Health Care Cost Transparency Board's Advisory Committee on Primary Care meeting

August 28, 2025

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

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

August 28, 2025
2–4:30 p.m.
Hybrid Meeting

Meeting Agenda

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

Time	Agenda Items	Tab	Lead
2:00–2:05 (5 min)	Welcome, roll call, and agenda review	1	Dr. Judy Zerzan-Thul, Committee Chair, Medical Director, Health Care Authority
2:05–2:10 (5 min)	Approval of June 2024 meeting summary	2	Dr. Judy Zerzan-Thul, Committee Chair, Medical Director, Health Care Authority
2:10–2:15 (5 min)	Public Comment	3	Rachelle Bogue, Cost & Transparency Manager Health Care Authority

2:15–3:00 (45 mins)	Primary Care Expenditure in Washington State
	• Overview of revised definition of primary care
	• Primary care expenditure from 2025 data call:
	  ○ Overall, by market, by carrier
	  ○ Q&A
		4	Jingping Xing, Ph.D., Cost & Quality Analytics Manager, Health Care Authority

3:00–3:45 (45 mins)	Updates on passing of SB 5084 (OIC)	5	Nico Janssen, Senior Health Policy Analyst, OIC & Rocky Patterson II, ASA, MAAA – Actuary, OIC
3:45–4:25 (40 mins)	Policies and strategies to reach the 12% primary care expenditure target • Review policies, any updates and/or efforts currently underway • Discuss and vote on for any policy modifications	6	Dr. Judy Zerzan-Thul, Committee Chair, Medical Director, Health Care Authority
4:25–4:30 (5 mins)	Next steps, 2026 meeting dates Wrap-up and adjourn		Dr. Judy Zerzan-Thul, Committee Chair, Medical Director, Health Care Authority

Tab 2

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Health Care Cost Transparency Board's

Advisory Committee on Primary Care meeting summary

June 26, 2024

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
2–4 p.m.

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

Members present

Judy Zerzan-Thul, Chair
Kristal Albrecht
Sharon Brown
Michele Causley
David DiGiuseppe
D.C. Dugdale
Sharon Eloranta
Chandra Hicks
Sheryl Morelli (late)
Lan Nguyen
Katina Rue
Mandy Stahre (late)
Jonathan Staloff (provided feedback from Tony Butruille)
Staici West
Maddy Wiley

Members absent

Tony Butruille (left feedback with Jonathan Staloff)
Tracy Corgiat
Meg Jones
Gregory Marchand
Sarah Stokes
Shawn West
Ginny Weir
~~Linda Van Hoff~~ - resigned (replaced by Shannon Fitzgerald)

Call to order

Chair Dr. Judy Zerzan-Thul called the meeting of the Advisory Committee on Primary Care (committee) to order at 2:02 p.m.

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Agenda items

Welcoming remarks

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

Meeting summary review from the previous meeting

Members present **voted by consensus to adopt the May meeting summary** without changes.

Public comment

Rachelle Bogue called for comments from the public.

Chris Kaasa of Washington Association for Community Health (WACH) offered support for recommendation #6, exploring alternative payment models, which could set a path to transforming primary care (PC). Community health centers care for many low-income and underserved people, and a team-based approach would serve these patients well. Health centers are ready for Making Care Primary, the model that CMS has chosen for Washington. WACH also provided written comment.

There were no other public comments.

Policies and strategies to reach the 12% primary care expenditure target

Shane Mofford, Center for Evidence-based Policy (CEbP)
Gretchen Morely, CEbP
Chair Dr. Judy Zerzan-Thul, Medical Director, HCA

The CEbP team requested feedback on seven policy recommendations currently under review. Sending all seven recommendations to the Health Care Cost Transparency Board (Cost Board) could be overwhelming to the members, so terminology was clarified regarding how these recommendations would be supported by the committee. The first two policies under review would be direct recommendations. The last five would be committee endorsements of work currently underway at different institutions.

Original recommendations and those offered by written comment and incorporated in final language are in bold. These represent the final passed recommendation or endorsement. Topics relevant to the recommendation for further discussion but not incorporated are not in bold. Clauses in **blue** reflect amendments which passed and were accepted in the final recommendation.

1. Increase Primary Care Expenditure
   - **a. Recommend that the Legislature codify a specific ~~1%~~ 2% annual goal.**
   - **b. Recommend the Legislature require agencies to publicly report primary care expenditure ratios (HCA, HBE, OIC).**
   - **c. Recommend that the Office of the Insurance Commissioner (OIC) should submit a report to the Legislature by 2026 describing how payers will be held accountable for achieving primary care expenditure targets, beyond publicly reported transparency measures. This report should include making recommendations for changes to the OIC's regulatory oversight authority if necessary.**
   - d. Expanding enforcement authority at the OIC for missed goals.
   - e. Create the new role of Health Insurance Commissioner at OIC.
   - f. Include specific consequences if not target not met.
   - g. Suggestion that the target be set to 2% rather than 1%.

During discussion, one member suggested “should” be removed with regards to the OIC report clause and promoted the 2% target over the 1%. Another member suggested language to specify that enforcement is not

just for transparency of ratio reporting, but for achieving the goal as well. This member also passed along written support for prioritizing this recommendation from another member absent from the meeting. One member expressed concern regarding the 2% target, noting that additional money spent in PC without commensurate savings in other categories would only drive premiums up. In support of this, a member asked if sustainability considerations could be captured in the recommendation. Another member suggested there needed to be mechanisms to avoid bad actors who increase prices to attain the PC spend increase.

The amendment to change to 2% passed by a 12-4 margin. This was followed by discussion on the 1c clause. It was emphasized that a public report *is* an enforcement mechanism, but the committee wanted to make sure enforcement goes beyond just transparency. A member wanted the OIC to think about additional powers in their submitted report, along the lines of the Rhode Island example. This amendment passed 14-2.

Ultimately, **the amended recommendation #1 passed 12-1**.

2. Increase Medicaid Reimbursement
    - **a. HCA should increase Medicaid reimbursement for PC services to no less than Medicare rates for PC by ~~2028~~ 2026.**
    - **b. The Legislature should direct HCA to:**
        - **i. Implement the increase by using the Enhanced Adult Primary Care and Enhanced Pediatric fee schedules.**
        - **ii. Revise those fee schedules to more closely align with the service codes in the Cost Board's adopted definition of PC services.**
    - **c. The payment rate for any services on the enhanced fee schedules already reimbursed at or above Medicare equivalent rates should not be changed.**
    - **d. HCA should implement the increase using existing enhanced fee schedules no later than ~~2028~~ 2026.**
    - e. Increases in Medicaid reimbursement should span more than just PC services.
    - f. Timeline for increased rates should be attained by 2026 rather than 2028.
    - g. Suggestion to add specificity regarding how the goal would be attained.
    - h. Specifically reference legislative appropriation.
    - i. Request for how best to capture capitation payments in this scenario.
    - j. Request how policy would advance the 12% target.

One member asked for clarity regarding where Medicaid reimbursement is relative to Medicare. Chair Zerzan-Thul responded that the ratio is close to 80% depending on specific services. Another member relayed written support for Medicaid reimbursement increases across the board, not just on PC services.

Recommendation #2 passed as amended, 14-0.

From here, policies are endorsed rather than recommended.

3. Multipayer alignment
    - **a. The Multi-payer Collaborative's work in aligning standards, quality metrics, practice supports, and payment models.**
    - **b. The Collaborative's efforts to align the Primary Care Transformation ~~Model~~ Initiative with the federal Making Care Primary program.**
    - **c. Legislature advance multi-payer primary care alignment efforts, particularly for state-funded plans to participate in a Making Care Primary aligned transformation model.**

Endorse Primary Care Transformation alignment with Making Care Primary. **The amended endorsement passed 14-0.**

4. Patient Engagement
    - **a. HCA's efforts to participate in Making Care Primary and the Primary Care Transformation Initiative including support for pursuing resources for eligible primary care practices to grow capacity to provide comprehensive, whole person ~~primary~~ care.**

b. Any state agency efforts to support availability of incentives for employee or member to access primary care services.

One member asked for a minor word order tweak, while another wanted final "primary" stricken as it was redundant. **The amended endorsement passed 14-0.**

5. Workforce Development
   a. The Committee endorses Health Workforce Council (HCW) recommendations that would increase access to primary care services.
   b. Additional suggested workforce support beyond the HCW include loan repayment support, public service loan forgiveness, and funding for Washington Health Corps.

