Health Care Cost Transparency Board
Board Book

April 20, 2022
2:00 p.m. – 4:00 p.m.
(Zoom Attendance Only)

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Agenda

TAB 1
# Health Care Cost Transparency Board

## AGENDA

**Board Members:**

- Susan E. Birch, Chair
- Sonja Kellen
- Kim Wallace
- Lois C. Cook
- Pam MacEwan
- Carol Wilmes
- John Doyle
- Molly Nollette
- Edwin Wong
- Bianca Frogner
- Mark Siegel
- Jodi Joyce
- Margaret Stanley

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<tr>
<td>2:00 – 2:05 (5 min)</td>
<td>Welcome, Roll Call, and Agenda Review</td>
<td>1</td>
<td>Susan E. Birch, Chair, Director Health Care Authority</td>
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<tr>
<td>2:05 – 2:10 (5 min)</td>
<td>Approval of March meeting minutes</td>
<td>2</td>
<td>AnnaLisa Gellermann, Board Manager Health Care Authority</td>
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<td>2:10 – 2:15 (5 min)</td>
<td>Recap of March Board meeting</td>
<td>3</td>
<td>Michael Bailit and January Angeles Bailit Health</td>
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<td>2:15 – 2:20 (5 min)</td>
<td>Advisory Committee feedback on impacts on criteria and strategies to support benchmark attainment</td>
<td>4</td>
<td>AnnaLisa Gellermann Health Care Authority</td>
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<td>2:20-2:40 (20 min)</td>
<td>2022 Legislative Session recap</td>
<td>5</td>
<td>Evan Klein Special Asst., Legislative &amp; Policy Affairs Health Care Authority</td>
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<td>2:40 – 3:10 (30 min)</td>
<td>Introduction to Primary Care Expenditures</td>
<td>6</td>
<td>Emily Transue, MD ERB Medical Director Health Care Authority</td>
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<td>3:10 – 3:20 (10 min)</td>
<td>Public Comment</td>
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<td>Susan E. Birch, Chair, Director Health Care Authority</td>
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<tr>
<td>3:20 – 3:35 (15 min)</td>
<td>Key Issues in Defining and Measuring Primary Care Spend</td>
<td>7</td>
<td>Michael Bailit and January Angeles Bailit Health</td>
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<tr>
<td>3:35 – 3:55 (20 min)</td>
<td>Value-based Purchasing</td>
<td>8</td>
<td>JD Fischer Value-based Purchasing Manager Health Care Authority</td>
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<tr>
<td>3:55 – 4:00 (5 min)</td>
<td>Adjournment</td>
<td></td>
<td>Susan E. Birch, Chair, Director Health Care Authority</td>
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*In accordance with Governor Inslee’s Proclamation 20-28 et seq amending requirements of the Open Public Meeting Act (Chapter 42.30 RCW) during the COVID-19 public health emergency, and out of an abundance of caution for the health and welfare of the Board and the public, this meeting of the Health Care Cost Transparency Board meeting will be conducted virtually.*
March meeting minutes

TAB 2
Health Care Cost Transparency Board meeting minutes
March 16, 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
Sue Birch, chair
John Doyle
Bianca Frogner
Jodi Joyce
Molly Nollette
Pam MacEwan
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent
Lois Cook
Sonja Kellen
Mark Siegel

Call to order
Sue Birch, Board Chair, called the meeting to order at 2:02 p.m.

Agenda items
Welcoming remarks
Ms. Birch welcomed the members.

Approval of minutes
The minutes were approved.

Recap of February board meeting
Michael Bailit and January Angeles, Bailit Health PowerPoint presentation
Ms. Angeles reminded the Board of the areas they had selected for deeper dives: market oversight (including consolidation and setting affordability standards), hospital-based pricing strategy (including global budgets and...
Board members approved amended criteria for selecting strategies to support cost growth benchmark attainment. The approved criteria are:

- Implementation of the strategy is likely to have a substantive impact on cost growth benchmark attainment
  Evidence supports the strategy, or if not, there is a compelling logic model for the strategy.
- The strategy is actionable for the State, payers or provider organizations.
  Approval from federal partners is not required to implement the strategy, or there is a high likelihood of obtaining required approval.
- Relevant stakeholders have the capacity to design and execute the strategy thoughtfully and successfully.

Advisory committee feedback on impacts to consider and cost growth driver analyses
AnnaLisa Gellermann, HCA
January Angeles, Bailit Health

Ms. Gellermann presented a summary of feedback from the Advisory committee of Providers and Carriers on possible consequences of transparency and cost reduction efforts, and suggestions from the committee of areas for monitoring and counter-measurement. These included unintended negative impacts on vulnerable populations, fragile health delivery systems, small practices, and primary care utilization and reimbursement, and unwanted cost-cutting. The committee agreed that the effects of the pandemic would influence benchmark results with rising labor costs, changes in utilization and required benefit changes.

Ms. Angeles presented feedback from the Advisory Committee on Data issues on the cost growth driver analysis. The committee agreed that HCA’s recommendation for initial analyses of cost drivers seemed reasonable. The initial analyses are proposed as the following: Spend and trend by geography, trends in price and utilization, spend and trend by health condition, spend and trend by demographics, and monitoring of potential unintended adverse consequences. One member suggested use of the CMS Chronic Condition Warehouse for identifying and grouping conditions to analyze. Some members were interested in independent analyses of pediatric conditions.

