Advisory Committee of Health Care Providers and Carriers meeting

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Advisory Committee of the Health Care Providers and Carriers

September 7, 2023
2:00 p.m. – 4:00 p.m.
Zoom Meeting
Hybrid at Cherry Street Plaza

AGENDA

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

Committee Facilitators:
Mandy Weeks-Green and Theresa Tamura

Time	Agenda Items	Tab	Lead
2:00 - 2:05 (5 min)	Welcome and roll call	1	Mandy Weeks-Green Health Care Authority
2:05 - 2:10 (5 min)	Approval of meeting minutes from December 2022, March 2023, and June 2023	2	Mandy Weeks-Green Health Care Authority
2:10 - 2:20 (10 min)	Public Comment	3	Mandy Weeks-Green Health Care Authority
2:20 - 2:55 (35 min)	Making Care Primary Overview	4	Kahlie Dufresne and Judy Zerzan-Thul Health Care Authority
2:55 - 3:50 (55 min)	Washington State Health Care Affordability Activities • Introduction and Overview • Health Benefit Exchange Strategies to Approach Rising Costs • Office of the Insurance Commissioner Affordability Activities	5	Mich'l Needham, Health Care Authority Laura Kate Zaichkin, Health Benefit Exchange Jane Beyer, Office of the Insurance Commissioner and Board Member
3:50 - 4:00 (10 min)	Member Motion to Revisit Benchmark Data	6	Mika Sinanan UW Medical Center
4:00	Adjourn		Mandy Weeks-Green Health Care Authority

Tab 2

Advisory Committee of Providers and Carriers Meeting Summary

December 1, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the board is available on the Advisory Committee of Providers and Carriers webpage.

Members present

Justin Evander
Louise Kaplan
Stacy Kessel
Todd Lovshin
Vicki Lowe
Mike Marsh
Natalia Martinez-Kohler
Megan McIntyre
Mika Sinanan
Dorothy Teeter
Wes Waters
Ross Laursen

Members absent

Mark Barnhart
Bob Crittenden
Paul Fishman
Jodi Joyce

Call to order

AnnaLisa Gellermann called the meeting to order at 2:01 p.m.

Agenda items

Welcome, roll call, and agenda review

AnnaLisa Gellermann, Committee Facilitator

Approval of August meeting summary

The committee voted to adopt the Meeting Summary from the August 2022 meeting.

Topics for Today

The main topics were meetings and milestones, primary care definition, and a presentation on claims-based measurement.

Meetings and Milestones

AnnaLisa Gellermann, Committee Facilitator

Committee member Ross Laursen asked about the scope of the committee and the board. AnnaLisa Gellermann responded that primary care has been added to the scope of the committee. The board is in an exploratory phase and hasn't come to a decision on benchmark implementation. The benchmark and cost driver analysis will both be revisited in 2023.

The board's major milestones include the 2022 cost driver analysis, benchmark Report and primary care recommendations for 2023, the August legislative report, and 2023 cost driver analysis. Benchmark results will not be shared publicly at the beginning, and 2023 is the first year for data release. The benchmark data always includes two years of data. The primary role of the providers and carriers committee is to continue to make recommendations to the board. The cost driver analysis is updated annually. The benchmark uses high level aggregate cost data and the cost driver analysis is always claims-based.

Committee member Mike Marsh suggested it would be helpful in each meeting, particularly earlier meetings in 2023, to see evidence of the committee's feedback in the reports and analysis. AnnaLisa pointed out that the presentation reflects months for large deliverables.

Committee member Mika Sinanan asked for clarification on which year, 2022 or 2023, represented the first year of data for the benchmark. AnnaLisa Gellermann clarified that 2022 is the first benchmark report, which will be released in 2023. The naming convention comes from the benchmark report comes from the technical manual. Data will be from 2017 through 2019 that was collected in 2022.

Mika Sinanan suggested adding a comment section from the providers and carriers committee into the board's legislative report. The comment section would serve as a counterpoint/comment section in the report. AnnaLisa Gellermann replied that to add a comment section, the *committee* would need to provide a recommendation, not just one individual committee member. Mika Sinanan made a motion to include a brief comment section authored by the advisory committee. AnnaLisa Gellerman presented a motion for the committee to recommend that a committee written segment be included in the board's legislative report. Committee member Dorothy Teeter voiced support for the motion and noted that it would demonstrate a level of transparency appreciated by the legislature. AnnaLisa Gellermann called for a vote to approve the motion to recommend to the board that the board request a written contribution from this committee that would be included in the board's annual legislative report. The motion passed. The motion will be written down to email for the board's review. Ross Laursen asked when the committee would need to have something drafted for the board to review. AnnaLisa responded that a draft should be written by May, the latest would be June.

Next, AnnaLisa Gellermann provided an overview of the board's meetings and the board's subcommittees, starting with requests from committees around submission of feedback. The board is the funnel through which all recommendations go. The board's workplan is subject to change.

Ross Laursen asked who is on the board and how to handle turnover for the providers and carriers committee. AnnaLisa Gellermann responded that members are listed on the board's website – all board positions are specified by statute. This committee has specific criteria for which organizations are represented. There will be a process for departing committee members where the represented entity will nominate a replacement.

Mike Marsh noted a general desire on the part of committee members to have a formal process to codify recommendations. There are times where a topic is brought up and discussed and there are varying or even incongruent positions within the committee. AnnaLisa Gellermann suggested exploring more formal recommendations for each topic in the form of a motion. Mike Marsh pointed out that meeting summaries highlight individual comments. What's more powerful is "Dr. Sinanan made a motion which was unanimously endorsed by the board." Mika Sinanan agreed. If someone who isn't a meeting participant and hadn't listened to the recording were to read only the summaries, the summaries would give the impression of individual comments, which are easy to discount. The committee should try to determine whether a perspective represented by one or more people is shared broadly by the committee, to strengthen positions. AnnaLisa Gellermann suggested that the committee move toward creating a motion to create recommendations. The recommendation would call upon some committee members to speak and engage more actively. For now, there will be no motion to make everything a motion. However, there can be a general collective movement towards making motions for certain topics. Committee member Stacy Kessel suggested that rather than making motions, maybe committee members could say they'd like to put their name on something. Some topics might not result in outright dissent, but also might lack outright support. AnnaLisa Gellermann replied that there must be a differentiation between consensus and additional nuance.

AnnaLisa Gellermann presented the providers' and carriers' committee schedule. The providers and carriers committee will review the primary care recommendations, OnPoint's cost-driver report, the risk-adjusted hospital report, the 2023 benchmark data call reported entities, and provide feedback on the 2022 benchmark results. AnnaLisa Gellermann also reviewed the schedules for the data committee and primary care committee.

Primary Care Committee Recommendation

Jean Marie Dreyer, Health Care Authority (HCA)

Jean Marie provided an overview of the Advisory Committee on Primary Care's process for developing a definition of primary care and reviewed the existing statutory and regulatory definitions on record. Jean Marie presented the Office of Financial Management's (OFM's) 2019 definition, the National Academy of Sciences Engineering and Medicine's (NASEM's) definition, and the Bree Collaborative's 2021 definition of primary care. The Bree definition expanded on OFM's definition. NASEM and Bree have many elements in common. The committee decided to blend NASEM and Bree's definitions to create a hybrid definition.

Public Comment

There was no public comment.

Discussion and Feedback to the Board on Primary Care Recommendation

Mike Mash approved of the emphasis on a team-based approach rather than calling out specific specialties. The inclusion of "equitable" in the definition is also good. It would be helpful to have a preamble e.g., lowering costs, improving health, etc. The implications of how to fund and reinforce primary care need a holistic orientation towards the totality of medical specialties.

Mika Sinanan suggested testing the definition against relationships, e.g., urgent care. Is a facility that is an urgent care clinic, a primary care facility, or not? Would an obstetrician gynecologist (OBGYN) providing ongoing care during and outside of pregnancy count as a primary care clinician? It's important not to exclude specialists by imposing excessive caveats. There are two ways to craft a definition: data-driven vs. holistic. The holistic approach appeals to health care professionals. Jean Marie Dreyer noted that locations and specialists will be considered as part of the primary care committee's discussion of claims-based measurement. The committee plans to use both a narrow and broad definition for measurement.

Committee member Louise Kaplan noted her previous experience working on a definition for the Bree Collaborative. Operationalizing the definition is more important than the exact words used. The definition should be broad-based and an inclusive definition - it's a guide.

Stacy Kessel expressed support for the inclusion of "equitable" in the definition. The primary care committee should also emphasize cultural sensitivity since it's different than equity. Additionally, the primary care committee should consider incorporating or referencing Social Determinants of Health (SDOH) to determine the impact on a patient's ability to comply with provider recommendations. Jean Marie Dreyer noted that the primary care committee hasn't discussed cultural sensitivity or SDOH. To a certain extent, the mention of the word "equitable" serves as coverage for that. Stacy Kessel added that specialists should be included but acknowledged that they don't always coordinate preventive care. Jean Marie Dreyer clarified that the primary care committee reviewed several criteria for provider and facility inclusion at previous committee meetings.

Dorothy Teeter emphasized that the focus of the definition should be to help the legislature support primary care services. The primary care committee needs to close the gap between where systems currently are and where data has been in the past. Stacy Kessel noted that one of the payment mechanisms for primary care is value-based purchasing (VBP) using quality incentive payments that aren't part of the claims-based system. It is important to recognize existing methods of payment that account for preventive care. Mika Sinanan asked if the definition helps drive toward the future of primary care, e.g., a cardiologist managing someone with chronic heart disease, are they also checking vaccines? Is there follow-up after a hospital visit?

Todd Lovshin expressed concern as a health plan representative regarding the many different reporting requirements and regulatory agencies who request different things depending on the primary care definition they use when parsing out services. HCA, the Health Benefits Exchange (HBE), and the board could have three different primary care reports. Multiple reports are time consuming and increase administrative burden. How will the primary care committee track and report consistently across many different entities?

AnnaLisa Gellermann noted that the majority of providers and carriers committee members were aligned in their support of the recommended definition. Committee member Wes Waters suggested adding a preamble or context statement for the definition. What is it being used for? For purposes of measuring the 12 percent, for purposes of measuring total cost of care, etc.? There needs to be continuity in purpose. Stacy Kessel reiterated a desire to add a reference to SDOH.

Primary Care: Introduction to Claims-Based Measurement

Jean Marie Dreyer, HCA

Jean Marie Dreyer presented the different examples of primary care claims-based measurement from the last three primary care committee meetings, including data from OFM's 2019 report on primary care spending, data from the Primary Care Collaborative on national primary care spending efforts, and data from the University of Washington.

Ross Laursen asked if the data from the OFM report included both Medicaid and commercial. Jean Marie Dreyer affirmed that OFM's report included both Medicaid and commercial data. Ross Laursen asked which CPT codes were included in OFM's report and asked to see the data criteria. Jean Marie Dreyer will email a link to the report.

Mike Marsh asked that it be reflected in the meeting summary that the presentation on claims-based measurement was rushed due to time constraints. AnnaLisa Gellermann noted that today's presentation was intended to be an introduction, not a comprehensive explanation. There is more to come as the primary care committee continues its work in upcoming meetings. It may be helpful for members of the providers and carriers committee to look at the primary care committee meeting recordings.

Adjournment

The meeting was adjourned at 4 p.m.

Next meeting

January 5, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Advisory Committee on Data Issues & Advisory Committee of Health Care Providers and Carriers
Joint meeting summary

February 7, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2 p.m. -4 p.m.

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

Data Committee Members present

Megan Atkinson
Allison Bailey
Ana Morales
David Mancuso
Hunter Plumer
Jerome Dugan
Jonathan Bennett
Julie Sylvester
Lichiou Lee
Mandy Stahre
Mark Pregler
Russ Shust

Members absent

Amanda Avalos
Bruce Brazier
Chandra Hicks
Jason Brown
Leah Hole-Marshall
Josh Liao

Providers and Carriers Committee Members present

Bob Crittenden
Paul Fishman
Jodi Joyce
Louise Kaplan

Stacy Kessel
Ross Laursen
Todd Lovshin
Mike Marsh
Megan McIntyre
Mika Sinanan
Dorothy Teeter
Wes Waters

Members absent

Justin Evander
Vicki Lowe
Natalia Martinex-Kohler

Agenda items

Welcome, Roll call, Agenda Review

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 2:02 p.m.

Topics for Today

Today's meeting is a joint meeting between the Advisory Committee on Data Issues and the Advisory Committee of Health Care Providers and Carriers. Topics include an introduction to the 2022 cost growth drivers study, discussion and feedback to the Board on the cost growth driver study, a presentation on the Primary Care Transformation Model and Primary Care Definition, and discussion and feedback to the Board on the definition of Primary Care.

2022 Cost Growth Drivers Study: Preliminary Findings

Amy Kinner, OnPoint, Director of Health Analytics

Amy Kinner presented an overview of OnPoint's study of cost growth drivers. The study reviewed cost trends and drivers of cost growth in the health care system by market, geography, health conditions and other demographics, and examined potential unintended consequences to inform the Board on how to curb spending growth.
In quarter one of 2023, OnPoint will begin to examine chronic conditions.
Ross Laursen asked whether the scope of the cost driver analysis includes measuring trends against past discussions regarding the benchmark. AnnaLisa Gellerman clarified that the benchmark is a separate but parallel effort from the cost growth study. Results of the first benchmark measurement (using retrospective data from 2017-2019) will be ready in the summer of 2023.
The study used 5 years of data from 2017 – 2021 to align with the cost-benchmarking period. Products analyzed included commercial (limited data from self-insured plans), Medicaid (managed care only), Medicare Fee-For-Service (FFS) (only available through 2019), Medicare Advantage (MA) (covered by commercial plans), Public Employees Benefits (PEB) (commercial and MA), Washington Health Benefit Exchange (HBE) (commercial). Dual-eligibles were not broken out separately due to missing FFS data beyond 2019. Wes Waters noted that the study's material exclusions in Medicaid could skew the data and asked how assumptions are clarified in the analysis to avoid misinterpretation of the data. It was noted that previously, FFS line-level payments were unusable for cost reporting due to limitations in the way data was submitted, however this issue has been fixed and will not be an

issue going forward. AnnaLisa will share with committee members OnPoint's specifications document which includes detailed codes and definitions. Mika Sinanan posed whether the data limitations will limit the ability to apply what has been learned from the subset in the study to the overall set.
Categories of service were aligned with the benchmarking initiative and include hospital inpatient, hospital outpatient, a narrow definition of primary care providers, non-primary care specialty providers, other providers, long-term care, retail pharmacy, and all other spending (ambulances, durable medical equipment, etc.).
The following are limitations of the study: lack of data for self-insured individuals, no Alternative Payment Model data, no uninsured data, no Medicaid FFS data, and Medicare FFS data being available only through 2019. Long-term care data for Medicaid is not reported but is a significant contributor to spending.
The All-Payer Claims Database (APCD) data represents approximately 4 out of 7 million (the total state population). Between 2017 and 2021, enrollment increased from 3.5 to 4 million (not including Medicare FFS).
Mandy Stahre asked when School Employee Benefits Board (SEBB) plans were added, and it was clarified that SEBB data was identified in 2021. Megan Atkinson added that SEB as a state-operated centralized program began coverage in 2020.
The study compared population growth to membership growth, where population growth was stable at around 1.6 percent, with a ~6.3 percent shift in membership in 2020.
The study examined enrollment by product (Medicare FFS only 2017 - 2019, with all other products ranging from 2017 - 2021). There was significant growth in Medicaid and commercial remained steady. Nationwide, MA plans became more popular. Medicaid lost membership in 2018 and 2019 and then increased during the COVID-19 public health emergency (PHE). The PHE also prompted some growth in the HBE population. Dorothy Teeter asked if the study included about half of Washington's population, and it was clarified that it was.
Inpatient was the highest category of spending in 2017 -2021. There was more growth in outpatient than inpatient, and no significant growth in primary care. Louise Kaplan asked how outpatient differed from primary care, and it was clarified that outpatient is on the facility side, and primary care includes professional fees. Between 2017 - 2021, inpatient spending decreased relative to other spending, as did specialist, long-term care, and primary care. Pharmacy claims expenditures increased from $4.6 billion in 2017 to $6 billion in 2021.
Per member per month (PMPM) spending increased from $271 to $340 between 2017 – 2021. There was an aggregate increase of 25 percent over time, mostly focused in 2021. Pharmacy PMPMs showed the same aggregate 25 percent growth with an increase of $21 per month. For pharmacy spending by product (not including MA due to Part D coverage), spending was slightly higher under HBE. All products increased between 21 and 29 percent.
Regarding increasing costs over time, Jonathan Bennett asked what factors were considered to provide better context and framing for the data, e.g., patients with high-cost needs. Amy Kinner clarified that this topic would be covered later in the presentation.
Regarding total PMPM medical expenditures, Mika Sinanan asked what proportion the exclusions (e.g., Medicare FFS) are of the total, and whether the exclusions would markedly impact the PMPM values. Amy Kinner replied that this question could be taken back to OnPoint and the Health Care Authority (HCA).
Megan Atkinson stated that HCA can easily analyze the impact of targeted program changes on Medicaid spending, but it will be important to try to understand other impacts, e.g., changes in the population, utilization, inflation, etc., across all payers. Without that additional context, it will be difficult to fully understand how well the state is doing compared to the Board's cost growth target. Wes Waters agreed with trying to understand factors that impact spend and trend, noting that commercial products have a different level of member liability at each tier which affects the trend of the product.
The study also analyzed PMPM by category. Most spending was on inpatient and outpatient. Other professional and other medical, while lower than inpatient and outpatient, still saw significant growth.
For inpatient PMPM spending by product, inpatient and outpatient spending for MA was higher than other plans. Commercial showed steadier growth and Medicaid growth remained low.

