Washington State Health Care Authority

Advisory Committee on Primary Care Meeting Summary

August 31, 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

Kristal Albrecht
Sharon Brown
Tony Butruille
Michele Causley
Tracy Corgiat
D.C. Dugdale
Sharon Eloranta
Meg Jones
Katina Rue
Jonathan Staloff
Linda Van Hoff
Shawn West
Maddy Wiley

Members absent

Judy Zerzan-Thul
Nancy Connolly
David DiGiuseppe
Gregory Marchand
Chandra Hicks
Sheryl Morelli
Lan H. Nguyen
Mandy Stahre
Kevin Phelan
Eileen Ravella
Sarah Stokes
Staici West
Ginny Weir

Call to order

Co-chair Jonathan Staloff called the meeting to order at 2:02 p.m.

Welcome, roll call, and agenda review

Committee member and co-chair, Jonathan Staloff, reviewed the meeting's agenda and led roll call.

Approval of July meeting summary

The committee voted to adopt the Meeting Summary from the July 2023 meeting.

Topics for Today

The main topics were a presentation on primary care payment reform strategies, a presentation on and discussion of primary care policy context, and a presentation on United Healthcare's experience with the primary care target in Rhode Island.

Public Comment

There were no public comments.

Presentation: Primary care payment reform strategies

Summer Boslaugh, Transformation Analyst, Oregon Health Authority (OHA)

Summer Boslaugh presented Oregon's primary care payment reform policies, its value-based payment (VBP) compact, primary care VBP model, and lessons learned. In 2015, Oregon passed Senate Bill 231 which required OHA and the Department of Consumer and Business Services to report annually on health care expenditures allocated to primary care by Medicaid, public employee benefit plans, and commercial health plans. OHA also added Medicare Advantage (MA) to the collected data. The annual report is public and used as a tool for policymakers and other interested parties to track primary care spending by payer. The bill directed OHA to establish the Primary Care Payment Reform Collaborative, which is a multi-stakeholder advisory group charged with increasing investment in primary care, improving payment methods, and aligning payment across payers and purchasers. The Collaborative has over 30 members and has convened since 2016.

In 2017, the Oregon Legislature passed another bill, Senate Bill 934 to further specify previous requirements. The bill required all payers to allocate at least 12 percent of health care expenditures to primary care by 2023. Payers failing to meet the target must submit a plan on how they will increase primary care expenditures by at least one percent each year. The 12 percent target was based on national research indicating that current primary care expenditure allocation is around seven percent. Senate Bill 934 also further defined the charge to include the use of VBP methods, to support behavioral and physical health integration and metric alignment. The end date of the Collaborative was extended to 2027.

Oregon's VBP Compact began in 2021 and grew out of Oregon's focus on the creation of a sustainable cost growth target. The Compact represented a voluntary commitment by payers and providers across the state to increase VBP through specific targets across all settings of care. There are 47 signatories in the Compact including commercial, all Medicaid payers, health systems and clinics, and MA, representing 73 percent of Oregonians in state. The Compact includes provider organizations like Oregon Family Physicians, the Oregon Hospital Association, the Oregon Medical Association, and the Oregon Primary Care Association. The purpose of the Compact was to lower the rate of cost growth, foster health equity, and improve quality and outcomes.
There were several lessons learned from Oregon's primary care reform process. It was important to establish an active relationship between the Collaborative and the primary care spending report. Both the Collaborative and the report arose from the same legislation and the report is presented to the Collaborative, but the Collaborative

doesn’t own the report. Going forward, it would be helpful to have this relationship more well-defined. The rule defining primary care for the report wasn’t developed directly by the Collaborative.

Committee members expressed interest in hearing more details about the VBP model. Summer Boslaugh provided a high-level overview of the model. The primary care VBP model is a prospective capitated payment model that also includes fee-for-service (FFS) payments for all other covered services. There are infrastructure payments including a required base payment tied to the patient center primary care home (PCPCH) tier with additional tiers for specific high-value services. The prospective payments cover about 85 to 95 percent of primary care services with variation by payer and age group. Some codes paid on an FFS basis were preserved to include utilization: behavioral health codes, home visits, prenatal visits, after hour codes, and others.

