Advisory Committee on Primary Care meeting

Washington State Health Care Authority

Washington State Health Care Authority

Advisory Committee on Primary Care
Meeting Materials

April 27, 2023
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting materials

Meeting agenda 1
Approval of June meeting minutes..2
Public comment...3
Discussion of committee charges and proposed amendment..............................4

Tab 1

Washington State Health Care Authority

Advisory Committee on Primary Care

July 25, 2023
2:00 p.m. – 4:00 p.m.
Hybrid Meeting

AGENDA

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

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome, roll call, and agenda review	1	Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
2:05-2:10 (5 min)	Approval of June meeting summary	2	Jean Marie Dreyer, Committee Manager Washington State Health Care Authority
2:10-2:25 (15 min)	Public Comment	3	
2:25-3:55 (90 min)	Discussion: Policies to support achievement of the 12 percent expenditure target	4	Shane Mofford and Amy Clary, Center for Evidence-based Policy (CEbP)
3:55-4:00 (5 min)	Wrap-up and adjournment		Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority

Tab 2

Washington State Health Care Authority

Advisory Committee on Primary Care Meeting Summary

June 28, 2023
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 committee is available on the Advisory Committee on Primary Care webpage.

Members present

Judy Zerzan-Thul
Kristal Albrecht
Michele Causley
Nancy Connolly
David DiGiuseppe
Sharon Eloranta
Lan H. Nguyen
Katina Rue
Mandy Stahre
Jonathan Staloff
Staici West
Ginny Weir
Maddy Wiley

Members absent

Tony Butruille
Sharon Brown
Tracy Corgiat
DC Dugdale
Chandra Hicks
Meg Jones
Sheryl Morelli
Kevin Phelan
Eileen Ravella
Sarah Stokes
Linda Van Hoff
Shawn West
Gregory Marchand

Call to order

Chair Dr. Judy Zeran-Thul called the meeting to order at 2:02 p.m.

Agenda items

Welcome, roll call, and agenda review

Dr. Judy Zerzan-Thul, Health Care Authority (HCA)

Approval of May meeting summary

The committee voted to adopt the Meeting Summary from the May 2023 meeting with some modifications made to remove duplicate listings of attendees and absentees.

Topics for Today

The main topics were a presentation on and discussion of committee charges to identify data collection barriers and propose solutions, code review finalization, and preparation for the next meeting.

Public Comment

There were no public comments.

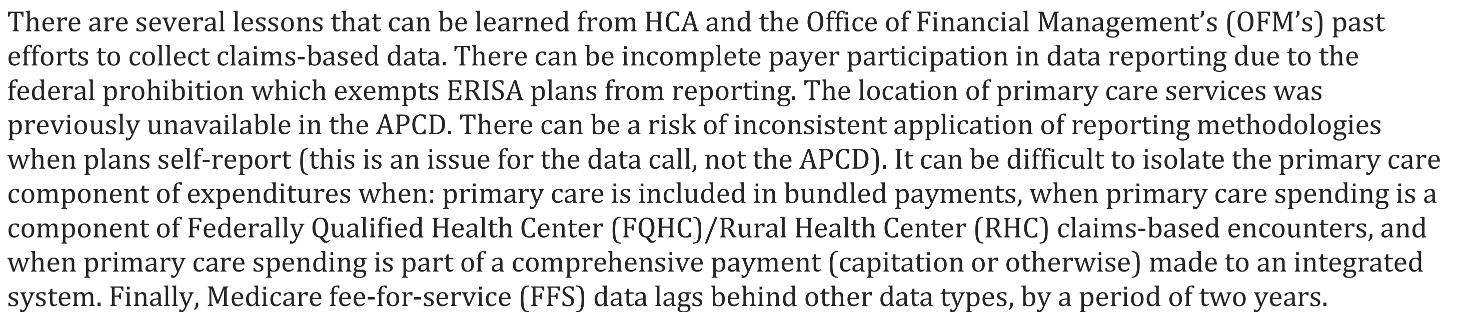
Discussion: Committee charge to identify data collection barriers and propose solutions

Shane Mofford, Center for Evidence-based Policy (CEbP)

Shane Mofford reviewed the goals of the meeting: Identifying gaps/challenges for primary care spending data collection, developing a baseline understanding of status quo data collection strategies, making recommendations for future policies to address gaps and challenges, voting on one outstanding code for the primary care definition, and preparing for policy discussion in upcoming meetings.

The legislative charge for primary care data collection included three directives: 1) reporting on annual barriers to access and use of primary care data and recommending ways to overcome barriers, 2) reporting on the annual progress needed for primary care expenditures to reach the 12 percent target of total health care spending, and 3) tracking accountability for annual primary care expenditure targets. Along with these directives, there were several instructions for how to report the data. The annual reports must include annual primary care expenditures for the most recent year for which data is available by insurance carrier, by market or payer, in total and as a percentage of total health care expenditures. Primary care expenditures must be broken down by relevant characteristics, such as whether expenditures were for physical or behavioral health, by type of provider, and by payment mechanism.