In examining inpatient, outpatient, and total pharmacy PMPM spending, outpatient PMPM growth was driven by a 32 percent increase in utilization. Pharmacy PMPM spending increased by 25 percent. Inpatient saw a decrease in utilization, but an increase in average allowed amount per service.
There were regional variations in spending. Medical PMPMs ranged from $150 to $1,200. Commercial medical PMPM spending by Accountable Community of Health (ACH) of patient residence was examined.
For medical PMPMs by age and gender in 2021, PMPM was higher for infants and aging populations. There was spending growth across ages for both men and women.
Patients with high-cost needs, or "high-cost members" were defined as individuals with greater than $125,000 in total medical spending. For each product, high-cost members comprised less than 1 percent of membership but 15 to 21 percent of total spending. High-cost members tend to have $20,000 or more in PMPM.
Phase two of the analysis will drill down further into several specifications, e.g., areas of growth by product and region, how chronic conditions impact spending and growth, and if there is a relationship between spending and quality/access to care.
Mike Marsh recommended that this information be made more translatable to various audiences by making sure that the attribution methodology of expenses is clearer. Additionally, PMPM could be made clearer, including how "price makers" such as supply chain, and "price makers" such as utilization, influence the cost of care curve.

Public Comment

There were no public comments.

Primary Care Recommendation

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

Dr. Judy Zerzan-Thul gave a presentation to the committee that contained an updated on the Primary Care Transformation Model (PCTM) and a recommended definition of primary care formulated by the Advisory Committee on Primary Care (the primary care committee).
Dr. Zerzan-Thul reviewed an updated framework for the PCTM that includes provider, state, payer, and purchaser accountabilities. Dr. Zerzan-Thul compared the PCTM and SB 5589. It will take several years to implement new measurements for primary care spending. Both the PCTM and the primary care spending measurement work aim to increase primary care spending while decreasing total health care spending. There is no date by which the 12 percent spending goal must be attained.
The primary care committee has completed its work to recommend a definition of primary care and has begun its assessment of claims-based spending. In October and November 2022, the Primary Care Collaborative and the University of Washington presented methodologies for measuring claims-based spending to the primary care committee. In January, the primary care committee began a discussion of providers and facilities. The committee used both narrow and broad categories to define providers. The broad category includes Obstetrics and Gynecology (OBGYN) and therapists. The Board will review a final definition of primary care at its February 15 meeting.
Dr. Zerzan-Thul concluded with a review of the primary care committee's finalized definition of primary care. This definition won't conflict with existing statutes. It will be useful for measuring services, e.g., vaccinations but will depend on the who, e.g., family physician versus specialist.
Providers and carriers committee member Louise Kaplan advised settling on something and moving forward rather than debating the definition at length. Why is there a question regarding Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs)as primary care providers? Half of all Medicaid patients receive care from Nurse Practitioners (NPs. Dr. Zerzan-Thul noted that there isn't a debate about them as generally

meeting the criteria for primary care providers, however, some APRNs and PAs work for specialists. There isn't a great system for breaking out specialty work. Urgent care and Emergency Room (ER) facilities are not primary care.
Louise Kaplan recommended a change in the way the data is collected. Dr. Zerzan-Thul responded that the definition used for measurement will be an intersection of who, what, where. The Office of Financial Management (OFM) ended up reporting 60 percent of PAs as practicing primary care. It would be good to have a more defined capability for determination.
Brittney Cherry noted that urgent care is expanding and providing manual wellness visits and other services that would qualify as primary care. Why would urgent care be excluded? Are there any situations where it might be excluded? Dr. Zerzan-Thul clarified that the primary care committee hasn't discussed setting/facilities yet.

Adjournment
Meeting adjourned at 4:00 p.m.

Next Data Committee meeting
April 4, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Next Providers and Carriers Committee meeting
March 7, 2023
Meeting to be held on Zoom
2:00 p.m. –4:00 p.m.

Joint meeting minutes: Advisory Committee on Data Issues and Advisory Committee of Health Care Providers and Carriers

June 6, 2023
Health Care Authority
Hybrid Meeting held electronically (Zoom), telephonically, and in person at the Health Care Authority
2 p.m. – 4 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials are available on the Advisory Committee on Data Issues webpage and the Advisory Committee of Health Care Providers and Carriers webpage.

Advisory Committee on Data Issues Members

Present

Christa Able
Amanda Avalos
Allison Bailey
Jonathan Bennett
Bruce Brazier
Leah Hole-Marshall
Lichiou Lee
David Mancuso
Ana Morales
Hunter Plumer
Russ Shust
Mandy Stahre
Julie Sylvester

Absent

Megan Atkinson
Jason Brown
Chandra Hicks
Mark Pregler

Advisory Committee of Health Care Providers and Carriers Members

Present

Bob Crittenden
Justin Evander
Paul Fishman
Louise Kaplan
Stacy Kessel
Ross Laursen
Todd Lovshin
Megan McIntyre

Mika Sinanan
Dorothy Teeter
Wes Waters

Absent
Jodi Joyce
Vicki Lowe
Mike Marsh
Natalia Martinez-Kohler

Agenda items
Welcoming, Roll Call, Agenda Review
Mandy Weeks-Green, committee facilitator, called the meeting to order at 2:02 p.m.

Topics for Today
Topics include an introduction of Christa Able as a new member of the Advisory Committee on Data Issues and the following presentation topics:

- Advisory Committee on Primary Care: Status Update and Claims-Based Measurement Recommendation.
- Institute for Health Metrics and Evaluation (IHME) Analytic Support Initiative.
- Cost Growth Driver Study: Phase II.

New committee member on the Advisory Committee on Data Issues
Christa Able was welcomed as a new committee member. Christa Able is the Financial Contracting Director for Virginia Mason Franciscan Health and has over 25 years of experience in the health care industry.

Public comment
Mandy Weeks-Green, committee facilitator, called for verbal comments from the public.

Katerina LaMarche, Washington State Hospital Association (WSHA), commented that the previous committee meeting in April provided an overview of how providers would be measured against the benchmark. However, the meeting didn't address details critical to providers. There are lingering questions regarding how providers are attributed, how to ensure data is accurate and verifiable, how risk adjustment is handled, and if/how the providers will be able to analyze the data and their performance to undertake reforms. Further clarification would be beneficial to providers for understanding measurements and expectations. There should be more clarity about which providers will be considered large entities subject to the benchmark, how they're being measured, and what adjustments are needed to meet the benchmark in the future.

Jeb Shepard, representing the Washington State Medical Association (WSMA), echoed Katerina Lamarche's comments. Jeb Shepard commented that there appears to be a misalignment among stakeholders in terms of understanding the methodologies that will be used in terms of attribution, such as which entities are subject to the benchmark and what measures are in place to ensure data accuracy. WSMA would like to understand these finer points so it can help their members be successful. A benchmark is in effect for this year, but the large provider entities that will be publicly reported against the benchmark have not been informed of that. WSMA requested more detail for public and stakeholder review through presentations and written materials so providers can understand and adjust their performance if needed.

Advisory Committee on Primary Care: Status Update and Claims-Based Measurement Recommendation

Dr. Judy Zerzan-Thul, HCA

The Advisory Committee on Primary Care (primary care committee) has been working on its charges to provide recommendations for the definition of "primary care" and measurement methodologies to assess claims-based and non-claims-based spending.

To determine what counts as primary care, the main framework the primary care committee has used is the *who, what,* and *where.*

- *Who:* Is the provider considered a primary care provider?
- *What:* Is the service considered a primary care service?
- *Where:* Is the facility considered a primary care facility?

If all three of the above criteria are met, then the service or provider counts towards the 12 percent target. As the primary care committee's work continues, changes may be made to the definition - it's not yet clear if the *where* is needed. The committee added a *why* criterion: "to support patients in working toward their goals of physical, mental, and social health and the general wellbeing of each person, through illness prevention and minimizing disease burden."

Dr. Judy Zerzan-Thul discussed the broad versus narrow definitions of primary care, including the lists of clinicians under each category. A naturopath is considered primary care under state statutes and is included in the narrow definition. The primary care committee worked to refine both a broad and narrow definition and the two definitions will be evaluated in the future to determine which to use when measuring progress towards the 12 percent expenditure target. The presentation also discussed the lists of clinicians included under the broad and narrow definitions.

The Advisory Committee of Health Care Providers and Carriers (provider and carrier committee) member Mika Sinanan asked for clarification on the clinicians listed under the broad and narrow definitions. When comparing the lists, there are clinicians listed in the narrow definition, such as pediatric and geriatric, that are not included under the broad definition. Dr. Judy Zerzan-Thul explained that the broad definition should include the narrow definition and acknowledged that the primary care committee discussed specialists.

Provider and carrier committee member Louise Kaplan commented that under both the broad and narrow definitions, the Advanced Practice Registered Nurse (APRN) and Advanced Registered Nurse Practitioner (ARNP) terms are used. The state licensure is ARNP. ARNP is inclusive of nurse practitioners, nurse anesthetist, nurse midwives, and clinical nurse specialists. The most typical provider of primary care among ARNPs is the Nurse Practitioner. There are some licensure designations that are not primary care. Licensed midwives now have a more expanded scope and provide some primary care services.

Provider and carrier committee member Dorothy Teeter asked why behavioral health was not listed under the narrow definition. Dr. Judy Zerzan-Thul explained there are billing codes, but the first part is *who*, and the next part is *what.* The National Provider Identifier (NPI) and codes are used to come up with a claims-based spend on primary care. There are about 10 to 12 states that measure primary care, which the primary care committee reviewed. Most states have adopted a 12 percent definition of primary care spend.

Dr. Judy Zerzan-Thul also provided an overview of the broad list of the *where* of primary care (e.g., primary care clinics, rural health clinics, ambulatory health clinics, school-based health centers, virtual care). The primary care committee reviewed an extensive list of procedure codes and specific services to include in the primary care definition which were used by other states and programs in their primary care measurement efforts. Additional data analysis may be conducted to further refine the primary care code list.

The primary care committee has begun to discuss policy recommendations to increase and sustain primary care. developed a ranked list of strategies aligned with preliminary interests. Over the remainder of the year, the primary care committee will address the statutory charges related to data policy. Mika Sinanan asked if the bulleted list in the presentation slide only names the top choices from the ranked list, or if there were more strategies identified, and how these were chosen from the ranked list.

Next, Dr. Judy Zerzan-Thul discussed the committee's policy recommendations to incentivize achievement of the 12 percent target and to recommend specific practices and methods of reimbursement to achieve and sustain those targets. The primary care committee used a four-domain framework to explore different strategies for advancing toward a 12 percent target to support the goal of access and quality: 1) Direct Investment, 2) Capacity Growth, 3) Patient Behavior, and 4) Reduced Expenditure on Other Services. The list of policy strategies was introduced in order of committee preference.

Advisory Committee on Data Issues (data committee) member Leah Hole-Marshall advised that it might be helpful to have a high-level work plan of the activities the primary care committee intends to work through. Dr. Judy Zerzan-Thul discussed the primary care committee's next steps. The primary care committee has begun to discuss non-claims-based measurements. In the next meeting, they will discuss how to measure the different parts, such as quality bonuses that are earned or per member per month that isn't tied to claims. The primary care committee will provide further details on implementation.

Mika Sinanan commented that the fourth listed policy under "Patient Engagement" focuses on redirecting patients. This policy may need to be expanded to consider other areas and to think creatively about the ways patients think about the care they receive and how they seek. Dr. Judy Zerzan-Thul responded that the primary care committee will dig deeper into the strategies as moving forward.

Dorothy Teeter asked about the percentage of primary care practices in Washington that are still independent as opposed to those that are a part of a larger system – the investment strategies may differ. The Washington State Health Alliance has useful information on this topic.

Louise Kaplan stated that her own practice is a part of a small physician-owned practice that multiple health systems have attempted to purchase. In the news recently, Olympia Obstetrics and Gynecology was bought by Providence Swedish and will now be part of the Providence system. In Olympia, there are few privately-owned independent practices. There are some practices that may be billing nurse practitioner services under physician numbers. The *who* may be an issue to consider in terms of looking at how someone identifies who is providing the primary care.

The HCA and IHME Analytical Support Initiative

Joseph Dieleman, Associate Professor at the University of Washington, Institution for Health Metrics and Evaluation (IHME)

Joseph Dieleman provided an introduction of IHME and the analytical support initiative. IHME is charged with completing work related to measurements and health. IHME's previous projects connect closely with the report, *A Data Use Strategy for State Action to Address Health Care Cost Growth*, funded by the Peterson Center on Healthcare and Milbank Memorial Fund. The report posed the question of what data is needed and how it should be used to provide information about curving cost growth. The first part of the project describes all the health care spending in Washington using ten key metrics. The second part uses a trends analysis that compares growth to other states and counties; the analysis reviews which geographic units, health conditions, markets, and service categories have the most growth; and how changes in population, disease prevalence, service utilization, and prices contribute to spending growth.

The project, externally funded by the Peterson Center on Healthcare and Gates Ventures, is a partnership with HCA and IHME, with IHME supplying analytical support to HCA. The project is expected to last from June 2023 to July 2025. Joseph Dieleman provided a brief overview of key deliverables and respective due dates.

Next, the committee heard an overview of the Disease Expenditure (DEX) research project and its findings, which include proportions of national personal health care spending for 161 health conditions and growth rates over time. IHME conducted an analysis to understand why health care spending has been increasing. At the national level, the analysis reviewed all health care spending, diseases, and age groups and attributed cost growth to one of five categories. The analysis identified the factors driving the increases in spending (such as ambulatory care, pharmaceuticals, nursing facility care, and emergency departments) for specific health conditions. The analysis included spending estimates for race/ethnicity groups, decomposing differences in spending, and health spending attributable to risk factors. For its work with HCA, IHME will take a similar approach to its earlier analyses but with a focus on Washington. The first steps will be to access the Washington All Payer Claims Database (APCD), begin data landscaping (finding and understanding data sources unique to Washington), to learn and receive feedback, and form an analytical strategy which will act as guide for the first year on the project.

Mika Sinanan commented that from a provider viewpoint, if a provider entity is exceeding the benchmark, they would want to know which expenditures, practitioners, and clinics need to be looked at and what they should do and recommended greater granularity in the analysis. Joseph Dieleman responded that the project's intent is to be dynamic, collaborative and to receive feedback early. The project is meant to be comprehensive for Washington – not an assessment of each provider entity.

Dorothy Teeter asked if IHME can link data analytics with quality of care. Joseph Dieleman stated that linking to quality may not occur in the first year but agreed that it is important and would remain on IHME's radar.

Data committee member Jonathan Bennett advised consideration of informational versus actionable information. There needs to be a strategic plan to make available information actionable, especially when looking at large network providers. Joseph Dieleman acknowledged the feedback from the committees about granularity and actionability.

Bob Crittenden agreed with the discussion on actionability, but also mentioned that IHME has data from many other places. There are different ways services are organized and a lot may depend on a system of care. Joseph Dieleman said there has been a push to identify exemplars. Bob Crittenden noted that local comparisons would be helpful, as well as other examples in the U.S. IHME should consider examples that seem to fit as the project unfolds, particularly if there are issues where there's a large price increase or problem with the outcomes relative to other places.

Louise Kaplan asked IHME to look investigate local and rural access to care issues. Joseph Dieleman replied that much of the data IHME has analyzed in the past was organized to focus on location of residence for the person seeking care rather than where the care is provided. For a service, health condition or type of care, IHME could quantify the number of encounters occurring in a patient's county versus encounters occurring outside a patient's county of residence.