There was little discussion, but **the endorsement passed 13-0.**

6. Alternative Payment Models (APM)
   a. Endorse HCA efforts to track and set targets for primary care expenditures using the Health Care Payment & Learning Action Network (HCA-LAN) Alternative Payment Model Framework categories, with the goal of increasing the percent of PC expenditures paid through population-based or shared financial risk-based payments. HCA will report expenditures by HCPLAN APM category to future Primary Care Advisory Committees with the intent of developing recommendations for a statewide APM expenditure targets and achievement timeframes, aligned with the HCP-LAN targets. ~~and to make future recommendation on modifications to the expenditure targets based on related findings. This could include setting a minimum percentage of primary care expenditures that must be paid through more advanced payment models for the primary care expenditures to count towards the annual expenditure target.~~

Initial language only offered broad support of APMs, but one commenter suggested aiming specifically for 50% of payments through Category 4b by 2030. Commenters supported adding some "teeth", like enforcement mechanisms or penalties, should APM targets be missed. One member requested the striking of vague sections to clarify the ask. A committee member mentions the health care system is currently stalled on population-based APM, even in the Medicare system. Finally, a member asked whether the goal is to align with HCP-LAN specifically or if it is a moving target? Ultimately, **the amended endorsement passed 12-0.**

7. Measurement Strategy
   a. **The Committee endorses an effort by HCA to measure expenditures both on a PMPM or per capita basis and primary care expenditures as a percent of total expenditures and to make future recommendations to improve primary care expenditure tracking based on any findings.**

The endorsement passed 12-0.

Vote on recommendation package for submission to Cost Board

Shane Mofford, CEbP
Gretchen Morely, CEbP
Chair Dr. Judy Zerzan-Thul, Medical Director, HCA

Chair Zerzan-Thul held a final vote for the total package of 2 recommendations and 5 endorsement of efforts by other organizations. The package was approved 11-0.

Primary Care Committee wrap up for 2024 & next steps

Chair Dr. Judy Zerzan-Thul, Medical Director, HCA

With the package of recommendations and endorsements approved, the committee has fulfilled the tasks set before them. This committee will pause and create a meeting schedule for 2025, geared toward a review of PC data in the late spring. Finally, the Chair intended to update the committee after the July 30, 2025 Cost Board meeting regarding the consideration of the recommendations.

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Next Meeting of Advisory Committee on Primary Care

The 2025 meeting calendar is currently being planned. Future meeting dates will be shared with the committee.

Adjournment

Meeting adjourned at 3:43 p.m.

Tab 3

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Public comment

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Tab 4

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Primary Care Expenditure in Washington State

Findings from the Health Care Cost Transparency Board's 2025 Data Call

August 28, 2025

Washington State Health Care Authority

Agenda

- Overview of the Advisory Committee on Primary Care's new primary care definition
- Primary care expenditure: Findings from the Health Care Cost Transparency Board's 2025 Data Call
  - Overall
  - By market
  - By carrier
- Limitations and conclusions
- Q&A

2025 data call overview

- Collects 2022 and 2023 data
- Adds to historical data (2017–2022)
- New primary care definition

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Updated 2025 data call reporting timeline

1

February 18:
Launch data call

2

April 18:
Receive data submission

3

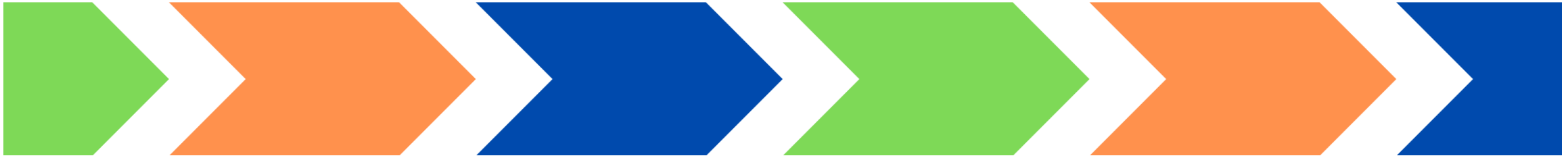
April–June:
Conduct data validation

4

July–October:
Conduct analysis and generate carrier and provider reports

5

November:
Report publicly on performance against the benchmark



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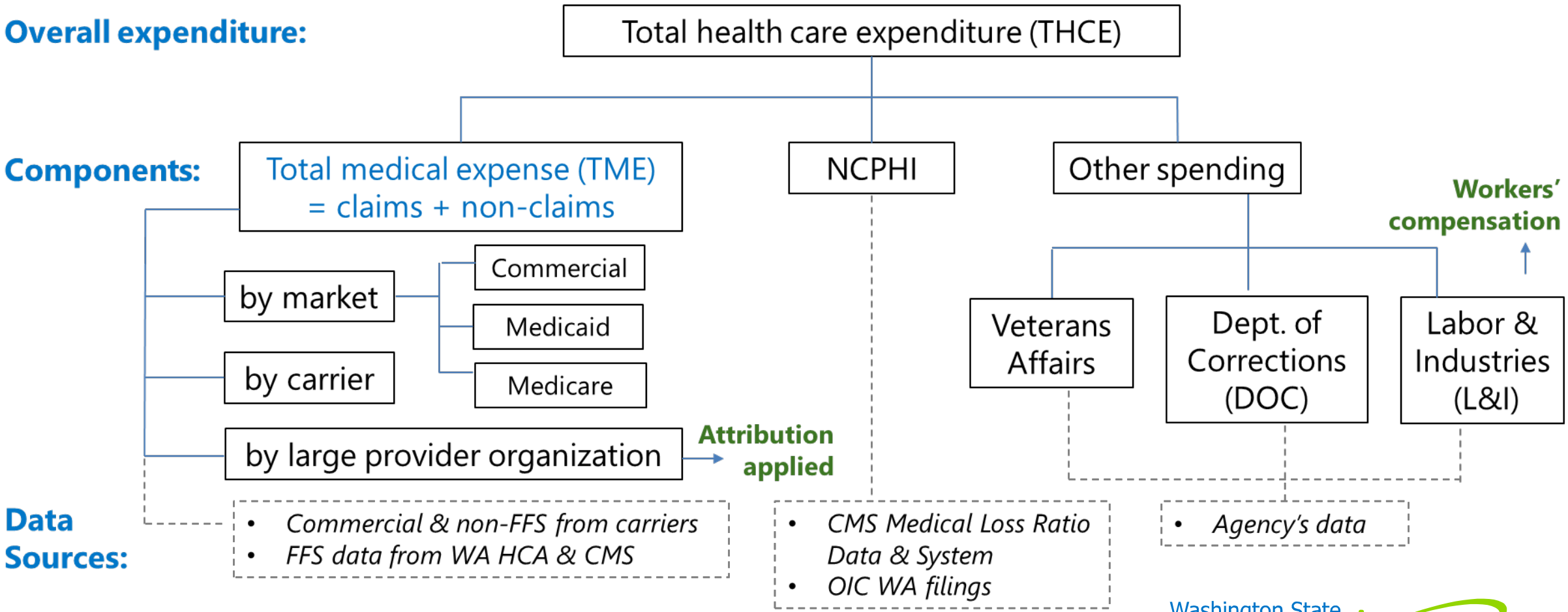
Health care cost data overview



NCPHI: Net Cost of Private Health Insurance; FFS: Fee-for-service; Non-FFS refers to Medicaid Managed Care and Medicare Advantage Plans; HCA: Health Care Authority; CMS: Centers for Medicare & Medicaid Services; OIC: Office of the Insurance Commissioner
For more details on data collection and submission, please see the Cost Board's Data Call Technical Manual.

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New definition

Claims: professional, primary care providers

- Sum of the allowed amount from the claims paid to primary care providers for primary care services using the provider taxonomy, procedure, and place of service codes in Appendix A of the Implementation Manual.
- Now based on the Advisory Committee on Primary Care's definition.*
- No longer based on primary care outlined in the Office of Financial Management's (OFM) Primary Care Expenditures Report.
- Changes include addition of place of service codes to the definition and updated provider taxonomy and procedure codes.
  - See Appendix A Attachment 1 in technical manual; or
  - See Advisory Committee on Primary Care's webpage to download the value sets in excel format (provider and subspecialty codes, procedure codes, and place of service codes tabs).

Please refer to the committee's webpage for more information.

