Washington State Health Care Authority

Health Care Cost Transparency Board's

Advisory Committee on Primary Care meeting summary

January 23, 2024

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

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

Members present

Judy Zerzan-Thul, Chair
Sharon Brown
Tony Butruille
Michele Causley
Tracy Corgiat
D.C. Dugdale
Sharon Eloranta
Chandra Hicks
Meg Jones
Gregory Marchand
Sheryl Morelli
Lan Nguyen
Katina Rue
Mandy Stahre
Jonathan Staloff
Shawn West
Staici West
Ginny Weir
Maddy Wiley

Members absent

Kristal Albrecht
David DiGiuseppe
Sarah Stokes
Linda Van Hoff

Call to order

Dr. Judy Zerzan-Thul, Committee Chair, called the meeting to order at 2:03 p.m.

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Agenda items

Welcoming remarks

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

Meeting summary review from the previous meeting

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

Public comment

Mandy Weeks-Green, committee facilitator, called for comments from the public. There were no public comments.

Updates on Making Care Primary

Kahlie Dufresne, Special Assistant for Health Policy and Programs, Health Care Authority

The Center for Medicare and Medicaid Innovation (CMMI), a division of the Center for Medicare and Medicaid Services (CMS), accepted applications for the new **Making Care Primary** Model through the middle of December 2023. The demonstration model seeks to drive the capacity and use of primary care through a progressive payment model. Medicare fee-for-service is utilizing this new model, and additionally, Washington received 44 applications representing 437 unique sites. Applicants are spread throughout both urban and rural areas, roughly half of which are Federally Qualified Health Centers (FQHCs), and include several multi-specialty systems. The ten-and-a-half-year timeline includes a key upcoming milestone in April 2024 when providers sign participation agreements following discussions with CMS.

Strategies to Increase and Sustain Primary Care

Chair Dr. Judy Zerzan-Thul, Chief Medical Officer, Health Care Authority

Building on prior work, the Committee will review a number of policy options that seek to increase and sustain the use of primary care, incentivizing the movement toward a minimum 12% of health care spending being used for primary care. Policy recommendations from the Committee should adhere to four principles: Unambiguous linkage between the policy and achieving the 12% goal, clearly defined action and actors, financially, operationally, and politically feasible, and must result in improved access and quality, not just expenditure. Specific policy recommendations that will be under review include:

1. Legislation mandating commercial and private providers increase primary care expenditure by 1% annually
2. Increase Medicaid reimbursement for primary care to Medicare levels
3. Multi-payer alignment
4. Focused efforts to promote primary care and preventative services
5. Workforce development
6. Work with the Cost Board to recommend levels of primary care expenditure ties to alternate payment models
7. Shift measurement of 12% primary care expenditure from aggregate to per capita

Discussion among the members touched upon the absence of recommendations regarding consolidation, that Making Care Primary does not account for pediatric care and worry regarding the speed of implementation. The definition of “preventative services” was requested to be discussed in more detail at a later meeting.

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Workforce Development and the Primary Care Spending Benchmark

Bianca K. Frogner, PhD, Professor of Family Medicine and Director of the Center for Health Workforce Studies (CHWS) at the University of Washington

Disclosure: Dr. Frogner is a member of the Cost Board but spoke as a subject matter expert on research performed at the **CHWS**. The presentation focused on studies investigating potential policies to retain a healthy, engaged health workforce at both the state and federal levels. It is important to keep in mind that containing health care spending can run counter to wage growth and the growth of the health care labor force, both of which are key aspects to maintaining workforce continuity. Higher wages help retain staff and adequate staffing levels prevent burnout, so choosing which levers to utilize when controlling costs is never simple. Of note, while the average proportion of the workforce engaged in ambulatory care is between 35-45% in the US, in Washington the figure is roughly 53%. According to licensure data, Washington has fewer physicians per capita than the national average, 228 versus 248 per 100,000, leading also to having fewer primary care physicians. The same dataset reveals that only 17.4% of registered nurses (RNs) are employed in ambulatory care of community health settings. The Medical Assistant (MA) workforce was assessed, noting that converting registered MAs to fully licensed MAs could boost the primary care workforce in Washington. In general, wages for the health workforce in Washington are higher than the national average.

Solving the challenge of meeting workforce demand requires a combination of increasing productivity, improving retention, engaging and expanding existing workers to new roles and responsibilities, and overcoming community and societal barriers. The COVID pandemic prompted more rapid rates of staff turnover across medical settings, especially among women with children. As such, support for the labor force would increase retention, including such efforts as carpool reimbursement, improved training, and better funding for childcare. Specifically studying the primary care workforce is a challenge, as specific data collection can be lacking, but the work of the Committee can support effective solutions to all these challenges.

Comments and discussions from members touched upon dealing with low-quality procedures and work that does not improve patient health. Opportunities for patient self-care could be a valuable contribution, as would hiring for technical support roles as telehealth options expand. Shifting services from medical doctors (MDs) to advanced registered nurse practitioners (ARNPs) would likely lower health care costs, but comparisons to MAs is not possible due to lack of data.

Primary Care Workforce Presentation

Renee Fullerton, Staff to the Health Workforce Council

The Health Workforce Council has been a policy development and advisory group for more than 20 years in Washington, recently focusing on behavioral health, long-term care, and dental workforces. The health care workforce is highly interconnected, with lack of staffing in one setting leading to issues in another. Advocating for improved planning data, research, and evaluation in primary care settings can lay the foundation for a stable, engaged workforce. The number of people completing Certified Medical Assistant (MA-C) training has been declining for the past ten years, which has led to strain in the health care system. While Washington is training more MDs following the opening of a third medical college in the state, the number entering family medicine has been static, prompting an increased number of doctors of osteopathy (DOs) moving to fill the gap. Expanding where and how primary care is being provided could drive its usage. Policies which seek to better understand the demographics of providers could help build a workforce best prepared to care for the populace of Washington. The **2023 Health Workforce Council report** to policymakers supported addressing educational debt, childcare, affordable housing, and transportation. Comments from committee members sought understanding of what lag might be seen between education loan forgiveness and improved workforce retention rates. Generally, the policy is more useful to entice workers toward positions more difficult to fill, such as rural clinics, but evidence of increased retention is less clear.

Adjournment

Meeting adjourned at 3:50 p.m.