The Board engaged in discussion about the CCW, and the availability of other data sources related to conditions and demographics. One Board member suggested selection based on current use and ease of access, another suggested considering alignment with Oregon as advantageous for participants in both states. Another suggested caution about the impact of the pandemic as potentially undercounting impacted individuals. Mr. Bailit responded that they had created a guide for states but was not aware of an empirical basis for selecting one data source over another. Ms. Gellermann indicated that the specific data sources would be the topic of future discussion with the data committee and Board as staff continued design of the cost driver analysis.

Data on spending and spending growth in Washington
Michael Bailit and January Angeles, Bailit Health
PowerPoint presentation

Mr. Bailit presented an introduction to the discussion of Washington specific data, reminding Board members that data was tool used to identify opportunities and strategies to slow cost growth. He reminded the Board that it could take notice of multiple sources and stressed that reports would vary based on the data content and methodology. He encouraged the Board to ask questions and critical thinking to conclusions presented in data.
He asked the Board to consider what the data said about where costs were rising highest and fastest, what concerns should be considered when interpreting the data, and what further analyses should be considered to better understand what is driving spending and spending growth.

Jane Beyer, Office of the Insurance Commissioner
Amy Kinner, OnPoint
PowerPoint presentation

Ms. Beyer introduced the OnPoint presentation by sharing the OIC’s goal of having Washington specific information on trends in the commercial market that they regulate: full insured individual, large and small group health plans. The analysis requested of OnPoint was of price and utilization over a three-year period. Ms. Beyer shared that after viewing the dashboard, the office had determined that it might support their efforts to investigate and regulate mental health parity and consumer payments for ground ambulance services. Ms. Beyer also informed the Board that they would likely not be updating the tool to include data after 2019, as that work was substantially similar to the Board’s legislative directive.

Ms. Kinner walked the Board through the dashboard created by the OIC. One Board member asked for clarification of the number of covered lives in the commercial market, and Ms. Beyer estimated the number at between 1.2 and 1.5 million lives. One Board member asked if there had been an attempt to determine if self-insured costs were similar. Ms. Beyer shared that the OIC did not conduct that analysis, which might require exploration of the Fair Health database or coordination with the Washington Health Alliance.

**Public comment**
Ms. Birch called for comments from the public.

Eric Lewis, CFO, Washington State Hospital Association
Mr. Lewis stated that the Board had important work and a big challenge to ingest data to determine and slow cost growth. He emphasized that the impact of significant changes to due Covid, inflation, labor costs and energy costs presented a challenge, and urged the Board to consider an adjustment to the benchmark to a higher number or using 2022 as a base year rather than 2021. He stated that half of hospital expenditures are spent on wages, that hospitals have been paying wage increases of over 10%. He also urged the board to consider these challenges with ad hoc reporting and attention to the context when reporting on providers who exceed the benchmark. He offered partnership in determining future cost mitigation strategies. In response to a question from the Board about accounting for federal relief money, Mr. Lewis shared that the majority of those funds were used to replace lost revenue from halting non-emergency procedures as directed by federal and state directives, and to support increase cost of procedures, with the result of stabilizing hospitals and supporting continued services.

**Other data on health care cost trends in Washington**
Michael Bailit and January Angeles, Bailit Health
PowerPoint presentation

Mr. Bailit presented a survey of various measures tracking spending growth from varied sources including the OIC, the Washington Health Alliance, and the Health Care Cost Institute. These showed increasing cost trends in various markets including Medicaid, PEBB, and Washington vs. national growth in service category spending. He indicated
that these types of data reports are the types that should be reviewed by the Board on a regular basis to determine cost mitigation strategies.

The Board engaged in discussion about several aspects of the presentation, asking clarifying questions about the data sources and methodology. The Board generally expressed interest in pharmacy cost generally, with correlation between new drug development and mandates to understand their impact. One member expressed an interest in understanding impacts in both cost shifting and utilization shifting (from acute inpatient to outpatient). One Board member urged the consideration of consolidation, especially acquisition of physician practices, as a significant area to understand. One Board member requested data on comparable with other states related to trend changes, and a breakdown of price utilization. Mr. Bailit shared that only limited data was available for 2020, but that a comparison could be shared in the future. He also shared that understanding the impact of price vs. volume would be important and required a measure of service mix (which would need to be based on a tool such as one developed by Milliman or HCCI). The Board also identified a priority for a deeper dive into hospital costs.

**Impact of COVID 19 and rising inflation on the Cost Growth Benchmark program**

Michael Bailit and January Angeles, Bailit Health

PowerPoint presentation

Ms. Angeles informed the Board about the impact of Covid on spending trends in 2019 and 2020. Minnesota and Massachusetts have both reported a decline in health care spending for that period. The trend for 2020 and 2021 is expected to be higher. She also shared information about rising costs, affected by supply chain issues, labor shortages and elevated labor costs. All these factors raise concerns about near term prospects for meeting the benchmark.

Ms. Angeles also discussed some economic indicators including a trend chart of personal consumption expenditures from 1996-2021 showing that 2019 and 2021 were very different than historic trends. Inflation and real gross domestic product are strong predictors of health care spending growth, but the impact is often delayed due to the contracting cycle.

The board was reminded of the criteria it had adopted to revisiting the cost growth benchmark and invited to engage in a discussion. Ms. Angeles shared other states have retained their benchmark values and interpret 2020 and 2021 results (at least) in the context of the pandemic and its economic impact.

The board engaged in discussion.

