Advisory Committee on Primary Care meeting

May 30th, 2024

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

HEALTH CARE COST TRANSPARENCY BOARD'S
Advisory Committee on Primary Care

May 30, 2024
2 – 4 p.m.
Hybrid Meeting

Meeting Agenda

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

Time	Agenda Items	Tab	Lead
2:00 - 2:05 (5 min)	Welcome, roll call, and agenda review	1	Dr. Judy Zerzan-Thul, Committee Chair, Medical Director, Health Care Authority
2:05 - 2:10 (5 min)	Approval of April meeting summary	2	Rachelle Bogue, Health Care Authority
2:10 - 2:15 (5 min)	Public Comment	3	Rachelle Bogue, Health Care Authority
2:15 - 2:30 (15 min)	Presentation: Policy recommendations for increasing the primary care expenditure ratio: ▪ Strategy 1: Increase primary care expenditures by 1 percentage point annually	4	Elena Soyer, Health Care Authority
2:30 – 2:40 (10 mins)	Presentation: Policy recommendations for increasing the primary care expenditure ratio: ▪ Strategy 2: Increased Medicaid reimbursement for primary care	5	Hana Hartman, Health Care Authority
2:40 – 3:05 (25 mins)	Presentation & discussion: Policy recommendation 6: Incentivizing and measuring non-fee-for-service payment	6	Karen Johnson, Vice-President, Practice Advancement American Academy of Family Physicians
3:05 – 3:15 (10 mins)	Presentation: Policy recommendations for increasing the primary care expenditure ratio: ▪ Strategy 6: Tie primary care spending to alternative payment models	7	Hana Hartman, Health Care Authority

3:15 – 3:20 (5 min)	Primary Care Committee wrap up for 2024	8	Dr. Judy Zerzan-Thul, Committee Chair, Medical Director, Health Care Authority
3:20 – 3:30 (10 min)	Next steps for Primary Care Committee	9	Gretchen Morley Center for Evidence-based Policy (CEbP)
3:30 – 3:35 (5 mins)	Wrap-up and adjourn		Dr. Judy Zerzan-Thul, Committee Chair, Medical Director, Health Care Authority
3:35 – 4:00	*Additional time held for runover presentation time and discussion.*		

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board's

Advisory Committee on Primary Care meeting summary

April 24, 2024

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

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

Members present

Judy Zerzan-Thul, Chair
Kristal Albrecht
Sharon Brown
Tony Butruille
David DiGiuseppe
D.C. Dugdale
Chandra Hicks
Gregory Marchand
Sheryl Morelli
Lan Nguyen
Katina Rue
Jonathan Staloff
Shawn West
Staici West
Maddy Wiley

Members absent

Michele Causley
Tracy Corgiat
Sharon Eloranta
Meg Jones
Mandy Stahre
Sarah Stokes
Linda Van Hoff
Ginny Weir

Call to order

Rachelle Bogue, the meeting facilitator, called the meeting of the Advisory Committee on Primary Care (committee) to order at 2:05 p.m.

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Agenda items

Welcoming remarks

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

Meeting summary review from the previous meeting

The Members present **voted to adopt the meeting summaries** for November 2023 without changes, and February 2024 with the correction of $4.5 trillion for 2022 health care spending in the United States under Aligning Primary Care and Public Health.

Public comment

Rachelle Bogue called for comments from the public. There were no public comments.

Policy Recommendations

Chair Dr. Judy Zerzan-Thul announced that of the seven policy recommendations for consideration by the Health Care Cost Transparency Board (Cost Board), two will be presented during the meeting. One concerning patient engagement and one about primary care expenditure targets on a per-member-per-month (PMPM) basis. In May 2024, the committee will be presented three recommendations not previously discussed: increasing primary care expenditures, increasing Medicaid reimbursement to be no less than 100% of Medicare, and measuring and incentivizing primary care expenditures. After the May meeting, committee members will receive packets with all seven policy options for review and email feedback, edits, or considerations. In June 2024, the committee will reexamine all seven policy options and committee members will cast prioritization votes. The goal is to bring the top two or three committee recommendations to the Cost Board in July 2024 to adopt and incorporate into their legislative report. The remaining policy options can be discussed in future committee meetings for consideration.

Policy Recommendation – Patient Engagement Presentation

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

Everyone has a role in patient engagement including seeking preventative care including employers, insurance carriers, providers, and patients. Patient engagement is important because it's a driver of utilization. People need to participate in their care and seek out primary care services which can contribute to the state's 12% primary care expenditure target.

Washington is one of eight states participating in Making Care Primary, a federal model that includes practices requirements to improve patient engagement. Washington also has the Primary Care Transformation Initiative, a multi-payer effort supporting primary care aligned with Making Care Primary, but on a broader basis. Elements of this model are very supportive of patient engagement including providing culturally attuned care and language support. General patient engagement strategies include patient incentives and education through insurance carriers. Another strategy could be provider incentives and support through insurance carriers including offering payment models that support and incentivize, ensuring patients receive preventative care. Patient incentives and education through employers is another strategy incentivizing completed wellness visits or other primary care engagements. Another strategy could be the state taking action to promote patient engagement through regulatory action. For example, in 2023, Oregon passed Senate Bill 1529 (SB 1529) which required carriers assign primary care providers to enrollees if one is not selected within 90 days. The key takeaway is everyone has a role and there are many different strategies that can be effective at bolstering primary care utilization through patient engagement.

There are multiple studies examining the efficacy of different patient engagement methods and promoting strategies. In terms of impact, the evidence base is mixed because there are multiple actors and varied circumstances in which an incentive is offered. Still, there is some evidence that shows incentives provided by

insurers and employers increased utilization both of primary care and screening services. Some studies show this results in healthier lifestyle choices and reduces clinical factors resulting in lower health care costs for actively engaged members. Patient engagement is only one element needed to increase primary care utilization. Access barriers must be addressed to ensure sufficient capacity for providers to meet increased demand for primary care services. Many policy options are outside of what could be required or supported by the state including requiring primary care provider (PCP) assignment or investing additional funding to promote primary care engagement relative to other pressing needs.

Policy options proposed by CEbP for the committee's consideration are:

1. Support HCA's efforts to participate in Making Care Primary and the Primary Care Transformation Initiative, including support for pursuing resources for eligible primary care practices to grow capacity to provide comprehensive, whole-person primary care.
2. HCA should conduct an opportunity analysis of patient incentive programs that could be implemented to increase engagement with PCPs while improving patients' health. Promising, feasible opportunities should be pursued through the appropriate authority and operational processes.

A committee member asked if Oregon's SB 1529 targeted public plans only and requested further clarification about the legislation. CEbP will confirm, but believes the bill applies more broadly because of reference to "health plans," not specifically those acting on behalf of public insurers. SB 1529 summary states assigning a PCP within 90 days if one is not already selected.

Chair Dr. Zerzan-Thul asked if Washington could do the same or if because there are not enough PCP's it might not be the best option. Another committee member questioned if it's even effective due to several factors, including PCPs with availability to serve, and more evidence is needed to support that approach. Chair Dr. Zerzan-Thul acknowledged there are some employer groups that assign PCPs if one is not selected. For example, there is one plan in King County that uses this approach. However, PCPs with too many patients might not agree with this approach so trying to find a balance that could be helpful is important. A committee member mentioned a large out-of-state employer where this approach went poorly because PCPs could not support assigned patients creating a capacity issue and a frustrating experience for employees.

Committee members had concerns regarding PCP assignment from the standpoint of clinic capacity and consumer choice. Shane summarized that though there is a potential value proposition for this approach in Washington there are barriers that would require a demonstrable value proposition to overcome.

Regarding the policy options, a committee member requested more specificity about which populations are referred to in the first option, and another asked if the potential vote would be in support of one or both policy options. Shane clarified that it would be both options together as a patient engagement strategy to vote on.

Engaging Patients Through Shared Decision Making in Washington Presentation

Laura Pennington, Quality Measurement & Improvement Manager, HCA

Laura reviewed the definition of Shared Decision Making (SDM) is a process in which clinicians and patients work together to make decisions and select tests, treatments, and care plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values. HCA focuses on patients and clinicians working together based on clinical evidence and patient preferences and values. SDM is not appropriate for every conversation, best suited for preference-sensitive conditions, meaning more than one "right answer" for treatment options or when there is a high uncertainty about options. Research shows SDM has the potential to improve health outcomes and patients have higher engagement with their care including self-management. It also reduces variation and health disparities while increasing equity. SDM supports value-based care and population health strategies.

Patients respond to SDM because it honors their personal choices, increases perception of personal safety, supports informed consent, and improves their experience. Personal preferences and values can guide patients'

choices when it comes to health care. This includes considering health plans, health care providers, treatment options, and advanced care planning.

In the early 2000s, Jack Wennberg presented to healthcare leaders and legislators in Washington on clinical variation across regions of the state. As a result, RCW 7.70.060 was enacted in Washington to reduce variation without restricting choice and appropriate utilization based on patient preferences using SDM. Evidence suggests that SDM decreases overutilization and helps correct underutilization. The role HCA takes with SDM is certifying Patient Decision Aids, tools providers can use to help patients understand and compare their options in a non-biased way. This certification ensures the quality of the aids, but it is not required.

One committee member asked what this looks like in practice including the logistics of Electronic Health Record (EHR) documentation. But there is no right or wrong way. It doesn't have to be embedded in the EHR though some larger health systems do. Some Patient Decision Aids can be downloaded and printed from a website. Implementing SDM into clinical workflow helps providers know when it's appropriate to use it and can easily access Patient Decision Aids.

The member also asked what SDM would look like as a policy recommendation and how it ties to the 12% primary care expenditure target. Laura responded that The Bree Collaborative has some proposed recommendations to ensure providers have support when using SDM. It is also important to consider how to incentivize providers to use SDM and educate patients about how to request this information. Chair Dr. Zerzan-Thul agrees implementing SDM would make care better. A committee member voiced concern about potential the administrative burden of documentation. Laura responded that the SDM training is 90 minutes and can start and stop as needed. Although there is no right way of doing it, at this point SDM is encouraged.

Policy Recommendation – Measuring Primary Care Expenditure Targets on a Per-Member-Per-Month (PMPM) Basis Presentation

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

Shane presented that when establishing the 12% primary care expenditure target, Washington legislators relied heavily on the experience of other states. Rhode Island led with this policy nationally, using the same expenditure target with success. A 12% expenditure target will drive investment in primary care based on early analysis, but may not be the best target indefinitely. Changes in expenditures in other service categories, such as hospitals, would dictate the level of primary care investment independent of the actual need of primary care practices. Based on lessons learned from Rhode Island, there's consideration of transitioning to a different unit of measurement for their primary care expenditure policy.