Cost Growth Driver Study: Options for Phase II

Ross McCool, HCA

Ross McCool gave a presentation on additional options for a phase two cost growth driver study. OnPoint presented its initial findings from the cost driver analysis to the board and its committees in December 2022 which covered data from 2017 to 2019. The findings from OnPoint's initial analysis mostly align with other states' cost driver analyses and their presentation was intended to present options and receive feedback from the committees. While OnPoint's analysis showed increased spending in pharmacy, pharmacy related analyses were not presented as there is a newly created Pharmacy Drug Affordability Board that will review pharmacy trends.

In previous committee meetings, the board and its committees expressed interest in chronic condition flags. Additional chronic condition flags can be added from the Chronic Conditions Data Warehouse. Chronic condition flags from other sources can be included but will require additional resources.

In 2017 through 2019, there was a slight decrease in spending on inpatient services but an increase in outpatient spending. Reviewing overall price growth for both inpatient and outpatient could provide additional information on this trend. This review would include trends in volume of services and price per service and stratifying by facility type and geography. Other cost boards in other states are working on are reviewing trends in severity for inpatient and outpatient services. A few states have investigated if an increase in outpatient services is due to inpatient services transitioning to outpatient services. A similar analysis can be done, where OnPoint could look at changes in services, case mixes, and diagnosis-related group (DRG). OnPoint could also analyze out-of-pocket spending is another option.

Mika Sinanan commented that looking for outpatient and inpatient transition in the data is important but also to consider what providers are trying to accomplish. Ross McCool responded that the data will be used to create talking points and investigate whether there is some consistency across different regions, groups, and types of descriptives to discuss how to positively affect price growth.

Mika Sinanan asked if phase two cost driver analysis will be included in the proposed report from the board to the legislature later this year. Ross McCool replied that the phase two cost driver analysis will not be complete or ready before the report is due. Mika Sinanan asked about the data years included in the report. Ross McCool stated the historical cost driver data is from 2017 through 2019. The benchmark data call includes data from 2017 through 2019 and will have old data as part of its design to provide historical data for review before providing new data.

Ross McCool concluded his presentation with a preview of the cost driver analysis dashboard. The dashboard will be posted to a new section of the Washington HealthCareCompare website and will include links for different resources that use APCD data and will show different studies being conducted in the state.

Wrap Up Questions and Comments

Jonathan Bennett and Mika Sinanan requested to put forward a motion. Following up and expanding on the public comments from Jeb Shepard (WMSA) and Katerina LaMarche (WHSA), Mika Sinanan explained that the motion addresses previously discussed points regarding data actionability and accuracy. Leah Hole-Marshall requested to delay any motion in order to have the opportunity to hear it. Mandy Weeks-Green stated that the motion could be presented at today's meeting and voted on at the next committee meeting.

Mika included the motion in the meeting chat. The motion read as follows: "The joint committees respectfully request that the Board address the following critical operational elements as they relate to the health care cost growth benchmark process at an upcoming board meeting:

1. Methodology – how will we fairly attribute members to providers because providers will be held accountable to the benchmark for those patients.
2. Data Accuracy - how will data be attributed and verified to providers because this will determine compliance with the benchmark.
3. Risk Adjustment - an essential requirement to account for the appropriate healthcare intensity of attributable members because risk adjusted health status will impact the scope and magnitude of services, cost, and outcome and must be fair, equitable, and consistent.
4. Metrics for Provider Performance - what key metrics will be considered the contributors to cost growth because an underperforming provider must be able to understand why and see how to fix it."

Adjournment

Meeting adjourned at 4:04 p.m.

Next committee meetings

Advisory Committee of Health Care Providers and Carriers
September 7, 2023
2 p.m. – 4 p.m.

Advisory Committee on Data Issues
October 3, 2023
2 p.m. – 4 p.m.

The meetings will be held electronically through Zoom, telephonically, and in-person at the Health Care Authority.

Tab 3

Washington State Health Care Authority

Washington State Hospital Association

Washington State Medical Association
Physician Driven, Patient Focused

August 25, 2023

Dear Members of Advisory Committee of Health Care Providers and Carriers (Advisory Committee):

The Washington State Hospital Association and Washington State Medical Association support the Board's work to address our shared goal in understanding health care spending and promoting affordability while maintaining appropriate, effective, affordable, and accessible care.

During the April 2023 Board meeting, the state's consultants provided an overview of how performance for providers would be measured against the benchmark. The overview was helpful in providing a broad picture understanding but left us with many questions.

We respectfully request that the Advisory Committee consider the following questions and approve the proposed motion to help provide additional clarity and understanding of the performance measurement process.

Advisory Committee representatives from WSHA and WSMA introduced a motion at the June 6 combined Provider and Data Advisory Committee meeting that has been updated and included as an enclosure below for the advisory committee's consideration at the September 7 meeting. We believe it is important to have a comprehensive understanding of the measurement process, including both its strengths and weaknesses, since it is one of the primary tools being used to help control cost growth. The motion reflects the following elements that we hope can be addressed:

1. **Attribution methodology.** Patients are attributed to providers using several methods. Will plans report the numbers of attributions made using each method? Plans will also be attributing primary care providers to large provider entities. Will large provider entities be able to review and vet these specific provider attributions to ensure accuracy?
2. **Risk adjustment for attributable members.** Will the specific adjustment methodology be disclosed and reviewable?
3. **Analysis for specific provider performance.** What information will be given to large provider entities that exceed the benchmark and will that information help inform their practices, e.g., whether exceeding the benchmark was due to increased price of services versus increased use of services? This would better enable providers to make corrections to improve performance. Is there other information that can be provided to inform their practices?
4. **Notice.** Are the large provider entities identified in the technical manual the finalized list of providers that will be compared against the benchmark? How and when will providers be notified that they are subject to the benchmark?

Clarification and further explanation will help facilitate a better understanding of measurement and expectation. More broadly, and most importantly, it is imperative that data gathered during this process is accessible, accurate, interpretable, and actionable. Providers' ability to meet the benchmark hinges on these factors so that targeted corrections can be made and improvement can be realized.

Sincerely,

Katerina LaMarche, JD
Policy Director, Government Affairs
Washington State Hospital Association
katerinal@wsha.org

Jeb Shepard
Director of Policy
Washington State Medical Association
jeb@wsma.org

Enclosures: Updated motion for consideration at the September 7 Advisory Committee meeting.

Updated motion for consideration at the September 7 Provider Advisory Committee meeting:

The committee respectfully requests that the Board address the following critical operational elements as they relate to the health care cost growth benchmark process, and as further detailed in the letter above, at an upcoming Board meeting:

- Attribution Methodology: transparency and accuracy of attributed members and primary care providers is important, because large provider entities will be held accountable for those patients and primary care providers.

- Risk Adjustment: adjustment methodology for age and sex should be disclosed and reviewable, because it will better inform primary care providers and large provider entities.

- Analysis for Specific Provider Performance: information and metrics that identify contributors to cost growth should be given to large provider entities, because large provider entities must be able to understand why they exceeded the benchmark in order to improve performance.

- Provider Identification and Notice: identification of large provider entities and the process by which they are notified should be established, because large provider entities must be aware that they are subject to the benchmark.

Tab 4

Washington State Health Care Authority

CMMI model overview: Making Care Primary

Health Care Cost Transparency Board-
Health Care Provider and Carrier Committee
September 7, 2023

Washington State Health Care Authority

Agenda

- "Making Care Primary" model overview
- Multi-payer participation
- Eligibility for participation in Medicare FFS demo
- Payment model overview
  - Tracks
  - Payment approach
  - Specialty integration
- Quality performance measures
- Timeline
- Resources

Making Care Primary (MCP) Summary

Goals

- 10.5 years
- Cost neutral
- Improve quality
- Sustainable transformation
- Pathway for more practices to enter in value-based care arrangements

Care Teams

- Care management & coordination
- Specialty care integration
- BH integration
- Address health related social needs and equity

Flexible Payment

- Progression to prospective payment
- Progression in accountability
- Specialty integration payments
- Reward quality outcomes

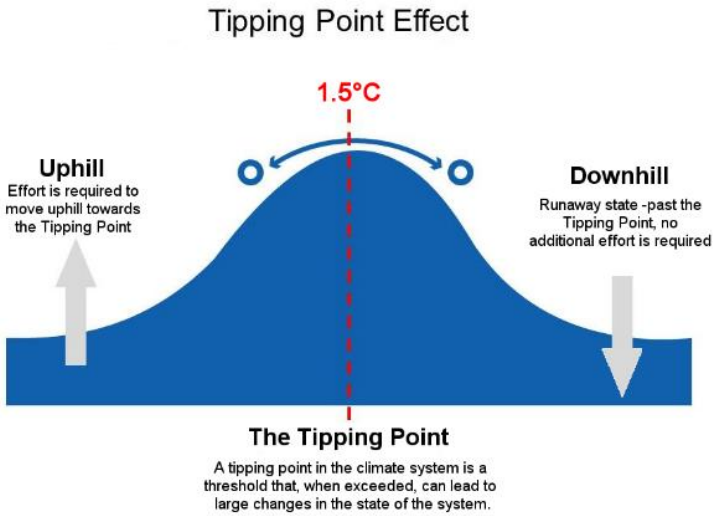
Multi-payer alignment can support transformation

Transformation "tipping point"

- Practice transformation is burdensome
- Meaningful alignment across payers necessary to justify participant effort

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

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



Payer Partnership is Core to the Success of MCP

CMS Innovation Center will partner with public and private payers to implement MCP. Through these partnerships, CMS will foster alignment in areas to reduce clinician burden and provide flexibility to encourage increased payer participation.

Directional Alignment

- CMS will work with payers in MCP states to encourage close alignment in areas that directly reduce burden on clinicians:
  - Performance measurement and reporting
  - Moving primary care payment away from FFS to prospective basis
  - Timely and consistent data sharing
  - Leveraging Technical Assistance
- CMS is partnering with State Medicaid Agencies (SMAs) and other payers to streamline primary care reform and reduce fragmentation to help practices focus on care.

Local Implementation

- CMS, SMAs, and payer partners will make practice- and patient-level data available to participants through data sharing efforts within the state
- CMS will provide flexibility for payers to include additional measures that reflect local priorities for their patient population(s)

HCA Participation in Making Care Primary

- Traditional ("original", or "FFS") Medicare is testing this model in Washington.

- HCA is interested in aligning w/the Medicare model principles
  - Comparable to the Primary Care Transformation Model (PCTM) efforts, with Medicare at the table
  - Make the investments worthwhile for practices

- HCA does not yet have funding or legislative direction to require participation in its PEBB/SEBB or Medicaid populations. Our contracted carriers could choose to launch this model anytime.

Eligibility to Participate *for Medicare FFS Demo*

Organizations that provide primary care services to patients may be eligible to apply to MCP. Due to MCP's payment and quality reporting design, certain organizations are not eligible to participate in MCP.

Organizations Eligible for MCP

- Independent or solo primary care practices
- Group practices
- Federally Qualified Health Centers (FQHCs)
- Health Systems
- Indian Health Programs
- Certain CAHs
- Organizations operating in the listed MCP states
- Organizations with at least 125 attributed Medicare FFS beneficiaries

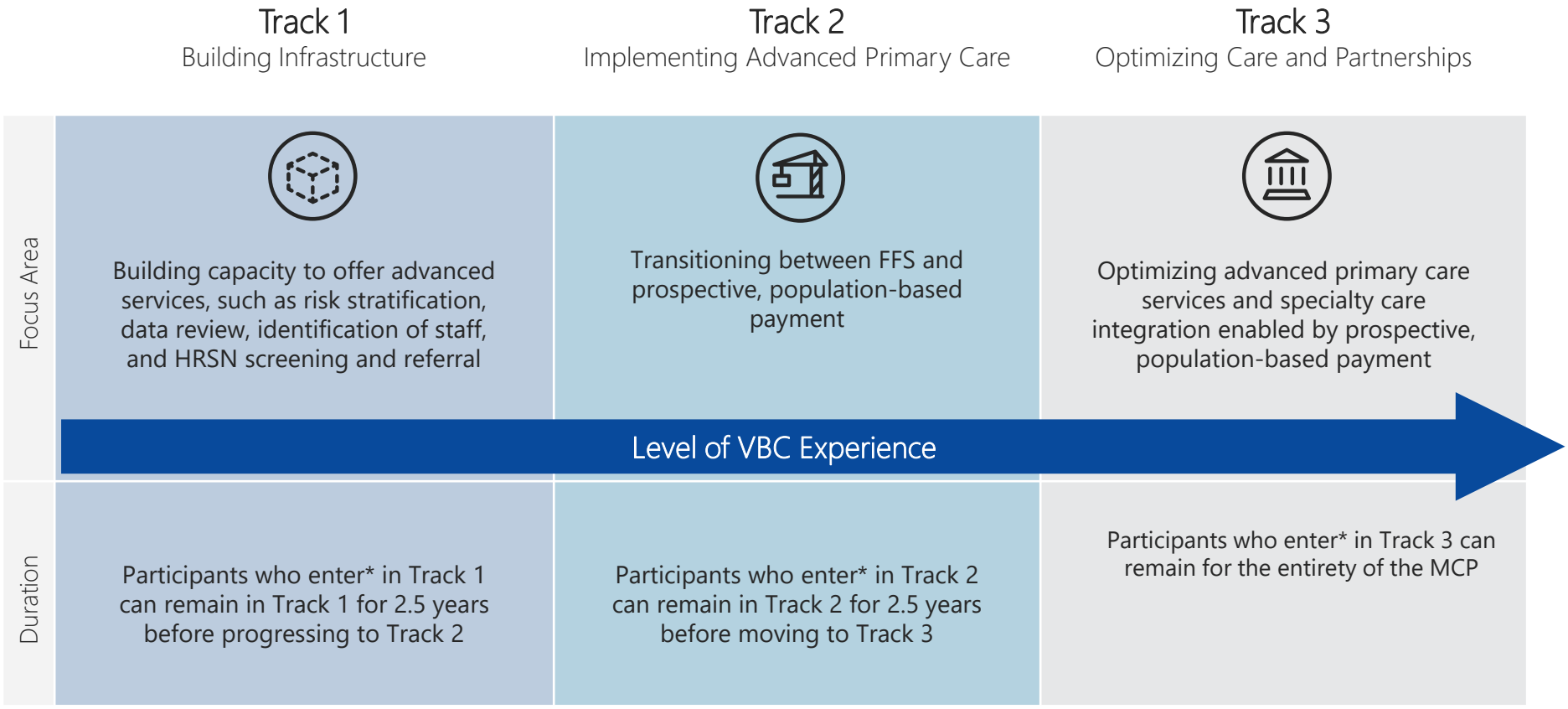
Organizations Not Eligible for MCP

- Rural Health Clinics
- Concierge practices
- Grandfathered Tribal FQHCs
- Primary Care First (PCF) practices and ACO REACH Participant Providers active as of 5/31/23
- Organizations not operating in the listed MCP states
- In general, organizations enrolled in CMMI models (such as MSSP and ACO REACH) will not be allowed to simultaneously participate in MCP, with the exception of bundled payment models

Other payers can adopt model with pediatric practices, RHCs, etc.

Participation Track Options Overview

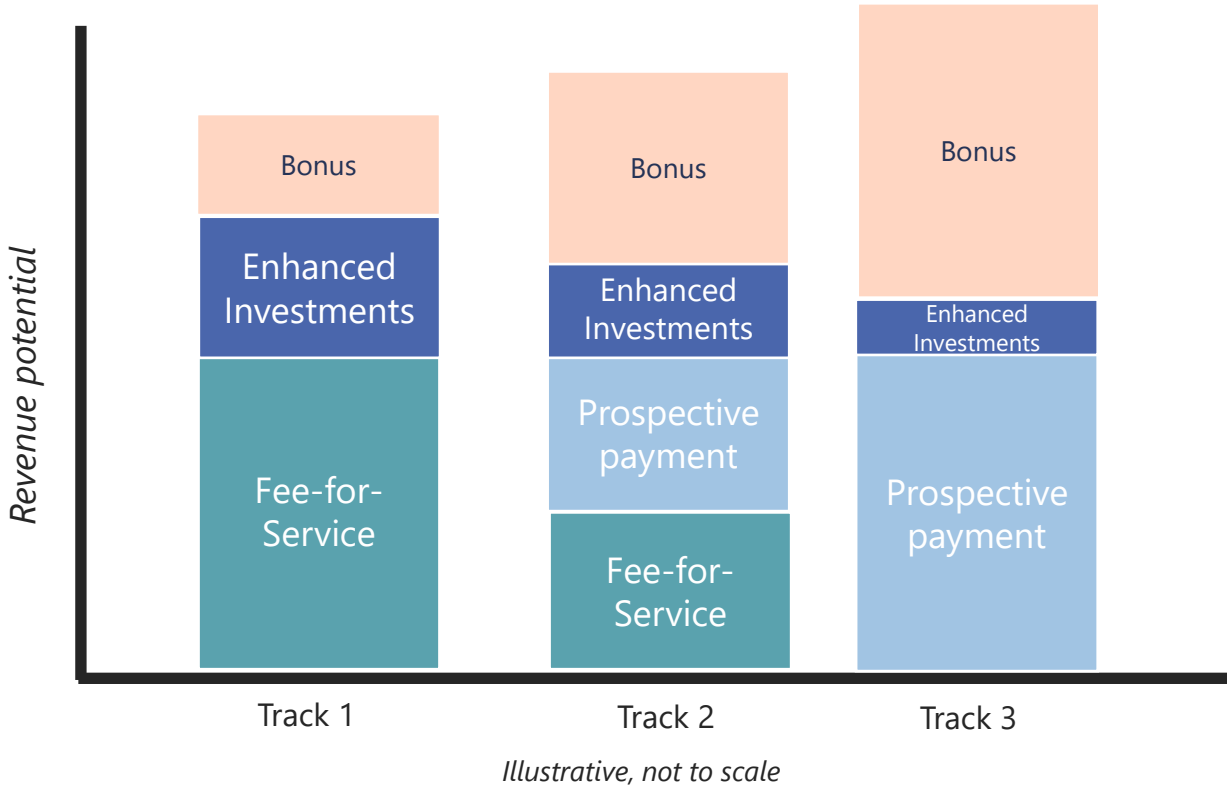
MCP includes three tracks that health care organizations can select from when applying to the model. An organization's prior experience with VBC will determine their eligibility for individual Tracks. The Tracks provide opportunities for organizations with differing levels of care delivery and value-based payment experience to enter the model at a point that matches their capabilities at the start.