In general, the Board supported increased communication and feedback with stakeholders, including their advisory boards. One member suggested the Board acknowledge the comments of both WSHA and WSMA to the Board describing the challenges they are currently facing. Another member stressed the importance of continued dialog with stakeholders in the face of long-lasting stresses to the health care system.

Members generally agreed not to adjust the benchmark because that they lacked sufficient information and clarity to consider a change. Several members stressed that the challenges described by stakeholders should and would be considered when considering benchmark results. The Board determined not to adjust the benchmark, but to monitor the situation closely. Ms. Birch directed staff to work with her on acknowledgement strategies.

**Adjournment**

Meeting adjourned at 3:56 p.m.

**Next meeting**

Wednesday, March 16, 2022
Meeting to be held on Zoom
Recap of March Board meeting

TAB 3
Recap of the March Board meeting
Recap of the March Board meeting

- Board members heard feedback from the advisory committees on:
  - Possible consequences of transparency and cost reduction efforts and how to monitor for them.
  - Plan for cost growth driver analyses.

- Board members reviewed data on spending and spending growth in Washington, including:
  - Results of an analysis commissioned by the Office of Insurance Commissioner.
  - Other publicly available data from the Washington Health Alliance, the Health Care Cost Institute and other sources.
Recap of the March Board meeting

Based on the data presented, Board members expressed interest in better understanding:

- Pharmacy costs and the impact of new drug development and insurance coverage mandates on costs.
- The impact of shifting care settings from inpatient to outpatient care.
- Hospital pricing, and the impact of labor costs.

Board members also considered the impact of COVID-19 and rising inflation on the cost growth benchmark program.

- The Board decided not to adjust the benchmark because it lacks sufficient information and clarity to consider a change, but agreed with the need to acknowledge these issues when considering benchmark results, and to “stay the course but stay in dialogue.”
Advisory Committee feedback on impacts

TAB 4
Advisory Committee of Providers and Health Carriers feedback
3 Criteria for selecting strategies to support cost growth benchmark attainment

- Committee members reviewed the criteria approved by the Board
  - Implementation of the strategy is likely to have a substantive impact on cost growth benchmark attainment.
    - Evidence supports the strategy, or if not, there is a compelling logic model for the strategy.
  - The strategy is actionable for the state, payers or provider organizations
    - Approval from federal partners is not required to implement the strategy, or there is a high likelihood of obtaining required approval.
  - Relevant stakeholder have the capacity to design and execute the strategy thoughtfully and successfully.

- Strongly recommended adding a criteria related to impact on access.

- Recommended committee involvement prior to discussion and recommendations.
Committee members reviewed the three areas identified by the Board for educational “deeper dives”: 

- Market consolidation
- Hospital pricing strategies
- Value-based payment

Members suggested that

- industry be asked to identify “high-value targets”, which may not be areas of highest cost/spend.
- The Board should review efforts in other states that were tried and failed to reduce cost growth.
- Pharmacy costs would present a challenge requiring granular data and assistance from both committees.
- Impacts of Covid (including labor cost, staff shortages, and supply costs) would persist well beyond endemic status.
2022 Legislative Session Recap

TAB 5
Overview

• 2022 session background
• Policy bills
• Budget
Background

- 2022 Legislative session ended March 10, 2022
- Short session – 60 days
- Supplemental budget year
  - Statewide General Fund-State (GF-S) spending increased from $59B to $64B
  - HCA budget (State + Federal) increased by ~$1.5B
- HCA analyzed over 200 bills and drafted 166 fiscal notes
- Over 55 new reporting requirements (70+ for FY 2023)
Policy bill highlights
## HCA priorities

### HB 1052 – Performance measures
- Aligns insurance code with HCA requirements to engage in performance-based contracting for PEBB/SEBB

### HB 1728 – Insulin Work Group
- Previously enacted in 2020 to design strategies to reduce cost of insulin
  - No initial funding to support
- Extends deadlines and adjusts membership
  - Initial report due December 1, 2022
  - Final report due July 1, 2023
Health care costs

SB 5589 – Primary care spending

SB 5610 – Prescription drug coupons

SB 5532 – Prescription Drug Affordability Board
Board must measure and report on primary care spending and progress toward increasing spending to 12% of total health care expenditures

Preliminary Report – 12/1/22
- Define “primary care”
- Barriers to accessing data
- Annual progress toward 12% target
- Methods to incentivize achieving desired levels of primary care spending
Annual Reports – beginning 8/1/23
  ➤ Primary care expenditures for most recent year:
    ➤ By Carrier, Market or Payer
    ➤ In total and as a percentage of total health care spending
  ➤ Evaluate annual spending by type of care, provider, and payment mechanism
  ➤ Identify barriers to meeting reporting requirements and recommendations to resolve

OIC authorized to assess health carriers’ primary care expenditures in review of health plan form and rate filings
Supplemental budget highlights
SSB 5693 (2022)
New programs & Coverage Mandates

- 1115 Medicaid Transformation Waiver renewal
- Apple Health coverage for uninsured immigrants
- Continuous enrollment for children
- Fertility Treatment Study
- Acupuncture & chiropractic coverage
- Health Care Cost Board
- HIV Antiviral Coverage
Rate Increases & Provider Investments

- 2022 behavioral health provider relief funding
- 2023 behavioral health provider rate increase
- Investments in children’s dental
- Opioid treatment provider rate increase
- Community health worker & behavioral health integration grants
- Home Health & Private Duty Nursing
- Mobile crisis teams
Questions?
Contact

Evan Klein
Special Assistant, Legislative & Policy Affairs
Phone – 360-725-9808
Email – evan.klein@hca.wa.gov
Introduction to Primary Care expenditures

TAB 6
Introduction to Primary Care Expenditures

Emily Transue, MD
ERB Medical Director
Overview

- Why is spending in primary care important?
- What are some of the challenges in measuring primary care expenditures?
  - Providers, services, non-claims spend
- What existing efforts can we build on?
  - OFM, Bree
- Targets
  - What does the target mean?
  - How might we get there?
Why does primary care spending matter?