There are two primary methods of data collection from payers: data from the all-payer claims database (APCD) and HCA's aggregate data call. The APCD includes detailed data submitted by a subset of payers but does not include non-claims-based spending. This data can be queried by HCA. Federal regulations prohibit certain payers from reporting, including payers covered by the Employee Income Retirement Act (ERISA) plans. The HCA aggregate data call aggregates data submitted by all payers directly to HCA. The call includes some, but not all, ERISA plan data and includes a subset of non-claims-based expenditures. ERISA plan data is reported as commercial plan data rather than being carved out. HCA updates reporting specifications for the data call to meet current policy needs regularly, which allows for greater flexibility. Next year's updated primary care definition can be easily incorporated into the data call.



There are several lessons that can be learned from HCA and the Office of Financial Management's (OFM's) past efforts to collect claims-based data. There can be incomplete payer participation in data reporting due to the federal prohibition which exempts ERISA plans from reporting. The location of primary care services was previously unavailable in the APCD. There can be a risk of inconsistent application of reporting methodologies when plans self-report (this is an issue for the data call, not the APCD). It can be difficult to isolate the primary care component of expenditures when: primary care is included in bundled payments, when primary care spending is a component of Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) claims-based encounters, and when primary care spending is part of a comprehensive payment (capitation or otherwise) made to an integrated system. Finally, Medicare fee-for-service (FFS) data lags behind other data types, by a period of two years.

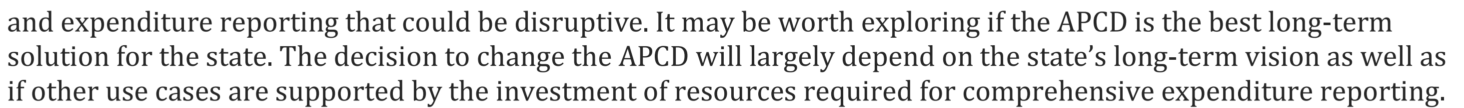
The presentations at the previous primary care committee meeting outlined several data collection barriers for non-claims-based spending. It is hard to isolate primary care spending in a non-claims payment of services that are part of a broader scope of services. To properly account for non-based-claims payments, there must be a standard categorical framework applied to the payments by subcategory. There is a risk of inconsistent application of reporting methodologies when plans self-report data (this is also a barrier for traditional claims-based data). Some of these barriers apply to the APCD as a data source, some apply to HCA's data call, and some don't apply to Washington's current data infrastructure.

Committee member David DiGiuseppe suggested accounting for how the definition varies by percent threshold across states. There may be policy considerations to account for based on the different definitions which can be applied as data is collected. Shane Mofford noted that the aggregated data call solves for many of the challenges posed. The committee will be choosing principles/criteria for data collection and one of those principles could be to maintain the integrity and consistency of the data by applying processes consistently over time to the extent possible.

A gap analysis revealed two high-level categories of data collection issues: the mechanism of data collection and a standardized reporting framework. Questions related to the mechanism of data collection include: how is the data collected and what are the implications for consistency, completeness, and accountability? Questions related to the data reporting framework include: what data is reported and how is it organized?

The committee has made progress on the data collection mechanism by developing a Washington specific definition that can be updated into the current data call process. HCA already collects some information on non-claims-based expenditures. There are, however, some persistent challenges. The committee needs to think about whether the challenges are tolerable or must be changed and improved upon. Some of the challenges include: multiple entities calculate primary care spending based on state-provided specifications, there is an opportunity for inconsistent application of the specifications; self-reported aggregate data reduces accountability and transparency (e.g., to the extent that there is a mechanism to hold payers accountable for a spending target, when there's room for interpretation, there isn't a proper validation mechanism); the collection process is administratively burdensome and partially duplicative with APCD reporting by plans. These challenges show what the current processes are and potential weaknesses.

Some states have updated the data collection of their APCD to collect non-claims-based expenditures and other data elements used to calculate primary care spending. There are several considerations: Some payers that optionally report aggregate data may not opt to report detailed data, it would take significant time (could take many years) and resources for the APCD to become a single solution for payer expenditure reporting, changing methodologies (from data call to APCD if it became available in the future) would result in changes in benchmark