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Claims-based Definition

- Services (what)
  - New patient visits
  - Preventive visits
  - Treatment visits
  - Contraceptive care
  - Routine and developmental screenings

- Providers (by whom)
  - Pediatricians
  - Family medicine physicians
  - Internal medicine physicians specializing in geriatric or adolescent medicine
  - Physician assistants, nurse practitioners, and clinical nurse specialists specializing in pediatrics, gerontology, adult health, women's health, and more

- Locations (where)
  - Schools
  - Outpatient offices
  - Telehealth
  - Tribal and Indian Health Service facilities
  - Federally Qualified Health Centers (FQHCs)

Non-claims-based Definition

- Capitation
- Salaries
- Incentives
- Population health payments
- Practice support payments

Old definition

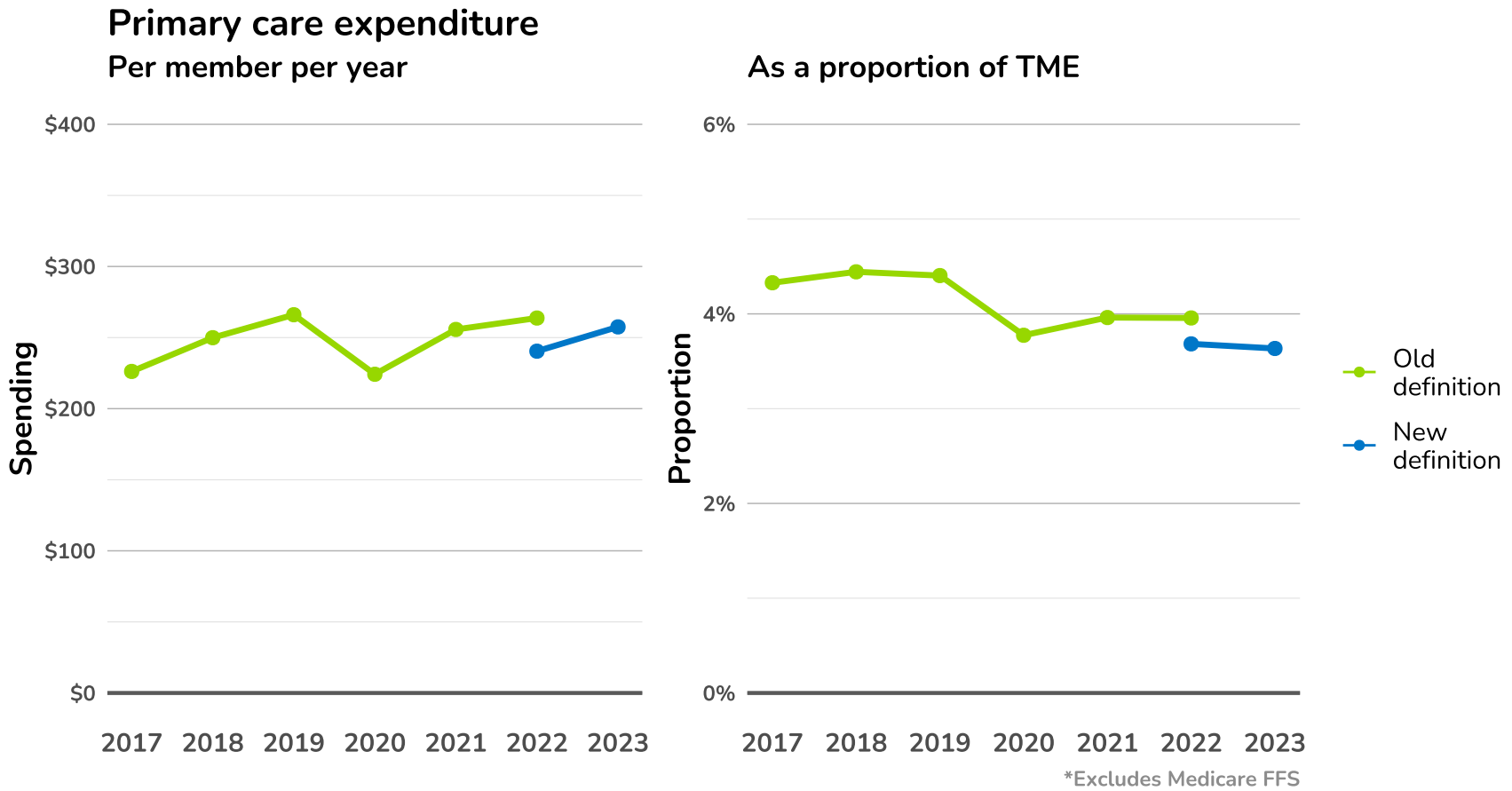
Claims: professional, primary care providers (Old definition)

- Sum of the allowed amount from the claims paid to primary care providers for primary care services using the provider taxonomy and procedure codes in Appendix A of the Implementation Manual
- Based on primary care outlined in the Office of Financial Management's (OFM) Primary Care Expenditures Report

Results

Primary care expenditures

- Per capita primary care spending has rebounded in the post-pandemic period, but has stagnated as a proportion of total market expenditure (TME)
- The implementation of the new, **narrower** definition of primary care is observed as a drop in the blue line, including re-reported data from 2022



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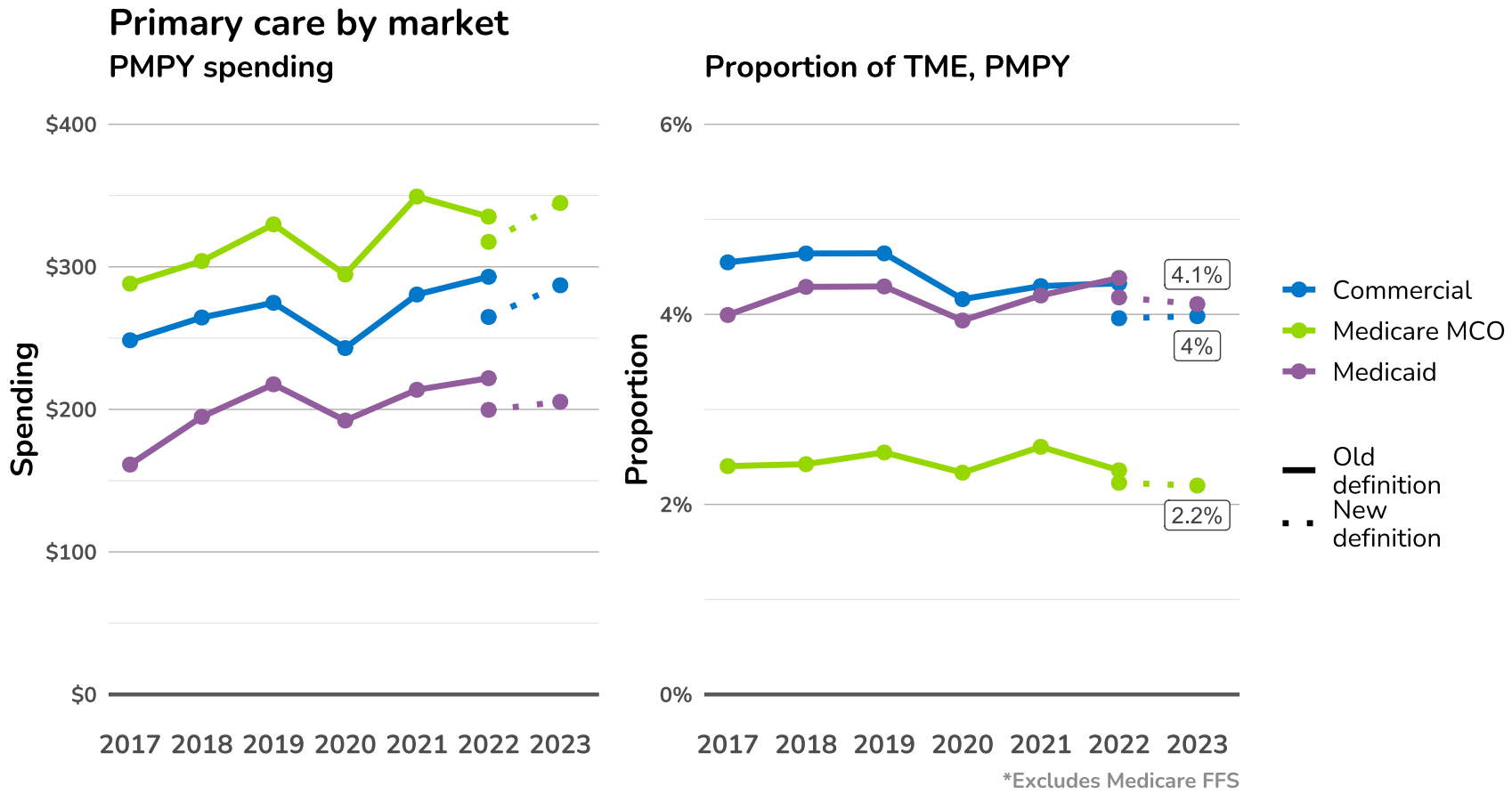
Note: **Preliminary** 2025 data call

