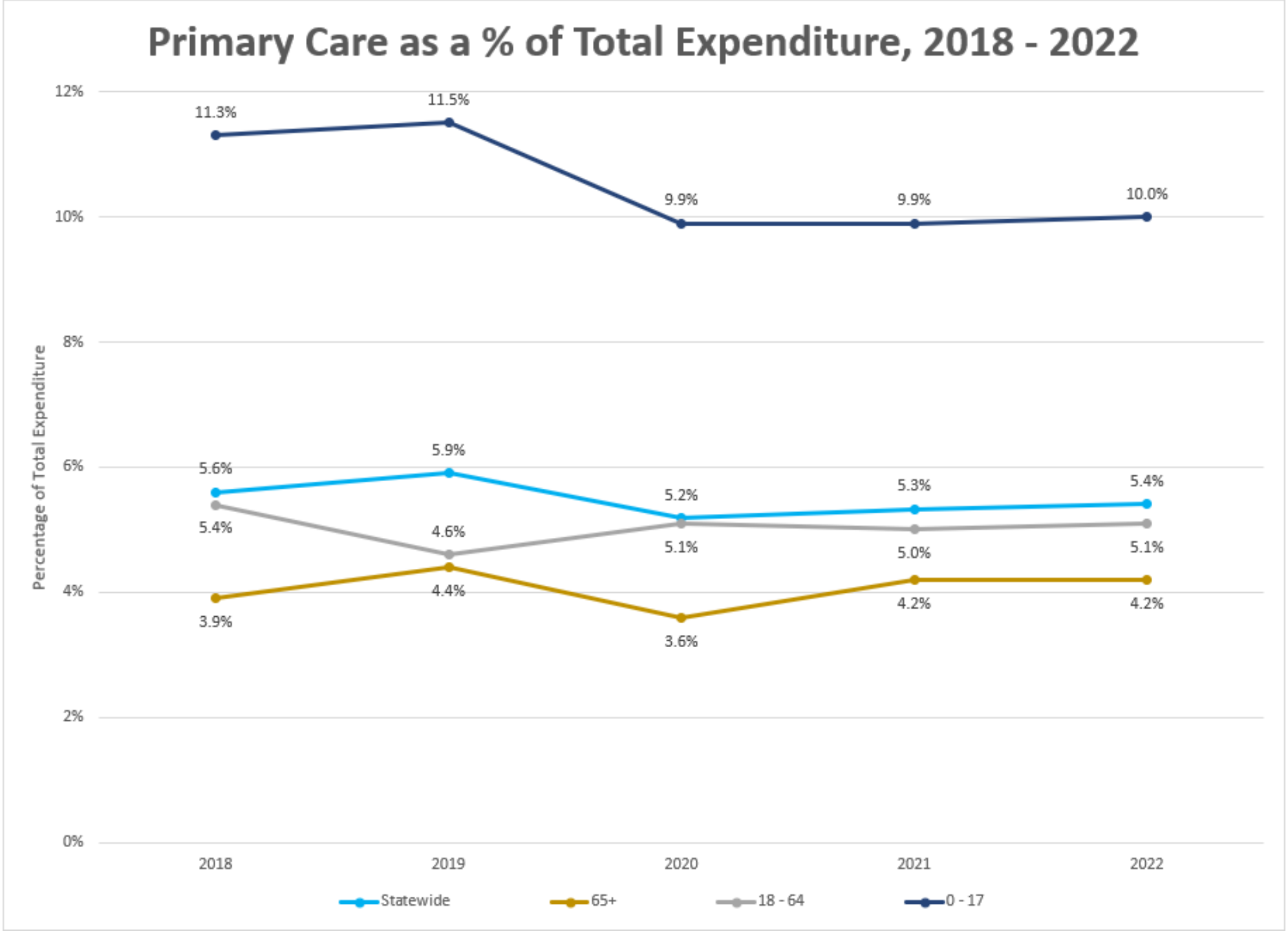

Primary Care Spending Comprised 5.4% of Total in 2022
Pharmacy
$7.21B
(22.8%)
Primary Care
$1.71B
(5.4%)
Other Medical
$22.63B
(71.7%)
Broad Definition
$373.9M
(1.2%)
Narrow Definition
$1.33B
(4.2%)