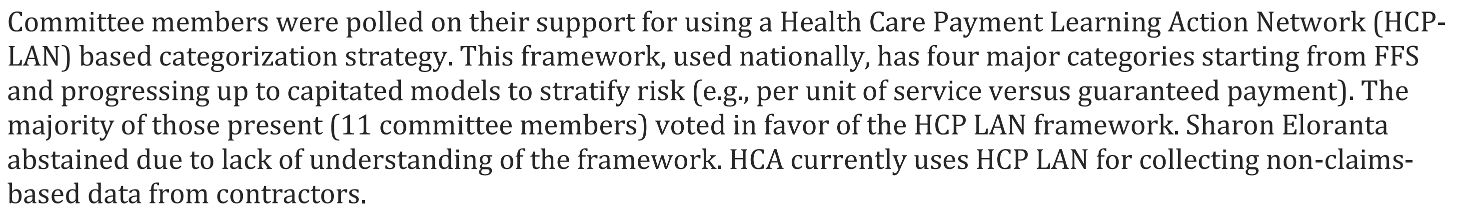


and expenditure reporting that could be disruptive. It may be worth exploring if the APCD is the best long-term solution for the state. The decision to change the APCD will largely depend on the state's long-term vision as well as if other use cases are supported by the investment of resources required for comprehensive expenditure reporting.

Committee members were polled to provide principles they would recommend the state adhere to when implementing data reporting processes to calculate primary care expenditures. Policy recommendations don't have to be constrained by what's available today. There could be recommendations for additional resources from the Legislature in the future. Some of the principles selected were completeness, ease of collection, consistency, transparency, ability to apply reasonability checks on data, ability of HCA to analyze APCD data, and pragmatism.

David DiGiuseppe asked for clarification of state resources for analytic capabilities. There are some resources allocated to the cost board, but they are limited. A preliminary analysis will provide more information on what the codes look like before they are fully finalized. There is a tradeoff between interpreting the APCD for detailed access versus relying on data suppliers running a primary care algorithm to submit a total dollar amount. The aggregate data call captures more plans' data which can't be captured fully by the ACPD. If there are 20 entities applying a standard to a calculation, that standard may be inconsistently applied. It's difficult to estimate the magnitude of some of the reporting issues (e.g., variation). David DiGiuseppe asked whether claims could be limited to APCD processing where non-claims-based would be supplied by the data call. Shane Mofford pointed out there would still be some data loss from the APCD process for claims-based data. Dr. Zerzan-Thul noted it would be hard to divide claims and non-claims-based information from different sources, rendering the process incomplete to an uncertain degree. David DiGiuseppe asked whether completeness as a principle would rule out using the APCD. Shane Mofford noted that completeness is only a problem if there is significant variation in reporting, which is hard to know at this time. One principle could focus on maximizing the stability of the primary care definition over time so that there is a single data solution in the future to reduce instability in reported statistics. Committee member Michele Causley asked for further clarification between the two data sources. It's unknown how differently payers might interpret measurement methodologies. Committee member Mandy Stahre pointed out that it's easier for one person to apply methodologies across available data rather than multiple entities handing off results. It's easier to put parameters on the data when there's only one data processor. Committee member Sharon Eloranta explained that the Washington Health Alliance notes when data comes in from a certain payer and there's an expected ballpark for how many claims will be received. Committee member Nancy Connolly asked whether there are models that rely more on providers than payers to submit claims. This doesn't exist for claims-based expenditures currently due to administrative burden. Dr. Zerzan-Thul noted that payers only pay a portion of provider submitted claims. It would be difficult to distinguish the different amounts received by providers from different payers depending upon payment arrangements. Nancy Connolly noted that payments to providers get diluted when transmitted to payers. Shane Mofford noted that a disconnect between services rendered and final payment connects to the principle of data completeness. Committee member Katina Rue also endorsed looking more closely at data from a provider perspective to account for services that might be underpaid. Shane Mofford suggested that the committee could look at this more closely when the committee discusses policy principles, e.g., how to pay more for primary care and consider alternative payment methodologies.

The second high-level category in the data collection gap analysis was the use of a standardized reporting format. The current legislative statute requires stratification of payments by payment type. Reporting by payment type is also an accountability mechanism that allows for tracking progress on offering sustainable/accountable payment models to providers. The state will need to develop allocation methodologies to estimate the portion of bundled/capitated/non-claims-based reimbursements that should be classified as primary care expenditures.



Committee members were polled on their support for using a Health Care Payment Learning Action Network (HCP-LAN) based categorization strategy. This framework, used nationally, has four major categories starting from FFS and progressing up to capitated models to stratify risk (e.g., per unit of service versus guaranteed payment). The majority of those present (11 committee members) voted in favor of the HCP LAN framework. Sharon Eloranta abstained due to lack of understanding of the framework. HCA currently uses HCP LAN for collecting non-claims-based data from contractors.