In the long term, Washington could consider transitioning to a per-member-per-month (PMPM) or a per-capita expenditure target. When using these types of statistics, the amount of primary care investment needed to achieve a target would not be inappropriately influenced by changes in price and utilization of other services. Unlike other policies, there isn't evidence-based data for this change, relying on a logic model rather than existing evidence from other states. Using a PMPM or per-capita measure would mean that primary care spending targets are not determined in relation to non-primary care expenditure. It also allows for primary care spending targets to be tailored to meet the actual needs of primary care, not indirectly estimating primary care needs in relation to other spending. A major innovation or price control that could reduce total spending could result in a reduction in the primary care investment independent of the need for primary care services or cost of providing those services. A primary care investment policy would ideally consider that need. This could be a policy pursued in the future, but worth considering now based on lessons learned from other states.

Transition to a PMPM or per-capita target could be an effective solution for the challenges identified with the percent of total expenditures measurement strategy. Changing the unit of measuremnt for the primary care expediture would require political and administrative considerations. Politically, changing the unit of measurement of the expenditure target would require changing the statute and it is unclear whether there would be support for this action. Administratively, it would not be a trivial effort to find what an appropriate

PMPM or per-capita spending target would be. Likely, this would be informed by an assessment of provider costs, population health status, and clinical best practice. Actual measurement using a PMPM or per-capita target would not be more burdensome than using the current statistic of the percent of total expenditures. There is some infrastructure in place to calculate for the data collection and calculation.

Policy options proposed by CEbP for the committee's consideration are:

1. The Cost Board should evaluate the feasibility and appropriateness of using a primary care expenditure target based on aggregate PMPM or per capita expenditures instead of an aggregate expenditure ratio of 12%.
2. If the Cost Board determines a PMPM or per-capita target is feasible and desireable, and targets are identified, recommendations should be made to the Legislature to replace the 12% primary care expenditure target with the revied PMPM or per-capita target.

A committee member commented that there is wisdom in looking at a model that could withstand the test of time, while another member stated that both the current expenditure percentage and the PMPM have their imperfections. Both need an anchor point where the baseline and the out year are measured on the same terms. The possible downside of the PMPM is if for example specialty care expenditures on a per capita basis are going up 15% per year and primary care expenditures are going up 10% per year, its unclear if that means more is invested in primary care as opposed to a cost trend imbalance. Shane responded that the thinking is more along the lines of a dollar amount based on cost plus margins. That could turn into a per capita expenditure target, pulling away from the percentage change movement. This grounds the expenditure target in what the population actually needs versus how are trends moving. Finally, a member said that it seems like 12% is the target spend and the PMPM is acknowledging we need to get into fee-for-service, non-claims based data and this is a mechanism to revise the 12% once it's implemented.

Adjournment

Meeting adjourned at 3:31 p.m.

Public comment

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Tab 4

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Recommendations for increasing the primary care expenditure ratio

Presentation to the Health Care Cost Transparency Board's Advisory Committee on Primary Care

May 30, 2024

Washington State Health Care Authority

Primary care spending: background

- The United States underinvests in primary care
  - Country-wide investment in primary care as a share of total health care spending dropped from 5.4% in 2012 to 4.7% in 2021[1]
- Washington's primary care spend is less than desired
  - ~8.8% overall (9.5% Medicaid, 6.7% commercial) in 2022[2]
- In SB 5589 (2022), Washington established a goal of spending 12% of total heath care expenditures on primary care

[1]Milbank Memorial Fund: The Health of US Primary Care: 2024 Scorecard Report
[2]Carrier self-reported primary care expenditures

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Primary care definition

Claims-based component

- Place of Service code, and
- Practitioner type, and
- Service code

Non-claims-based component

- Capitated or salaried expenditures
- Payments for non-billable services (e.g. care coordination)
- Health IT and workforce investments
- Incentives (bonuses) for quality performance or shared savings

Ways to reach 12% primary care expenditure ratio target

$$\text{Primary Care Expenditure Ratio} = \frac{\text{Primary care spend (numerator)}}{\text{Total spend (denominator)}}$$

$$\text{Spend} = \text{price} \times \text{utilization}$$

- Increase primary care spend without decreasing overall health care spend
  - **Numerator** increases, **denominator** stays the same
  - Denominator stays the same only if there's spending reductions on other services
- Decrease non-primary care spend
  - **Numerator** stays the same, **denominator** decreases

Strategies to increase and sustain investment in primary care

1. **Increase primary care expenditure ratio** by one percentage point annually until a primary care expenditure ratio of 12% is achieved.
2. **Increase Medicaid reimbursement** for primary care to no less than 100% of Medicare no later than 2028.
3. **Multi-payer alignment policy** - support for the Multi-payer Collaborative's alignment efforts.
4. **Patient engagement policy** – payer and purchaser education and incentives to promote utilization of primary care and preventive services.
5. **Workforce development** – prioritize funding for state primary care workforce initiatives as collaboratively identified through the Health Workforce Council.
6. Following the 2024 reporting of primary care expenditures by HCP-LAN category, the **committee may make recommendations to the Cost Board for the portion of primary care expenditures that must be tied to alternative payment methodologies** for spending to count towards the expenditure growth target.
7. The Cost Board should **identify primary care expenditure targets that are based on per capita expenditures** instead of an aggregate ratio of 12% of total health expenditures.

Strategy #1: Increase primary care expenditures by one percentage point annually

Prepared by Elena Soyer, HCA's Strategy, Policy & Innovation Division

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Rhode Island's minimum primary care spending targets

What Rhode Island did:

- Rhode Island's Office of the Health Insurance Commissioner (OHIC) required carriers to increase primary care payments by 1% per year from 2010 to 2014
- State's approach was to increase primary care investment (numerator) and curb growth of overall spend via a **hospital spend cap and overall system cost benchmark targets** (keeping denominator the same)

Did it influence the ratio? (Impact/Effectiveness)

- **Yes.** The dual effort of primary care investment *and* OHIC's requirement that insurers limit the average price increases for hospital services both increases numerator and stabilizes the denominator.

Would it work in Washington? (Feasibility)

- **No.** The WA OIC does not have authority over hospital rate negotiations with insurers.
- Without rate review authority or broader payment reform, it will be impossible to increase the primary care ratio in the same manner as RI.

Primary Care in Rhode Island
Primary Care Collaborative: State Primary Care Investment Initiatives
Insurance Rate Review as a Hospital Cost Containment Tool: Rhode Island's Experience

California's Primary Care Benchmarks

What California did:

- CA's Office of Health Care Affordability (OHCA, established via SB 184 in 2022) proposed **two Primary Care Investment Benchmarks:**
  - Relative improvement benchmark for each payer of 0.5 to 1 percent per year through 2034
  - Statewide absolute benchmark of 15% of total medical expense allocated to primary care by 2034

Did it influence the ratio? (Impact/Effectiveness)

- **Unclear.** While the formation of the OHCA emphasizes CA's commitment to lowering health care costs, it is too soon to say whether OHCA's primary care benchmarks will have any impact.
- OHCA does not have the authority to enforce the benchmarks but does have the authority for payer data collection and public reporting.

Would it work in Washington? (Feasibility)

- **Maybe.** While California's recommendations are new, they may be able to serve as a guide or inform Washington's recommendations moving forward.

OHCA Recommendations to the California Health Care Affordability Board: Proposed Primary Care Investment Benchmark

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Oregon's monitoring and performance improvement requirements

What Oregon did:

- OR passed legislation requiring carriers to report on primary care's share of overall health care spending and to achieve 12% primary care spend target by 2023
- Commercial carriers that do not meet 12% target are required to **submit plans to Oregon Health Authority and Department of Consumer and Business Services to increase primary care spending by one percentage point each year**

Did it influence the ratio? (Impact/Effectiveness)

- **Unclear.** Data is not yet available to confirm 2023 data. Requiring carriers to submit plans for shifting expenditure ratio annually may provide ongoing accountability.

Would it work in Washington? (Feasibility)

- **Likely yes,** although it is unclear whether it will influence the ratio.
- Asking carriers to submit plans for shifting expenditure ratio annually may be beneficial for ongoing accountability and incremental change.

Recommendations and monitoring activities

- **Cost Board recommendations**
  - Recommend that Legislature codify a goal to increase primary care spending by one percentage point per year
  - Recommend that Legislature require agencies to publicly report primary care expenditure ratios of all carriers (HCA, HBE, OIC)
- **Other next steps for HCA**
  - HCA should ask carriers to provide plans for how they intend to shift their expenditure ratio incrementally in the coming years during their annual expenditure reporting.
  - Annual Advisory Committee on Primary Care review
  - Consult with partner states to learn from their ongoing activities

Contact

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Tab 5

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Strategy #2: Increased Medicaid reimbursement for primary care

Prepared by Hana Hartman, HCA's Strategy, Policy & Innovation Division

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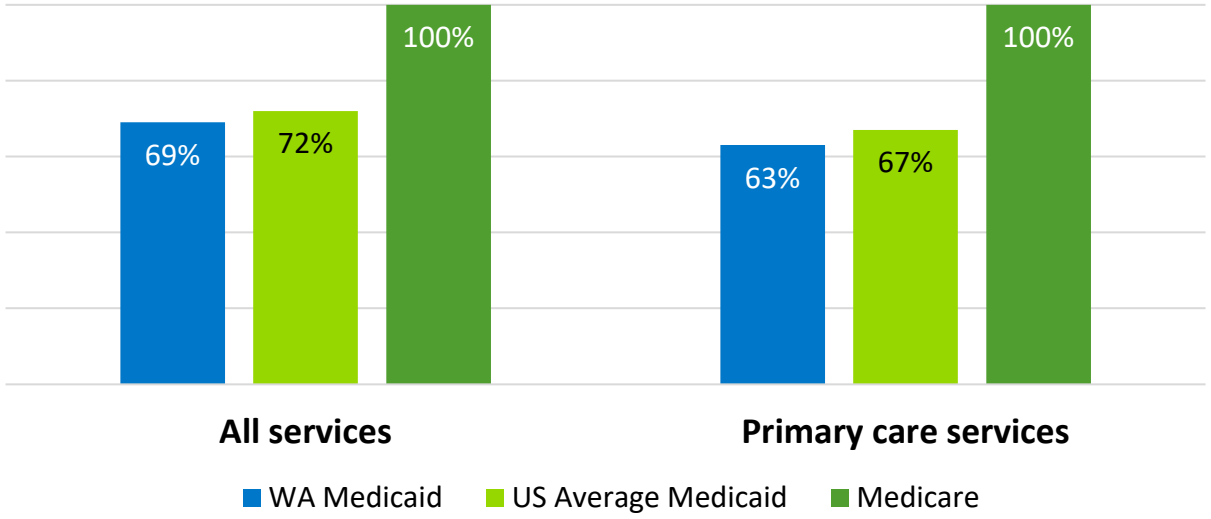
Reimbursement as a percent of Medicare

- Reimbursement rates for health care services vary across payers (Medicaid, traditional Medicare, Medicare Advantage, etc.).
- Medicaid typically reimburses less than Medicare for the same services, while commercial plans typically reimburse more.

Reimbursement as a percent of Medicare

- In 2019, **fee-for-service** (FFS) Medicaid paid….



- Note that these numbers do not include managed care (85% of Medicaid enrollment in WA)
- This graph compares fee schedules only (the bars are not weighted by utilization and do not represent actual spend).