- Over time, expectations of primary care have steadily increased
  - Quality: accountability for preventive, acute and chronic care measures
  - Expectation of proactive outreach and management, team based care, integrated behavioral health approaches, etc.
- Resources have not increased commensurate with expectations, leading to a crisis in primary care (workforce, access, etc)
- Strong evidence supports the value of resourcing primary care better
Primary Care Associated with Higher Quality

EXHIBIT 8
Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000

Quality rank

1

26

51

General practitioners per 10,000

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004

Several slides adapted with permission from Chris Koller, Milbank Fund
Primary care associated with lower total costs

Source: Baicker & Chandra, Health Affairs, April 7, 2004
Overall spending remains low

Source: CMS Actuary. All Payments
Measuring Primary Care Spend: States with statutory or regulatory action

- Statutory or regulatory action
- Proposed legislation
- Statewide measurement of primary care spending
RI Affordability Standards for Commercial Insurers

2010: RI Office Health Insurance Commissioner:

1. Required commercial health plans to invest in primary care, raise primary care spending by 1%/yr for 5 yrs
   - New payments had to be made through non-FFS payments
   - Could not increase overall health care spending
2. Promoted multi-payer primary care efforts
3. Invested in health information technology
4. Implemented Value Based Payment models, with caps on hospital rate increases

Standards enforced through insurance rate review process
Small Changes Make Big Impact on Payments to Primary Care

RI primary care payments by commercial insurers on primary care increased from $47M/yr to $73M/yr (over 7yrs)

Primary Care Spending as Percent of Total Medical Spending Insurer (2008-2017)
(Self-insured plan payments not captured)

Source: Office of the Health Insurance Commissioner, State of Rhode Island
And... RI Saw Increased Primary Care Supply (and no “Specialty Flight”)

Notes: MDs only; Primary Care: FP, Peds, IM; Sources: AMA Licensure and Census.Gov
Commercial Insurance Spend: RI’s Insurance Reform Interventions Bent the Curve

Risk Adjusted Commercial Insurance Spending per Enrollees in Rhode Island vs. Matched Control

Source: Landon et al, Academy Health Annual Research Meeting, 2018

Spill Over Effects?
Per CMS Actuary, across all payers RI went from 4th to 9th most expensive state for health care (2009 to 2014)
Impact of RI Strategy

- Analyzed trends in health care commercial plan spending in RI compared to other states over 10yr period
- Saw $21pmpm increase in non-FFS payments to primary care, along with...
- $76pmpm (8%) decrease in overall health care spending
Oregon: SB231 (2015)

- Established Primary Care Payment Reform Collaborative
- Required state to determine percent primary care spend by payer
- Required recommendations on primary care spend targets & alternative payment models

Some baseline data
(Note that definitions vary)

Vermont: 9.7% (Medicare, Medicaid, & Commercial, 2016)

Massachusetts 6.6% (Commercial Payers, 2015)

Rhode Island: 11.5% (All Commercial Payers, 2016)

Connecticut: 4.7% (State Employees, 2017)

Source: NESCSO Primary Care Workgroup Presentation, 18 October 2018
Primary Care Spend: Definitions and Challenges

- **Who** is primary care?
  - Which providers/provider types are included

- **What** is primary care?
  - Which services are included?

- **How** is spend measured?
  - In particular, how is non-claims spend defined and captured?
Who is Primary Care?

- **Straightforward:**
  - Family Medicine
  - Internal Medicine
  - Pediatrics

- **Less straightforward:**
  - OB/Gyn
  - Providers who do a mix of primary and specialty care (endocrine, sports medicine, HIV specialists, etc)

- **Messy:**
  - Midlevel providers (ARNP, PA)
    - Clearly play a major role in providing primary care but taxonomy often not available, or may practice in multiple settings (primary care and specialty)
  - Chiropractors, BH providers, others especially if practicing in integrated settings as part of a team
What services are primary care?

- **Straightforward:**
  - Office visits
  - Wellness visits
  - Simple procedures (vaccine administration, etc)

- **Less straightforward:**
  - Procedures only some PCPs do
    - Skin biopsies, sigmoidoscopies, deliveries, etc

- **Messy:**
  - Primary care provider type who only does specialty care (i.e., family medicine provider whose practice is exclusively vasectomies)
How is spend measured?