Committee members were polled on what principles the state should adhere to when refining the data reporting framework. Responses will be taken back to HCA staff to consider and vet for further refinement. Committee member Jon Staloff asked for clarification on what was meant by the reporting framework. Shane Mofford clarified that the data call has a specific way to gather information from payers. Whatever principles the committee chooses may be used to update the current collection process, e.g., risk stratification categories, notation of primary care payment types, etc. David DiGiuseppe asked if the reporting came from carriers to HCA or from HCA to the Legislature. Shane Mofford clarified that this is how payers report to HCA. David DiGiuseppe asked whether there would be detailed criteria for payers to use when reporting. Some of the principles selected included: transparency, alignment with industry standards, when possible, the ability to track data over time, including demographic information (as able) to track primary care investment with an equity lens, and ease of access.

Code review finalization

Dr. Judy Zerzan-Thul, HCA

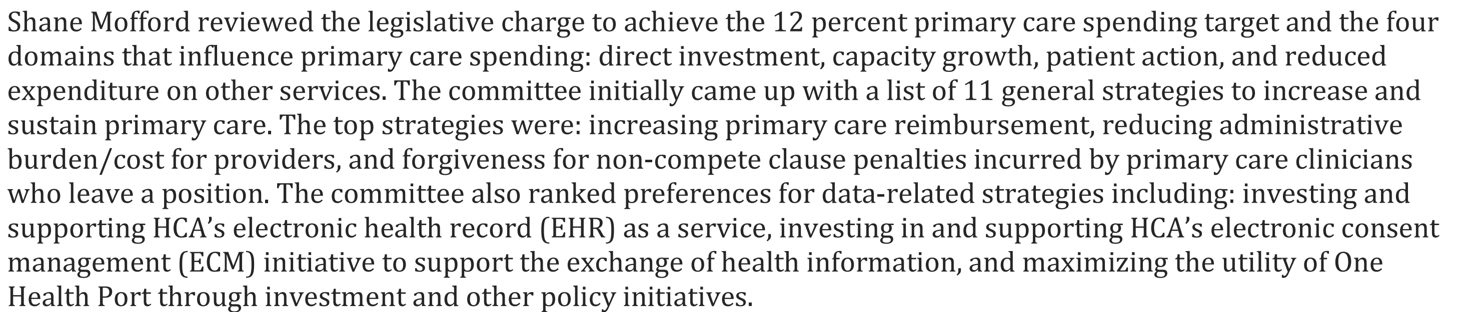
The committee previously approved intrauterine device (IUD) placement codes. Dr. Zerzan-Thul called for a motion to approve adding code 58301(removal of IUDs). The motion was seconded and passed with a majority of votes.

HCA is currently performing a utilization analysis of codes selected and voted on by the committee. These codes have been stratified by location and utilization. Highlighted codes will fall into two categories: codes that were included but had low utilization, and codes that were excluded by the committee, but utilization is very high or the utilization by primary care providers is a large percent of the overall utilization of the codes. The committee will also review the provider location to see how much it impacts the combination of who, what, and where and if the field is reliably populated.

David DiGiuseppe suggested differentiating between the different percentage thresholds used by Washington and other states when analyzing the data. Nancy Connolly asked whether location is purely physical or accounts for team-based delivery of services. Dr. Zerzan-Thul clarified that it won't be possible to identify a team-based component, so location is limited to physical address. Sharon Eloranta noted that location makes a great deal of difference. One of the issues with price transparency is that the biller of services will bill from the address inside an office building instead of the place of service code. This is a big issue with the current trend towards the consolidation of health systems. This is a data collection barrier. Sharon Eloranta will check with the Alliance to follow up on this issue to see what reasonability checks currently exist. Jonathan Staloff asked whether the combined methods of who, what, and where came from the University of Washington (UW) lab. The combined method does come from UW and there will be more details provided on the methodology when the analysis results come back to the group for review.

Preparation for next meeting – policy recommendation framework

Shane Mofford, CEbP



Shane Mofford reviewed the legislative charge to achieve the 12 percent primary care spending target and the four domains that influence primary care spending: direct investment, capacity growth, patient action, and reduced expenditure on other services. The committee initially came up with a list of 11 general strategies to increase and sustain primary care. The top strategies were: increasing primary care reimbursement, reducing administrative burden/cost for providers, and forgiveness for non-compete clause penalties incurred by primary care clinicians who leave a position. The committee also ranked preferences for data-related strategies including: investing and supporting HCA's electronic health record (EHR) as a service, investing in and supporting HCA's electronic consent management (ECM) initiative to support the exchange of health information, and maximizing the utility of One Health Port through investment and other policy initiatives.

At the next meeting, the committee will revisit the lists of policies and will: refine the lists, provide a greater level of detail on individual policies, discuss high-level strategies for each recommendation, and discuss accountability and incentives for the different actors to execute the policy recommendations. Committee member Maddy Wiley asked what other states and regions have done to implement primary care policies. There will be additional context provided around other states' policies and how they align with the policies this committee is interested in. Jon Staloff asked that any materials related to the making care primary initiative be included for review before the next committee meeting.