**Organizations that start in Track 1, 2, or 3 will have an additional 6 months (or half of a year) in that track, given the mid-year start date for the model. A participant's length of time in a track depends on which track they started in.*

Payment Approach

- **Prospective Primary Care Payment** (PPCP) **increases** over time, while Fee-for-Service *decreases*, to support the interprofessional team.
- **Enhanced Services Payments** (ESP) ***decrease*** over time as practices become more advanced, and potential for payments tied to quality performance increases.
- **Performance Incentive Payment** (PIP) *potential* greatly **increases** over time to make up for decreases in guaranteed payments.



MCP Payment Types

MCP will introduce six (6) payment types to support MCP participants as they work to reach their patient care goals.

Prospective Primary Care Payment (PPCP)

Track 1 | **Track 2** | **Track 3**

Quarterly per-beneficiary-per-month (PBPM) payment (calculated based on historical billing) to support a gradual progression from FFS payment to a population-based payment structure

Enhanced Services Payment (ESP)

Track 1 | **Track 2** | **Track 3**

Non-visit-based per-beneficiary-per-month (PBPM) payment that is adjusted to reflect the attributed population's level of clinical (CM-HCC) and social (ADI) risk to provide proportionally more resources to organizations that serve high-needs patients.

Performance Incentive Payment (PIP)

Track 1 | **Track 2** | **Track 3**

Upside-only performance incentive payment designed to reward MCP participants for improvements in patient outcomes and quality measures. Structured to maximize revenue stability (half of estimated PIP will be paid in the first quarter of performance year).

Upfront Infrastructure Payment (UIP)

Track 1 | Track 2 | Track 3

One-time payment for select Track 1 participants to support organizations with fewer resources to invest in staffing, SDOH strategies, and HIT infrastructure.

MCP E-Consult (MEC)

Track 1 | **Track 2** | **Track 3**

Ambulatory Co-Management (ACM)

Track 1 | Track 2 | **Track 3**

Payments to support specialty integration strategy to support communication and collaboration for longitudinal primary care and short-term specialized care for chronic conditions. MEC code billable by MCP primary care clinicals, while ACM is billable by specialty care partners.

Specialty Care Integration Strategy

MCP provides participants with payment mechanisms, as well as data, learning tools, and peer-to-peer learning opportunities to support the Specialty Integration Care Delivery requirements, focused on coordination and improving patient care.

Payment: Once MCP participants enter Tracks 2 and 3, they are expected to implement e-consults as part of their care delivery requirements.

Data: CMS will provide participants with performance data on specialists in their region, prioritizing measures related to cardiology, pulmonology, and orthopedics.

Learning Tools: CMS will partner with stakeholders, state Medicaid programs, and other payer partners to connect MCP participants with each other, specialty practices, and CBOs.

Peer-to-Peer Learning: CMS will provide a collaboration platform and other forums to help participants learn from each other.

Payment Details

MCP will feature two payment types to encourage specialty care integration and support participants as they take on care delivery requirements:

	MCP eConsult (MEC) Code *Billable by MCP Primary Care Clinicians*	**Ambulatory Co-Management (ACM) Code** *Billable by Specialty Care Partners*
Goal	Address current barriers to eConsult billing, including its inclusion of post-service time to implement the specialist's recommendation	Support ongoing communication and collaboration of shared MCP patients who require both longitudinal primary care and also short-term specialized care to stabilize an exacerbated chronic condition
Eligibility	Participants in Tracks 2 and 3 *(These codes are absorbed into the capitated prospective primary care payments (PPCPs) in Track 3).*	Rostered Specialty Care Partner clinicians *(whose TIN has a Collaborative Care Arrangement (CCA) in place with an MCP Participant)*
Potential Amount	$40 per service (subject to geographic adjustment)*	$50 per month (subject to geographic adjustment)*

**To account for regional cost differences, MCP will apply a geographic adjustment factor (GAF) to the MEC and ACM.*

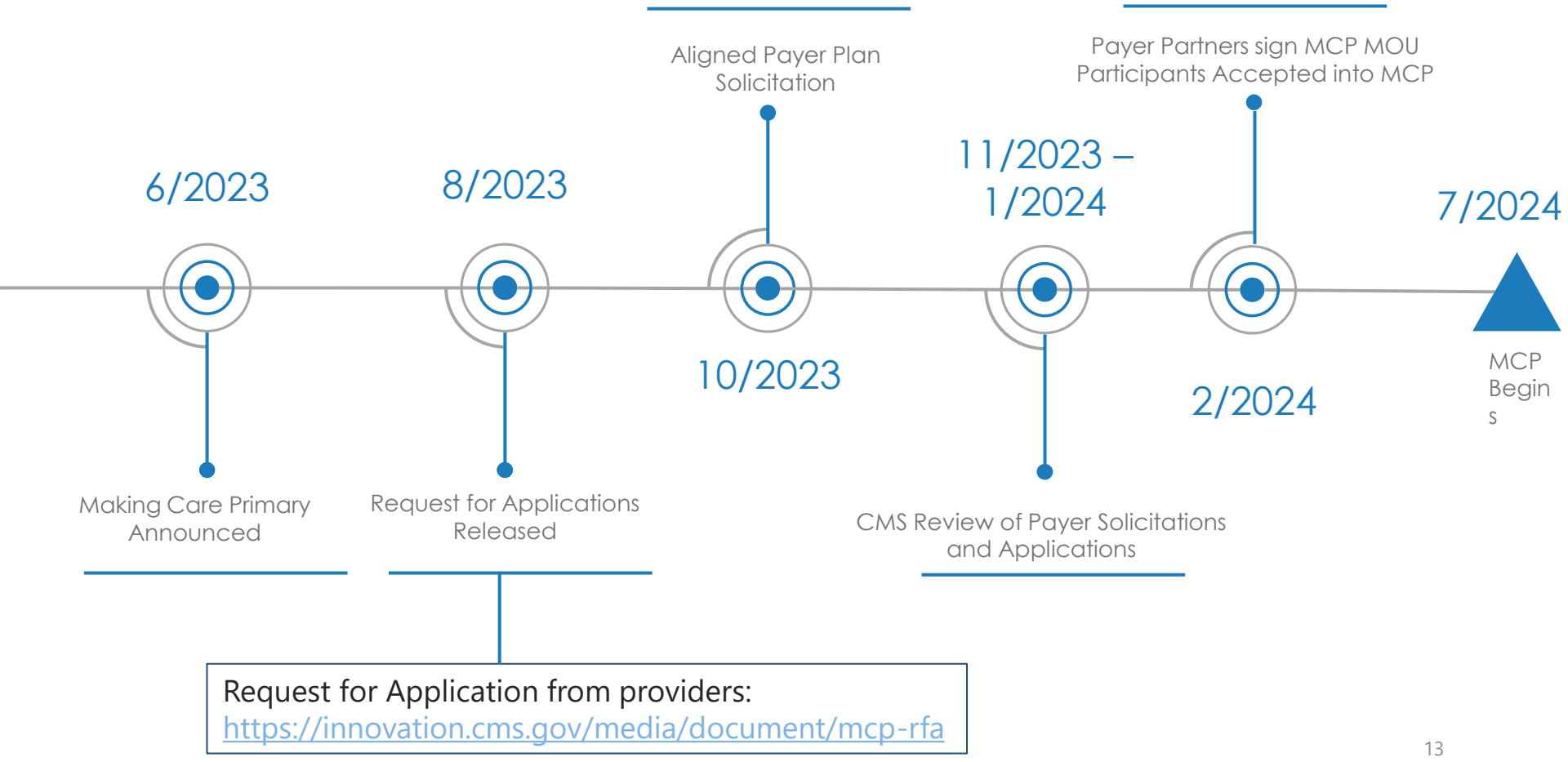
Performance Measures

Mirroring CMS's broader quality measurement strategy, measures for Medicare were selected to be actionable, clinically meaningful, and aligned with other CMS quality programs, including the Universal Foundation Measure Set *(as indicated below with an asterisk "*"),* Quality Payment Program (QPP) and other existing measure sets. **Payer Partners may adapt measure set below to target their population health needs.**

Focus	Measure	Mode	Track		
			1	2	3
Chronic Conditions	Controlling High Blood Pressure*	eCQM	X	X	X
	Diabetes Hba1C Poor Control (>9%)*	eCQM	X	X	X
Wellness and Prevention	Colorectal Cancer Screening*	eCQM	X	X	X
Person-Centered Care	Person-Centered Primary Care Measure (PCPCM)	Survey	X	X	X
Behavioral Health	Screening for Depression with Follow Up Plan*	eCQM		X	X
	Depression Remission at 12 months	eCQM		X	X
Equity	Screening for Social Drivers of Health*+	TBD		X	X
Cost/ Utilization	Total Per Capita Cost (TPCC)	Claims		X	X
	Emergency Department Utilization (EDU)	Claims		X	X
	TPCC Continuous Improvement (CI) *(Non-Health Centers and Non-Indian Health Programs)*	Claims		X	X
	EDU CI *(Health Centers and IHPs only)*	Claims		X	X

+Screening for Social Drivers of Health (Quality ID#487) is a new, evolving measure focused on assessing the percent of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. The measure specifications are currently under development and CMS will work with participants to ensure they have the appropriate health IT infrastructure information to successfully report this measure.

Making Care Primary Timeline



Request for Application from providers:
https://innovation.cms.gov/media/document/mcp-rfa

Additional Information and Resources

CMS

Visit

https://innovation.cms.gov/innovation-models/making-care-primary

Help Desk

MCP@cms.hhs.gov

HCA

Visit

https://www.hca.wa.gov/about-hca/programs-and-initiatives/value-based-purchasing/multi-payer-primary-care-transformation-model

Help Desk

HCAPCTM@hca.wa.gov

Washington State Health Care Authority

Discussion

Appendices

Washington State Health Care Authority

Upfront Infrastructure Payment (UIP)

Start-up funding to support smaller organizations with fewer resources participate in and be successful in MCP through investments in infrastructure to support MCP's transformational goals as they take on the Model's care delivery and health IT capabilities. Optional payment only available to eligible Track 1 participants.

Eligibility: "Low-revenue" Track 1 participants and Track 1 applicants without an e-consult platform
("Low revenue" criteria will be specified in the Request for Applications)

Timing: Initial $72,500 distributed as a lump sum at the start of model; second payment of $72,500 distributed as a lump sum one year later

Amount: $145,000 per eligible Track 1 participant

MCP participants will submit a spend plan with anticipated spending prior to receiving the UIP, and report on how the UIP funds were spent

Reconciliation: Any unspent or misused UIPs must be repaid to CMS at the end of the participant's 30-month Track 1 participation period and can be recouped if the participant withdraws or CMS terminates its participation in the model prior to entering Track 3

Examples of Permitted Uses

- ***Increased staffing*** such as hiring nurse care managers to implement SDOH screening, behavioral health clinicians to integrate behavioral health treatment into primary care setting; or encouraging partnerships with healthcare systems and local CBOs to connect individuals with culturally and linguistically tailored, accessible health care services and supports
- ***SDOH strategies*** such as partnering with CBOs to address SDOH needs; providing patient caregiver supports; or implementing systems to provide and track patient referrals to community-based social services that assess and address social needs, as well as enable coordination and measurement of health and social care across communities where beneficiaries reside
- ***Health care clinician infrastructure*** such as investing in CEHRT system enhancements and upgrades; expanding HIT systems to include patient portals, telehealth systems for video visits, and/or e-consult technology; or developing infrastructure that would enhance sociodemographic data collection

Enhanced Services Payment (ESP)

Quarterly per-beneficiary-per-month (PBPM) payment that is adjusted to reflect the attributed population's risk level to provide proportionally more resources to organizations that serve high-needs patients, as they develop capabilities and provide enhanced services. Designed to support care management, patient navigation, connection to behavioral health, and other enhanced care coordination services, according to specific needs of patient population.

Eligibility: Participants in Tracks 1, 2, and 3

Timing: Prospective quarterly payment

Potential Amount: Track-based amount based on participant's MCP attributed population and adjusted for social and clinical risk factors, including CMS Hierarchical Condition (HCC), Low Income Subsidy (LIS), and Area Deprivation Index (ADI). *Estimated average* ESP PBPM amounts will be $15 in Track 1, $10 in Track 2, and $8 in Track 3.

See *Calculation Details* for more information on how CMS will determine ESP payment amounts.

Calculation Details

The decision tree below describes the steps CMS will use to determine ESP payment for each MCP patient:

Enrolled in Low-Income Subsidy?	
No	**Yes**
Amount varies based on patient's HCC and ADI-designated risk tier (see table below)	$25

CMS-HCC Clinical Risk Tier (Risk Score Percentile)	ADI Social Risk Tier (ADI Percentile)	Track 1	Track 2	Track 3
Tier 1 (< 25th)	NA±	$9	$4	$2
Tier 2 (25th – 49th)	NA±	$11	$5	$2.50
Tier 3 (50th – 74th)	NA±	$14	$7	$3.50
Tier 4 (≥75th)	Tier 1, Tier 2, or Tier 3 (< 75th)	$18	$8	$4
	Tier 4 (≥75th)	$25		

Notes: 1) MCP payments are for Medicare FFS beneficiaries attributed to the MCP and will be subject to geographic adjustments.
2) ± Listed as NA, or Not Applicable, because payment for patients in HCC tiers 1 to 3 is only based on LIS or HCC.

Prospective Primary Care Payment (PPCP)

Quarterly per-beneficiary-per-month (PBPM) payment that is calculated for each participant's patient population and is designed to support a gradual progression from fee-for-service (FFS) payment for primary care services* to a population-based payment structure. These payments are designed to allow practices to deliver enhanced, comprehensive services without the incentive to increase volume of patients or services to achieve a favorable financial outcome.

Eligibility: Participants in Tracks 2 and 3

Timing: Prospective quarterly payment

Potential Amount: For the first two PYs, the amount is based on each participant's historical billing data for its attributed Medicare beneficiaries over a two year period and will be updated annually; CMS will introduce a regional component to the payment methodology by PY3.

Reconciliation: Amount is partially reconciled against actual claims expenditures based on portion of primary care services sought by beneficiaries outside the participant organization. See *Calculation Details* for more information on how CMS will determine PPCP amounts.

Calculation Details

The type of payment for primary care services will vary based on an organization's MCP Track.

Payment Type for Primary Care Services	Track 1	Track 2	Track 3
Prospective Primary Care Payment (PPCP)	0%	50%	100%
Fee-for-Service (FFS)	100%	50%	0%

Data sources for billing calculation differs by organization type:

- **FQHCs:** PPCP based on services billed under the Medicare FQHC Prospective Payment System (PPS)
- **Non-FQHCs:** PPCP based on services billed under the Physician Fee Schedule (PFS)

**The primary care services included in or affected by the PPCP will be shared in the MCP Request for Applications (RFA) that will be released in August 2023.*

Performance Incentive Payment (PIP)

Upside-only performance incentive payment designed to reward MCP participants for improvements in patient outcomes and quality measures

Eligibility: Participants in Tracks 1, 2, and 3

Timing: Half of estimated PIP will be paid in the first quarter of each performance year and second half will be paid in the third quarter of the following performance year

Potential Amount: Track-based percentage adjustment to the sum of payments for primary care services (FFS and/or PPCP)

Risk: Upside only; paid up-front and reconciled based on performance

See *Calculation Details* for more information on how CMS will determine PIP.

