Advisory Committee of Health Care Providers and Carriers meeting summary

August 3, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

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

Members present

Bob Crittenden
Justin Evander
Jodi Joyce
Stacy Kessel
Ross Laursen
Todd Lovshin
Mike Marsh
Natalia Martinez-Kohler
Mika Sinanan
Dorothy Teeter
Wes Waters

Members absent

Paul Fishman
Louise Kaplan
Vicki Lowe
Megan McIntyre

Agenda items

Welcome, call to order, approval of June meeting summary

The June meeting summary was approved.

Topics for today

The topics included a review of the primary care statute, a presentation led by Dr. Judy Zerzan on primary care expenditures, and a discussion, also led by Dr. Zerzan, of next steps for primary care work, including the formation of the primary care committee.

Primary Care Statute and Primary Care

AnnaLisa presented an overview of SSB 5589, the statute establishing a state target for primary care expenditures. The presentation described the recommendations required of the Board to the legislature, and a legislative report. The recommendations for how to track primary care spending will be reviewed by Advisory Committees and

considered by the Board. There are several conditions in the legislation within which the 12 percent target must be achieved. There are many subsets under improving value for the health care system. The preliminary report on primary care expenditures is due in December with an annual report due every August. The breakdown by carrier, market, or payer fits with the cost benchmark reporting rubric. One of the required recommendations in the initial December report will include reporting barriers, which could include how to incentivize providers, or barriers to adoption of health information technology and how that drives costs. Dr. Judy Zerzan, Chief Medical Officer will serve as the subject matter expert for the primary care committee and will work in conjunction with the project team, along with some additional support from HCA's clinical quality care transformation (CQCT) team. The Board already approved the creation of the primary care committee and will approve members in September. The Committee of Providers and Carriers might need an additional meeting or two to engage in the stakeholdering and review process for the December primary care expenditures legislative report.

One committee member asked about the origin of the 12 percent target and its relationship to the Oregon statute and asked if there was more detail about how it was determined. AnnaLisa committed to contacting HCA's legislative team to find additional information behind the reasoning for the 12 percent target.

One member asked whether the 12 percent target for primary care spending would include spending on social determinants of health (SDOH) and whether the expected outcomes would consider the provider's ability to control the spending. AnnaLisa clarified that total health care expenditures would be the denominator for determining performance relative to the 12% target, and that primary care expenditures would include behavioral health spending and non-claims-based spending.

A new policy analyst will be hired to support the primary care work and primary care committee. The analyst will be onboarded in either mid-August or early September. Dr. Judy Zerzan will serve as the subject matter expert for the primary care committee and will work in conjunction with the project team, along with some additional support from HCA's clinical quality care transformation (CQCT) team. The Board has already approved the creation of the primary care committee and would approve members in September. The Committee of Providers and Carriers might need an additional meeting or two to engage in the stakeholdering and review process for the December primary care expenditures legislative report.

Mika relayed concerns about an apparent lack of focus on access to care. Increasing primary care spending could make the system smaller and better for people who receive care but still deliver insufficient care across the state.

Bob Crittenden noted problems with outcomes that are heavily overrepresented by low-income individuals, people with linguistic barriers, and undocumented persons. Further category breakdowns are needed to look at these populations, specifically looking beyond areas like Bellevue and Madrona to places like Yakima. Language and ethnicity should also be analyzed.

Jodi Joyce explained an acronym used to describe care delivery from the Institute for Healthcare Improvement (IHI), STEEP: safe timely, equitable, efficient, effective, and patient-centered. The committee should think about these six lenses when analyzing outcomes. Access should serve as a marker of quality rather than just supply and demand management.

Todd Lovshin brought up that the insurance section of Washington's state code has a primary care definition. Would the primary care committee make suggestions that might change the interpretation outlined by the state code? AnnaLisa responded that the Board could look at the legal definition within the insurance code, but that the primary committee's recommendation would mainly focus on a definition used for measurement purposes. The committee will focus less on what insurers would pay and more on how to measure and track the 12 percent target. If issuers want to look at the code to be in alignment with the definition used for measurement, they can. Todd clarified that the committee's definition doesn't have to align perfectly with the one provided in the insurance

code, but that the code should be taken into consideration. Multiple regulatory bodies use different definitions of primary care. AnnaLisa asked if Todd meant in state or elsewhere. Todd responded that the reference was to state agencies and organizations like the Exchange Board, the insurance commissioner in contracts, Cascade Care, and other products with rates for primary care. AnnaLisa clarified that the committee will attempt to define primary care in a way that will be as consistent as possible. The committee will evaluate the impact of different definitions in regulatory or contractual settings to determine how disparate they might be.

Public Comment

There was no public comment.

Primary Care Next Steps: Overview and Discussion

Dr. Judy Zerzan-Thul, HCA's Chief Medical Officer (CMO) gave a presentation on covering a background of primary spending, work from other states, and HCA-led work conducted through the Multi-Payer Primary Care Transformation Model (MPCTM). The presentation focused on challenges, existing efforts, and targets.