- Many adult and pediatric primary care services have received rate increases since 2019, and more are planned for 2024 and 2025.
  - In aggregate, Medicaid rates are still likely below 100% of Medicare.

Kaiser Family Foundation, Medicaid-to-Medicare Fee Index
HCA, Legislatively funded managed care rate increase

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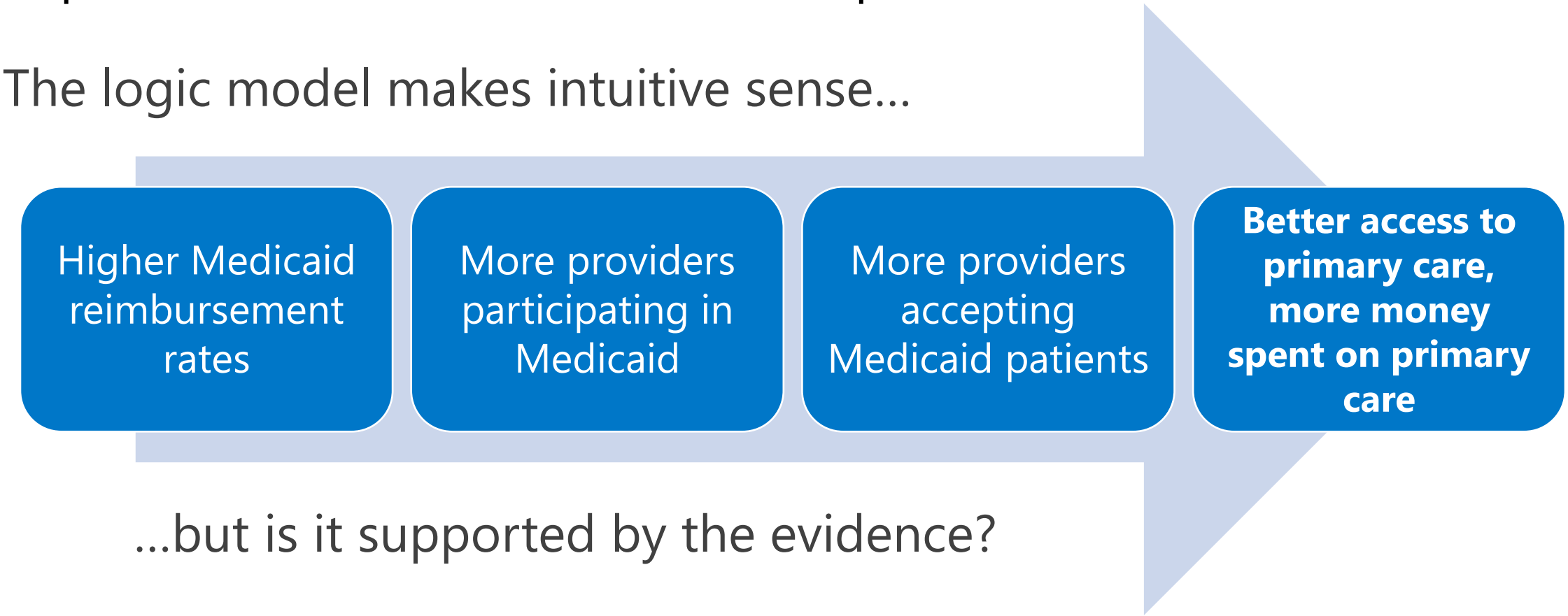
Hypothesis:

Increasing Medicaid reimbursement to 100% of Medicare will improve access and increase the PC spend ratio.

The logic model makes intuitive sense…



…but is it supported by the evidence?

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Experience from other states

- As of 2019, 12 states had primary care Medicaid FFS rates at or above 90% of Medicare
  - Only 4 (AK, MT, DE, and ND) had rates at or above 100% of Medicare[1].
- As a condition of approval for 1115 waivers, CMS requires states to increase payment in primary care, behavioral health, and obstetrics care by at least 2%, if the current payment is below 80% of Medicare in any of the three categories.
  - WA's increase went into effect in January 2024, and there's another scheduled for July 2024.[2]
- Montana[3] and New Mexico[4] conducted comprehensive benchmark assessments of their Medicaid service rates—leading state legislatures to implement increases.

1 Kaiser Family Foundation, Medicaid-to-Medicare Fee Index
2 Manatt, New York State's Approved Health Equity 1115 Waiver Amendment: Summary of Key Provisions
3 Montana Department of Public Health and Human Services, Healthcare Programs Notice, July 6, 2023
4 New Mexico Human Services Department, New Mexico Medicaid providers receive $409 million rate increase

Mixed evidence on the relationship between PC rates and provider participation in Medicaid

Evidence of a strong relationship:

- Physicians in states that pay above the median Medicaid-FFS-to-Medicare-fee ratio accepted new Medicaid patients at higher rates than those in states that pay below the median (2019).[1]
  - Participation rates increase by 0.78% for every 1% increase in the fee ratio

Evidence of a weaker relationship:

- Multiple analyses of the 2014-2015 ACA "fee bump" show no effect on provider participation in Medicaid.[2,3]
  - Implementation delays and the limited duration of the policy may have blunted the potential impact on provider behavior.

1 Health Affairs, Physician Acceptance Of New Medicaid Patients: What Matters And What Doesn't
2 Int. Journal of Health Econ. Mgmt.: Medicaid physician fees and the use of primary care services: evidence from before and after the ACA fee bump
3 MACPAC: An Update on the Medicaid Primary Care Payment Increase

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Factors mediating the impact of rates on provider participation in Medicaid

- **Patient coverage mix:** Providers may respond differently to a fee increase depending on their current payer mix, and the prevalence of Medicaid coverage in their local area.[1]
- **Provider perception:** Providers with negative views of Medicaid as a "low" payer, or of Medicaid patients as “undesirable” may be less responsive to a fee increase.[2]
- **Independent vs system-owned:** Large systems may be more likely to accept Medicaid if they have diversified revenue streams, while independent providers may be more sensitive to rate changes.[1,3]
- **Administrative burden:** Providers with limited resources may not accept Medicaid regardless of payment if the administrative burden is too high (may differ for FFS vs. managed care).[2,3]

1 Health Affairs, Physician Acceptance Of New Medicaid Patients: What Matters And What Doesn’t
2 BMC Health Services Research: Qualitative perspectives of primary care providers who treat Medicaid managed care patients
3 Health Affairs, Avoiding Medicaid: Characteristics Of Primary Care Practices With No Medicaid Revenue

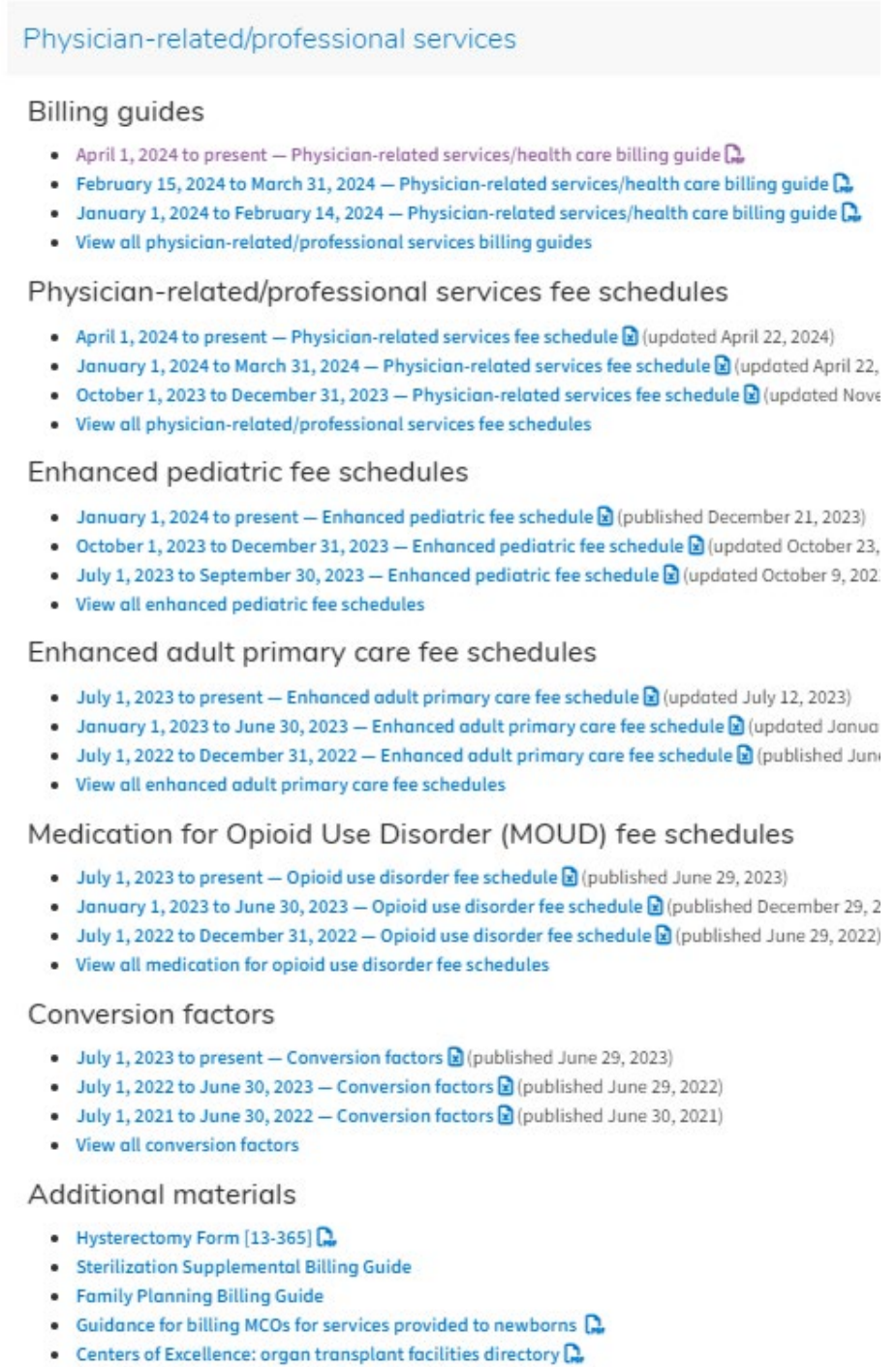
Inequitable payment can contribute to racial disparities

- Different reimbursement rates can confer value judgments.
  - Research shows that many providers view Medicaid patients as less desirable than others, even if they still participate in Medicaid.[1]
- Compared to the general population of Washington…[2]
  - **White people** are overrepresented in **Medicare.**[3]
  - **People of color** are overrepresented in **Medicaid.**[4]
- In addition, relatively low Medicaid reimbursement disadvantages providers who primarily serve Medicaid patients, and can contribute to workforce shortages, provider job dissatisfaction, and high rates of turnover at practices serving vulnerable populations.[1]

1 BMC Health Services Research: Qualitative perspectives of primary care providers who treat Medicaid managed care patients
2 Census.gov, Washington State Facts | 3 KFF, Distribution of Medicare Beneficiaries by Race/Ethnicity | 4 HCA client eligibility dashboard