Adjournment

The meeting adjourned at 4:00 p.m.

Next meeting

July 25, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Tab 3

Public comment

Tab 4

HCCTB Advisory Committee on Primary Care Meeting

July 25, 2023

2:00-4:00 PM

Washington State Health Care Authority

Process Overview and Refresher

Meeting Goals

- Review and refine draft policy recommendations to support achievement of the primary care expenditure target

Washington State Health Care Authority

Primary Care Definition

“Team-based care led by an accountable primary care clinician that serves as a person’s source of primary contact with the larger healthcare system. Primary care includes a comprehensive array of equitable, evidence-informed services to support patients in working toward their goals of physical, mental, and social health and the general wellbeing of each person, through illness prevention, and minimizing disease burden, through a continuous relationship over time. This array of services is coordinated by the accountable primary care clinician but may exist in multiple care settings or be delivered in a variety of modes.”

HCCTB Advisory Committee on Primary Care Charges

- Primary Care Definition
  - Recommend a definition of primary care
  - Recommend measurement methodologies to assess claims-based spending
  - Recommend measurement methodologies to assess non-claims-based spending
- Data Focused to support primary care
  - Report on barriers to access and use of primary care data and how to overcome them
  - Report annual progress needed for primary care expenditures to reach 12 percent of total health care expenditures
  - Track accountability for annual primary care expenditure targets
- Policies to Increase and Sustain Primary Care
  - Recommend methods to incentivize achievement of the 12 percent target
  - Recommend specific practices and methods of reimbursement to achieve and sustain primary care expenditure targets

Policy Refinement

- Committee developed a list of ideas to get the conversation started
- Need to refine draft list of policies and the specifics of each policy
  - Greater specificity to ensure policy is actionable
  - Ensure recommendations are realistic/feasible
  - Prioritize actions based on ability to drive progress towards 12% target

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Policy Recommendation Principles

Policy Recommendation Principles

Policy recommendations should adhere to the following principles:

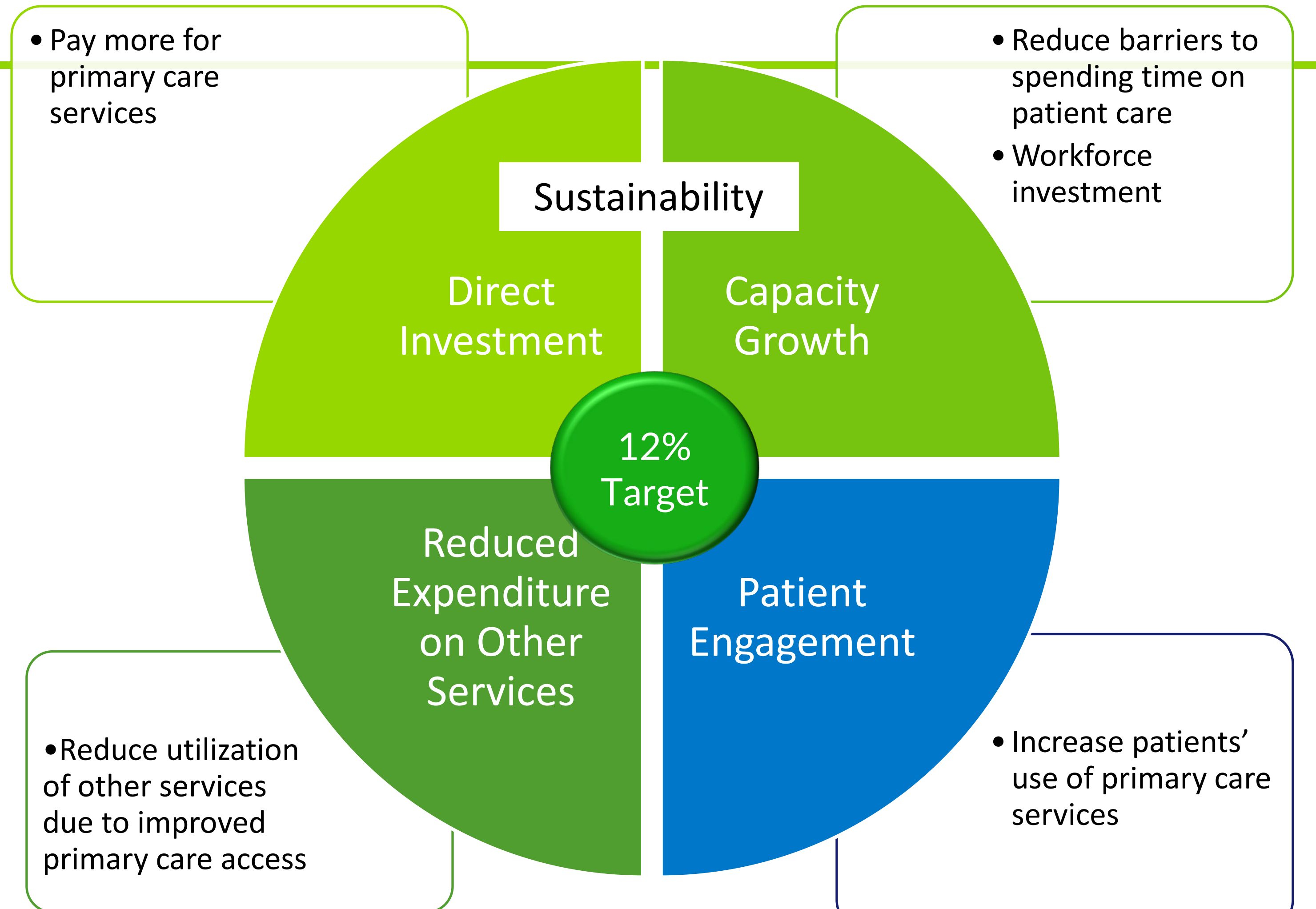
- Unambiguous linkage between policy and achieving 12% primary care expenditure target
- Clearly defined action and actors
- Policies are feasible:
  - Financially
  - Operationally
  - Across competing stakeholder interests
- Policies result in improved access and quality, not just expenditure