Summer Boslaugh reviewed the participation, attribution, and payment rates of the model, as well as risk adjustment, performance-based incentives, infrastructure payments, and the model’s focus on equity. Currently, Oregon is seeking to promote the VBP model with multiple audiences. OHA is reviewing its role as a purchaser to incorporate the model in its contracts with Coordinated Care Organizations (CCOs), Medicaid organizations, and public employee benefit and Oregon educator benefit board plans.

Shane Mofford asked whether there were other unintended consequences that Oregon would want to account for if they were repeating the process of creating the target. Oregon’s primary care definition is partially defined by statute and partially defined in rule. There needs to be support and consensus across all aspects of how primary care is defined because those aspects feed into the target. Oregon’s methodology shifts year to year to account for code changes. It’s difficult to change the statutory definition – it hasn’t been changed since the bill was passed in 2015 despite feedback asking for change from advocates.

Committee member questions and answers:

What statutory or regulatory authorities does Oregon have in place to hold payers accountable for the investment piece? What consequences arise from failing to meet a target? For Medicaid CCOs and public employee or educator plans, OHA has greater authority to modify contracts based on performance. Commercial plans must submit a plan on how to improve if they fail to meet the target, but OHA lacks an accountability mechanism to enforce compliance. Currently, any proposed improvement plans are folded into the annual primary care spending report, but future accountability mechanisms haven’t been determined.

Did OHA feel the primary care definition was too broad or too narrow, and which groups caused the most difficulty in the selection process? One of the key sticking points was provider type – Oregon included obstetricians and gynecologists (OBGYNs) and psychiatry – but there was a strong perception from the provider community that those two types didn’t belong. Behavioral health providers felt clinical social workers should be included when they were excluded. There was also negative feedback for excluding pharmacy from the definition.

Are there any requirements that recipients of the primary care funds use them exclusively for primary care services or providers, or is that left to the discretion of the organization? Fund use is left to the discretion of the recipients. Spending could occur on the system level but that doesn’t mean that individual clinician rates were increased.
How were analytics used to assess the primary care data resourced? Resourcing took a lot more time and funding than originally anticipated to hire senior analytics staff. The all-payer all claims database captures both claims and non-claims spending through the same system but it’s time intensive to stratify the data. Every year, there’s one

analyst who spends six months working solely on processing the data. There are no external contractors, only state of Oregon staff. Oregon has no statewide provider directory, which makes identifying individual providers difficult.

What outcomes, patient and fiscal, occurred from implementation of the primary care spending target? There was no impact on rates due to target implementation. For patient outcomes, there is no direct way to assess the relationship between achieving the spending target and improved quality outcomes. When looked at collectively on average, CCOs and Medicaid plans meet the target, but at the individual level, there are plans that deviate sharply from the target.

What consideration has been given to workforce components of primary care investment? Oregon recently passed several bills increasing workforce investment, e.g., loan repayment assistance to certain provider groups to increase provider retention. There hasn't been a direct effort to address workforce related to the primary care spending target or the VBP model.

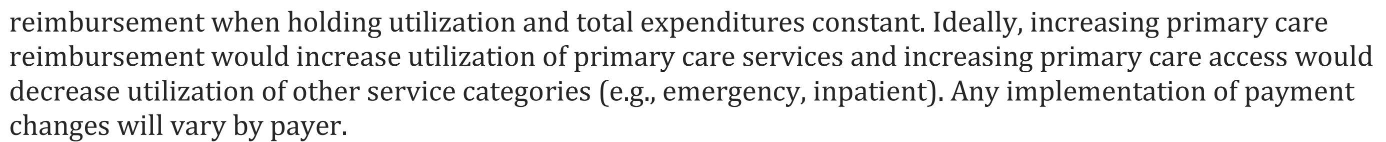
Presentation and discussion: Primary care policy context continued

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

Shane Mofford reviewed the committees' introductory conversations related to how to achieve the 12 percent spending target. More information is needed to frame the reasonability of targets over time and statewide spending estimates using the new primary care definition, which won't be available until after the 2024 data call. The committee is continuing to review outcomes in other states that have implemented similar primary care spending policies. In general, other states have used three levers to achieve spending targets, including executive orders, legislative mandates, and actions taken by insurance commissioners.