- Straightforward: Claims data
  - APCD, carrier data

- Less straightforward
  - Does patient cost share count in spend? etc

- Messy: Non-claims data
  - Alternative payment models
    - Capitation, subcapitation, bundled payments
  - Quality incentives
  - Shared savings/risk arrangements
  - Infrastructure supports (IT, etc)
  - For payments made at a system level, how is contribution to primary care assessed?
Percentage spend

- 12% goal was likely based on Oregon goal
- Percentage requires defining both numerator (primary care spend) and denominator (total spend)
  - Inclusions and exclusions from denominator will significantly impact percentage calculation
  - E.g., are pharmacy costs part of total spend?
Existing Washington Primary Care Definitions

Office of Financial Management (OFM) definition
- In 2019, OFM was charged by legislature (Chapter 415) to assess primary care expenditure
- Multistakeholder workgroup determined definitions, with a “narrow” and “broad” definition for both providers (based on taxonomy) and services (based on CPT codes)

Bree definition
- The Bree Collaborative convened a workgroup in 2020 on Primary Care and developed a report
- [Primary Care | Bree Collaborative (qualityhealth.org)](https://qualityhealth.org)
- Definition based on function/role as well as taxonomy

RCW 74.09.010
- “General practice physician, family practitioner, internist, pediatrician, osteopathic physician, naturopath, physician assistant, osteopathic physician assistant, and advanced registered nurse practitioner”
Existing Washington Primary Care Expenditure Reports

- **OFM report**
  - Report to the Legislature Primary care expenditures As required by Chapter 415, Laws of 2019 December 2019 (wa.gov)
  - Claims based, APCD data, OFM definitions
  - For 2018, PC expenditures were 4.4% ($838M) based on narrow definition and 5.6% (about $1B) based on broad definition
  - Data refresh with same definitions 2022 (not a full report)

- **HCA carrier reporting**
  - Contract requirement in Apple Health MCO contracts, PEBB and SEBB contracts, and Cascade Care contracts, phased in starting with 2020 payments
  - HCA has supplied template for HCA carriers to self-report
  - Claims definitions largely based in OFM report, with additional non-claims categories derived from national sources
  - Self-report percentages range from 5 to 14%
    - Note: interpretations of non-claims spend varied, and no audit of self report
How can we approach increasing expenditures?

- While increased resources are necessary, they are not sufficient to achieve goals of improving quality, reducing total costs of care.
- Need payment models that will ensure strengthening of primary care infrastructure, team based models, patient-centric approaches to care and access, accountability for outcomes, etc.
Washington Multi-payer Primary Care Transformation Model

Goals:

- Align payment, incentives, and metrics across payers and providers
- Promote and incentivize integrated, whole-person and team-based care that includes primary care, physical and behavioral health care, and preventive services
- Improve provider capacity and access
- Increase primary care expenditures while decreasing total health spending
- Work with interested public and private employers to spread and scale the model throughout Washington State

Collaborative effort between HCA, WA payers, and primary care providers, started in 2019 and ongoing
Primary Care Transformation Components

Payers work to:

- **Align payment and incentives across payers to support the model**
  - Finance primary care (% of spend on primary care)

Providers work to:

- Improve provider capacity and access
- Apply actionable analytics (clinical, financial, social supports)

In support of:

- Primary care as integrated whole person care, including BH and preventive services
- Shared understanding of care coordination and providers in that continuum

Resulting in:

- Aligned measurement of “value” from the model (quadruple aim outcome measures)
WA Multi-payer Primary Care Model
Key Implementation Elements

Provider Accountabilities
- 1) Whole person care
- 2) A team for every patient
- 3) Risk stratification
- 4) Behavioral health screening and follow-up
- 5) Patient support
- 6) Care coordination strategy
- 7) Expanded access
- 8) Culturally attuned care
- 9) Health literacy
- 10) Data capacity
- 11) Measurement of improvement

Centralized Provider Certification
- Level 1: Meets minimum participation standards & working towards transformation
- Level 2: Making progress toward transformation
- Level 3: Implementing model with fidelity

Payer Accountabilities
- Aligned Practice Supports
  - Aligned data sharing
  - Common attribution principles
  - Shared resources for providers
- Shared Quality Standards
- Aligned Payment Model
  - Transformation Payment
  - Prospective Comprehensive Care Payment
  - Quality Incentive Payment
Proposed Payment Model

The payment model will be comprised of three components:

1) a **transformation of care fee (TCF)** paid to support the transformation to a coordinated delivery model that integrates behavioral and physical health care provided in a range of settings to ensure access;

2) a prospective PMPM **comprehensive primary care payment (CPCP)** to cover costs of basic primary care services; and,

3) **performance incentives** available after three years with performance measured according to a combination of quality of clinical care and utilization measures.

To begin to receive TCFs, practices will be required to agree to make progress toward transformation as defined by specified transformation measures.

TCF will be provided up to three years before transitioning to PIPs

- The transition period within the three years may vary based on individual practices’ progress on transformation measures.
Provider Supports – Stakeholder Input

Data & Technology
- Regular actionable claims & utilization data for attributed patients
- Common tool to provide patient data across payers
- Common referral resource
- Expanded care notification and coordination mechanisms across range of providers and settings
- Transparent attribution process and timely accurate data

Common Tools & Training
- BH screening
- Models of BH integration & coordination
- Addressing bias & removing cultural barriers to care
- Incorporating patient feedback, shared decision making, & patient self-management into care practices
- Designing & implementing team-oriented care
Quality Alignment: Clinical Quality Measures

1. Child and Adolescent Well-Care Visit (WCV)
2. Childhood Immunization Status (CIS) (Combo 10)
3. Screening for Colorectal Cancer (COL)
4. Breast Cancer Screening (BCS)
5. Cervical Cancer Screening (CCS)
6. Depression Screening and Follow up for Adolescents and Adults (DSF-E): Screening submeasure only (Note: inclusion not yet finalized by PMCC)
7. Controlling High Blood Pressure (CBP)
8. Asthma Medication Ratio (AMR)
9. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (CDCN)
10. Antidepressant Medication Management (AMM)
11. Follow-up after ED visit for Alcohol and Other Drug Abuse of Dependence (FUA)
12. Ambulatory Care - Emergency Department (ED) Visits per 1,000 (AMB) (Medicaid only in HEDIS, but will adapt for use across populations)
Centralized Provider Certification