Calculation Details

Track 1	Track 2	Track 3
Potential to receive upside-only PIP of up to **3%** sum of fee-for-service (FFS)	Potential to receive upside-only PIP of **up to 45%** sum of FFS and prospective primary care payments (PPCP)	Potential to receive upside-only PIP of **up to 60%** sum of prospective primary care payments (PPCP)

- MCP participants must report all required quality measures and achieve the national 30th percentile on TPCC to *qualify* for any PIP
- Quality measures will have varying degree of impact on the PIP calculation based on the participant's track*
- Full credit for a measure for exceeding upper benchmark (70th percentile in Tracks 1 and 2, 80th percentile in Track 3). Half credit for exceeding lower benchmark (50th percentile)
- Participants in Tracks 2 and 3 will have the opportunity to receive additional PIPs for continuous improvement (CI) in utilization/cost

**More information on how MCP's quality measures will impact the PIP calculation, refer to the MCP Request for Applications (RFA) that will be released in August 2023.*

Tab 5

Washington State Health Care Authority

Affordability Activities & Reports Through Jan 2024

HBE: Health Benefit Exchange
HCA: Health Care Authority
HCCTB: Health Care Cost Transparency Board
PDAB: Prescription Drug Accountability Board
OIC: Office of the Insurance Commissioner
UHHC: Universal Health Care Commission

State Affordability Activities and Reports through January 2024

Agency Responsible	Activity	Description/Scope	Deadline/Timing
Health Care Authority	*PEBB/SEBB Rates*	Rates released for PEBB/SEBB plans.	**July 2023** (Annually)
Health Care Cost Transparency Board	*Annual Report*	The first annual report shall determine the total health care expenditures for the most recent year for which data is available and establish the health care cost growth benchmark for the following year. Annual reports may include policy recommendations applicable to the Board's activities and analysis of its work, including any recommendations related to lowering health care costs, focusing on private sector purchasers, and the establishment of a rating system of health care providers and payers. (HB 2457, 2020)	**August 1, 2023**
Office of the Insurance Commissioner	*Individual Market Rate Review*	Rate review for individual and small group health plan for reasonableness and actuarial justification.	**September 2023**
Health Benefit Exchange	*QHP Plan Certification*	Exchange Board certifies QHPs offered on the marketplace. The Exchange Board certifies QHP plans after the OIC has already approved all plans. The Board has always certified every plan, however this is a potential "hard" lever that could be employed. Potential for large customer impacts.	**September 2023** for next plan year (Annually)
Health Benefit Exchange	*Annual QHP Plan Mapping*	Exchange places renewing enrollees into a plan for the next plan year. Facilitates enrollment in high-value plans to 1) ensure enrollee continuity of coverage and care, and 2) maximize customer coverage and subsidies. Most enrollees auto-enroll into their same plan, however with some populations, HBE will auto-enroll customers into a different plan even if their existing plan is still offered to correct for plan choice error and to help maximize their coverage and subsidies. Most enrollees will not experience a change in their plan choice, however special populations are handled at an individual level. Recently more focus on mapping to plans that facilitate access to subsidies and CSRs.	**September 2023** for next plan year (Annually)

Office of the Insurance Commissioner	*Behavioral Health Spending and Utilization*	APCD claims analysis for commercial market. Will report utilization, price, spending for crisis and non-crisis behavioral health services	**October 1, 2023**
Office of the Insurance Commissioner	*Ground Ambulance Services and Balance Billing*	How balance billing for ground ambulance services can be prevented and whether ground ambulance services should be subject to BBPA balance billing restrictions. In consultation with HCA, DOH, SAO, consumers, hospitals, private ground ambulance service providers, fire service agencies, and local government. (HB 1688, 2022)	**October 1, 2023**
Health Care Authority	*Medicaid MCO Rates*	Preliminary Medicaid MCO rates released in advance of contracts going into effect January 1 of the next year.	**October 1, 2023** for January 1, 2024 contract (Annually)
Health Care Authority	*Drug Price Transparency Reporting*	Health carriers, pharmacy benefit managers (PBMs), pharmacy services administrative organizations (PSAOs), and drug manufacturers are required to annually report on certain prescription drug cost, utilization, pricing, rebate, and other pharmacy data to HCA. HCA uses this information to produce an annual report, but the data must be aggregated and cannot reveal information specific to individual entities, drugs, or drug classes. The raw data collected is not subject to public disclosure. (RCW 43.71C)	**October 1, 2023** (Annually; Carriers, Manufacturers, PSOAs) March 1, 2023 (Annually; PBMs)
Health Care Authority	*Public Option Aggregate Rate Target Review*	Analysis of Cascade Select/public option plan provider payment rates relative to the aggregate, critical access hospital, and primary care provider rates specified in RCW 41.05.410. 2021-2022 pass/fail results for reimbursement requirements.	**Fall 2023**
Health Care Cost Transparency Board	*Washington Hospital Costs, Price, and Profit Analysis*	Using Medicare cost reports submitted by Washington hospitals, evaluating how Washington hospitals compare to all similarly sized hospitals in the nation on price and cost per discharge. Conducted by Bartholomew & Nash.	Phase I: Complete **Phase II: October/November 2023** (Preliminary report to Board)
Health Care Cost Transparency Board	*Cost Driver Analysis*	Using the Washington State All-Payer Health Care Claims Database (WA-APCD) to identify cost trends and drivers of cost growth in the health care system to inform the Board as it works to curb spending growth. Conducted by OnPoint.	Phase I: Complete **Phase II: Fall/Winter 2023**

Universal Health Care Commission	*Annual Report*	Detail the work of the Commission, the opportunities identified to advance goals which, if any, of the opportunities a state agency is implementing, which, if any, opportunities should be pursued with legislative policy or fiscal authority, and which opportunities have been identified as beneficial, but lack federal authority to implement. (SB 5399, 2021)	**November 1, 2023**
Health Benefit Exchange	*Open Enrollment, Expansion under the 1332 Waiver*	Provides access to QHPs and QDPs through Healthplanfinder to all Washington residents, regardless of immigration status. Provides access to state premium assistance for those who qualify. In 2021 there were 110,706 folks without a federally recognized status who were uninsured in WA and 76,782 folks without a federally recognized status that were at or below 250% FPL, and therefore eligible for the Cascade Care Savings subsidy.	**November 1, 2023**
Health Care Cost Transparency Board	*Washington Cost Growth Benchmark Data (Aggregate Spending)*	Baseline expenditure data: provider claims payments +non-claims payments + member cost-sharing + net cost of private health insurance (admin) = Total Health Care Expenditures by market, payer and large provider entities	**Anticipated November/December 2023**
Office of the Insurance Commissioner	*Small Group Market Rate Review*	Rate review for individual and small group health plan for reasonableness and actuarial justification.	**November 2023**
Office of the Insurance Commissioner	*Health Care Affordability Study*	Approaches to improve health care affordability including, but not limited to health provider price or rate regulation policies or programs, other than traditional health plan rate review, including payment rate or payment rate increase caps, reference pricing strategies, rate setting and global budgets. In partnership with AGO, in consultation with HCA, HBE, and DOH. (2023-25 Biennial Budget Proviso)	**December 1, 2023** (Preliminary) August 1, 2024 (Final)
Health Benefit Exchange	*Public Option: Impact on Consumers and Hospitals*	In the plan year during which public option enrollment is greater than 10,000: - HBE analyze public option plan rates paid to hospitals for in-network services and whether they have impacted hospital financial sustainability. - Health Care Cost Transparency Board analyze the effect enrollment in public option plans has had on consumers.	**December 1, 2023**

		- HBE reviews the analyses above and develop recommendations to the legislature to address financial or other issues identified in the analyses. (SB 5377, 2021)	
Health Benefit Exchange	*Eliminating Non-Standard Plans on the Exchange*	Analyze the impact to Exchange customers of offering only standard plans beginning 2025. Includes analysis of how plan choice and affordability will be impacted for Exchange consumers across the state. (SB 5526, 2019; SB 5377, 2021). Potential phased approach to offer only standard plans on Exchange.	**December 1, 2023**
Health Benefit Exchange	*1332 Waiver Pass Through Study*	Scope: How the Exchange's current section 1332 waiver could be amended to generate federal pass-through funding to support affordability programs. The actuarial study must focus on methods that could be most readily leveraged in Washington, considering those being used in other public option programs. In consultation with HCA and OIC. (2023-25 Biennial Budget Proviso). Potential public option policy and waiver amendment.	**December 1, 2023**
Prescription Drug Affordability Board	*Annual Report*	Detailing all actions the board has taken in the past year, including any rules adopted by the authority pursuant to this act, establishing any processes, such as the methodology for the upper payment limit, the list of drugs identified in section 3 of this act, the drugs the board completed an affordability review of and any determinations of whether the drug had led or will lead to excess costs, and the establishment of any upper payment limits.	**December 15, 2023** (Annually)
Office of the Insurance Commissioner	*Essential Health Benefits Study*	Review essential health benefits benchmark health plan for possible modification and study Impacts of including coverage for the following benefits: • Donor human milk as provided in RCW 48.43.815 • Hearing instruments and associated services as described in ESHB 1222. • Fertility services, • Biomarker testing, • Contralateral prophylactic mastectomies • Treatment for pediatric acute-onset neuropsychiatric syndrome and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections, and	**December 31, 2023**

		• MRI for breast cancer screening	
Health Care Authority	*Prescription Drug Cost Report*	HCA reports on the impact of prescription drug costs, rebates, and other discounts on health care premiums in an aggregated manner, beginning January 1, 2021, and annually thereafter. The report uses data collected from health carriers, PBMs, PSAOs, and drug manufacturers to provide Washingtonians insights in drug price transparency. (RCW 43.71C.100)	**January 1, 2024** (Annually)
N/A	*Legislative Session*	2024 legislative session; second half of the biennium, short session.	**January 9, 2024**

2023 Legislative Session Outcomes

BILLS THAT PASSED

Bill/Title	Sponsor	Summary
Cost Containment		
HB 1357 Prior Authorization	Simmons	Updates requirements for prior authorization processes for private health insurance, PEBB, SEBB, and Medicaid; expands reporting requirements to include prescription drug data authorization.
Cost Sharing Mandates		
SB 5338 Essential Health Benefits	Cleveland	Directs OIC to review essential health benefits benchmark health plan for possible modification and study impacts of including coverage for certain new benefits.
HB 1626 Colorectal Screening Tests	Bronoske	Requires medical assistance programs to cover noninvasive preventive colorectal cancer screenings and colonoscopies performed from a positive test result beginning Jan. 1, 2024.
HB 1222 Hearing Instruments Coverage	Orwall	Requires non-grandfathered, large group health plans to cover hearing instruments and modifies current coverage requirements for public employee health plans starting Jan. 1, 2024.
Coverage Mandates		
SB 5242 Abortion Cost Sharing	Cleveland	Prohibits cost sharing for abortion for health plans issued or renewed on/after Jan. 1, 2024.
SB 5300 Behavioral Health Continuity	Dhingra	Prohibits health plans and state purchased health care programs from substituting nonpreferred drugs behavioral health or serious mental illness prescriptions starting Jan. 1, 2025.

SB 5396 Breast Exam Cost Sharing	Wilson, L.	Prohibits cost sharing for diagnostic and supplemental breast exams for non-grandfathered health plans issued or renewed on/after Jan. 1, 2024.
SB 5581 Maternal Support Services	Muzzall	Requires OIC, in collaboration with carriers, to develop strategies to reduce or eliminate deductibles and other cost sharing for maternity care services, including prenatal care, delivery, and postpartum care.
SB 5729 Insulin Cost Sharing Cap	Keiser	Removes the expiration date for the requirement of health plans to provide coverage for prescription insulin drugs for diabetes treatment capped at $35 per 30-day supply.

Bills that Did Not Pass

Bill/Title	Sponsor	Summary
Cost Containment		
HB 1269 Rx Drug Price Accountability Board	Riccellli	Amends authority of the PDAB, including revising prescription drug threshold prices and percentage increases on prices that trigger review eligibility.
HB 1508 Health Care Cost Transparency Board	Macri	Expands the scope and authority of the HCCTB to conduct data analysis and establish accountability measures for payers and providers who exceed health care cost growth benchmarks.
SB 5241 Health Care Marketplace	Randall	Modifies reporting requirements for mergers, acquisitions, or contracting between hospitals and providers. Requires the attorney general to determine impacts on accessible, affordable health care in the state for at least ten years after the transaction occurs.
SB 5393 Health Care Provider Contracting	Robinson	Prohibits health plans issued or renewed on/after January 1, 2024, from including anti-competitive clauses in contracts between carriers and hospitals, with certain exemptions.
Cost Sharing Mandates		
HB 1079 Whole Genome Sequencing	Thai	Requires HCA to require coverage under medical assistance programs for rapid whole genome sequencing for enrollees up to age one.
HB 1151 Fertility Services Coverage	Stonier	Requires large group health plans to cover the diagnosis of infertility, treatment for infertility, and standard fertility preservation services.
HB 1450 Biomarker Testing	Stonier	Requires private insurance and PEBB/SEBB plans to cover biomarker testing for plans issued or renewed on/after January 1, 2024.

Coverage Mandates		
HB 1356 Biosimilar Medicines	Reeves	Clarifies certain entities are not prevented from requiring a patient try an interchangeable biological or biosimilar product prior to providing coverage for the equivalent branded prescription drug.
HB 1465 Prescription Cost Sharing	Riccelli	This bill would require health plans issued or renewed on/after January 1, 2025, to decrease cost sharing for prescription drugs by passing savings through to the enrollee at the point of sale.
HB 1725 Insulin Access Under 21	Riccelli	Prohibits cost sharing for insulin for enrollees under age 21 for health plans issued or renewed on/after Jan. 1, 2024, upon launch of a copayment offset program administered by HCA.
HB 1855 Preventative Services	Riccelli	Updates requirements for health plans to cover ACA-designated preventive services without cost sharing.
SB 5580: Maternal Support / Postpartum Care	Muzzall	Increases the federal poverty level requirement for pregnant and postpartum persons from 193% to 210% and requires updates to related HCA programs.
Other		
SB 5767 Hospital Excise Tax	Randall	Establishing excise tax on certain hospitals to fund health care access.
SB 5335 Washington Heath Trust	Hasegawa	Establishes the Washington Health Trust as a consolidated single-payer insurance program providing universal health care to Washington residents funded through payroll and capital gains taxes.

Exchange Strategies to Approach Rising Costs

Health Care Cost Transparency Board Advisory Committee of Health Care Providers & Carriers

September 7, 2023

Laura Kate Zaichkin, Senior Policy Advisor (she/her)

washington healthbenefitexchange
powering washington healthplanfinder

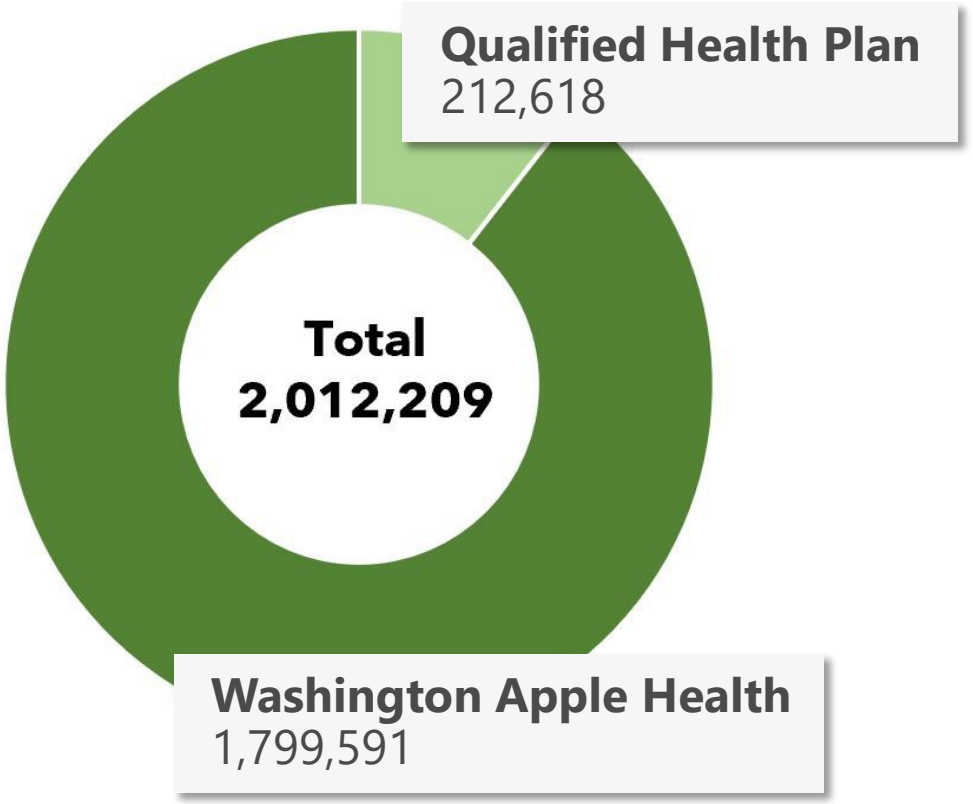
Exchange Background

The Exchange operates *Washington Healthplanfinder*, the state's online health insurance marketplace.

