Washington State Health Care Authority

Health Care Cost Transparency Board's

Advisory Committee on Primary Care meeting summary

November 28, 2023

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
2:00 –3:10 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the **Advisory Committee on Primary Care's webpage**.

Members present

Judy Zerzan-Thul, Chair
Kristal Albrecht
Sharon Brown
Michele Causley
Tracy Corgiat
David DiGiuseppe
Chandra Hicks
Meg Jones
Lan Nguyen
Mandy Stahre
Jonathan Staloff
Ginny Weir
Maddy Wiley

Members absent

Tony Butruille
D.C. Dugdale
Sharon Eloranta
Gregory Marchand
Sheryl Morelli
Katina Rue
Sarah Stokes
Linda Van Hoff
Shawn West
Staici West

Call to order

Dr. Judy Zerzan-Thul, Committee Chair, called the meeting to order at 2:05 p.m.

Washington State Health Care Authority

Agenda items

Welcoming remarks

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

Meeting summary review from the previous meeting

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

Public comment

Stacey Whiteman, committee facilitator, called for comments from the public. There were no public comments.

Primary Care Expenditures and Non-Claims-Based Spending

Kahlie Dufresne and Hana Hartman, Policy Division, Health Care Authority

The Legislature set a goal of spending 12% of total health care dollars on primary care. To achieve this, a shared definition of primary care and primary care spending is needed. The committee is in the process of recommending a definition of primary care and standards for reporting and measuring claims- and non-claims-based spending. Using the narrow definition for claims- and non-claims-based spending, self-reported information from HCA's contracted plans in 2022 indicated primary care spending for the Medicaid market was about 9.51 percent of total spending, the commercial market for HCA-contracted plans was about 6.71 percent, and the combined weighted average was 8.81 percent. Altogether, HCA-contracted plans accounted for about 25 percent of the Washington health insurance market in 2022. The share of expenditures in primary care has been decreasing over time. Non-claims spending includes expenditures that happen outside of the claims system, such as capitated payments, workforce investments, incentives for quality performance, and shared savings payments. About half of Medicaid spending is claims-based compared to 96-100 percent for HCA-contracted commercial plans. It is suspected that the higher rate of non-claims-based spending in Medicaid is due to the high proportion of patients that are attributed to Federally Qualified Health Centers (FQHC). The committee heard an overview of the definitions of non-claims-based spending that HCA-contracted plans use to self-report non-claims-based spending. A committee member expressed interest in using standardized age bands when measuring primary care expenditures. The Office of Financial Management (OFM) report on primary care included a breakdown by age. Currently, data from the All-Payer Claims Database (APCD) is being run to measure primary care expenditures using the old definition. A committee member remarked that many community behavioral health payments are under capitated models and asked if this data has been filtered out. Under the narrow definition of services and provider types, this spending was excluded.

Broad vs. Narrow Definitions

Shane Mofford, Consultant, Center for Evidence-based Policy

The committee heard a recap on the differences between the narrow and broad definitions of primary care, including provider types included or excluded. The narrow definition is more closely aligned with the definitions used in other states. The narrow definition will require greater primary care investment to meet the 12 percent target. The broad definition may be more direct in supporting team-based care, but the narrow definition can still be used to support team-based care due to the increased investment in primary care more broadly. A committee member commented that if spending does not decrease in non-primary care, but there is legislation to increase spending in primary care, this could lead to an increase in the total cost of care. In a commercial setting, this could increase premium rates for consumers. A committee member commented that the OFM report did not evaluate the difference between the narrow and broad primary care spending percentages and asked how much of the difference is attributed to obstetrician-gynecologists (OB-GYN). If OB-GYN is not included, there will be an age effect as it can be surmised that a substantial portion of primary care visits for younger adults are likely OBGYN visits. Compared to the broad definition, the narrow definition could have a stronger impact due to needing greater investment in primary care to reach 12 percent. A committee member

commented that the narrow definition more closely aligns with what the 12 percent target was set on and if they had used a different definition other than the narrow, the goal could have been higher at 14 or 15 percent. It is important to make the appropriate level of investment. Another committee member noted the benefit of having one narrow definition that is fairly aligned with other states. Most states only have one definition of primary care – the narrow definition. Sufficient members were present to allow a quorum. **By consensus, the committee voted to adopt the narrow definition of primary care**.

Adjournment

Meeting adjourned at 2:58 p.m.