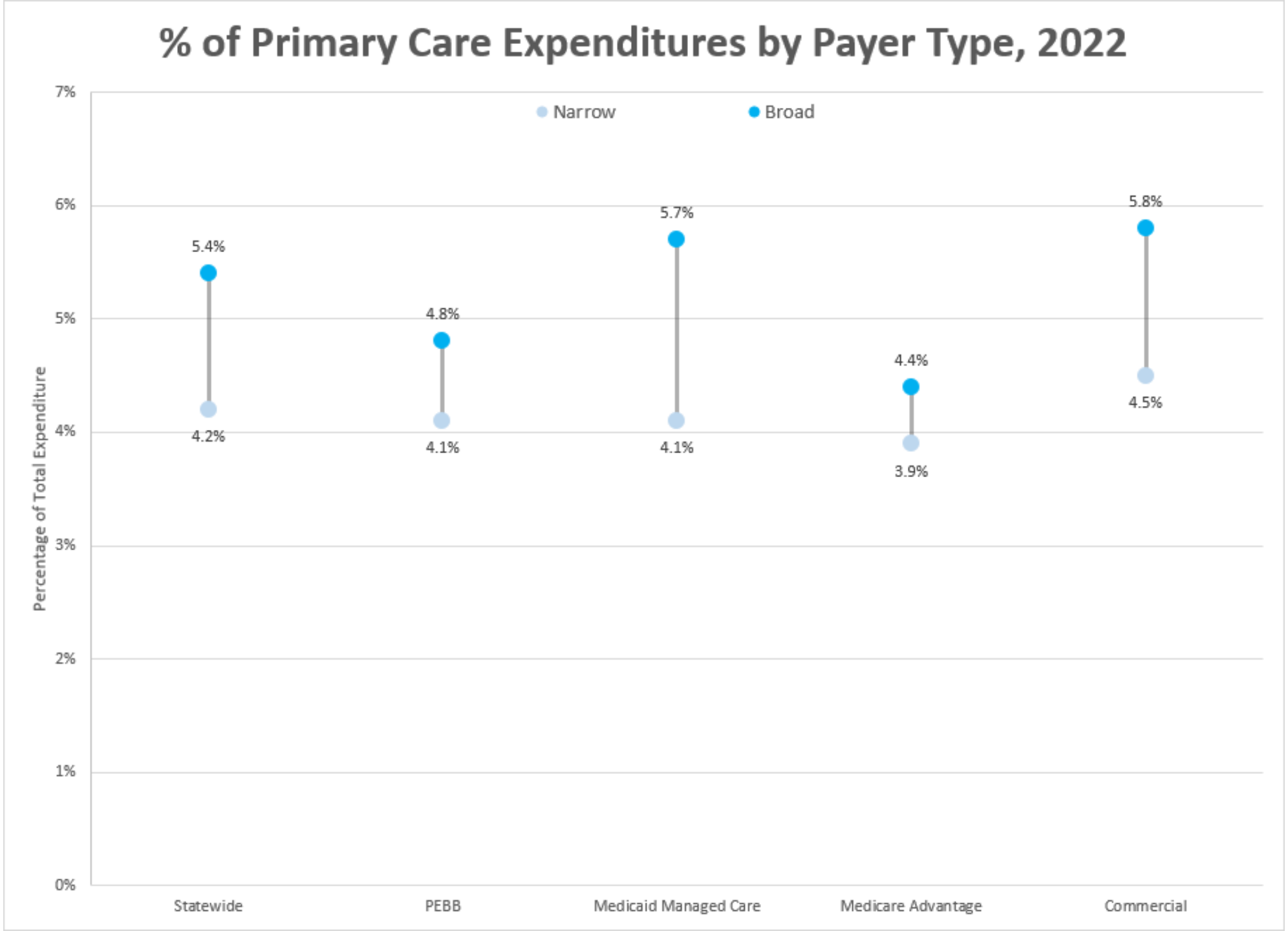
The % Primary Care Spending has started to recover after 2020, increasing to 5.4% in 2022