- All plans use the same set of standards for providers
- Single process (HCA or delegate) to evaluate provider’s achievement of standards (certification)
- Less burden on practices and less burden on payers
- Increases consistency/reduces different interpretation of performance across payers
Phased Implementation

**Participating Providers**
- Providers currently participating in other initiatives
- Any willing provider
- Targeted outreach

**Certification Process**
- Self attestation
- Self attestation + plan review

**Provider Supports**
- Supports critical for model operations/provider success
- High priority supports
- Difficult to implement/longer term priorities

**Plan Business Lines**
- Medicaid MCOs, PEBB/SEBB, Some Commercial
- Additional Commercial
Questions?

Emily Transue, MD
emily.transue@hca.wa.gov
Public comment
Key issues in defining and measuring Primary Care Spend

TAB 7
Key Issues in Defining and Measuring Primary Care Spend
States have established primary care spend targets through many different mechanisms

- Oregon’s primary care spend requirement, established in **statute**, is targeted to commercial health insurance carriers and Medicaid coordinated care organizations.

- Rhode Island has a primary care spending obligation of insurers established through commercial health insurance **regulation**.

- Connecticut has annual all-payer primary care spend targets defined in an **Executive Order**.
  - A bill was introduced in 2022 to authorize a state agency to set the primary care spend targets.
Primary care spending targets in other states

To date, six states have established primary care spend targets.

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<thead>
<tr>
<th>CO</th>
<th>CT</th>
<th>DE</th>
<th>OR</th>
<th>RI</th>
<th>WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 pct point increases in 2022 and 2023</td>
<td>10% by 2025 Interim: 2022: 5.3% 2023: 6.9% 2024: 8.5%</td>
<td>9-11% by 2025</td>
<td>12% by 2023</td>
<td>10.7%</td>
<td>Annual progress needed to reach 12% in a reasonable timeframe</td>
</tr>
</tbody>
</table>

Legislation has been introduced in Massachusetts and Utah for primary care spend targets in 2022.

SOURCE: Primary Care Investment | Primary Care Collaborative (pcpcc.org)
How the cost growth benchmark intersects with primary care spend targets

- In some states with both a cost growth benchmark and primary care spend target, there is significant overlap in the development and implementation of the two initiatives.
  - Except for Delaware, they leverage the same governing bodies to make design decisions.
  - In Connecticut and Rhode Island, data are collected together, with total health care spending for the benchmark often used as the denominator for calculating the percent of spending on primary care.
Rebalancing of spending with a cost growth benchmark and primary care spend target

Without the impact of the benchmark or target, spending will continue to rise quickly and primary care as a percent of overall spending will decline.

The benchmark lowers the overall growth rate, while the target increases primary care spend relative to the overall spend.

Diagram not drawn to scale.
Many other states have interest in increasing primary care investment.

SOURCE: Investing in Primary Care: Lessons from State-Based Efforts (chcf.org)
To increase primary care investment, one must measure primary care spending. Key decision points for measuring primary care spending include:

1. What is the data source(s)?
2. What services comprise primary care?
3. Who is a primary care provider?
4. Should spending be calculated on a paid or allowed basis?
5. What non-claims-based payments should be included in the calculation?
6. How should total health care expenditures be defined?
1. Identifying the data source(s)

Data availability strongly influences how to operationally define primary care.

There are three options for data, each with its own set of advantages and disadvantages:

- **All-Payer Claims Database** – is easier to collect but does not include self-insured and non-claims payment data.
- **Direct payer reporting** – allows customization but involves additional effort and expense and could be difficult to validate.
- **A combination of the two** – allows for a more comprehensive definition of primary care but requires additional effort, expense and validation.

CA and RI have also collected data from provider organizations to understand the distribution of non-claims-based payments.
2. Defining what services constitute primary care services

- Office-based visits comprise most of a primary care practice’s revenue, but there are many other services that may be delivered depending on scope of practice. For example:
  - Should home visits for newborn care be included?
  - Should preventive dental services for children be included?
3. Defining who is a primary care provider

Beyond traditional primary care specialties, there are specialists that deliver some primary care services. For example:

- How should services delivered by behavioral health clinicians in an integrated setting be treated?
- Should primary care services rendered by OB/GYN providers be included?
- Should primary care delivered in urgent care centers and retail clinics be included?
- Should services provided by a standalone telehealth provider be considered primary care?
4. Calculating spending on a paid or allowed basis

- The paid amount is the actual payment to a provider while the allowed amount also includes copays and other cost-sharing.

- Opinions vary on the degree to which the measure is being used to determine insurer accountability or to assess overall spend level. For example:
  - Rhode Island uses paid amounts based on the rationale that health plans have the ability to only control paid amounts. Oregon uses the same definition to focus on plan investments in primary care.
5. Inclusion of non-claims-based payments

- Non-claims-based payments, such as incentive payments and care management infrastructure payments can represent a sizeable portion of primary care practice revenue.

- There is currently no standard practice for capturing and reporting non-claims-based payments.
  - A 2021 Milbank paper proposes a standard definition and measurement methodology.

- Also, capitated payments to provider organizations present a particular challenge because of the difficulties in identifying what percentage of payments can be attributed to primary care.