Primary care expenditures by market

- Per capita primary care spending is highest in the Medicare managed care population across all years, followed by Commercial and Medicaid
- In 2023, primary care as a proportion of TME is highest in Medicaid
- Medicare managed care PC spending is the smallest proportion due to higher costs of care (hospital & Rx) for an older population



Note: **Preliminary** 2025 data call

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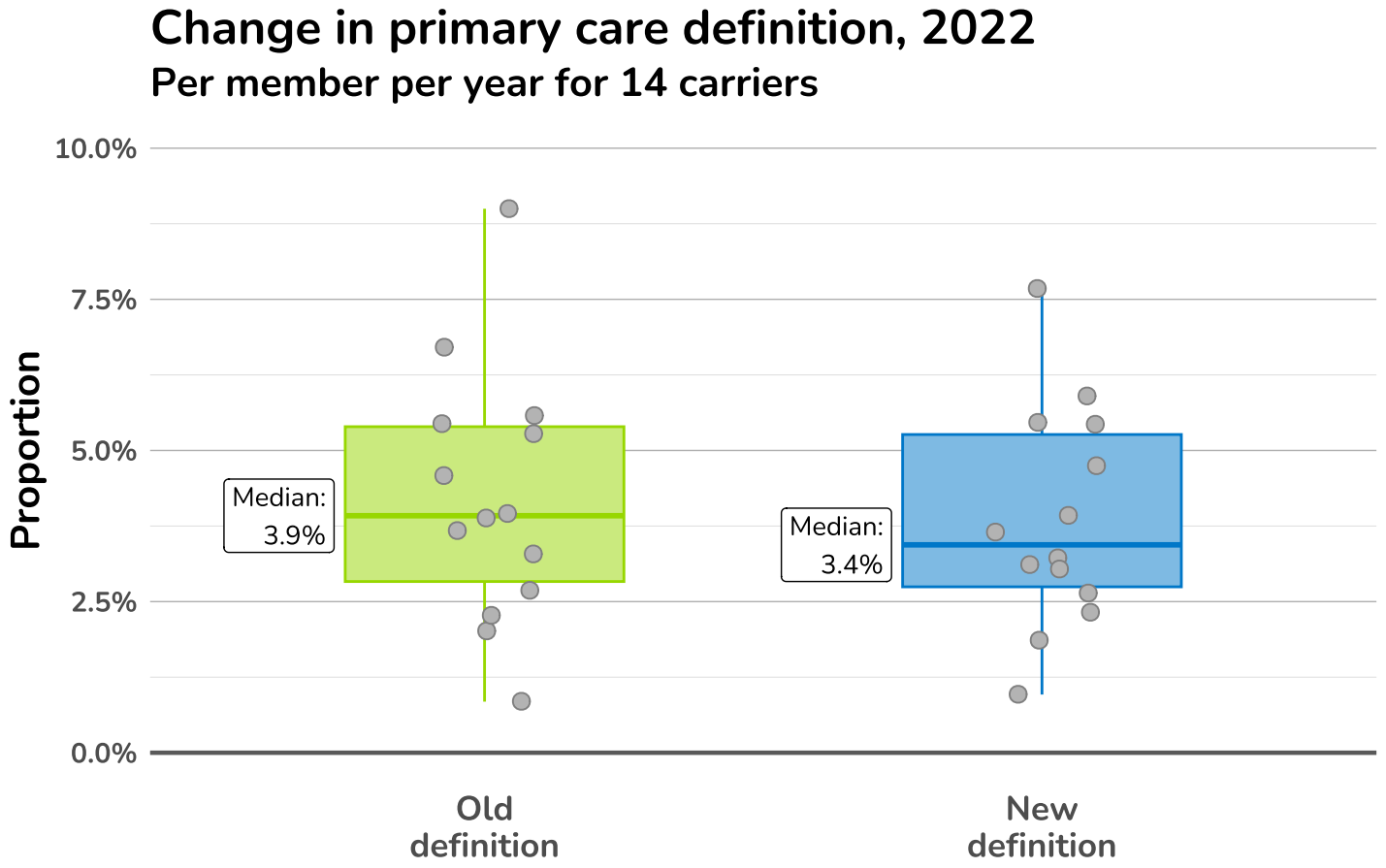
Primary care expenditures by carriers

- Comparing 2022 primary care expenditure across 14 carriers (including Medicaid FFS), the new definition yields both a lower median and a tighter range of TME proportions



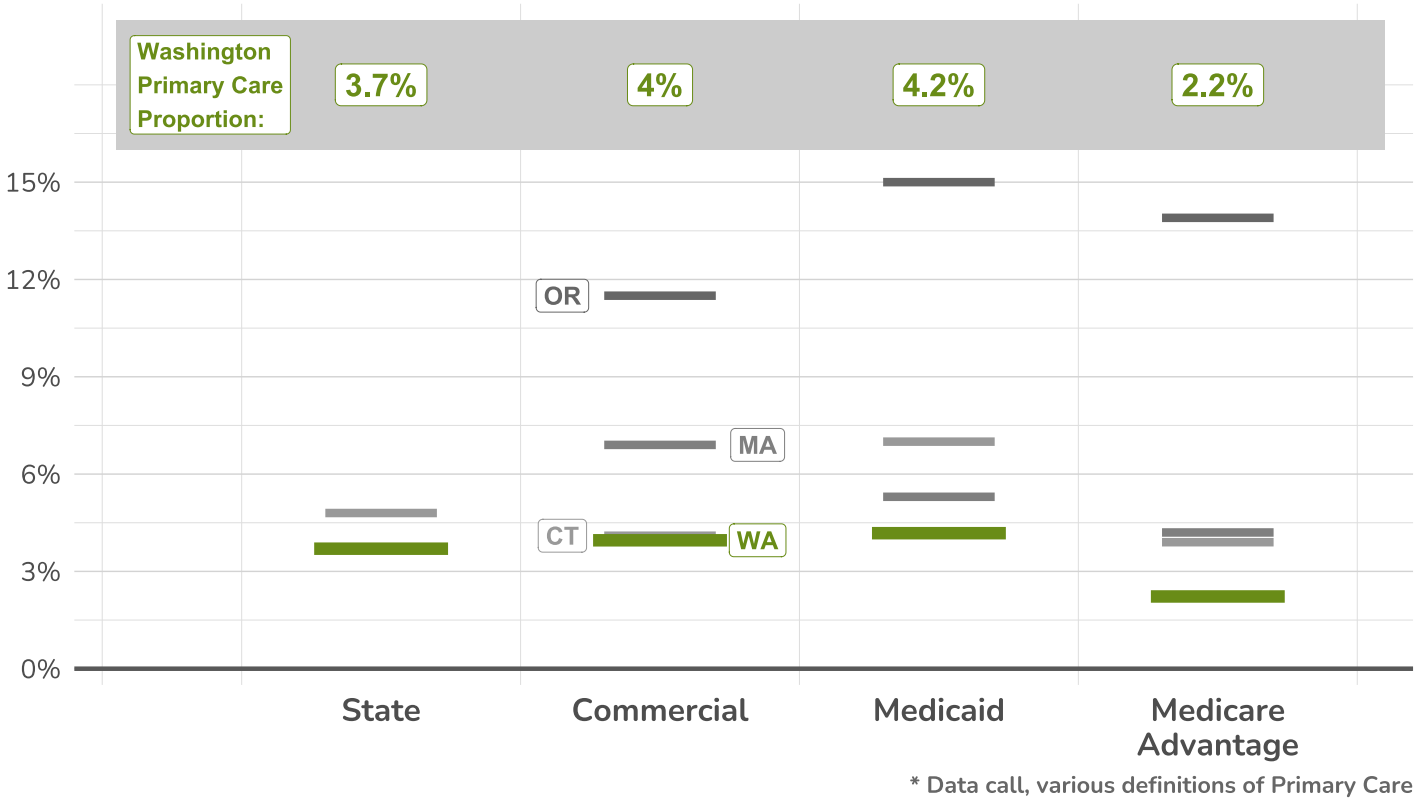
Note: **Preliminary** 2025 data call

Washington State Health Care Authority

Primary care expenditure in other states (1)