Shane Mofford presented three concepts to provide further context for primary care policies, using thought exercises rather than real data. The first concept was how an increase in the percent spent on primary care as a percent of total expenditures affects changes in primary care reimbursement. Holding total expenditures and primary care utilization constant, increasing primary care spending from five to 12 percent would require a 140 percent increase in primary care reimbursement. This example represents an aggregate-level perspective across all payers. Each payer would contribute to the total differently depending on their current payment policies and utilization patterns. Oregon's increase went from seven to 12 percent, representing a 72 percent increase, which translates to around a 14 percent annual increase over a five-year period. The second concept used to frame the primary care target was how the payer mix determines the size of the impact of policies when targeting individual payers. Policies focused on individual payer types will have proportionally smaller impacts on aggregate spending totals. Most policies apply differently to different payer types depending on current payment levels. As an example, if Medicaid reimburses at 65 percent of Medicare, and increases reimbursement to 100 percent of Medicare, because Medicaid is estimated at 31 percent of total primary spending, the 54 percent increase in reimbursement would result in only a relative 17 percent increase in total primary care reimbursement in aggregate (from 5 to 5.8 percent). The third framing concept was how price and utilization patterns vary for different primary care services. Expenditure trends differ by different categories, e.g., inpatient, outpatient, pharmacy, and physician services. The 12 percent spending target occurs in a dynamic environment, making it difficult to achieve the target when other spending areas change significantly, e.g., hospital costs.

To illustrate the general magnitude of reimbursement increases, there are three factors that must be considered: 1) underlying utilization patterns over time for both primary care and other services, 2) the underlying rate of price changes for other services, and 3) policy-driven expected changes to utilization of primary care and other services. Small increases in the percent of total spending require significant increases in primary care



reimbursement when holding utilization and total expenditures constant. Ideally, increasing primary care reimbursement would increase utilization of primary care services and increasing primary care access would decrease utilization of other service categories (e.g., emergency, inpatient). Any implementation of payment changes will vary by payer.

The committee reviewed future considerations for choosing a broad versus narrow primary care definition. To achieve the 12 percent target under a narrower definition, investments would be focused on the narrower set of providers. The magnitude of investment directed to a narrower set of providers would have to be greater to move the aggregate statistics. If the committee uses a narrow definition, the distance to the target will be greater. Results will change with the updated primary care definition and with the inclusion of non-claims-based expenditures. The chosen definition will directly impact investment strategies i.e., whether increases occur under a blanket FFS scheme or under an alternative payment model (APM). It's unknown the extent to which the chosen definition will differ from prior measurement efforts.

The committee was reminded about the Making Care Primary (MCP) model. The model supports VBP and equitable access through additional investments in primary care and focuses on improving care management, coordination, and integration. It will run for a 10.5-year period with the same cohort of providers maintained for the duration of the program. Applications are being accepted from September 4 through November 30 with a one-time onboarding to the program.

Presentation: United Healthcare plan perspective on primary care target in Rhode Island

Michele Causley, Vice President of Health Plan Operations, United Healthcare

Committee member Michele Causley gave an overview of United Healthcare's efforts to achieve the primary care target in Rhode Island. Rhode Island increased their primary care spend from around six percent to 10.7 percent. At least 9.7 percent of the target goes towards direct reimbursement to providers. The remaining one percent goes towards administrative fees. Most achievement of the target occurred through shared savings and care coordination payments embedded in VBP models. Practices were offered grants to meet the target. Rhode Island's target includes pharmacy net of rebates. Including pharmacy in the denominator can lead to significant fluctuation in primary care investment, making it more difficult for payers to meet the target. Rhode Island also controls hospital cost trends through caps. There was no definitive decline seen in total cost of care because of the primary care spending target, but there were increases in the use of VBP models and an increase in downside-risk models. Without direct offsets for other spending categories, it's hard to bring down the total cost of care. VBP models as a whole focus more on mitigating cost trends rather than lowering costs.

Adjournment

The meeting adjourned at 4:00 p.m.

Next meeting

September 28, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.