Over 2 million people –1 out of every 4 – Washingtonians use **www.wahealthplanfinder.org** to get health insurance.

- 1.8M Apple Health (Medicaid) customers
- 212K Qualified Health Plan (QHP) customers

The Exchange is publicly funded and governed by a bi-partisan board nominated by WA Legislature



Individual Market/QHP represents about **4.5%** of WA market

Market Health Summary

Washington has made progress improving the health of the individual market as measured by the uninsured rate, affordability of coverage, and access to care.

However, affordability as measured by high premiums and high cost sharing remain the primary barriers to more Washingtonians being insured and getting access to care.

- Washington's **uninsured rate** is at a historic low, but relies on customer premium stabilization measures like enhanced federal subsidies.
- Deeper **subsidization** is not a sustainable primary strategy for improving affordability.
- **Underlying costs of care** must be addressed.
- Washingtonians continue to face **disparities in quality of care and inequitable access to care**. These issues are not being substantively addressed in the individual market.
- Consumers continue to face **overload and choice error** due to the number of plans offered without meaningful differences.

Exchange Premium Increases Threaten Access & Affordability

2024 Exchange premiums proposed to increase by 9% for the second year

- 70% of customers face more than 5% rate increases.
- Average Exchange consumer would pay ~$40/month more or $480 a year more for coverage in 2024.
  - ~$950 more than in 2022
- 23% (~48,000) of consumers do not receive federal or state subsidies.

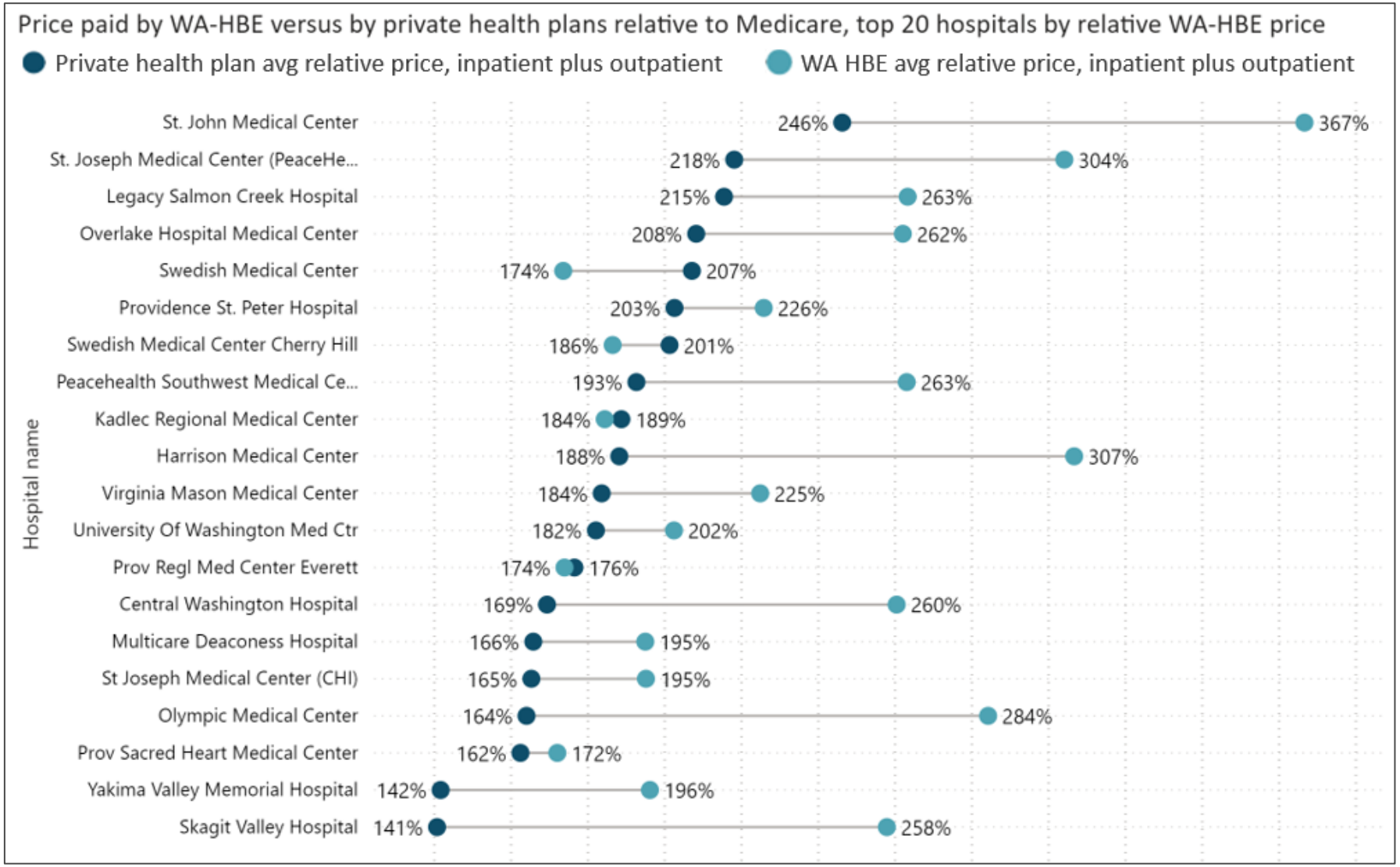
Carrier	Proposed Average Rate Change	Exchange Enrollment as of 5/2023
Kaiser Foundation Health Plan of Washington	18%	36,000
Premera Blue Cross	16%	13,000
BridgeSpan Health Company	15%	1,000
Kaiser Foundation Health Plan of the Northwest	9%	5,000
LifeWise Health Plan of Washington	8%	25,000
Molina Healthcare of Washington	7%	40,000
PacificSource Health Plans	7%	3,000
Regence BlueCross BlueShield of Oregon	6%	4,000
Coordinated Care Corporation	5%	58,000
Regence BlueShield WA	4%	17,000
Community Health Plan of Washington	3%	7,000
UnitedHealthcare of Oregon, Inc.	3%	4,000

Average rate changes are weighted for Exchange enrollment

Exchange Customers Pay More For Health Care

Exchange customers pay 35% more for their hospital care than other commercially insured WA residents.

- WA relative price: 174% of Medicare.
- Exchange customer relative price: 210% of Medicare.



Source: RAND 4.0, Prices Paid to Hospitals by Private Health Plans

State Policy Options to Reduce Cost

	Policy Category	Washington State Levers	Exchange/Cascade Care Levers*
1	**Market Based Approaches**	• Price transparency • Evidence based payment/Value Based Purchasing • Active Purchasing/Collaboratives • Reference Pricing	• Price Transparency • Cascade Select/Public Option Rate Cap • Standard Benefit Design • Selective Contracting

2	**Address Market Failures**	• Payment Limits/Oversight commission
		  • Balance Billing, Site neutral payments, Spread pricing, Rebate pass through
		  • Rate or Growth Caps
		• All-payer rate setting, global budgets
			• Public Insurance Plan Option
			• Market Participation (Carrier) Limits

3	**Eliminate Regulatory Barriers to Competition**	• Reform certificates of need • Licensing, scope of practice, telehealth	
4	**Prohibit Antitrust and Anticompetitive Practices**	• State merger enforcement • Address anticompetitive practices and contracts • Certificate of Public Advantage	

*Note: State Based Marketplaces also reduce consumer cost burden through subsidies such as Federal and State Premium and Cost Sharing Subsidies, Reinsurance and Basic Health Plan.

Exchange Affordability Action Plan

1. Cascade Care – a central affordability initiative
   - Standard Plans
   - Public Option
   - State Premium Subsidy
2. Price transparency and Exchange claims analysis
   - HBE is a member of WA Health Care Cost Transparency Board
   - RAND V4.0 hospital pricing study
   - UCLA research partnership on public option (underway)
3. Expand federal premium assistance
   - Maintain $200 million additional premium assistance through Inflation Reduction Act
4. Partner with Medicaid and employers
   - Washington Health Alliance and PGBH
   - Incent high quality care that improves health and reduces overall costs; Focus: Advanced primary care

Cascade Care

Cascade Care makes health insurance accessible and affordable for every *Washington Healthplanfinder* customer.

- **Lower premiums**
- **Higher quality benefits**
- **Lower copays**
- **Easier plan shopping**
- **Available in all counties**
- **Extra savings for those who qualify**

2 in 3

Washington Healthplanfinder QHP customers are enrolled in Cascade Care plans

55,000+

Washington Healthplanfinder customers have lowered their monthly premiums with Cascade Care Savings

14%

Lower premiums before subsidies in public option plans, on average, compared to non-Cascade plan premiums

Data as of 5/2023

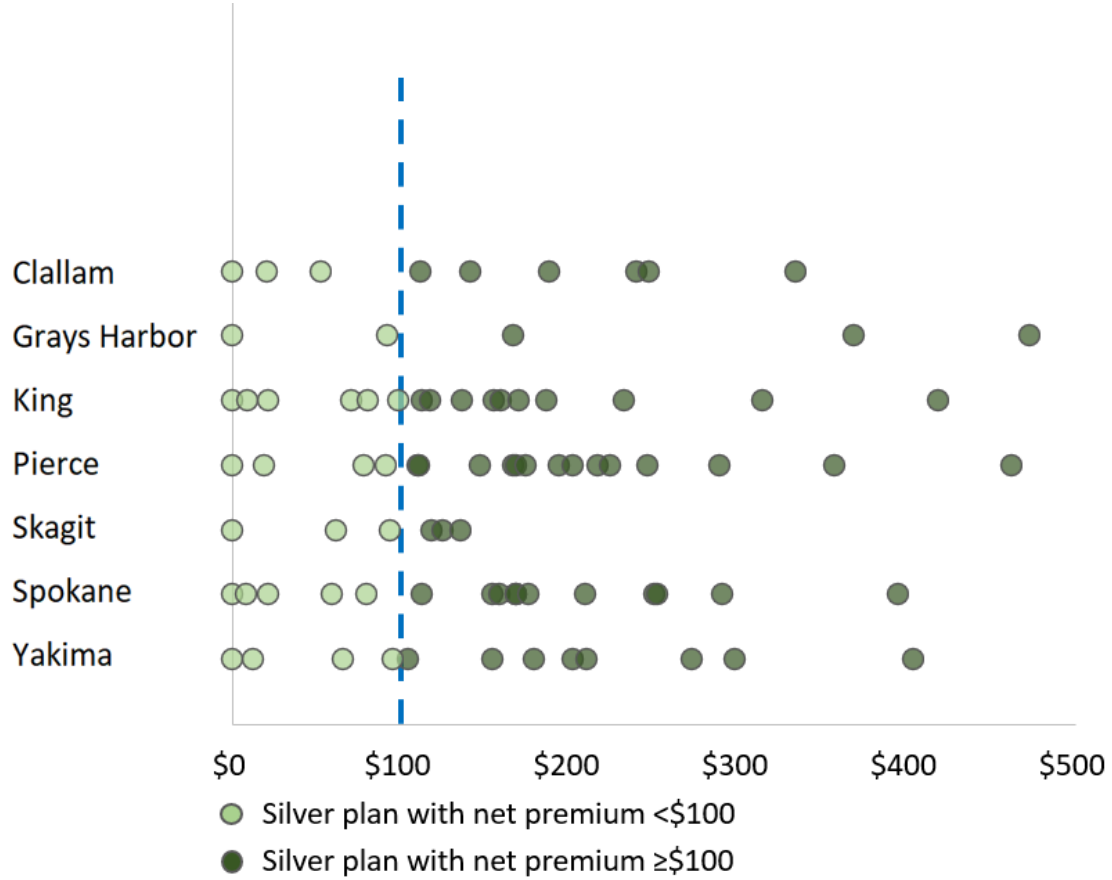
Cascade Care: Helping make health insurance affordable and accessible for every *Washington Healthplanfinder* customer

- All **Cascade Care plans** let customers pay less at the doctor's office with more predictable costs. For example, regular check-ups and mental health office visits are covered without a deductible.
- **Standard plans** are high-quality, low-cost, thoughtfully designed plans available exclusively to *Washington Healthplanfinder* customers.
- The nation's first **public option plan**, Cascade Select, is selected by the State and intended to be the most affordable plans for *Washington Healthplanfinder* customers.
- A **state subsidy** named Cascade Care Savings lowers customers' premiums through state-funded premium assistance. Low-income customers can get Cascade Care Silver or Gold plans for lower costs than non-Cascade plans.

Subsidies Alone Insufficient to Address Affordability

- Almost 48,000 Exchange customers do not receive subsidies
- Majority of plans are unaffordable even after Cascade Care Savings and Federal Tax Credits are applied
- For customer at 250% FPL ($34,000 income):
  - Only a few silver plans in each county have a net premium under $100
  - Monthly premium over ~$280 is more than 10% of income spent on premiums

Net Premium after APTC and Cascade Care Savings Applied, 2024 Proposed Rates, 40-year-old Non-Smoker at 250% FPL*

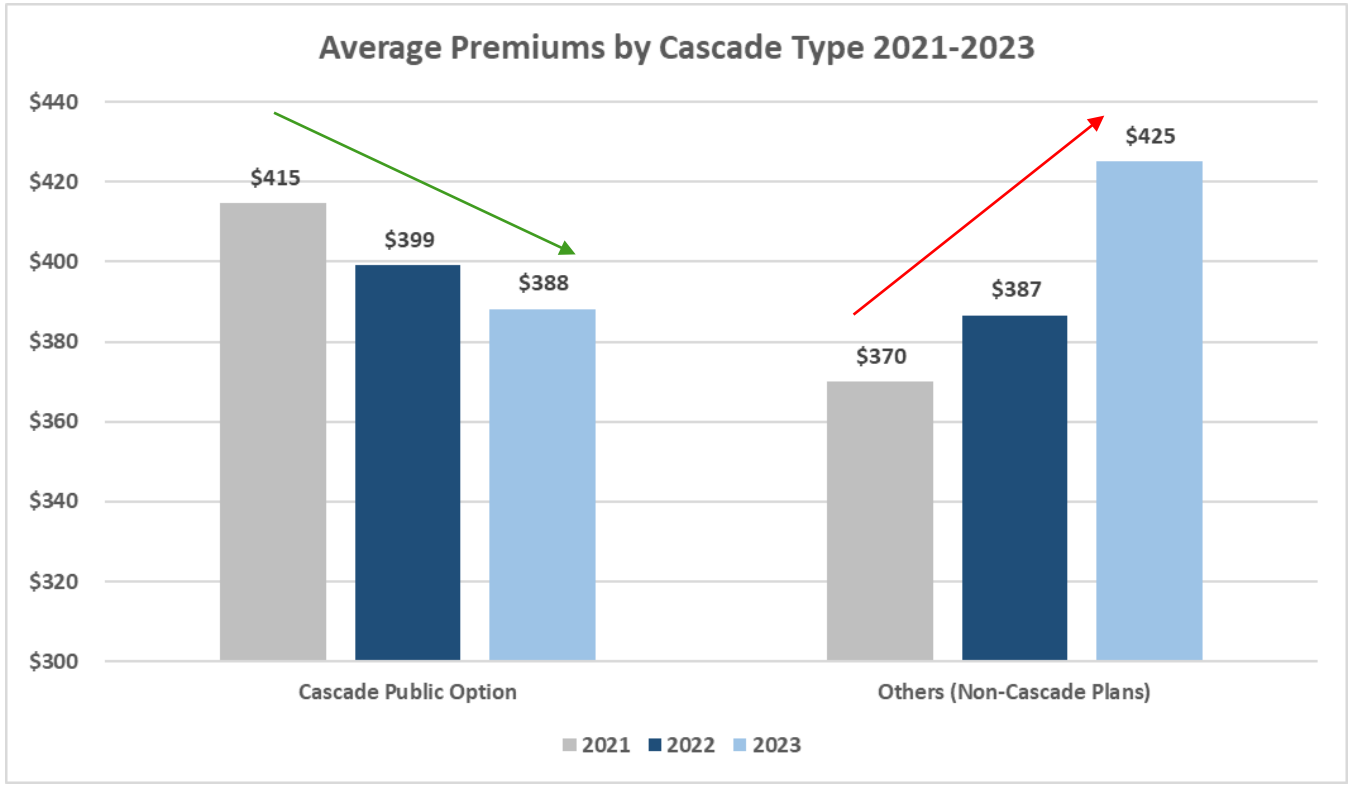


*Based on Plan Year 2023 FPL and monthly customer premium contribution levels; Data will be updated once 2024 plan rates final

CASCADE CARE

Public Option Shows Promise

Public option plans show promise in advancing customer affordability compared to other Exchange plans



Rates for 40-year-old nonsmoker; not weighted for enrollment

Plan Type	Rate Change % 2021-2023
Public Option	-6%
Non-Cascade	+15%

Source: 2021-2023 OIC Carrier Rate Filings

CASCADE CARE

Public Option Presents Opportunity To Meaningfully Reduce Premiums, But Needs Strengthening

- Participating public option plans are generally meeting the current provider reimbursement cap (160%).
- Intended premium reduction of 10% has not been achieved by the cap.