2022 Primary care spending, proportion of TME

Washington and 3 benchmark states



* Data call, various definitions of Primary Care

- Note that the spread here is large, as there are differing definitions and targets for PC spend as a proportion of TME
- Additionally, not all states publish PC for State & all markets, so we can compare WA with only 3 states

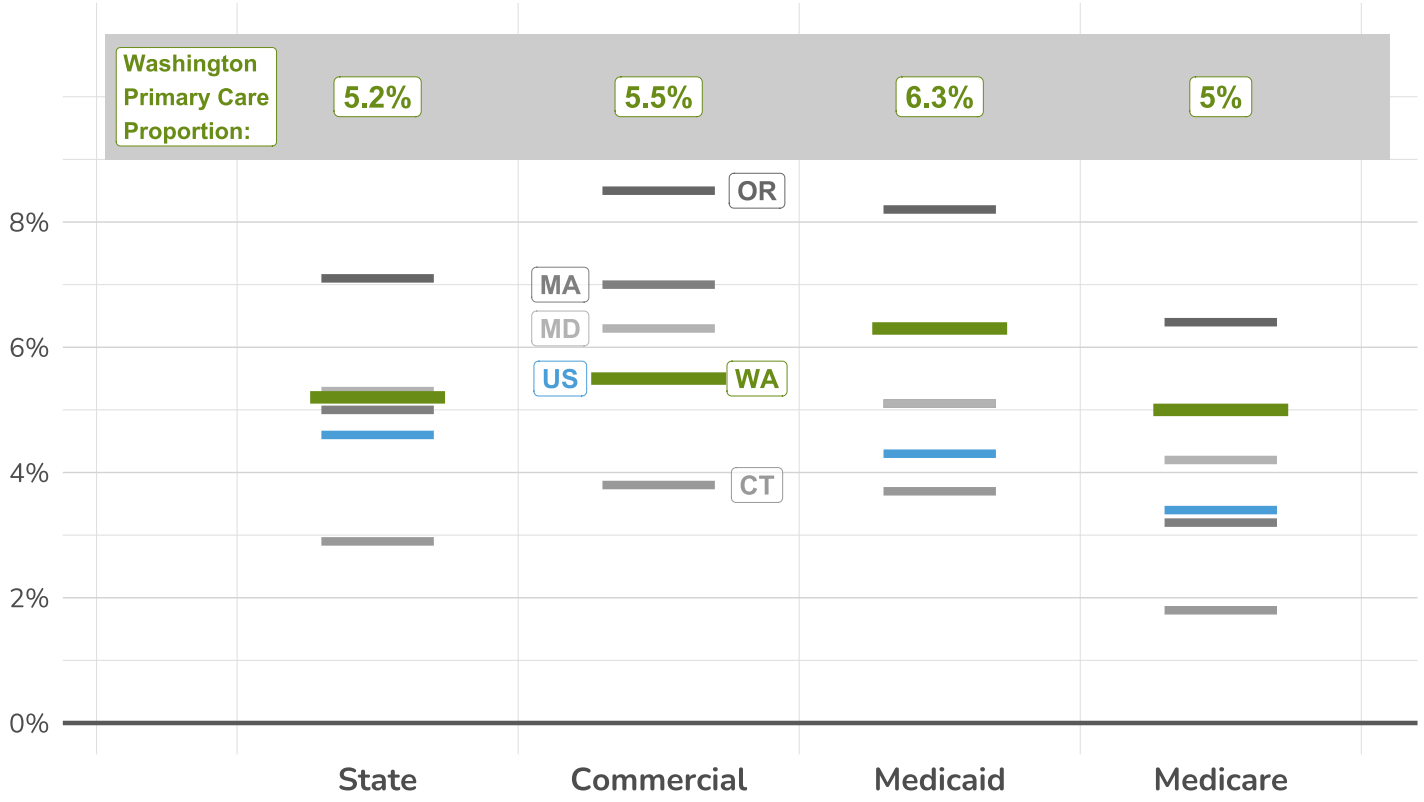
Source: Washington HCCTB data call, Oregon Health Authority, Connecticut Office of Health Strategy, Massachusetts CHIA

Washington State Health Care Authority

Primary care expenditure in other states (2)

2022 Primary care spending, proportion of TME

Washington with national and state data



- Based on the National Academy of Science, Engineering and Medicine (NASEM) narrow definition
- The trends across markets are directionally the same for WA

Source: Milbank Memorial Fund Primary Care Scorecard

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Limitations & Conclusions

Limitations

- Primary care expenditures calculation doesn't account for non-claims primary care expenditure
- Not enough data points to establish a clear trend of primary care expenditure (new definition)
- Medicare FFS is excluded because CMS's primary care definition doesn't align with our definition

Conclusions

- The annual Cost Board data call needs to collect non-claims primary care expenditure to accurately calculate primary care expenditure
- Primary care expenditures in Washington is much lower than the 12% target established by SB5589

Q&A

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Primary Care Providers (taxonomy)

New definition

Primary care provider and subspecialty codes

Specialty	Subspecialty	Provider taxonomy code
Clinic/Center	Primary Care	261QP2300X
Clinic/Center	Federally Qualified Health Center (FQHC)	261QF0400X
Clinic/Center	Critical Access Hospital	261QC0050X
Clinic/Center	Urgent Care	261QU0200X
Clinic/Center	Rural Health	261QR1300X
Clinical Nurse Specialist	Family Health	364SF0001X
Clinical Nurse Specialist	—	364S00000X
Clinical Nurse Specialist	Pediatrics	364SP0200X
Clinical Nurse Specialist	Gerontology	364SG0600X
Clinical Nurse Specialist	Adult Health	364SA2200X
Clinical Nurse Specialist	Women's Health	364SW0102X
Clinical Nurse Specialist	Chronic Care	364SC2300X
Clinical Nurse Specialist	Holistic	364SH1100X
Family Medicine	Geriatric Medicine	207QG0300X
Family Medicine	—	207Q00000X
Family Medicine	Adolescent Medicine	207QA0000X
Family Medicine	Adult Medicine	207QA0505X
General Practice	—	208D00000X
Internal Medicine	—	207R00000X
Internal Medicine	Geriatric Medicine	207RG0300X
Internal Medicine	Adolescent Medicine	207RA0000X
Naturopath	—	175F00000X
Nurse Practitioner	—	363L00000X
Nurse Practitioner	Pediatrics	363LP0200X
Nurse Practitioner	Primary Care	363LP2300X
Nurse Practitioner	Adult Health	363LA2200X
Nurse Practitioner	Family	363LF0000X
Pediatrics	—	208000000X
Pediatrics	Adolescent Medicine	2080A0000X
Physician Assistant	—	363A00000X
Physician Assistant	Medical	363AM0700X
Preventive Medicine	Preventive Medicine/Occupational Environmental Medicine	2083P0500X

Old definition

Narrow definition of primary care provider

Taxonomy Code	Description
207Q00000X	Family Medicine
207QA0000X	Family Medicine, Adolescent Medicine
207QA0505X	Family Medicine, Adult Medicine
207QG0300X	Family Medicine, Geriatric Medicine
261QF0400X	Federally Qualified Health Center
208D00000X	General Practice
207R00000X	Internal Medicine
207RG0300X	Internal Medicine, Geriatric Medicine
175F00000X	Naturopath
208000000X	Pediatrics
2080A0000X	Pediatrics, Adolescent Medicine
2083P0500X	Preventive Medicine, Preventive Medicine/Occupational Environmental Medicine
261QP2300X	Primary care clinic
261QR1300X	Rural health clinic

Nurse practitioner and physician assistant definitions

Taxonomy Code	Description
363L00000X	Nurse Practitioner
363LA2100X	Nurse Practitioner, Acute Care
363LA2200X	Nurse Practitioner, Adult Health
363LC1500X	Nurse Practitioner, Community Health
363LC0200X	Nurse Practitioner, Critical Care Medicine
363LF0000X	Nurse Practitioner, Family
363LG0600X	Nurse Practitioner, Gerontology
363LN0000X	Nurse Practitioner, Neonatal
363LN0005X	Nurse Practitioner, Neonatal, Critical Care
363LX0001X	Nurse Practitioner, Obstetrics & Gynecology
363LX0106X	Nurse Practitioner, Occupational Health
363LP0200X	Nurse Practitioner, Pediatrics
363LP0222X	Nurse Practitioner, Pediatrics, Critical Care
363LP1700X	Nurse Practitioner, Perinatal
363LP2300X	Nurse Practitioner, Primary Care
363LP0808X	Nurse Practitioner, Psychiatric/Mental Health
363LS0200X	Nurse Practitioner, School
363LW0102X	Nurse Practitioner, Women's Health
363A00000X	Physician Assistant
363AM0700X	Physician Assistant, Medical
363AS0400X	Physician Assistant, Surgical

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Tab 5

Washington State Health Care Authority

Primary Care Expenditure Reporting: SB 5084

Nico Janssen, Senior Health Policy Analyst
Rocky Patterson II, ASA, MAAA – Actuary

Advisory Committee on Primary Care

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

August 28, 2025

Background on SB 5084

- In 2025, the Legislature enacted SB 5084. The Act was effective July 27, 2025.