Mitigating provider burden

- Providers bill for services based on the applicable billing guide.
  - HCA financial staff report that providers are often confused about which billing guide to use.
- The new, simpler definition of primary care is still complicated.
  - The same service may be considered “primary care” in one setting but not another, or when offered by one provider type but not another.
- HCA should work closely with providers and billing experts to implement any rate changes in a way that is consistent with current systems and **does not increase provider confusion or burden.**



Physician-related/professional services

Billing guides

- April 1, 2024 to present — Physician-related services/health care billing guide
- February 15, 2024 to March 31, 2024 — Physician-related services/health care billing guide
- January 1, 2024 to February 14, 2024 — Physician-related services/health care billing guide
- View all physician-related/professional services billing guides

Physician-related/professional services fee schedules

- April 1, 2024 to present — Physician-related services fee schedule (updated April 22, 2024)
- January 1, 2024 to March 31, 2024 — Physician-related services fee schedule (updated April 22,
- October 1, 2023 to December 31, 2023 — Physician-related services fee schedule (updated Nove
- View all physician-related/professional services fee schedules

Enhanced pediatric fee schedules

- January 1, 2024 to present — Enhanced pediatric fee schedule (published December 21, 2023)
- October 1, 2023 to December 31, 2023 — Enhanced pediatric fee schedule (updated October 23,
- July 1, 2023 to September 30, 2023 — Enhanced pediatric fee schedule (updated October 9, 202
- View all enhanced pediatric fee schedules

Enhanced adult primary care fee schedules

- July 1, 2023 to present — Enhanced adult primary care fee schedule (updated July 12, 2023)
- January 1, 2023 to June 30, 2023 — Enhanced adult primary care fee schedule (updated Janua
- July 1, 2022 to December 31, 2022 — Enhanced adult primary care fee schedule (published Jun
- View all enhanced adult primary care fee schedules

Medication for Opioid Use Disorder (MOUD) fee schedules

- July 1, 2023 to present — Opioid use disorder fee schedule (published June 29, 2023)
- January 1, 2023 to June 30, 2023 — Opioid use disorder fee schedule (published December 29, 2
- July 1, 2022 to December 31, 2022 — Opioid use disorder fee schedule (published June 29, 2022)
- View all medication for opioid use disorder fee schedules

Conversion factors

- July 1, 2023 to present — Conversion factors (published June 29, 2023)
- July 1, 2022 to June 30, 2023 — Conversion factors (published June 29, 2022)
- July 1, 2021 to June 30, 2022 — Conversion factors (published June 30, 2021)
- View all conversion factors

Additional materials

- Hysterectomy Form [13-365]
- Sterilization Supplemental Billing Guide
- Family Planning Billing Guide
- Guidance for billing MCOs for services provided to newborns
- Centers of Excellence: organ transplant facilities directory

Will higher PC reimbursement increase the primary care spend ratio?

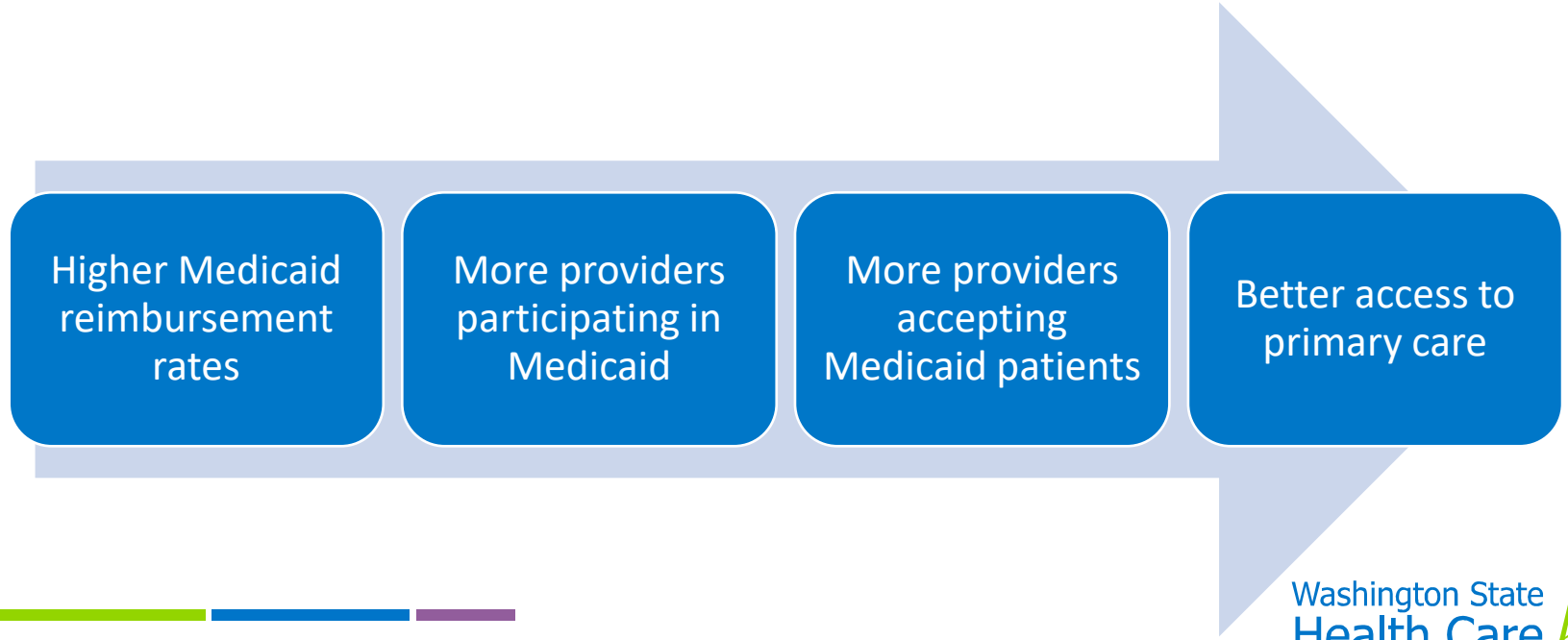
- Better access to primary care can **prevent** the need for expensive specialty and acute care, particularly unnecessary emergency department visits.[1]
- Better access to primary care can also **increase** the use of specialty and acute care when the PCP identifies conditions or issues that need additional treatment.[2]
  - This increased utilization is appropriate to improve health.
- The context, content, and timing of increased primary care utilization are critical to determining the effect on the overall spend ratio.[2]

1 Health Services Research, Are Primary Care Services a Substitute or Complement for Specialty and Inpatient Services?
2 JAMA, Will Increasing Primary Care Spending Alone Save Money?

Washington State Health Care Authority

Logic model (revisited)

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



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Summary

Evidence

- There is some evidence that increased Medicaid reimbursement for primary care can increase access and utilization – but the impact is mitigated by provider circumstances.
- There is some evidence that increased reimbursement improves provider participation rates.

Would it influence the ratio? (Impact/Effectiveness)

- **Maybe.**
- There is some evidence that effective use of primary care can prevent unnecessary specialty or acute care.
- There is also evidence that more primary care access could increase specialty care use.

Would it work in Washington? (Feasibility)

- **Likely yes,** although it is unclear how it will influence the ratio.

Recommendation

- **HCA should increase Medicaid rates for primary care services to parity with the Medicare fee schedule.**
- HCA should implement the increase using existing enhanced fee schedules to minimize confusion
- Next steps:
  - HCA will assess the fiscal impact of the rate increase and how it might impact the primary care spend target (underway)
  - Consider a budget proposal to Governor's Office (summer 2025)

Tab 6

Washington State Health Care Authority

Strengthening Primary Care

Incentivizing and Measuring Non-Fee-for-Service Payment

Karen S. Johnson, PhD
Vice President, Practice Advancement
kjohnson@aafp.org | 913.960.6041

May 30, 2024

Presentation Goals

1. Start with the basics:
   - Fee-for-service (FFS) does not serve primary care well
   - Well-designed primary care payment should include both FFS and non-FFS payment

2. Describe the HCP-LAN APM Framework and Measurement Approach

3. Consider and discuss how incentivizing and measuring non-FFS payment contributes to WA state goals for primary care by:

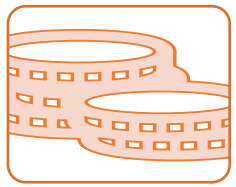
Presentation Goals

1. **Describe and gain consensus around some basics:**
   - **Fee-for-service (FFS) does not serve primary care well**
   - **Well-designed primary care payment should include both FFS and non-FFS payment**

2. Describe the HCP-LAN APM Framework and Measurement Approach

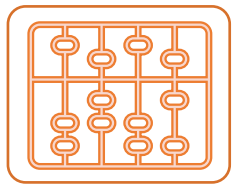
3. Consider and discuss how incentivizing and measuring non-FFS payment contributes to WA state goals for primary care by:

Why FFS Isn't Great for Primary Care



Undervalued Payments

Burdensome Documentation

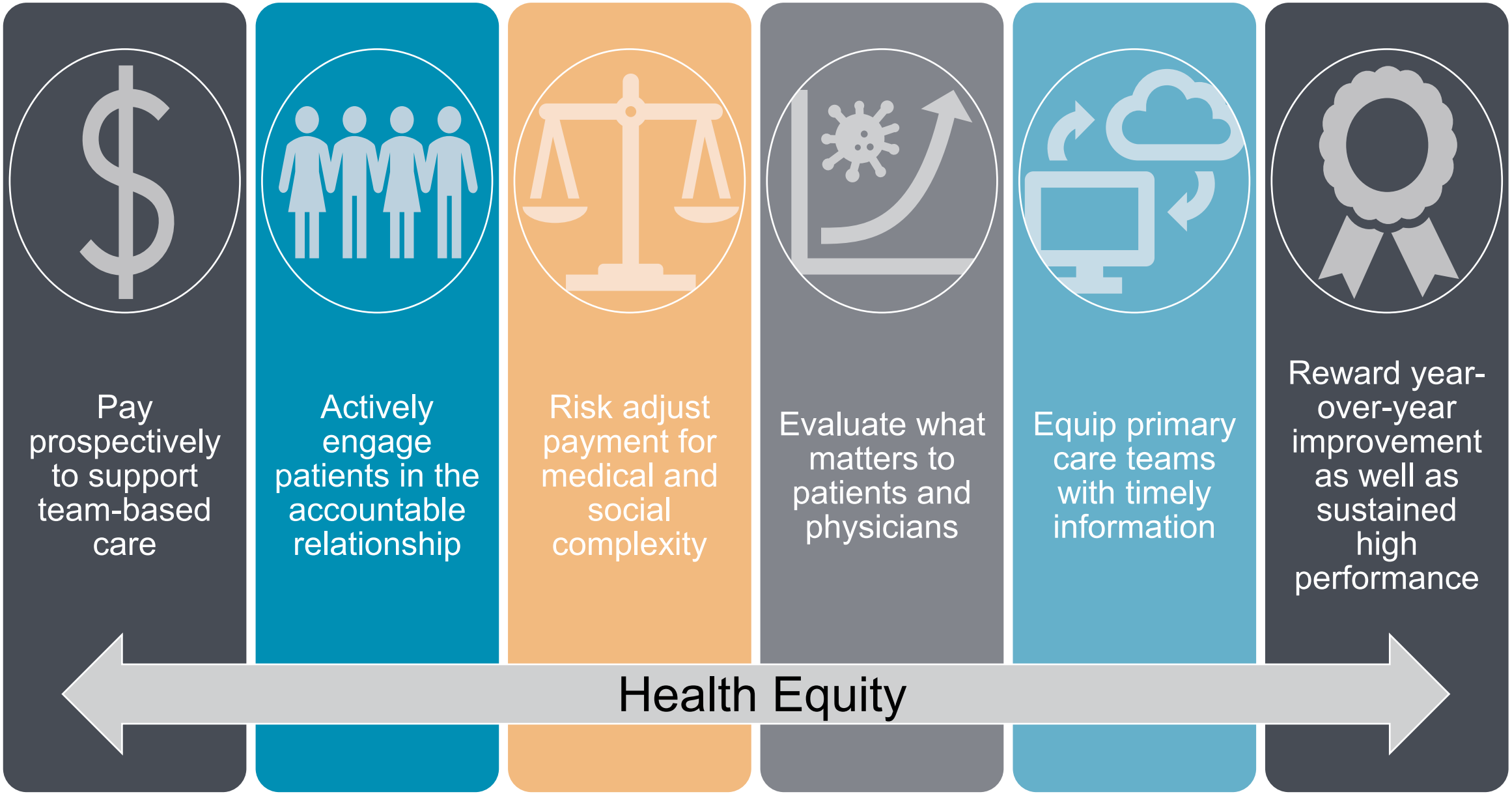


PC is not a discrete service

PAYMENT

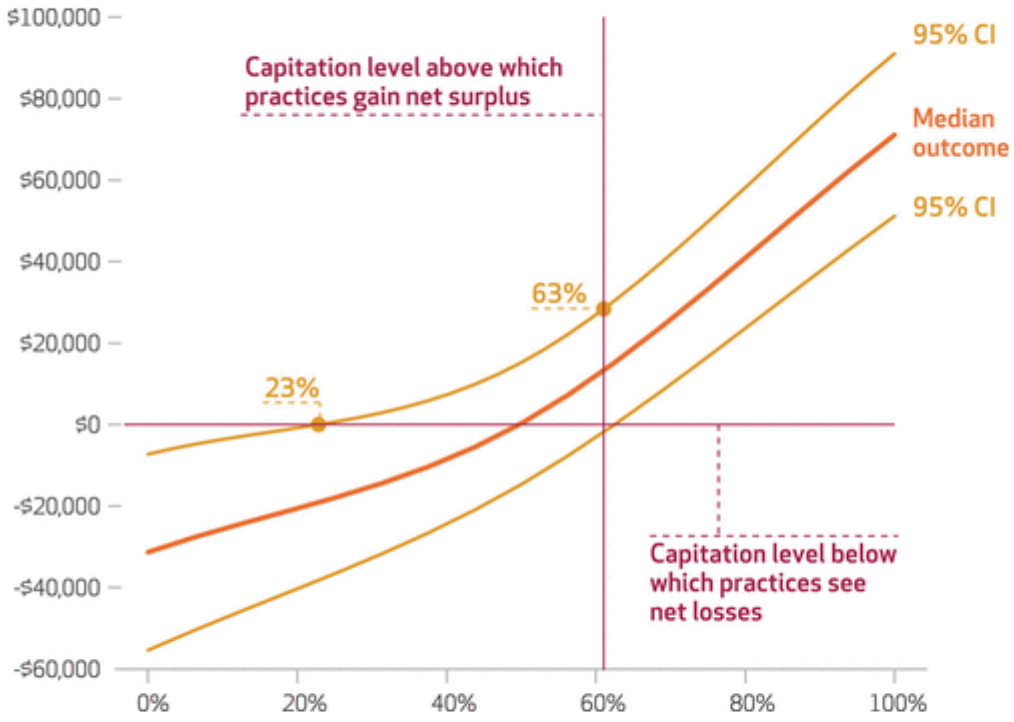
Pay for primary care teams to care for people, not doctors to deliver services.

National Academies of Science Engineering and Medicine Report Objective #1


Pay prospectively to support team-based care
Actively engage patients in the accountable relationship
Risk adjust payment for medical and social complexity
Evaluate what matters to patients and physicians
Equip primary care teams with timely information
Reward year-over-year improvement as well as sustained high performance
Health Equity

High Levels Of Capitation Payments Needed To Shift Primary Care Toward Proactive Team And Non-visit Care

Exhibit 3 Net surplus per FTE physician per year after shifting to team- and non-visit-based care, by percentage of patients with capitated payment



SOURCE Authors' calculations. NOTES Net surplus per full-time-equivalent (FTE) physician per year is defined in the Notes to Exhibit 2 . The minimum capitation level is the level above which 95 percent of practices would gain revenue by shifting to a team- and non-visit-based primary care delivery strategy. Appendix Exhibit 6 contains a conceptual illustration of the analysis used to determine this level (see Note 18 in text). CI is confidence interval.

Basu S, Phillips RS, Song Z, Bitton A, Landon BE. High Levels Of Capitation Payments Needed To Shift Primary Care Toward Proactive Team And Nonvisit Care. Health Aff (Millwood). 2017 Sep 1;36(9):1599-1605. doi: 10.1377/hlthaff.2017.0367. PMID: 28874487.

Presentation Goals

1. Describe and gain consensus around some basics:
   - Fee-for-service (FFS) does not serve primary care well
   - Well-designed primary care payment should include both FFS and non-FFS payment

2. **Describe the HCP-LAN APM Framework and Measurement Approach**

3. Consider and discuss how incentivizing and measuring non-FFS payment contributes to WA state goals for primary care by:
   - Strengthening accountability/engagement between patients and PCPs
   - Increase more flexible revenue streams to practices
   - Reduce burdens associated with payment

HCPLAN

Health Care Payment Learning & Action Network

VISION

Advance multi-stakeholder payment reforms to enable coordinated health care that achieves better health, equity, and affordability

INSPIRE

STANDARDIZE

EMPOWER

MEASURE

ENGAGE

The HCP-LAN APM Framework

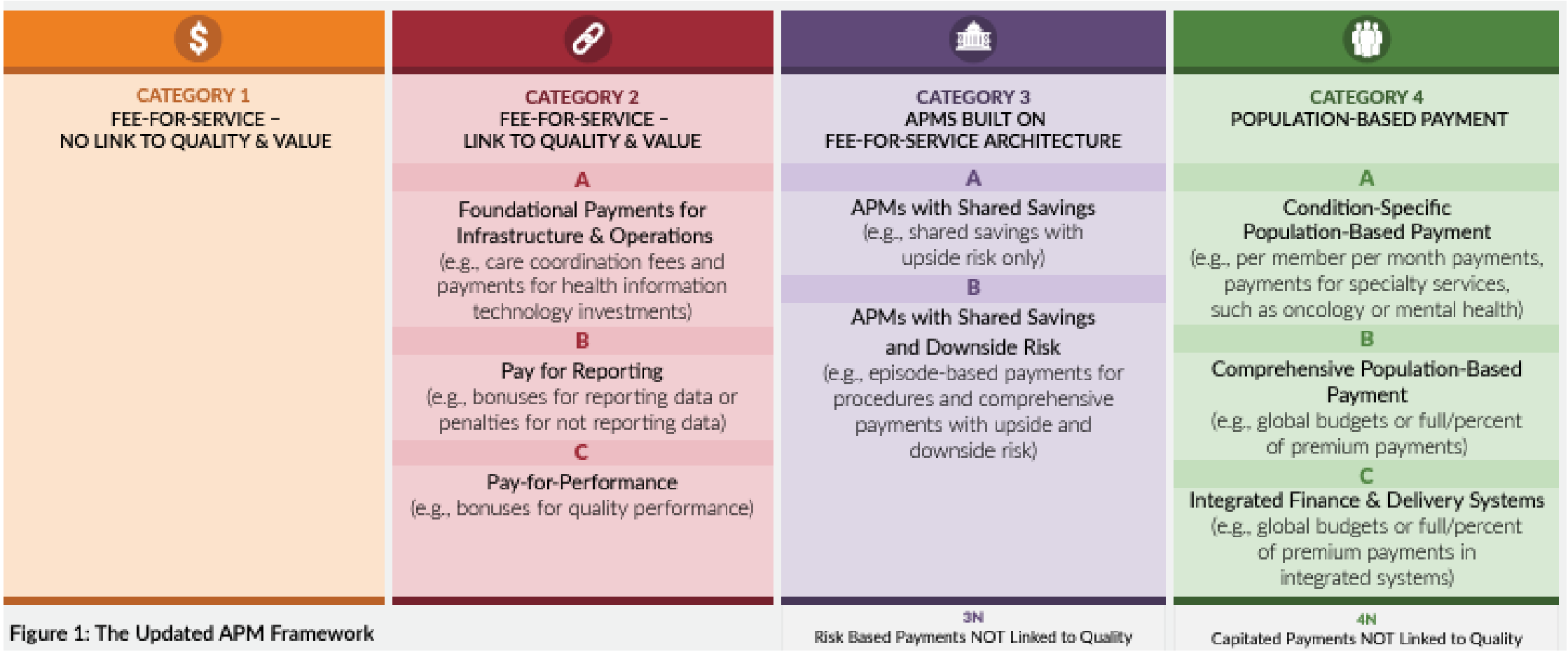
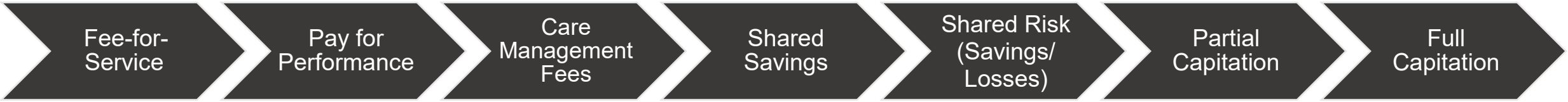