Discussion: How would you refine this list?

Strategies for Refinement

Policies to Increase & Sustain Primary Care – 12% in Context

- Four key domains that influence the primary care expenditure statistics:
  - Direct investment
  - Capacity Growth
  - Patient Engagement
  - Reduced Expenditure on Other Services



General Strategies to Increase & Sustain Primary Care

Options with some committee support, ordered by preference

1) Direct Investment - Increase primary care reimbursement. (13/14)
2) Capacity Growth - Payer focus on reducing administrative burden/costs for providers. (11/13)
3) Forgiveness for non-compete clause penalties incurred by primary care clinicians who leave a position to work elsewhere in WA. (9/14)
4) Patient Engagement - Encourage employers to support/incentivize/encourage patients in PCP selection. (9 net/14)
5) Capacity Growth - State funded expansion of loan forgiveness opportunity. (9/14)
6) Capacity Growth - Work with education system to bolster pipeline of healthcare professionals. (8/14)
7) Increasing Medicaid reimbursement for primary care services. (8/14)
8) Capacity Growth – Multi-payer collaboration to implement payment models that offer greater financial flexibility and incentives, while expanding access and improving quality. (7 net/14)
9) Provide options for practice teams to have a fully capitated system. (4 net/14)
10) Increase FFS for remote patient monitoring services, chronic care management. (3 net/14)
11) Increase FFS reimbursement for care team members such as clinical pharmacists, care coordinators /community health workers, registered nurses, etc. (1 net/14)

Note: Numbers (e.g., 13/14) indicate initial polling preferences, not formal votes for adoption of policies. "Net" indicates the policy received downvotes included in the total.

Strategies to Increase Primary Care Expenditure - Grouped

Multi-payer Alignments Efforts

- Administrative burden reduction
- Payment approach alignment

Provider Payment Level

- Increasing Medicaid payment
- Encourage overall increase in PC payment across public and private payers

Workforce

- Changes to noncompete
- Student loan forgiveness
- Pipeline/education system

Patient Engagement

- Selecting primary care provider

Overview: Strategy Refinement

- Further define the prioritized policies
- HCA will do an impact review and provide staff proposal
- Proposals will come back over the course of upcoming meetings for reviewing before voting

Washington State Health Care Authority

Provider Payment Level

Strategies to Increase Primary Care Expenditure

Provider Payment Level

- Increasing Medicaid payment
- Encourage overall increase in PC payment across public and private payers

Payment Level

Initial policy statements:

- Direct Investment - Increase primary care reimbursement. (13/14)
- Increasing Medicaid reimbursement for primary care services. (8/14)

Connection to 12% primary care expenditure target:

- Increasing reimbursement levels will have a direct and indirect impact in primary care expenditures by bolstering expenditures and financially supporting growth in primary care capacity.

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Payment Level - Context

Medicaid

- Requires legislative authorization of funding to support increases
- Requires approval by CMS
- Requires contractual changes with MCOs
- KFF reports 2019 Washington Medicaid reimbursement for primary care services at ~63% of Medicare.