- Before SB 5084, the Office of the Insurance Commissioner (OIC) had authority to assess primary care spending from health carriers, *but only* through health carrier rate and form filings; this process was *not feasible* in practice.

- SB 5084 authorizes OIC to require health carriers to annually report primary care expenditures in previous or upcoming calendar years.

Background on SB 5084 (Cont.)

- SB 5084 directs OIC to consider the Advisory Committee on Primary Care's definition of primary care expenditures and HCA's primary care reporting systems for Medicaid and PEBB/SEBB.

- Primary care expenditure reports submitted by carriers under SB 5084 are public information.

- OIC may determine the form and content of this reporting.

Goals of SB 5084

- Align OIC and HCAs' tracking of health insurers' primary care spending across:
  - Fully-insured commercial health insurance;
  - Medicaid;
  - PEBB/SEBB.

- Together, these programs and markets cover close to half of Washingtonians (OIC 2023 enrollment data).

- Consistent/accurate measurement of primary care spending across markets can inform the state's 12% primary care spending goal.

Implementation of SB 5084

- OIC working with HCA to implement SB 5084.
- Integrate primary care spending reporting into annual financial statements that health carriers already submit to OIC.
- Using HCA's existing template, OIC is working on enhancements to the template. Goal is streamlined, consistent approach to collecting information across markets/programs.

SB 5084 – Enhancements to Template

- Capture claims and non-claims expenditures.
- Capture primary care spending for WA residents that is provided out of state.
- Revise reporting to capture more information for calculation of PC spend percentage, distinguishing between direct care payments and PC support/investment spending.

SB 5084 – Enhancements to Template (Cont.)

- Measure primary care spending more specifically, i.e. spending for facility fees, urgent care, on campus hospital spending
    - Preventive services (future years)

- Ensure template follows statutory accounting standards.

- Determine which carriers will report and for which markets.

SB 5084 – Next Steps

- First year of primary care spend reporting to OIC = Plan Year 2025.
- OIC plans to send instructions to health carriers in fall 2025, with reports due from carriers by July 2026 for Plan Year 2025.
- OIC may adjust the annual statement instructions in future years.

Questions?

Nico Janssen

Sr. Health Policy Analyst

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Tab 6

Washington State Health Care Authority

Strategies to Increase and Sustain Primary Care

Review and Vote: 7 Policy Recommendations Made to the Health Care Cost Transparency Board

Washington State Health Care Authority

Background

- In 2022, the Legislature directed the Health Care Cost Transparency Board (Cost Board) to:
  - define and measure primary care spending
  - develop recommendations on how to achieve Washington's target to increase primary care expenditures to **12 percent of total health care expenditures**

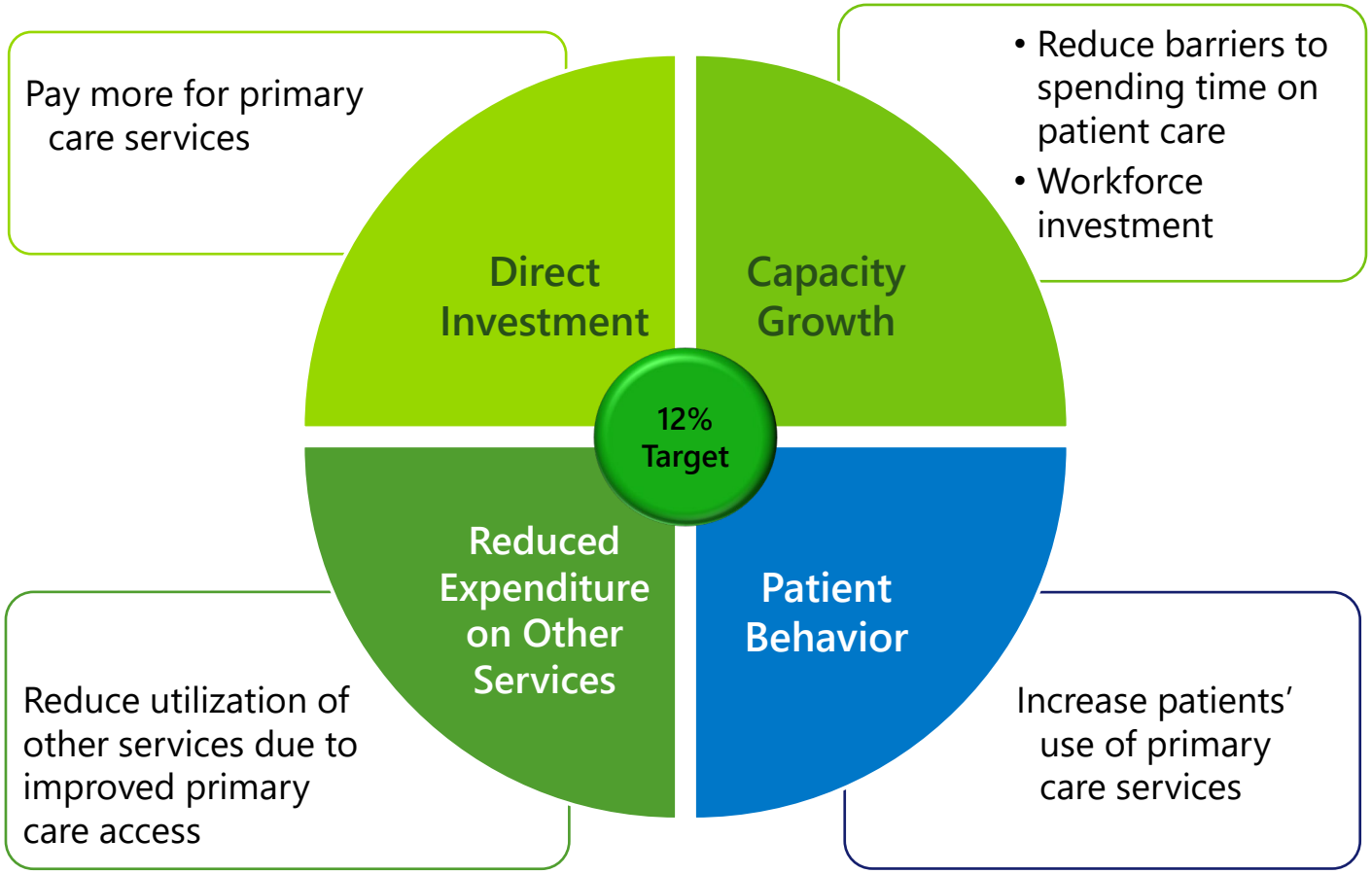
Why increase primary care expenditures to 12% of total health care expenditures?

- Primary care is a fundamental component of the health care system.
- Primary care provides patients with an entry point into the health system and a source of early detection and health management for chronic diseases.
- Research continues to show that access to primary care is associated with improved health outcomes, increased equity, and higher life expectancy by addressing health concerns early through health education and preventive services. Primary care delivery also results in lower health care costs by decreasing hospital utilization.

Why increase primary care expenditures to 12% of total health care expenditures? (cont.)

- Over time, expectations related to primary care service delivery have increased, while practitioners remain understaffed and underpaid compared to other medical specialties. This has led to multiple issues with primary care delivery, including sharp reductions in the primary care workforce, and limited access to care.
- Strong evidence supports the value of investing in primary care to deliver higher quality health outcomes and lower total health care costs.