Figure 1: The Updated APM Framework

https://hcp-lan.org/apm-framework/

Payment Incentives Matter



One Patient at a Time

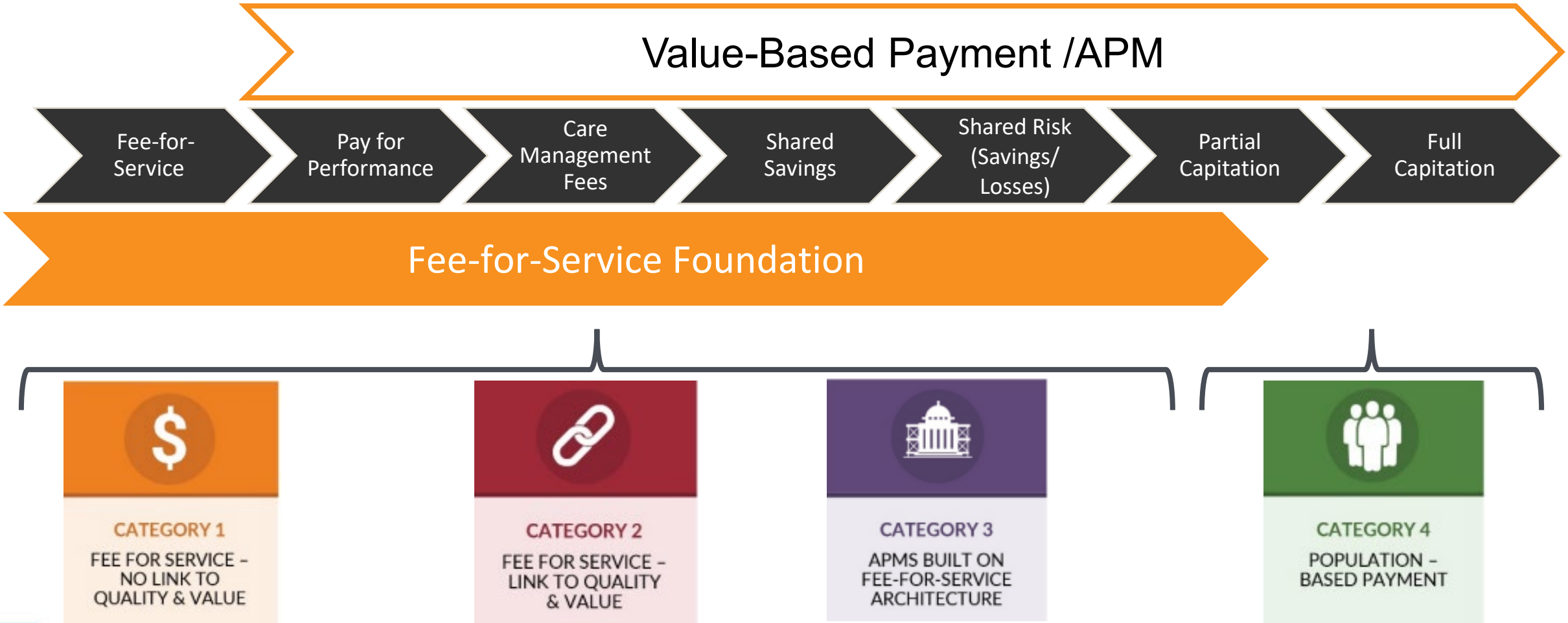
- Filling appointments
- Maximizing limited time with patients

Value-Based Care Accountable Patient Population

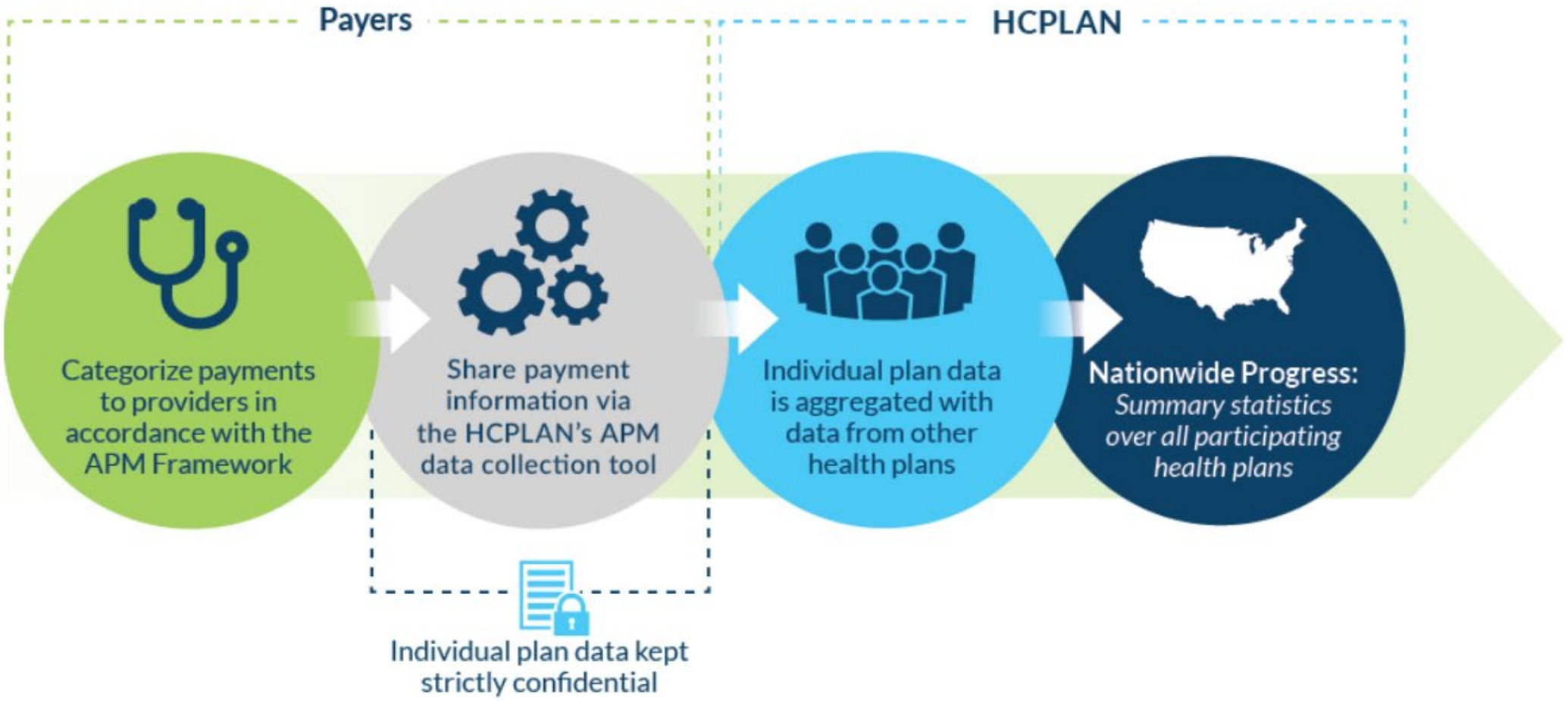
- Preventing disease and its progression
- Coordinating care
- Managing referrals
- Addressing Social Determinants of Health
- Integrating behavioral health
- Closing gaps in care

Applying the LAN Framework

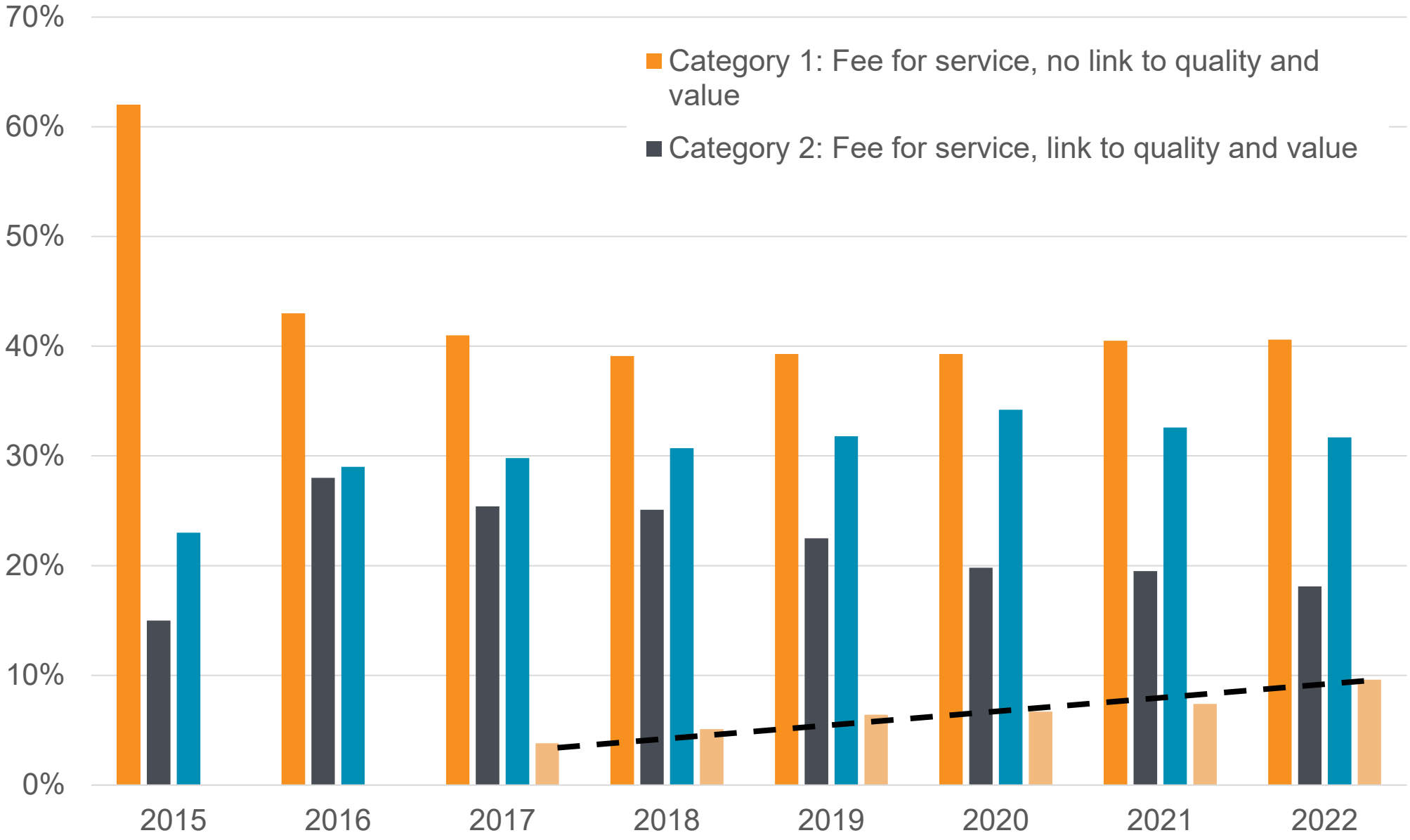
HCPLAN
Health Care Payment Learning & Action Network