Examples of public policy that incentivize increased payment rates for primary care

- **Rhode Island:** Required commercial insurers to approximately double primary care as a percentage of total spending over five years without causing overall spending to increase. Insurers were successful and subsequently required to maintain the level of primary care spending. (Office of the Health Insurance Commissioner)
- **Pennsylvania and Connecticut:** Set five-year voluntary annual targets to increase primary care spending (legislative action and executive order respectively)
- **Oregon:** Required health insurance carriers and CCOs to allocate at least 12% of their health care expenditures to primary care (SB934 2017)

Payment Level

Committee draft for refinement of policy statements:

- The Legislature should fund increased reimbursement for primary care practices/services covered by the Medicaid program with a goal of achieving a reimbursement level of no less than 100% of Medicare by 2027.
- The Legislature should pass legislation mandating commercial and public payers to allocate at least 12% of expenditures to primary care by 2029 with interim goals informed by committee analysis in 2024 based on primary care expenditure measurement efforts. (Oregon model)

Discussion:

How would you refine the draft proposal(s)?

Policy recommendations should adhere to the following principles:

- Unambiguous linkage between policy and achieving 12% primary care expenditure target
- Clearly defined action and actors
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- Policies result in improved access and quality, not just expenditure

Multi-Payer Alignment Efforts

Strategies to Increase Primary Care Expenditure

Multi-Payer Alignments Efforts

- Administrative burden reduction
- Payment approach alignment

Washington State Health Care Authority

Multi-payer Alignment

Initial policy statements:

- Multi-payer collaboration to develop and implement payment models that offer greater financial flexibility and incentives while growing access and improving quality. (7 net/14)
- Payer focus on reducing administrative burden/costs for providers. (11/13)

Connection to 12% primary care expenditure target:

- Multi-payer alignment combats system fragmentation that consumes practice resources without value add.
  - By reducing administrative burden, practices can spend less time on administration and more time on patient care, which will support increasing primary care access/utilization which will increase expenditures on primary care.
- Multi-payer alignment that drives increased access to different payment models supports sustainability and access but can also drive increased reimbursement through alternative payment methodologies and non-claims-based payments.

Multi-Payer Alignment - Context

- Existing Washington Multi-Payer Efforts
  - Washington's Multi-Payer Collaborative (MPC) has developed the Primary Care Transformation Model (PCTM) focused on aligning standards, quality measures, practice supports, and payment models for primary care practices
  - The MPC will initiate a provider Learning Cohort later this year to identify collaborative opportunities to support practices work
- CMS Making Care Primary Program (MCP)
  - Making Care Primary (MCP), is intended to be an aligned multi-payer approach and includes additional federal investment in primary care practices over a 10.5-year period.
- Alignment of WA and CMS Models
  - The MPC is working to align the PCTM and the new federal opportunity.
  - Unique opportunity to support practices in achieving critical mass for practice transformation.

Multi-payer Alignment

Committee draft for refinement of policy statements:

- Committee statement of support for MPC work in aligning standards, quality metrics, practice supports, and payment models
- Committee statement of support for MPC alignment with the Making Care Primary program
- Encourage the Legislature to identify opportunities to support and further Multi-payer primary care alignment efforts.

Discussion:

How would you refine the draft proposal(s)?

Policy recommendations should adhere to the following principles:

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- Policies are feasible
  - Financially
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Washington State Health Care Authority

Patient Engagement

Strategies to Increase Primary Care Expenditure

Patient Engagement

- Selecting primary care provider

Washington State Health Care Authority

Patient Engagement

Initial policy statements:

- Encourage employers to support/incentivize/encourage patients in selecting a PCP. (9 net/14)

Connection to 12% primary care expenditure target:

- A relationship with primary care can result in patients seeking care through their primary care physician instead of through more expensive alternative settings, which increases primary care expenditure and reduces expenditure in other services categories.
- A relationship with primary care increases the primary care provider's ability to effectively manage a patient's care, which can improve patient outcomes and reduce expenditures for more expensive settings such as inpatient hospitals, which subsequently increases the percent of expenditure attributed to primary care.

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Patient Engagement - Context

- Patient engagement goes beyond establishing a relationship with primary care. The relationship should be productive (member engaged and receiving key preventive care).
  - The Accountable Care Act prohibits cost sharing for US Preventive Services Taskforce A&B recommendations.
  - Litigation to be heard before the Supreme Court could remove this prohibition, potentially creating an opportunity for state action.
- Different actors have different levers for encouraging the public to engage primary care.
  - Employers can educate and incentivize employees to engage primary care and get preventive care
  - Carriers can educate and incentivize plan enrollees
  - Public health agencies can educate the public on the value of primary care
- Viable strategies in Washington will need to illustrate the benefits without impacting freedom of choice.

Patient Engagement

Committee draft for refinement of policy statements:

- Committee statement of support for payer (carriers) and purchaser (employers) education and incentives to promote creating a relationship with primary care and accessing preventive services (E.g., health fairs, employee wellness initiatives, educational resources, and employee incentives)
- Committee statement of support for public health agencies to include primary care engagement in public education efforts

Discussion:

How would you refine the draft proposal(s)?