6. Defining total payments

- Total payments constitutes the denominator for the primary care spending target calculation.
- States vary somewhat in their inclusion of certain spending categories in the denominator, such as prescription drugs or long-term care.
- Including more categories produces a more comprehensive estimate of total medical spending, but a narrower definition that includes categories that are applicable across multiple markets may be more equitable across payers.
State approaches to primary care spend measurement

States have used various (and inconsistent) approaches to measurement.

<table>
<thead>
<tr>
<th>PRIMARY CARE DEFINITION</th>
<th>PRACTICING</th>
<th>IN PROCESS</th>
<th>GETTING STARTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services and Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits/preventive visits/vaccine administration</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Behavioral health</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Care coordination and/or management</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Health information exchange/other infrastructure</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Maternity</td>
<td>✓&lt;sup&gt;5&lt;/sup&gt;</td>
<td>✓&lt;sup&gt;5&lt;/sup&gt;</td>
<td>✓</td>
</tr>
<tr>
<td>Primary care incentive payments</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

SOURCE: Investing in Primary Care: Lessons from State-Based Efforts (chcf.org)
Value-based purchasing

TAB 8
Value-based Purchasing (VBP)

Health Care Cost Transparency Board
April 20, 2022
Agenda

1. What is VBP, why is it important, and how are we doing it?
2. Does VBP work and what do we know about its impact?
3. What is next for VBP?
4. Discussion
1. What is VBP, why is it important, and how are we doing it?
Lingo

- Value-based Purchasing

- Value-based Payments & Alternative Payment Models (APMs)

- Value-based Care
What is value-based purchasing? (VBP)

VBP is the concept of **paying for quality rather than quantity** of health care.

In traditional fee-for-service (FFS) payment, each service (exam, procedure, test) has a set price.

- This creates a system that rewards providing a lot of expensive services, whether they improve patient health.

Shifting to value-based payment means creating a system where **patients get the care they need, when they need it**...

- ...and *don’t* get a lot of expensive, unnecessary care.
What is VBP?

**Fee-for-service**
When a health care provider is paid for each service they provide, regardless of the quality or patient’s need for that service.

**Value-based Payment**
When a health care provider is paid for providing high-quality and high-value care to their patients.
Alignment with the HCP-LAN Alternative Payment Models (APM) Framework

Figure 1: The Updated APM Framework

State’s VBP Standard: 2C -> 4C
Q: Why VBP?
A: Payment drives transformation

VBP should achieve the triple aim by:

- Reducing unnecessary and low-value health care (lower cost)
- Rewarding preventive and whole-person care (better health)
- Rewarding the delivery of high-quality care (better quality and experience)
HCA’s vision is to achieve a healthier Washington by:

- Aligning all HCA programs according to a “One-HCA” purchasing philosophy.
- Holding plan partners and delivery system networks accountable for quality and value.
- Exercising significant oversight and quality assurance over its contracting partners and implementing corrective action as necessary.
Driving common elements in all HCA’s new payment models

- Risk sharing at the provider level
- Quality measures from Washington Statewide Common Measure Set
- Quality improvement strategy that rewards improvement and attainment
- Care transformation strategies based on the Bree Collaborative recommendations
### Examples

<table>
<thead>
<tr>
<th>Public and School Employee Benefits</th>
<th>Apple Health (Medicaid)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Accountable Care Program, ACO model with upside and downside risk to incentivize clinical and quality accountability</td>
<td>• 2% MCO premium withhold based on quality and provider VBP arrangements</td>
</tr>
<tr>
<td>• Total Joint Replacement and Spine Fusion and Centers of Excellence</td>
<td>• Behavioral and physical (financial) health integration</td>
</tr>
<tr>
<td>• New self-insured TPA contract requires Regence to offer substantially similar ACO program to book of business (risk sharing and care transformation approaches) to spread VBP in the marketplace</td>
<td>• Medicaid Transformation regional VBP goals tied to incentive payments to Accountable Communities of Health (ACHs) and MCOs</td>
</tr>
<tr>
<td>• MLR tied to VBP attainment for SEBB fully-insured health plans</td>
<td>• Alternative Payment Model 4 for FQHCs moves clinics away from encounter-based system</td>
</tr>
<tr>
<td></td>
<td>• Developing a multi-payer primary care APM and aligned child primary health services APM</td>
</tr>
<tr>
<td></td>
<td>• Developing a Medicaid APM for CHART</td>
</tr>
</tbody>
</table>
MCO withhold

2% PMPM Withhold

25% - VBP

- 12.5% VBP Attainment
  - Qualifying Value-Based Payments
    - A Target \( \times 0.02 \times \text{PMPM} \times 0.125 \)
      - No greater than 1
    - B Target \( \times 0.02 \times \text{PMPM} \times 0.125 \)
      - No greater than 1

- 12.5% Provider Incentives
  - Qualifying Provider Incentives

75% - QIS

- Top Quartile?
  - If "NO"
    - Quality score improvement
      - Quality Measures
        - 1
          - y/n
        - 2
          - y/n
        - 3
          - y/n
        - 4
          - y/n
        - 5
          - y/n
        - 6
          - y/n
        - 7
          - y/n
      - If "NO"

- Withhold Earnback

SUM

\( \text{No greater than 1} \)

C (if y)

D (if y)

(\(C+D\)) 7 \( \times 0.02 \times \text{PMPM} \times 0.75 \)
2. Does VBP work and what do we know about its impact?
Recall: VBP changes the incentive structure