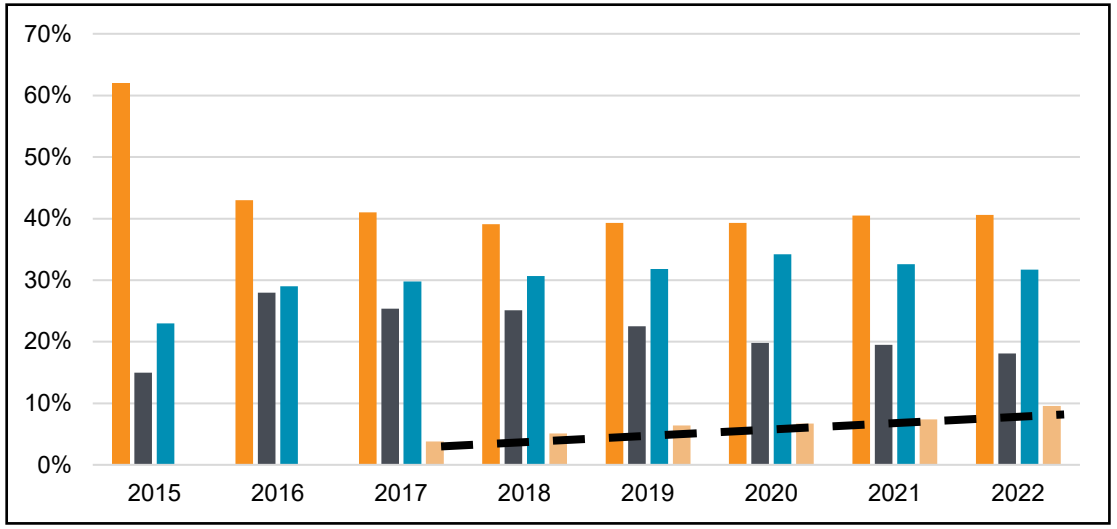
The Measurement Process



HCP-LAN Annual Measurement Summary 2015-2022



Measurement Insights



- ~40% - FFS ONLY
- ~50% - APMs on FFS foundation
- ~10% - Non-FFS

- **How much non-FFS is going to primary care?**

Presentation Goals

1. Describe and gain consensus around some basics:
   - Fee-for-service (FFS) does not serve primary care well
   - Well-designed primary care payment should include both FFS and non-FFS payment

2. Describe the HCP-LAN APM Framework and Measurement Approach

3. **Consider and discuss how incentivizing and measuring non-FFS payment contributes to WA state goals for primary care**

Increasing investment through non-FFS Payments can…

- **Strengthen accountability/engagement between patients and PCPs** by **ASKING** members/patients to select where they want to get their primary care to accurately direct non-FFS payments

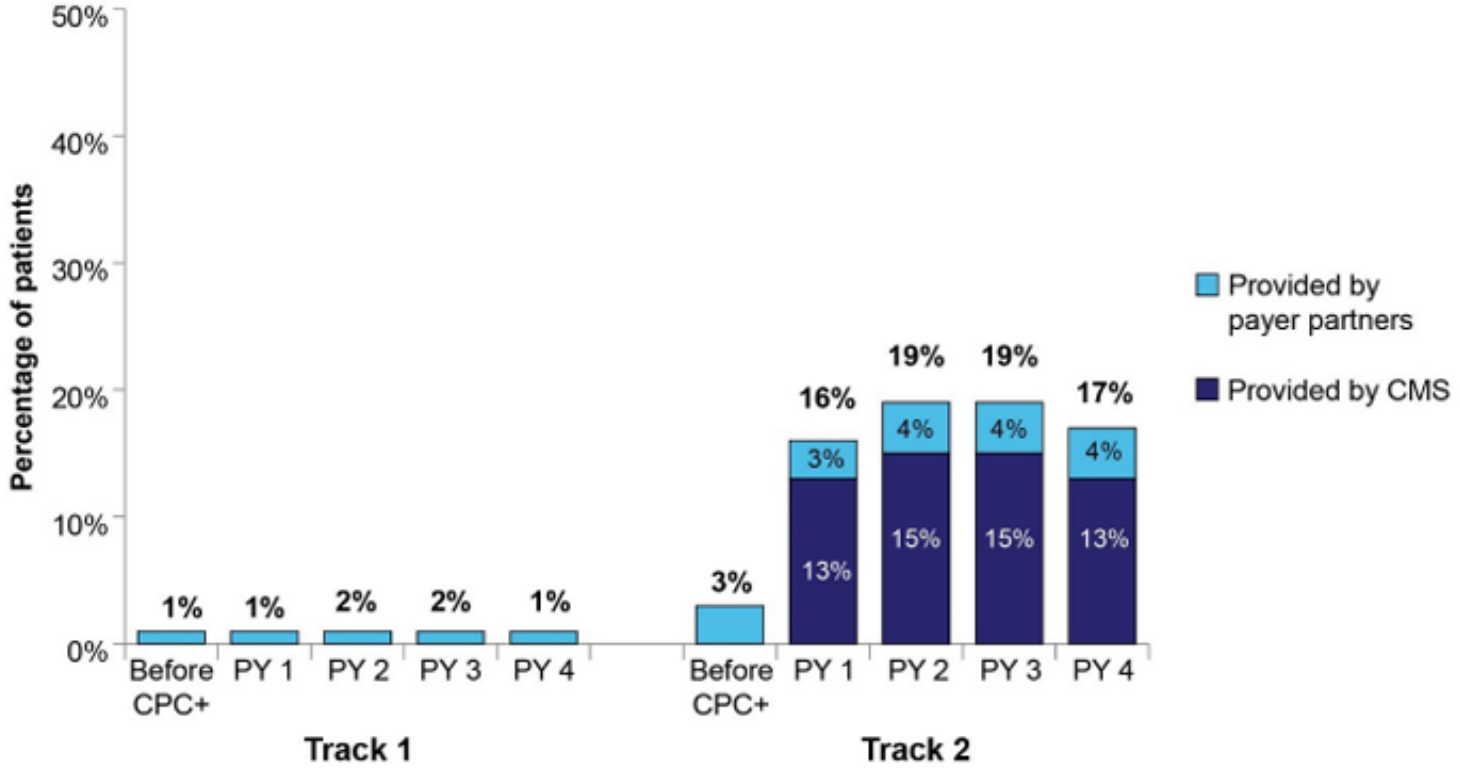
- **Increase more flexible revenue streams** to practices allowing for investment in people and infrastructure (technology, community partnerships, etc.)

- **Reduce burdens associated with payment** which can improve physician and team well-being/sustain much-needed primary care workforce

The shift to non-FFS will not happen on its own

Figure 3.10. Approximate percentage of all patients served by CPC+ practices for which CMS or payer partners provided alternative to FFS payments

During the first four years of CPC+, the proportion of patients covered by alternative payments was small and did not increase over time. This fell far short of CMS's expectations for moving Track 2 practices away from FFS.



HCP-LAN Public Resources

More detailed information and helpful resources on the HCPLAN Measurement Effort:

- 2024 APM Methodology Overview
- Frequently Asked Questions
- 2024 APM National Data Collection Metrics
  To request a copy of the Excel version, please email hcplan@deloitte.com "Attention: Excel Survey"
- 2024 HCPLAN National Data Collection Survey
- Guidance for Measuring Covered Lives in Accountable Care APM Arrangements
- Refreshed APM Framework White Paper
- 2024 HCPLAN National Data Collection Training Webinar

Tab 7

Washington State Health Care Authority

Strategy #6: Tie primary care spending to alternative payment models

Prepared by Hana Hartman, HCA's Strategy, Policy & Innovation Division

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Context

Assuming that the way providers are paid can impact health outcomes and total cost of care, a strategy to increase the primary care expenditure ratio:

Require some primary care expenditures to be tied to **alternative payment methodologies** for spending to count toward the 12% target.

Value-based payment and alternative payment models

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

HCP-LAN APM Framework (2017)