Exhibit 2
Cascade Care Public Option - Results of Reimbursement Target Review
Affordability Requirement Performance Summary
Claims Incurred from January 1, 2021 through December 31, 2021

ALL CARRIERS — Member months: 26,622

Affordability Requirement	Metric Results		
	Requirement	Performance	Results
A) Aggregate Percent of Medicare Reimbursement[1]	< 160%	164%	FAIL
B) Physician Primary Care Percent of Medicare Reimbursement	> 135%	139%	PASS
C) Critical Access and Sole Community Hospital Reimbursement	> 101%	160%	PASS
Summary of Affordability Requirements[2]	**FAIL**		

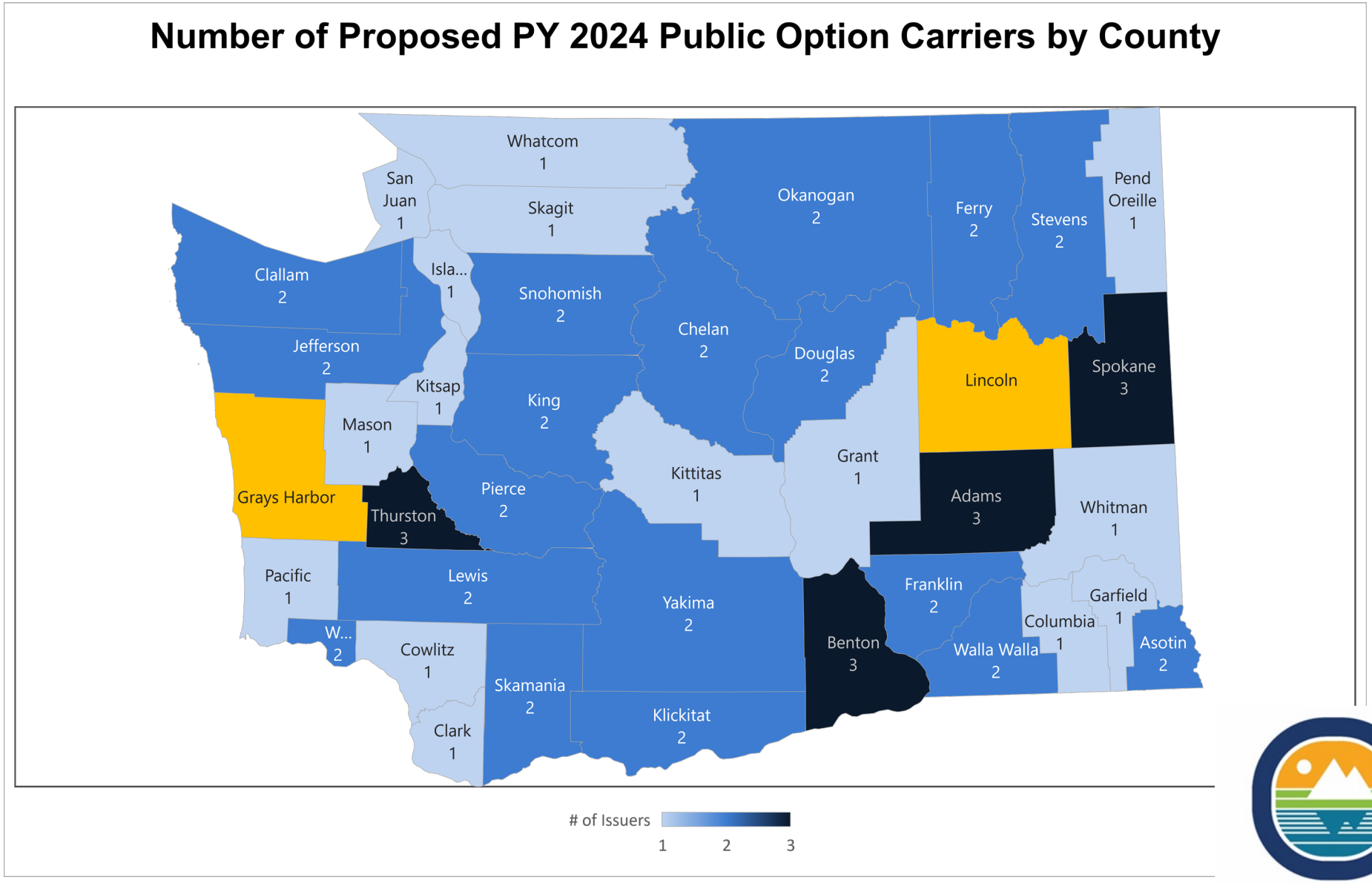
Notes
1. Inpatient hospital claims experience and percent of Medicare reimbursement rates adversely affected by several large outlier claims in late 2021.
2. Of five 2021 carriers, two carriers meet all three affordability requirements and one carrier has insufficient experience for evaluation.

Source: Milliman analysis of 2021 public option carrier claims: https://www.hca.wa.gov/assets/program/cascade-select-leg-report-20221216.pdf

CASCADE CARE

Public Option Presents Opportunity To Meaningfully Reduce Premiums, But Needs Strengthening

Strengthened provider participation requirements may be needed to ensure statewide public option access and healthy competition.



CASCADE CARE

Legislative Direction

Legislative reports due by December 1, 2023

Public Option Impacts

- Exchange report about the impact of public option on hospital financial sustainability.
- Health Care Cost Transparency Board report about the impact of public option on consumers.
- Based on above analyses, Exchange recommendations to the Legislature about how to address public option financial or other issues.

Offering Only Cascade Care Plans

- Analyze impact to Exchange customers of offering only Cascade Care (standard & public option) plans on the Exchange starting in 2025.

1332 Waiver Pass Through Study

- Assess waiver amendment(s) to capture federal pass-through funding to support affordability programs, focusing on methods being used in other states that could be most readily leveraged in Washington.

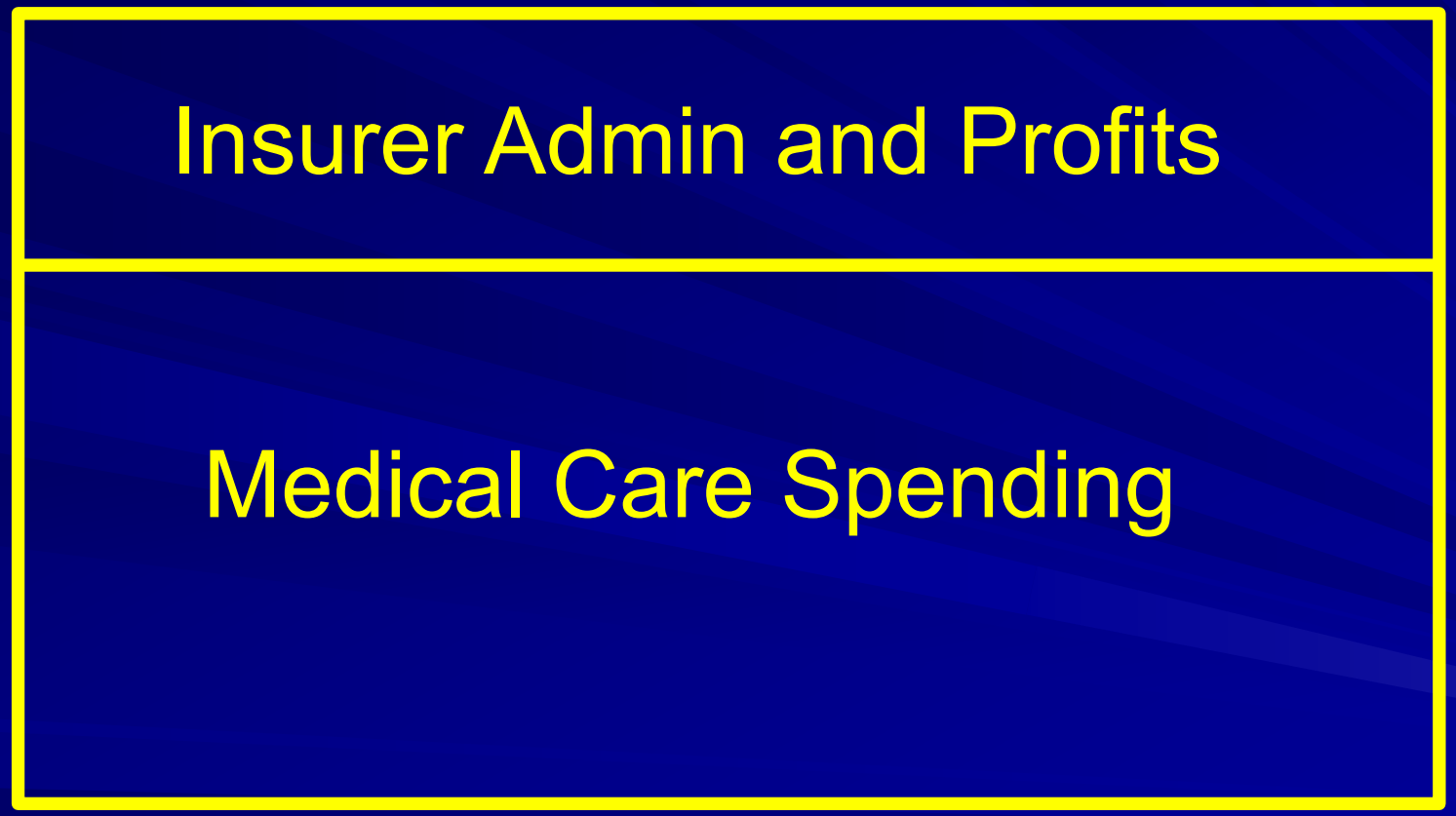
CASCADE CARE

Questions & Discussion

Laura Kate Zaichkin, Senior Policy Advisor
laurakate.zaichkin@wahbexchange.org

Appendix

Basic Spending Math



Price

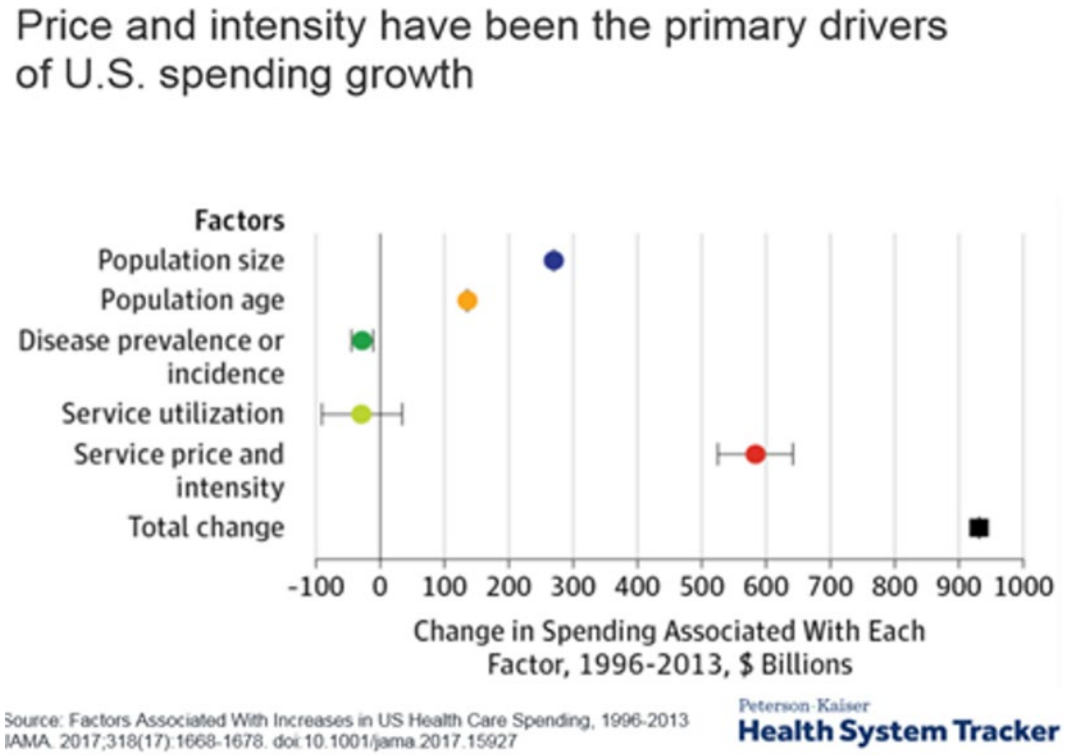
Utilization

Michael Chernew, PhD

Harvard Medical School

Nationally - Medical Costs are High

Prices are the driving factor and hospital costs are largest share of costs



Health Care Cost Institute 2021 Report

Exchange Market is Stable and Majority Cascade Care Enrollment

Exchange Enrollment as of May 2023

- ~214,000 Enrollees
- 12 Carriers offering 90 Plans
- ~65% of enrollees in Cascade Care plans

Average Net Premium*:

- Subsidized (77%): $176
- Non-subsidized (23%): $567
- Enrollment % by Metal Level: 40% Bronze, 19% Gold, 41% Silver

Carrier	May 2023 Enrollment	Percent
Coordinated Care	58,000	27%
Kaiser NW/WA	41,700	19%
Molina	40,000	19%
LifeWise/Premera	38,300	18%
Regence/BridgeSpan	22,000	10%
CHPW	7,000	3%
UnitedHealthCare OR	4,000	2%
PacificSource	3,000	2%

2024 Exchange Initial Filing

- 12 carriers offering 82 plans
- All counties have 2+ carrier options
- Pierce County has 10 carriers and 62 plans

Average proposed rate increase: 9%**

Cascade Care – Public Option

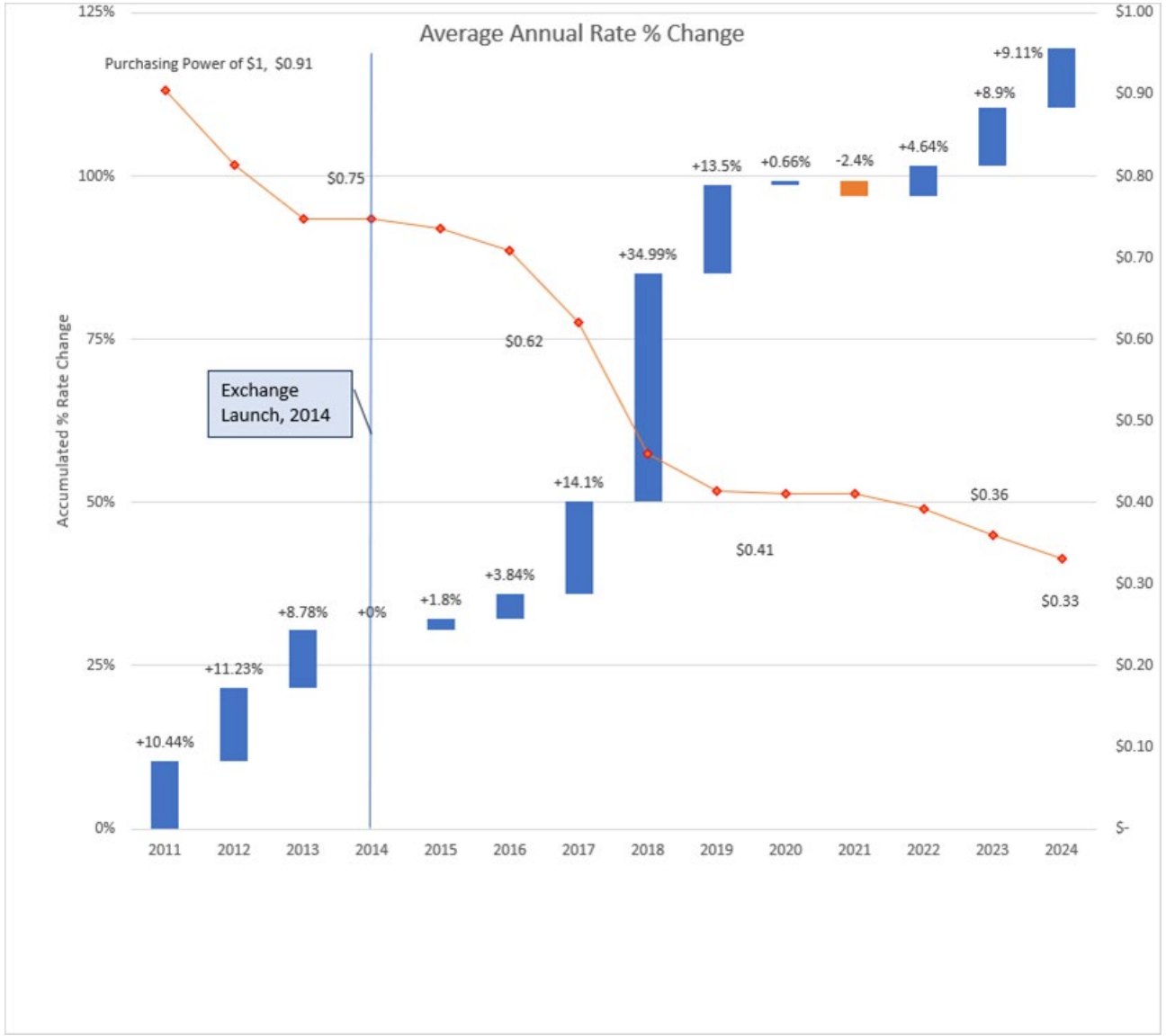
- Would be available in 37 counties

*Net premium from Spring enrollment report
** For renewing plans only and is weighted for enrollment