Four key areas used to evaluate primary care expenditures



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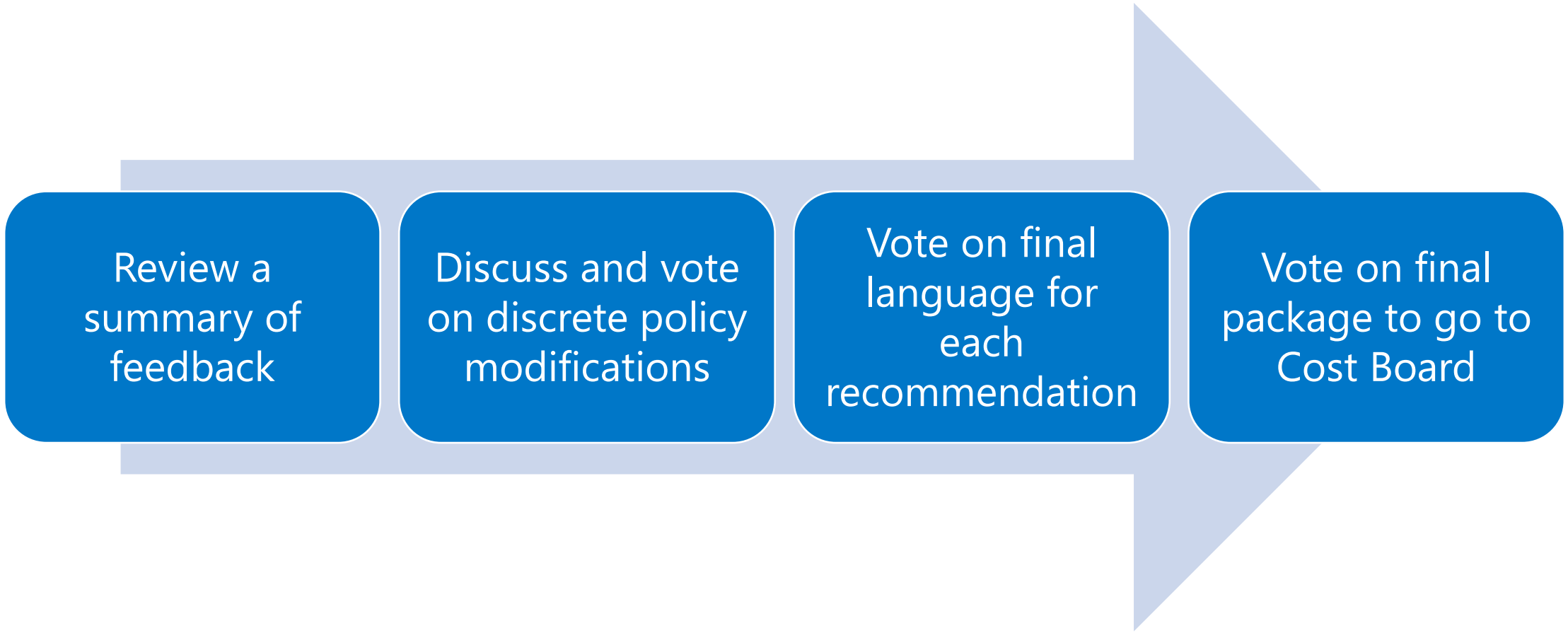
Policy development principles

- Policy recommendations should follow these principles:
  - Closely link to the 12 percent primary care expenditure target
  - Clearly define action and actors
  - Be financially, operationally, and politically feasible
  - Improve access and quality, not just expenditure

Policies we're evaluating

1. Increase primary care expenditures
2. Increase Medicaid reimbursement
3. Multi-payer alignment
4. Patient engagement
5. Workforce development
6. Use of alternative payment models
7. Measurement strategy

Policy Finalization Process



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Recommendation #1: Increase Primary Care Expenditures

- Recommend that the Legislature codify a goal to increase primary care spending by **two** percentage points per year.
- Recommend that the Legislature require the Health Care Authority (HCA), Health Benefit Exchange (HBE), and Office of the Insurance Commissioner (OIC) publicly report primary care expenditure ratios of all carriers.
- Recommend that OIC submit a report to the Legislature by 2026 proposing how payers will be held accountable for achieving primary care expenditure targets, beyond publicly reported transparency measures. This report should include making recommendations for changes to the OIC's regulatory oversight authority if necessary.

Recommendation #1: Increase Primary Care Expenditures | Why is this important?

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

Updates & efforts underway for recommendation #1

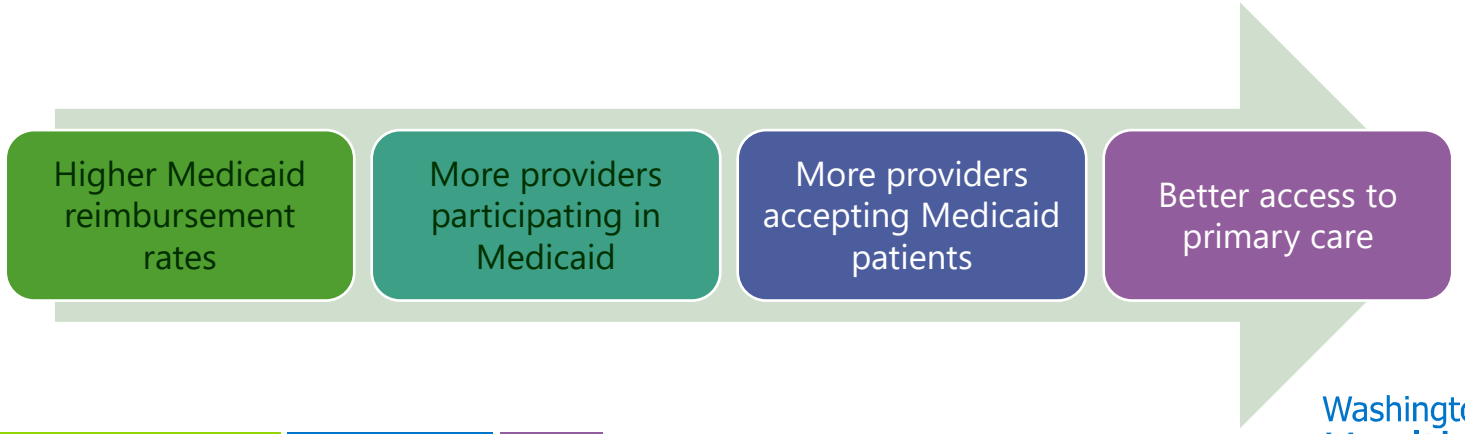
- Cost board changed primary care spend recommendation from 2 percent to 1 percent increase per year
- The legislature did not take this up
- SB 5084 did pass directing OIC to collect primary care spend information

Recommendation #2: Increase Medicaid Reimbursement

- The Legislature should increase Medicaid reimbursement for primary care services to no less than Medicare rates by 2026.
- The Legislature should direct HCA to:
  - Implement the increase by using the Enhanced Adult Primary Care and Enhanced Pediatric fee schedules.
  - Revise those fee schedules to more closely align with the service codes in the Cost Board's adopted definition of primary care services.
- The payment rate for any services on the enhanced fee schedules already reimbursed at or above Medicare equivalent rates should not be changed.
- The Legislature should implement the fee schedule increase no later than 2026.

Recommendation #2: Increase Medicaid Reimbursement | Why is this important?

- Evidence suggests that the connection between higher reimbursement and better access is plausible.
- Evidence suggests that the connection between higher reimbursement and an increased ratio of primary care expenditures to total health expenditures is plausible.
- There may be additional positive effects for equity and workforce stability.



Updates & efforts underway for recommendation #2

- No efforts currently underway

Washington State Health Care Authority

Recommendation #3: Multi-payer Alignment

The committee endorses:

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

Recommendation #3: Multi-payer Alignment | Why is this important?

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

Updates & efforts underway for recommendation #3

- MPC 2025 workplan includes attribution alignment, common PCTI communications with providers and purchasers, and identifying plan alignment opportunities to support VBP
- HCA soft launches the PCPR program, Greater Health Now ACH pilot practices are first to participate in recognition
- HCA continues to convene a quarterly purchaser group with the intent of encouraging collaborative work with the MPC
- Making Care Primary canceled by Trump Administration in March; HCA conveys PCTI work will continue without Medicare
- WA Health Benefit Exchange incentivizes primary care by having insurers to participate in the MPC and sign the MOU
- Legislative proviso to create provider forum

Recommendation #4: Patient Engagement

The committee endorses:

- HCA's efforts to participate in Making Care Primary and the Primary Care Transformation Initiative.
  - Especially, pursuing resources for primary care practices to better provide whole person care.
- Any state agency efforts to support incentives for members to access primary care services.

Recommendation #4: Patient Engagement | Why is this important?

- Employers, insurance carriers, providers, and patients all have a role in patient engagement:
  - Keep patients well through primary care.
  - Participate in your own care for a better chance to control medical problems at the primary care level.
- Patient engagement plays a critical role in improving health outcomes and can contribute to achieving the state's 12 percent target when employers encourage use of primary care services.