Judy began her presentation with an exhibit from 2003 from the Milbank Fund, which showed a positive association between the number of primary care providers and quality outcomes. The same data and article showed that primary care investments were associated with lower total costs. The evidence about the benefits of increasing investments in primary care has been around for 20 or 30 years, but overall spending remains low. Average primary care spending on a national level ranges from only 5 to 7 percent, with Washington falling within that range. Rhode Island and Oregon were early movers in adopting methods to measure primary care expenditures, and several states have passed laws or regulations related to primary care spending. Judy provided an overview of Rhode Island's primary care spending efforts. Rhode Island is the oldest adopter among states to track and increase primary care spending. Rhode Island's former insurance commissioner, Chris Kohler, spoke with this committee before. While primary care investment was likely a factor in bending Rhode Island's cost curve, their decision to cap hospital rate increases likely also contributed. Judy also described Oregon's primary care spending efforts, which began in 2015 with the establishment of the primary care payment reform collaborative.

Next, Judy discussed primary care spending more broadly. There is no universal definition of primary care spending. Tracking non-claims-based spending will be the trickiest to do for Washington. Judy provided an overview of who is involved with primary care (provider types), what constitutes primary care (services), and how primary care spending is measured. Oregon's goal resembles Washington's. The primary care committee will have the flexibility to engage with legislative sponsors to determine when the target must be reached. Judy described existing Washington primary care definitions including OFM, Bree, and RCW 74.09.010. Most states have both a narrow and a broad definition of primary care spending. Judy also gave an overview of existing Washington Primary Care expenditure reports, which included OFM and HCA carrier reporting (that started in 2020). Judy contrasted the results from the OFM report, which found spending rates of 4.4 percent based on a narrow definition and 5.6 based on a broader definition, with the HCA carrier self-reported range of 5 to 14 percent.

Mike Marsh brought up concerns around the need to account for private equity in healthcare provision. Private equity and technology disrupters have discovered healthcare as a business target. Most traditional providers are non-profits who serve people regardless of their ability to pay (Medicaid and Medicare being the primary examples of these types of populations). As the framework evolves, the healthcare ecosystem will undergo a significant shift with well-capitalized entrants who lacked the burden of caring for some populations.

Mika cautioned that Rhode Island's experience shows that causality between increased primary care spending and higher quality outcomes was inferred but that caps on hospital rates were a confounding factor. Judy responded that there is additional data in a national academies report that is available as well as more recent data from a plan

in California. Increasing primary care spending isn't' just for paying clinicians enough but also the team around them. Even in rural areas, most primary care is owned by rural hospitals, so taking note of consolidation and the changing market is important.

Judy presented an overview of Washington's MPCTM, and highlighted its goals to align all payers, increase access, and align quality measures and different payment methods. Judy described the basic components of the model and its associated workgroups: one is the multi-payer group and the other is a provider summit (clinicians, health systems, and patient representatives at the beginning, who later dropped off).

Bob commented that the MPCTM should consider issues of equity and how to reach out to the whole population. The model should account for how to measure community impact. Judy clarified that there is some equity as well as SDOH components integrated into the certification process, but that further discussions on equity will be needed. The plan is to get a structure in place for alignment and to add in equity as the model proceeds. Bob noted that other places around the country factor in equity with incentive payments to ensure outreach to non-English speaking populations or other hard to reach individuals.

Mike asked how HCA has partnered with or triangulated information from the Washington Healthcare Alliance. Judy responded that there has not been collaboration on a data front, however, the alliance has been engaged in the summit group for development. Ginny Weir from Bree was involved in the summit group. HCA has not compared data on primary care spending yet.

Mika commented on the quality measures included in the model. Judy agreed that the measures were chosen to maintain consistency across payers. The Performance Measures Coordinating Committee (PMCC) runs the common measure set and payers around the table committed to aligning the 12 measures with the measures in their contracts. HCA initiated work to change its measures and encountered some restrictions. Mika asked if the payers who agreed to the metrics included national companies like Cigna. Judy clarified that Cigna was not included but that every other payer is present, including Pacific Source.

Dorothy Teeter suggested that HCA should consider partnering with the Alliance and Bree. Judy acknowledged that patient experience isn't currently addressed in the MPCTM. The MPCTM stratifies measures by race, ethnicity, etc. Both the Bree Collaborative and the Washington Healthcare Alliance were on the primary care summit and are connected to the MPCTM.

Judy transitioned to next steps for the primary care committee and provided an overview of the recommendations required for the December legislative report: a definition of primary care, how to measure claims-based spending, how to measure non-claims-based spending, and a description of reporting requirements, barriers, and how to overcome them. Judy provided definitions of primary care from the MPCTM. Judy explained non-claims-based spending, which can include alternative payment models (APMs), collaborative care, community health workers (CHWs), and data management. Judy proposed that the primary care committee adopt the existing certification workgroup.

Ross Laursen asked whether there was a representative from Premera on the workgroup. The workgroup doesn't have a Premera rep but there is a Premera rep at the payer table. Judy already spoke with the certification workgroup members to inform them that they were being considered. Additional people will be added to the proposed member list. The Board will hold a discussion of nominations at their next meeting.

Jodi noted a lack of providers on the proposed member list. Judy clarified that the initial list presented today is intended to serve as a base and will not constitute a final list.

Ross pointed out that the proposed list doesn't include roles and titles and recommended expanding the list's details to include roles and responsibilities along with scope.

Adjournment

The meeting adjourned at 4:00 p.m.

Next meeting

Wednesday October 5, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.