Summary of Initial 2024 Filings

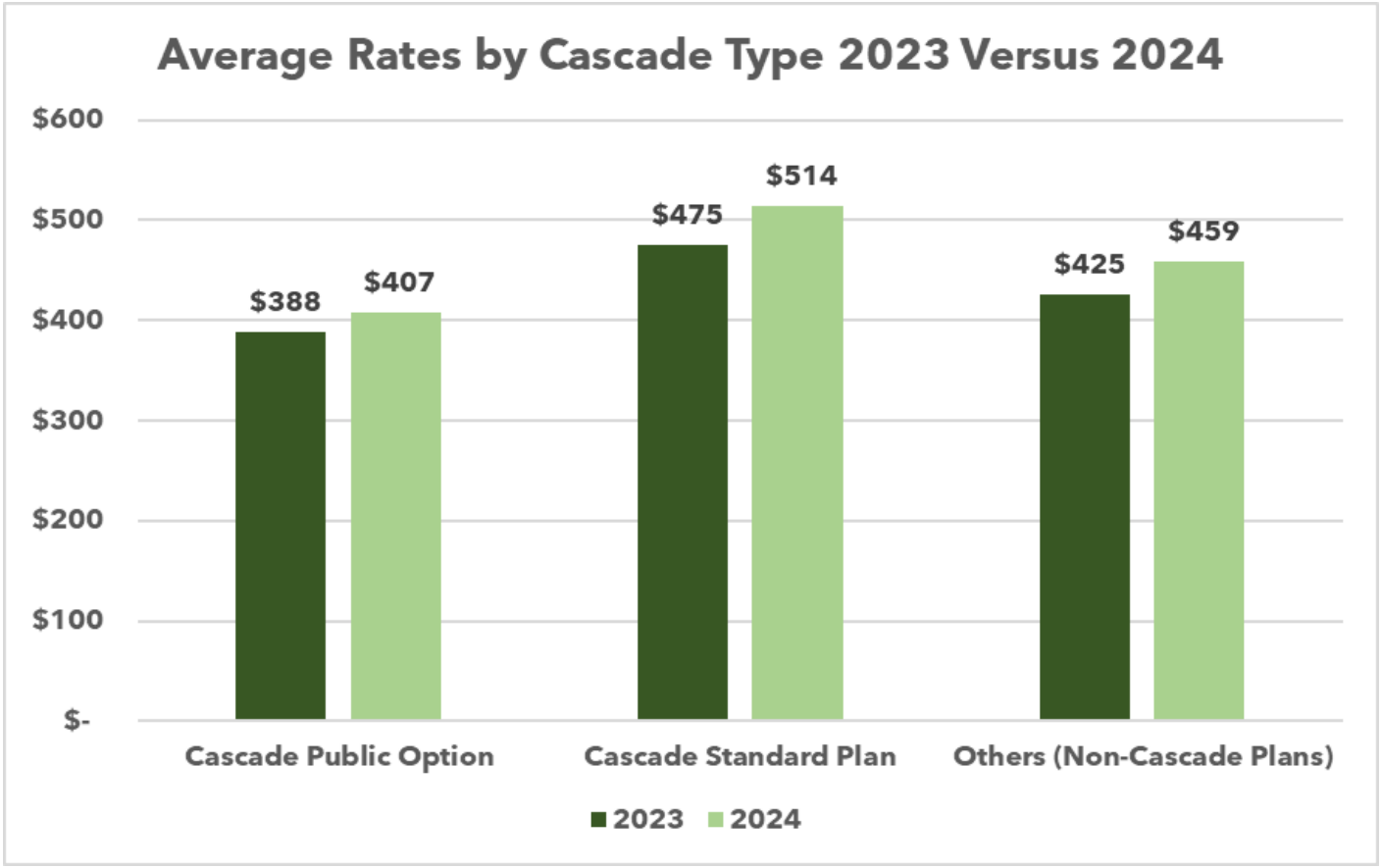
- Proposed rate increases and wide ranges in premiums threaten affordability and access
  - Subsidies cannot keep pace with rate and range of premium increases
- Exchange premiums proposed to increase by 9% for the second year in a row
- Consumers continue to face choice overload
  - 82 QHP offerings for 2024, with customers in seven counties choosing from 40+ plans
- Cascade Care – Exchange's primary affordability initiative:
  - Public option proposed to expand but still not statewide
  - Public option rates are not offering meaningfully lower premiums but are increasing at a slower rate than other plans
  - Watch points: market crowding, meaningful difference, meaningfully lower premiums.

Historical Rate Changes Compound Plan Year 2024's Large Rate Increase



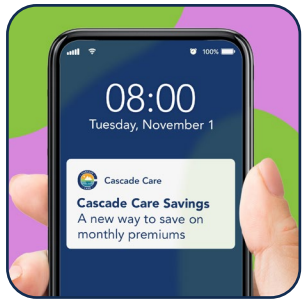
Cascade Care Public Option Plan Proposed Rate Increases Are Smaller

Cascade Type	Average Rate % Increase 2023-2024	Enrollment as of 5/2023
Cascade Public Option	5%	29,000
Cascade Standard	8%	110,000
Others (Non-Cascade Plans)	8%	76,000



Rates are for a 40-year-old non-smoker, inclusive of all counties and are not weighted for enrollment; 2024 rates are proposed rates before any available state or federal subsidy

Legislative Direction to Date



2019: Cascade Care 1.0

- Cascade Care is created, providing new coverage options available through *Washington Healthplanfinder*:
  - **Standard Plans** (Cascade) designed by HBE to have the same benefit design & lower cost sharing for easy comparison and better value.
  - **Public Option Plans** (Cascade Select) standard plans procured by HCA that include additional quality, value, and provider reimbursement expectations.
- The Exchange is directed to develop a plan to implement a state premium assistance program and analyze the impact of offering only standard plans beginning in 2025.

2021: Cascade Care 2.0

- Improvements are made to Cascade Care by:
  - Limiting the number of non-Cascade plans carriers could offer on the Exchange.
  - Requiring public option participation by hospital systems participating in other public programs.
- The Exchange is directed to establish a state premium assistance program (Cascade Care Savings) in 2023, with an initial annual funding level of $50 million.
- The Exchange is directed to explore coverage solutions for individuals without a federally recognized immigration status (1332 Waiver) beginning in 2024.

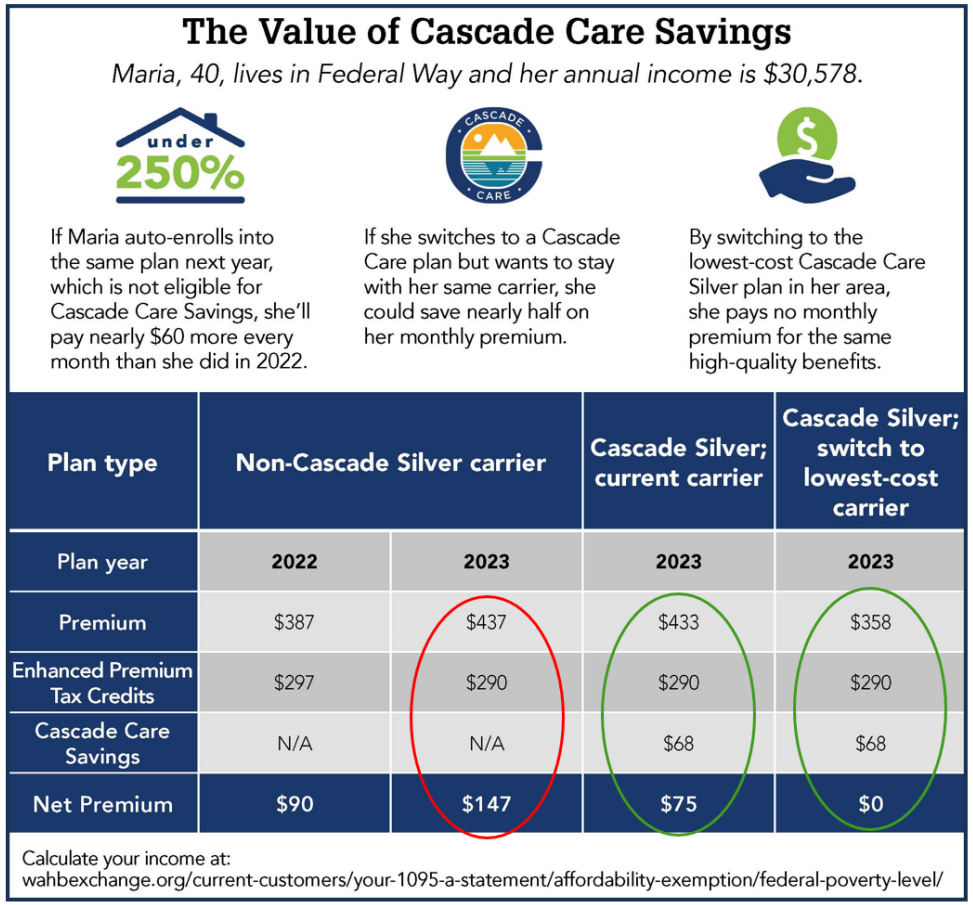
2023 Session

- Cascade Care Savings funding is sustained at $50 million annually, with an additional $5 million annually to provide subsidies to new customers under the 1332 Waiver.
- The Exchange is directed to conduct a study on how the 1332 Waiver could be amended to generate federal pass-through funding to support Exchange affordability programs.

Cascade Care 1.0 – Notable "Firsts"

- Broad-based recognition of how much Exchange customers were paying (as a percentage of their income) for both premiums and cost-sharing (particularly deductibles).
- Broad-based recognition of the difficulties Exchange customers were facing comparing plan designs and costs (premiums, co-pays, coinsurance, etc.).
- Exchange authorized to design standard plans.
- First state in the country to pass a public option bill.
- First time state's broader purchasing authority leveraged to help lower costs in Exchange market.
- First aggregate provider reimbursement cap in Exchange market (protections included for rural and primary care providers).
- First indication of support for a state premium subsidy.

Cascade Care 2.0 – Notable "Firsts"



The Value of Cascade Care Savings

Maria, 40, lives in Federal Way and her annual income is $30,578.

under 250%

If Maria auto-enrolls into the same plan next year, which is not eligible for Cascade Care Savings, she'll pay nearly $60 more every month than she did in 2022.

If she switches to a Cascade Care plan but wants to stay with her same carrier, she could save nearly half on her monthly premium.

By switching to the lowest-cost Cascade Care Silver plan in her area, she pays no monthly premium for the same high-quality benefits.

Plan type	Non-Cascade Silver carrier		Cascade Silver; current carrier	Cascade Silver; switch to lowest-cost carrier
Plan year	2022	2023	2023	2023
Premium	$387	$437	$433	$358
Enhanced Premium Tax Credits	$297	$290	$290	$290
Cascade Care Savings	N/A	N/A	$68	$68
Net Premium	$90	$147	$75	$0

Calculate your income at:
wahbexchange.org/current-customers/your-1095-a-statement/affordability-exemption/federal-poverty-level/

- First updates to Cascade Care to strengthen existing requirements post launch (2021). Focus on:
  - Improving plan offerings/limiting 'me too' plans/further addressing 'choice overload.'
  - Maximizing available federal subsidies (limiting non-standard plans at silver level).
  - Expanding availability of public option plans (provider participation requirements).
- First state premium assistance program established for low-income customers (up to 250% FPL).
  - Established for federally subsidized and non-federally subsidized customers.
  - Tied to silver and gold Cascade Care plans.
- Exchange authorized to pursue a first-in-kind federal 1332 waiver to expand QHP/QDP coverage to all Washingtonians, regardless of immigration status, starting in 2024.

2023 Session – Notable Accomplishments

- Sustained state investment in Cascade Care Savings.
- Member education on Cascade Care: increased enrollment, expanded availability and competitive pricing of public option plans (lower premiums and lower deductibles compared to non-Cascade).
- New state investments in 1332 waiver implementation, including enhanced community-based outreach.

	Required standard deductibles for all 2023 Cascade Care plans	Range of deductibles for 2023 non-Cascade plans
GOLD	$600	$0-$2,000
SILVER	$2,500	$750-$7,550
BRONZE	$6,000	$3,800-$8,900

Public Option Background

Standard Cascade Care Plans With Additional Quality, Value, & Affordability Requirements

Public Option Goal	Policy Lever to Advance Goal	Policy Description

Affordability: Meaningfully Lower Premiums	• State-defined provider reimbursement requirements.
	• Participation requirements for hospital systems that participate in other public programs.
	• Competitively procured by the State.
		• Provider reimbursement requirements:
		  • May not exceed 160% of Medicare for all covered benefits in statewide aggregate.
		  • Reimbursement floors for critical access/sole community hospitals and primary care services.
		• Hospitals must contract with at least one public option plan.
		• HCA procures and contracts for public option plans offered on the Exchange.

Statewide Access	• Participation requirements for hospital systems that participate in other public programs. • Competitively procured by the State.	
Quality & Equity	• Cost and quality transparency requirements. • Requires adoption of state quality, equity standards.	• Reporting on health improvement activities, primary care spend, quality measures. • Adoption of Bree and Health Technology Clinical Committee recommendations.

As required by SB 5526 & SB 5377

2023 Health Plans Offered on *Washington Healthplanfinder*

		Non-Cascade plans	Cascade Care Plans	
			Cascade (standard) plans	Cascade Select (public option) plans
Meets all QHP requirements	Requirements for all QHPs in 2023: • All plans must meet all requirements under RCW 43.71.065. • Carriers must offer gold and silver Cascade Care health plans to participate in Washington Healthplanfinder. • Carriers offering a non-Cascade bronze plan on Washington Healthplanfinder must also offer one bronze Cascade Care health plan on Washington Healthplanfinder in any county where it offers a bronze plan. • Carriers offering Cascade Care health plans may offer up to two non-Cascade gold plans, two non-Cascade bronze plans, one non-Cascade silver health plan, one non-Cascade platinum health plan, and one non-Cascade catastrophic health plan in each county where the carrier offers a qualified health plan.	X	X	X
Eligible for tax credits		X	X	X
Eligible for Cascade Care Savings state premium subsidy for residents earning up to 250% FPL.			X	X
Includes standard health plan benefit design set by the Exchange.			X	X
Includes quality, value, and provider reimbursement requirements set by the Legislature and Health Care Authority.				X
Hospital participation requirements set by the Legislature.				X
Procured through the Health Care Authority.				X

Tab 6

Washington State Health Care Authority

Updated motion for consideration at the September 7 Provider Advisory Committee meeting:

The committee respectfully requests that the Board address the following critical operational elements as they relate to the health care cost growth benchmark process, and as further detailed in the letter above, at an upcoming Board meeting:

- Attribution Methodology: transparency and accuracy of attributed members and primary care providers is important, because large provider entities will be held accountable for those patients and primary care providers.

- Risk Adjustment: adjustment methodology for age and sex should be disclosed and reviewable, because it will better inform primary care providers and large provider entities.

- Analysis for Specific Provider Performance: information and metrics that identify contributors to cost growth should be given to large provider entities, because large provider entities must be able to understand why they exceeded the benchmark in order to improve performance.

- Provider Identification and Notice: identification of large provider entities and the process by which they are notified should be established, because large provider entities must be aware that they are subject to the benchmark.

Thank you for attending the Advisory Committee of Health Care Providers and Carriers meeting!

Washington State Health Care Authority