Updates & efforts underway for recommendation #4

- No efforts currently underway

Washington State Health Care Authority

Recommendation #5: Workforce Development

The committee endorses Health Workforce Council recommendations that would increase access to primary care services.

Washington State Health Care Authority

Recommendation #5: Workforce Development | Why is this important?

- Workforce shortages create lack of access to primary care and burnout among primary care and other health care providers.
- Washington has fewer physicians per capita, including primary care physicians, compared to the U.S.
  - Only 35 percent of Washington physicians:
    - Work in primary care,
    - Provide direct patient care,
    - Are not federally employed, and
    - Are under the age of 75.
- Patients lacking access to care due to shortages seek care in the emergency department, which burdens hospital workforce.
- Behavioral health workforce shortages burden primary care clinics serving patients with complex behavioral health needs.
- Shortages at long-term care facilities lead to discharge issues at hospitals.

Updates & efforts underway for recommendation #5

- Health Workforce Council '25 Recommendations:
  - Overarching Rural Workforce Goal
    - "*The Council will develop and advocate for policy recommendations that enable rural students and workers to access and succeed in health professional training programs and career advancement opportunities without having to leave their communities.*"
    - Current: RHTP Application
  - Community Resources: Child Care, Housing, and Transportation
  - Educational Debt
    - '25 SUDP Scholarships - HCA's Workforce Unit contracted with WSAC to award 331 students across 9 WA community & technical colleges up to $500 to pay for expenses like housing, childcare, transportation, technology, books, etc.
    - *Full impact report coming soon*

Updates & efforts underway for recommendation #5 (cont.)

- Sentinel Network: Ongoing Support
  - Data Collection: Apr. 28 - Jun. 1, 2025
  - '25 Updates:
    - Employer recruitment targets for behavioral health, oral health, & rural providers
    - Improved questionnaire:
      - Vacancies and turnover for each facility
      - Organizational priorities and challenges
      - Behavioral health module (peer counselors)
      - Dental module (recruitment and retention strategies)

Updates & efforts underway for recommendation #5 (cont.)

- Integrated Care / Behavioral Health (BH) Workforce Updates:
  - ESSB 5167 - 2025-2027 Community BH Biennial Budget
    - 10-20% funding reduction for selected BH programs & services
  - 2SHB 1427 - Certified Peer Support Specialists
    - Changes the name of the profession to 'Certified Peer Support Specialist'
    - Directs HCA to contract to:
      - Develop supplemental courses related to domestic violence, sexual assault and human trafficking
      - Develop ways to expand access to peer support services through a variety of mechanisms
      - Requires access to peer services in an MCO's network be given significant weight during procurement for Medicaid services
  - SSB 5118 - International Medical Graduates (IMGs)
    - Removes residency requirement and additional changes intended to remove barriers to IMG licensure
  - New: Provider resources from HCA's Workforce Unit:
    - Recruitment & Retention Toolkit
    - SUD Organizational Development Assessment (SODA)

Recommendation #6: Use of Alternative Payment Models

The committee endorses:

- HCA efforts to track and set targets for primary care expenditures using the Health Care Payment & Learning Action Network (HCP-LAN) Alternative Payment Model (APM) Framework categories.
  - With the goal of increasing the percent of primary care expenditures paid through population-based or shared-risk-based payments.
- HCA will annually report expenditures by HCP-LAN APM category to any future Primary Care Advisory Committee.
  - The committee will make recommendations for statewide APM expenditure targets and achievement timeframes, aligned with the HCP-LAN targets.

Recommendation #6: Use of Alternative Payment Models | Why this is important?

- Value -based payment (VBP) describes a range of payment strategies intended to contain costs while improving outcomes by tying payment to care quality.
  - VBP is typically accomplished through contracting between plans and providers. These contracts are called alternative payment models (APMs).
  - APMs tie payment for services to the quality of those services or create financial penalties or rewards for providers that spend more or less than anticipated.
  - There are a variety of types of APMs, detailed in the Health Care Payment Learning and Action Network (HCP-LAN) APM Framework.

Updates & efforts underway for recommendation #6

- Agency and HCPLAN surveys are underway with results expected in the late fall/early winter
- Neither effort has primary care VBP reported separately this year

Recommendation #7: Measurement Strategy

- The committee endorses HCA efforts to:
  - Measure expenditures on a per-member-per-month (PMPM) or per-capita basis.
  - Measure primary care expenditures as a percent of total expenditures.
- The committee will make recommendations to improve primary care expenditure tracking based on any findings.

Recommendation #7: Measurement Strategy | Why is this important?

- When establishing the primary care expenditure target of 12 percent, the Legislature relied on the experience of other states.
  - Rhode Island implemented similar policies
- A 12 percent expenditure target will drive investment in primary care:
  - Consistent with the statutory direction, but
  - May not be the best target to use indefinitely.
  - Changes in expenditures in other service categories (e.g., hospitals) would dictate the level of primary care investment independent of actual need
- When using these types of statistics, the amount of primary care investment needed to achieve the target would not be inappropriately influenced by changed in price and utilization of other services.

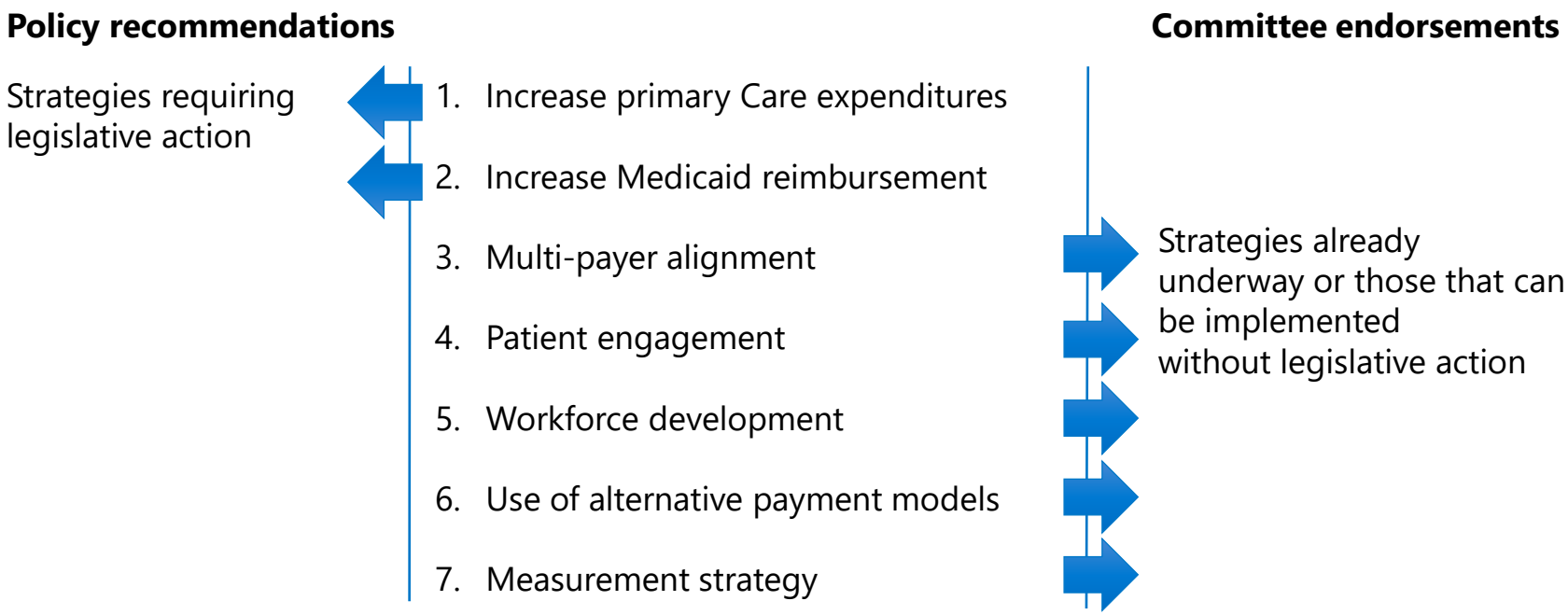
Updates & efforts underway for recommendation #7

- No efforts currently underway

Washington State Health Care Authority

Advancement Strategy Recompensated to the Cost Board in 2024

Staff recommendation: Instead of prioritizing 2–3 action items out of the 7, consider submitting a package where there are 2–3 action items and a suite of endorsements for other policies. The final recommendations and feedback have created a natural delineation between the two categories.



Washington State Health Care Authority

Questions?

Proposed changes?

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Vote to continue with current recommendation package of the Primary Care Advisory Committee

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Thank you for joining us.

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