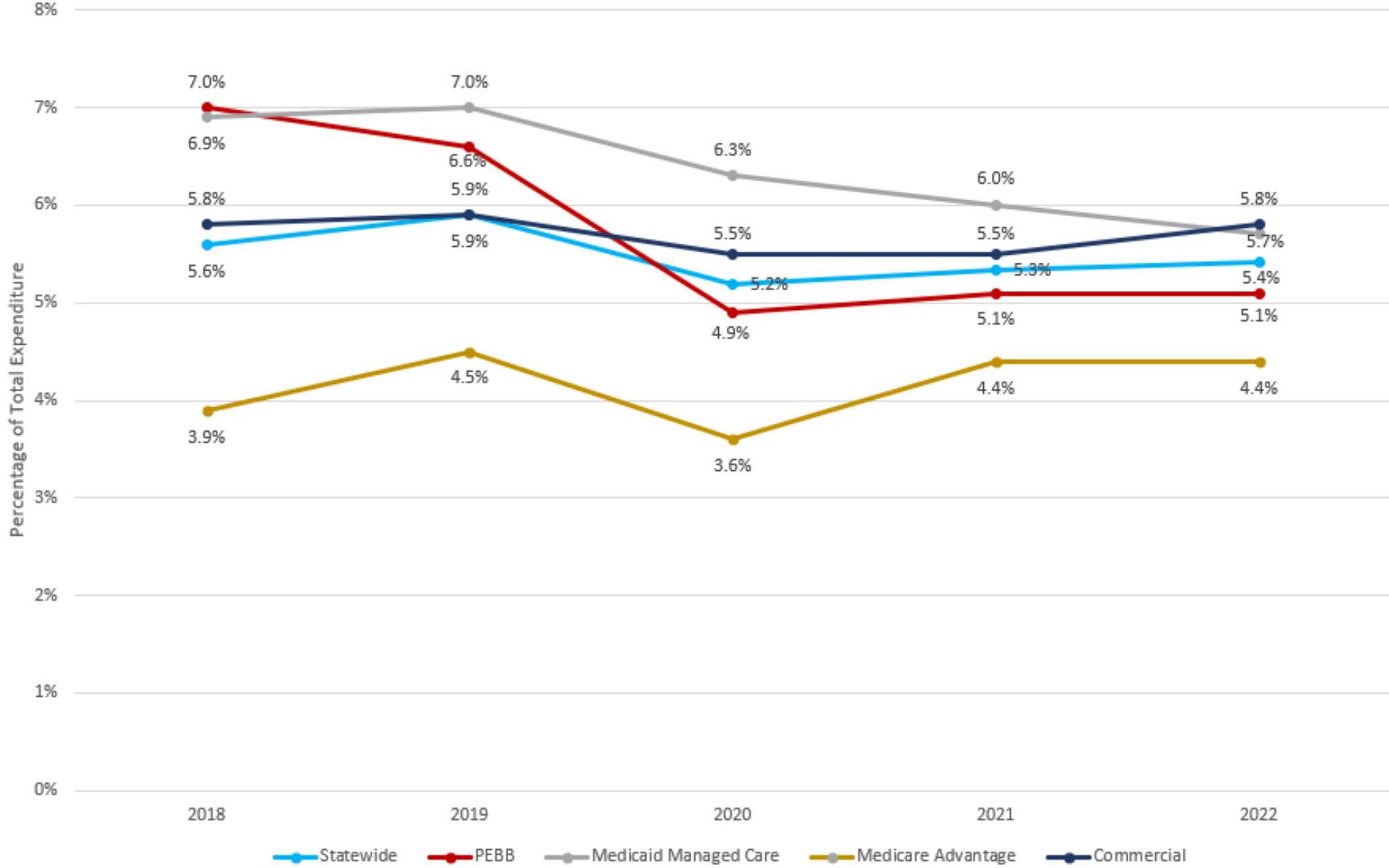

Changes in % Primary Care Spending Primarily Driven by Narrow Definition
Percentage of Total Expenditure
6%
5%
4%
3%
2%
1%
0%
1.0%
1.1%
1.1%
1.1%
1.2%
4.6%
4.8%
4.1%
4.3%
4.2%
2018
2019
2020
2021
2022
Narrow Definition
Broad Definition


% of Primary Care Expenditures by Age, 2022
Narrow Definition
Broad Definition
12%
10%
8%
6%
4%
2%
0%
Percentage of Total Expenditure
5.4%
4.2%
4.2%
3.8%
5.1%
3.5%
10.0%
9.2%
Statewide
65+
18 - 64
0 - 17
Age (in Years)


Primary Care as a % of Total Expenditure, 2018 - 2022
Percentage of Total Expenditure
12%
10%
8%
6%
4%
2%
0%
2018
2019
2020
2021
2022
11.3%
11.5%
9.9%
9.9%
10.0%
5.6%
5.9%
5.2%
5.3%
5.4%
5.4%
4.6%
5.1%
5.0%
5.1%
3.9%
4.4%
3.6%
4.2%
4.2%
Statewide
65+
18 - 64
0 - 17


% of Primary Care Expenditures by Payer Type, 2022
Narrow
Broad
Percentage of Total Expenditure
7%
6%
5%
4%
3%
2%
1%
0%
5.4%
4.2%
4.8%
4.1%
5.7%
4.1%
4.4%
3.9%
5.8%
4.5%
Statewide
PEBB
Medicaid Managed Care
Medicare Advantage
Commercial

Primary Care as a % of Total Expenditure by Payer Type, 2018 - 2022



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

Washington State Health Care Authority