Policy recommendations should adhere to the following principles:

- Unambiguous linkage between policy and achieving 12% primary care expenditure target
- Clearly defined action and actors
- Policies are feasible
  - Financially
  - Operationally
  - Across competing stakeholder interests
- Policies result in improved access and quality, not just expenditure

Washington State Health Care Authority

Workforce

Strategies to Increase Primary Care Expenditure

Workforce

- Changes to noncompete
- Student loan forgiveness
- Pipeline/education system

Workforce

Initial policy statement:

- Forgiveness for non-compete clause penalties incurred by primary care clinicians who leave a position to work elsewhere in Washington State. (9/14)

Connection to 12% primary care expenditure target:

- Ensuring that physicians changing employment can remain in the state supports higher levels of access to care which impacts utilization rates and ultimately expenditures.
- Investing in the clinician workforce pipeline through activities such as loan forgiveness programs increases the number of physicians providing care, which increase access, utilization, and ultimately expenditures.

Workforce - Context

Non-Compete

- **Washington current status**: RCW 49.62.020 and .030 prohibit non-compete agreements for employees making less than $100,000 (subject to inflationary adjustment) annually, independent contractors making $250,000 (subject to inflationary adjustment) or less annually, and agreements in excess of 18 months.
- **California**: Prohibits non-compete agreements. (State code Section 16600)
- **Rhode Island**: Prohibits restrictive covenants on physicians (Sec. 5-37-33)
- **Connecticut**: Allows non-compete for physicians if limited to one year and a geographic region of more than 15 miles from the primary practice site. (Sec. 20-14p.)
- **Federal**: In January 2023, the U.S. Federal Trade Commission proposed a rule to ban employers from imposing non-compete clauses on their workers. The preamble to the proposed rule says that there is evidence that non-compete clauses increase prices and market concentration in the health care sector.

Workforce

- **Committee draft for refinement of policy statements:**
- The Legislature should pass legislation that expands the current noncompete prohibitions to include primary care providers that continue to practice medicine in Washington.

Discussion:

How would you refine the draft proposal(s)?

Policy recommendations should adhere to the following principles:

- Unambiguous linkage between policy and achieving 12% primary care expenditure target
- Clearly defined action and actors
- Policies are feasible
  - Financially
  - Operationally
  - Across competing stakeholder interests
- Policies result in improved access and quality, not just expenditure

Workforce Context – Student Loan Forgiveness

- **Washington current status**: Washington Health Corps State Health Program forgives up to $75,000 for clinicians providing comprehensive primary care, including dental and behavioral health services. (Statute RCW 28B.115.130)
- **Oregon**: Primary Care Loan Forgiveness Program provides up to $35,000 per year for primary care providers working in a rural area of Oregon with a health professional shortage. (Statute: ORS 676.454. Rules: OAR 409-036-0020). Estimated to be $4 million annually.
- **Pennsylvania**: Primary Care Loan Repayment Program: Up to $80,000 per year for full-time physicians, dentists, and psychologists; up to $48,000 for other practitioners who work in an approved site in an underserved area.
- **Arizona**: Rural primary care provider loan repayment program for primary care providers in a shortage area. The higher the Health Professional Shortage Area score, the more money is paid back, up to $65,000 per year (Statute: ARS 36-2172). There is a separate program for providers with a rural private primary care practice in a shortage area (ARS 36-2174)

Workforce Context – Washington Pipeline Initiatives

- **Washington current status**:
  - ARNP residency programs through a range of partners. Health professional recruitment and retention clearinghouse (RCW 70.185.020).
  - Teaching health centers
  - The University of Washington operates the WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho) rural primary care program for clinical placements in rural areas that will attract medical students to practice over a longer term in rural settings.
  - Medical assistants may participate in apprenticeships in selected settings.
  - Health systems are increasingly sponsoring community-based physician residencies. Some examples include Providence health system, Kaiser Permanente. Residents often stay within the system and the clinics where they train.

Workforce Context – Pipeline Initiatives in Other States

- **Oregon**: Health Care Provider Incentive Program created in statute (ORS 676.454). Types of incentives to be offered per state rules (OAR 409-036-0020) include scholarships for students in health professional training programs, Community Workforce Assistance Grants to support recruitment and retention of providers, and medical malpractice insurance premium subsidies.
- **Colorado**: Used American Rescue Plan funds for home- and community-based services (HCBS) to establish a $9.5 million training fund to help direct care workers gain skills to advance within the HCBS workforce. Support advancement opportunities for the HCBS workforce.

Next Steps

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- HCA and other state agencies to review policy proposals to provide feedback on feasibility and process
- We will prioritize policy proposals, to the extent possible, allowing the staff team to begin developing an implementation plan
- We plan to review primary care data to support finalizing the definition
- We will discuss the data collection process and any policy options identified by HCA given the general principles identified by the workgroup in June.

Wrap-up and Adjournment

Thank you for attending the Advisory Committee on Primary Care meeting!