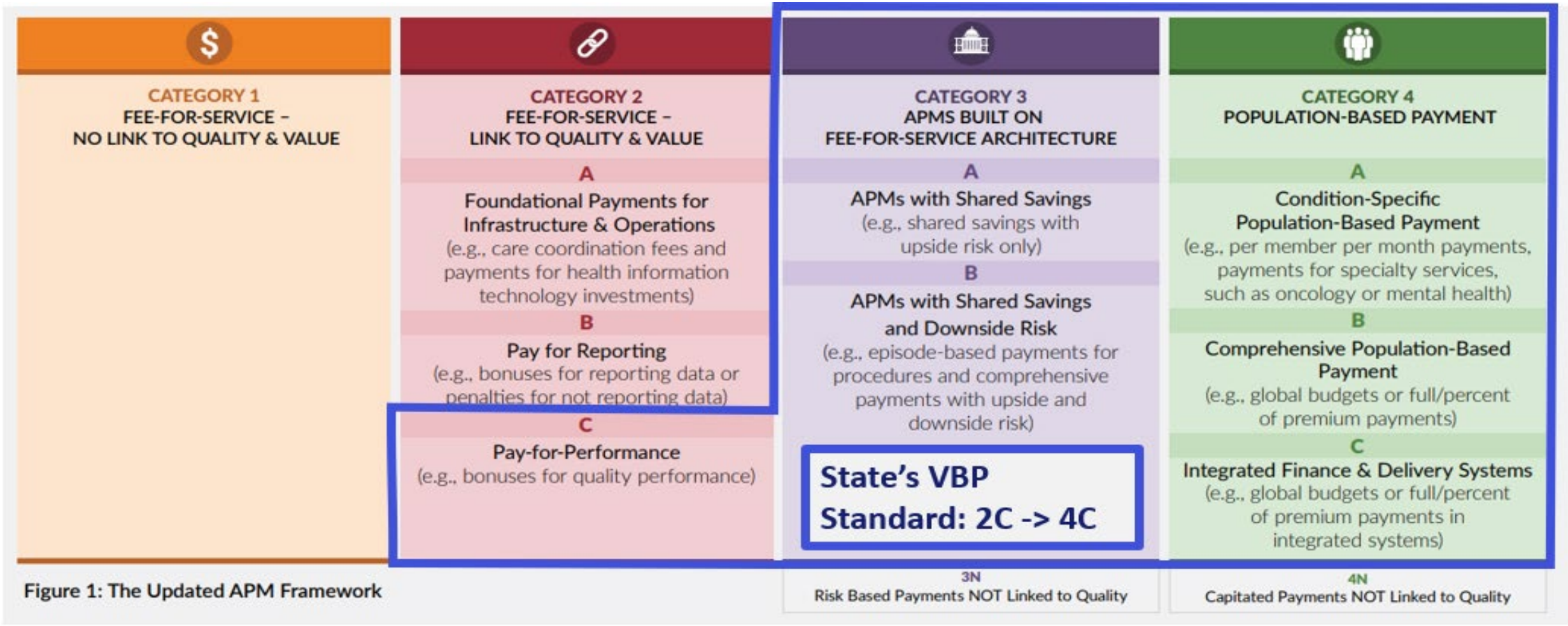

Figure 1: The Updated APM Framework

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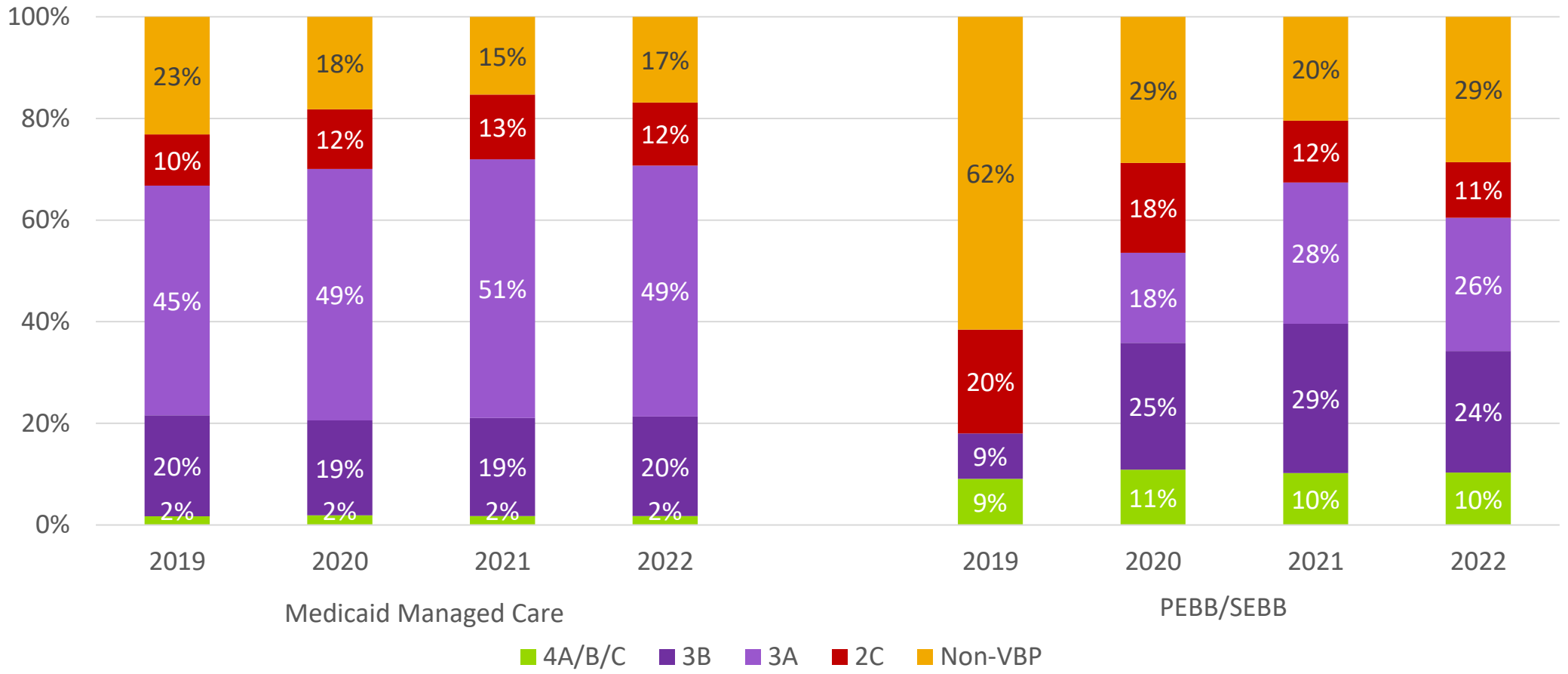
Washington VBP adoption over time



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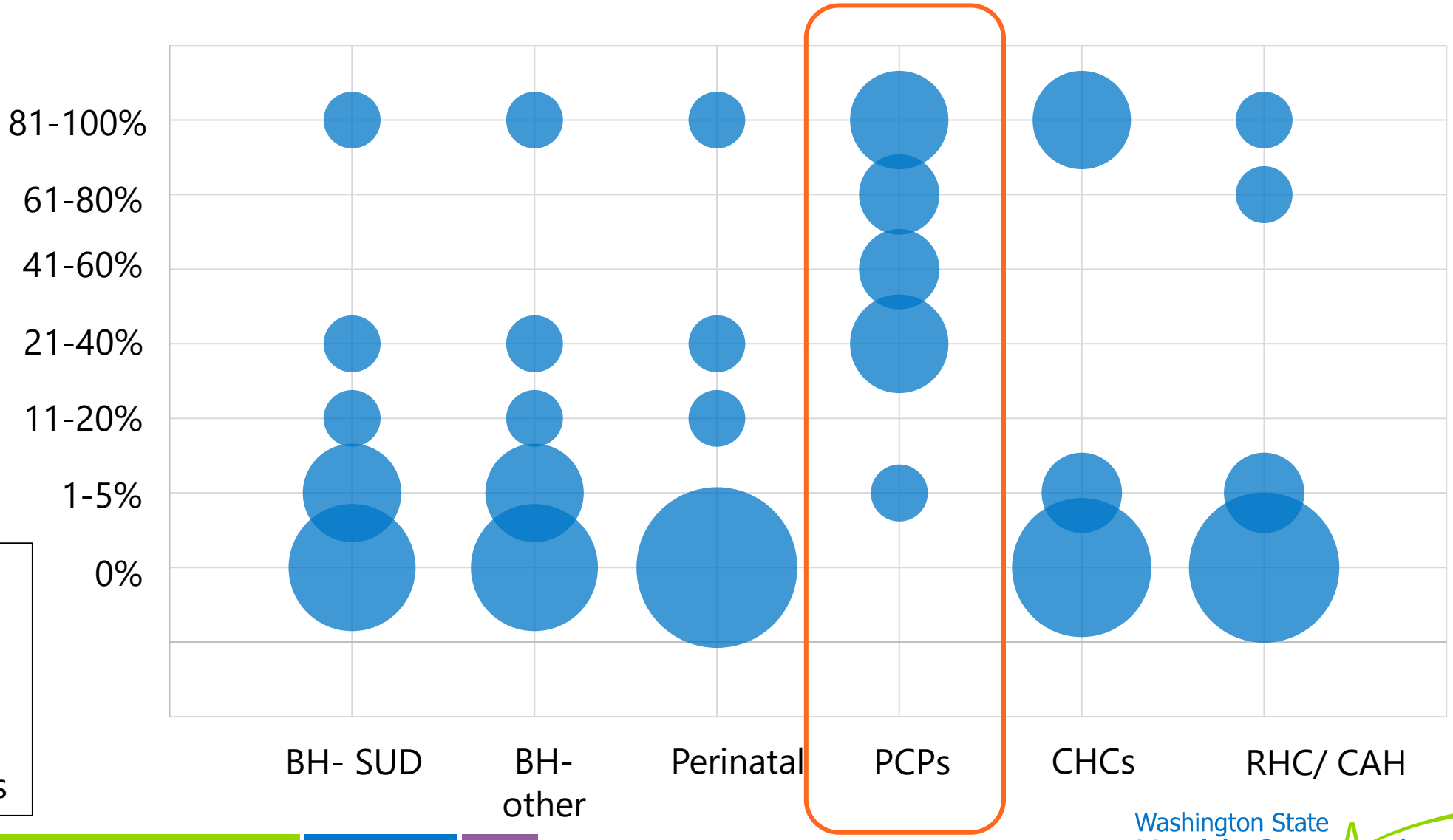
Most VBP contracting in Washington already focuses on primary care

- As of 2022, most providers engaged in APMs are primary care providers.
  - This may be related to HCA's quality incentives, which focus heavily on primary care services (screenings and chronic condition management)
- This leaves limited opportunities to expand VBP within primary care.

VBP adoption in Washington by specialty in 2022

What percent of each provider type in your network is engaged in VBP?



Size of circle represents number of plans

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Future opportunities for monitoring

- Distinct from the Paying for Value Survey, HCA also collects Primary Care Expenditure Reports each year.
- In 2024, Primary Care Expenditure reports will give more detail about spending by APM type than previous years.

State strategies leveraging APMs to reach primary care spend targets

- **Monitoring and evaluation:**
  - States (including CA, DE, OR, and RI) require carriers to report non-claims spending to a statewide database to allow regulators to evaluate primary care spending outside of FFS. [1]
  - Washington gathers non-claims primary care spending in our annual Primary Care Expenditure reports.
- **Mandatory APM participation:**
  - Massachusetts requires PCPs that participate in its Medicaid ACO to shift to a PMPM model that supports team-based care.[2]
- **Increasing rates overall with an emphasis on-claims payments***
  - Colorado – "Increased investments in primary care should be offered largely through infrastructure investments and alternative payment models that provide prospective funding and incentives for improving quality"
  - Delaware – Senate Bill 120 (2021-22) set a goal that primary care should be at least 10% of total cost of care in 2024 and 11.5% in 2025 and specified that "the increase in primary care spending should not be strictly an increase in FFS rates."
  - As a condition of rate approval, Rhode Island requires insurers to raise their primary care spending rate by 1% per year using strategies other than increasing fee-for-service payments.
- **Evidence about the effectiveness of these strategies is still emerging.**

1 CHCS, Advancing Primary Care Innovation in Medicaid Managed Care: A Toolkit for States
2 Milbank, How Massachusetts Medicaid Is Paying for Primary Care Teams to Take Care of People, Not Doctors to Deliver Services

Recommended monitoring activity

- The Primary Care Advisory Committee should annually review adoption of alternative payment models by HCP-LAN Category and by Making Care Primary alignment.

Summary

Strategy	Recommendations to Cost Board	Monitoring Activities
1. **Increase** primary care expenditure ratio **by one percentage point annually**	• Recommend that Legislature codify a goal to increase primary care spending by one percentage point per year • Recommend that Legislature require Agencies to publicly report primary care expenditure ratios of all carriers (HCA, HBE, OIC)	• HCA should ask carriers for annual plans to shift the expenditure ratio • Advisory Committee on Primary Care annually monitors for 1%point increase • Consult with partner states to learn from their ongoing activities
2. **Increase Medicaid reimbursement** for primary care to no less than 100% of Medicare		HCA should propose an increase to Medicaid rates for primary care services to parity with the Medicare fee schedule.
3. Consider if a portion of primary care expenditures must be **tied to alternative payment methods** for spending to count towards the expenditure growth target.		Advisory Committee on Primary Care should monitor primary care expenditures by LAN category.

Contact

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  - Kahlie.Dufresne@hca.wa.gov
- **Hana Hartman**, Senior Health Policy Analyst
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Tab 8

Washington State Health Care Authority

Strategies to Increase and Sustain Primary Care:

Seven Recommendations

1. **Increase primary expenditures** as a percentage of total health care spending by one percentage point annually until a primary care expenditure ratio of 12% is achieved.
2. **Increase Medicaid reimbursement** for primary care to no less than 100% of Medicare no later than 2028.
3. **Multi-payer alignment policy** - support for the Multi-payer Collaborative's alignment efforts.
4. **Patient engagement policy** – payer and purchaser education and incentives to promote utilization of primary care and preventive services.
5. **Workforce development** – prioritize funding for state primary care workforce initiatives as collaboratively identified through the Health Workforce Council.
6. Following the 2024 reporting of primary care expenditures by HCP-LAN category, the **committee may make recommendations to the Cost Board for the portion of primary care expenditures that must be tied to alternative payment methodologies** for spending to count towards the expenditure growth target.
7. The Cost Board should **identify primary care expenditure targets that are based on per capita expenditures** instead of an aggregate ratio of 12%.

Tab 9

Washington State Health Care Authority

NEXT STEPS FOR THE PRIMARY CARE COMMITTEE

OVERVIEW:

- HCA will send the committee the full list of primary care policies

- Committee homework:
  - Please respond to HCA with any further input on how the policies could be better articulated and why by ***June 7***
  - Please think about how you would prioritize this list of policies at the June meeting in terms of the most pressing for follow-up action

- At the June meeting, the Center will facilitate:
  - Committee discussion to finalize the policies
  - Ranking of the policies in preparation for making the Committee's recommendations to the Health Care Transparency Board

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

Washington State Health Care Authority