- Incentivizes providers to provide person-centered, coordinated care
- Directly ties payment to performance on quality
- Emphasizes prevention, theoretically reducing long-term costs and preventable utilization

Challenges to evaluation:
- Time and resource intensive
- Short-term vs. long-term
- Correlation vs. causation and confounders
Evaluating the impact

What we can “easily” measure:
- Health plan quality performance
- Health plan provider contracting
  - Breadth: total dollars in APMs
  - Depth: total dollars ‘at risk’ or as ‘incentive payments’
- Member experience for specific models (e.g., COE program)

HCA currently evaluates:
- Plan performance on quality and VBP elements
- HCA’s overall VBP progress
- Plan and provider experience with VBP (annual Paying for Value Survey)

State Innovation Model evaluation
- University of Washington evaluation (including evaluating the Accountable Care Program)
UW evaluation of the ACP

Assessed the impact of the ACP on utilization, cost, and quality after one year

- Evaluation funded through the State Innovation Model grant
- Findings:
  - Small decrease in outpatient hospital visits
  - Members increased primary care utilization
  - No significant decrease in spending, although without price data, evaluators were unable to assess possible cost savings
  - Limited practice transformation
- As expected, change takes time, and this is not a quick-fix APM strategy
Evaluating patient experience: HCA’s Centers of Excellence

- Centers of Excellence for knee and hip replacement and spine care
- Member satisfaction with the knee and hip COE was high in 217 and 2018:

<table>
<thead>
<tr>
<th>Feedback question</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>My case manager was courteous and helpful</td>
<td>9.8</td>
</tr>
<tr>
<td>I felt ready for my surgery</td>
<td>9.6</td>
</tr>
<tr>
<td>The travel arrangement met my needs</td>
<td>9.3</td>
</tr>
<tr>
<td>My recovery went well</td>
<td>9.3</td>
</tr>
<tr>
<td>If I have another joint replacement, I would choose to use this program</td>
<td>9.7</td>
</tr>
<tr>
<td>I would recommend this program to family and friends</td>
<td>9.8</td>
</tr>
<tr>
<td>Overall satisfaction with your total experience</td>
<td>9.5</td>
</tr>
</tbody>
</table>

- Members saved an average of $988.46 through the knee and hip COE

https://www.hca.wa.gov/about-hca/uniform-medical-plan-ump/centers-excellence#coe-results
<table>
<thead>
<tr>
<th>Value-Based Payment Measure</th>
<th>Amerigroup Washington</th>
<th>Coordinated Care of Washington</th>
<th>Community Health Plan of Washington</th>
<th>Molina Healthcare of Washington</th>
<th>UnitedHealthcare Community Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Percent Achieved</strong></td>
<td>60%</td>
<td>83%</td>
<td>83%</td>
<td>58%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Washington Apple Health Integrated Managed Care (AH-IMC) Shared Measures - Four shared measures reported by all MCOs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressant Medication Management (AMM)</td>
<td>Effective Acute Phase Treatment</td>
<td>No</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Effective Continuation Phase Treatment</td>
<td>No</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mental Health Treatment (Service) Penetration, Age 6-64; all MCO, excluding BHSD</td>
<td>No</td>
<td>No</td>
<td>✓</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Prenatal and Postpartum Care (PPC)</td>
<td>Timeliness of Prenatal Care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Postpartum Care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Asthma Medication Ratio (AMR, Total)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Washington Apple Health Integrated Managed Care (AH-IMC) Plan-Specific Measures - Three quality focus performance measures specific to each MCO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use Disorder Treatment Penetration, Age 12-64; all MCO, excluding BHSO</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Well Child Visits (WCV), Age 3-11</td>
<td>Data not available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow Up Care for Children Prescribed ADHD Medication (ADD), Initiation Phase</td>
<td>NA</td>
<td>✓</td>
<td>No</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC), Poor HbA1c Control (≥9%)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC), Medical Attention for Nephropathy</td>
<td>Data not available</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
Measuring VBP adoption (‘breadth’): CY2020

**HCA TOTAL**

- Medicaid Managed Care: $4,561,989,886
  - 18% FFS; 2A/2B; 3N; 4N
  - 12% 2C
  - 14% 3A/3B
  - 23% 4A/4B/4C
- PEBB & SEBB: $3,318,545,148
  - 29% FFS; 2A/2B; 3N; 4N
  - 11% 2C
  - 18% 3A/3B
  - 43% 4A/4B/4C

- FFS; 2A/2B; 3N; 4N: $7,880,535,034
  - 57% HCA TOTAL

2020 state-financed VBP = 77%
Measuring provider incentives (‘depth’)
3. What is next for VBP?
National context: HCP-LAN APM goals

Goal statement: “Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk APMs.” i.e., APM Framework categories 3B and up
HCA 2022-25 strategic plan

hca.wa.gov/about-hca/
our-mission-vision-and-values

*Refreshed VBP goals in development*
Continue refining and developing APMs

- Multi-payer primary care transformation model
- Community Health Access and Rural Transformation (CHART) Medicaid and Aligned Payer APM
- Medicaid Transformation renewal will continue community-based care and delivery system transformation
- Applying an equity lens to purchasing
- In development: consolidating and enhancing our measurement and evaluation of VBP efforts
VBP Roadmap: priorities

- Health equity
- SDoH
- Primary care
- Alignment
- Accountability and support
- Access
- Affordability
Questions?

More information:
https://www.hca.wa.gov/about-hca/value-based-purchasing-vbp

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