Advisory Committee on Primary Care Meeting

June 26, 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

June 26, 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	Dr. Judy Zerzan-Thul, Committee Chair, Medical Director, Health Care Authority
2:10 - 2:15 (5 min)	Public Comment	3	Rachelle Bogue, Health Care Authority
2:15 – 3:15 (1 hour)	Policies and strategies to reach the 12% primary care expenditure target For each of the 7 recommendations: • Review original language • Review a summary of committee feedback • Discuss and vote on discrete policy modifications • Vote on final language for each recommendation	4	Shane Mofford, Gretchen Morley Center for Evidence-based Policy (CEbP)
3:15 – 3:45 (30 mins)	Vote on recommendation package for submission to Cost Board	5	Shane Mofford, Gretchen Morley Center for Evidence-based Policy (CEbP)
3:45 – 3:55 (10 mins)	Primary Care Committee wrap up for 2024 & next steps	6	Dr. Judy Zerzan-Thul, Committee Chair, Medical Director, Health Care Authority
3:55 – 4:00 (5 mins)	Wrap-up and adjourn		Dr. Judy Zerzan-Thul, Committee Chair, Medical Director, Health Care Authority

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board's

Advisory Committee on Primary Care meeting summary

May 30, 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
Michele Causley
Tracy Corgiat
David DiGiuseppe
D.C. Dugdale
Sharon Eloranta
Sheryl Morelli
Lan Nguyen
Katina Rue
Jonathan Staloff
Ginny Weir
Shawn West
Staici West
Maddy Wiley

Members absent

Meg Jones
Chandra Hicks
Gregory Marchand
Mandy Stahre
Sarah Stokes
Linda Van Hoff - resigned (replaced by Shannon Fitzgerald)

Call to order

Chair Dr. Judy Zerzan-Thul called the meeting of the Advisory Committee on Primary Care (committee) to order at 2:04 p.m.

Washington State Health Care Authority

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

Members present **voted to adopt the April meeting summary** without changes.

Public comment

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

Presentation: Increase primary care expenditures by 1 percentage point annually

Kahlie Dufresne, Special Assistant for Health Policy & Programs, HCA
Elena Soyer, Senior Health Policy Analyst, HCA

In 2022, Washington Legislature passed SB 5589 establishing the goal of spending 12% of total health care expenditures on primary care. The committee was tasked with establishing the definition of "primary care" (PC) which included two components: claims-based and non-claims-based. The committee also had to consider how to reach the 12% PC expenditure ratio target by increasing PC spending and decrease non-primary care spend. Increasing PC expenditure by 1 percentage point annually until the 12% PC expenditure ratio is achieved is one of seven strategies under consideration by the committee.

Efforts have been made in Rhode Island (RI), Oregon (OR), and California (CA) to increase PC spend. RI required carriers to increase PC payments by 1% annually from 2010 – 2014. This was done by increasing PC investments and in the context of implementing a hospital spending cap and overall system cost benchmark targets. Although this was effective, it is not likely to work in Washington because, unlike RI, the Office of the Insurance Commissioner (OIC) does not have authority over hospital rate negotiations with insurers. Without rate review authority or broader payment reform, it may be impossible to increase the primary care ratio. Another example is CA which by 2034 seeks to incrementally increase a PC benchmark for each payer by 0.5 to 1% annually and achieve a 15% absolute benchmark of total medical expenses allocated to PC. CA's Office of Health Care Affordability does not have enforcement authority but does have the authority for payer data collection and public reporting. 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 the 12% target are required to submit plans to increase PC spending by 1% each year. Though results are not yet available for the methods in CA or OR's, both could possibly work in Washington.

Recommendations for the Health Care Cost Transparency Board (Cost Board) could include requesting the Legislature codify increasing PC spending by 1% annually and/or require agencies publicly report PC expenditure ratios of all carriers. Next steps for HCA could be asking carriers to provide plans showing how they are working towards the expenditure ratio. The committee could have an annual review of efforts and consult with other states about their lessons learned and ongoing efforts.

A committee member asked for more information about RI's process, and a fellow committee member provided an explanatory Health Affairs article. Kahlie explained that legislative statute gave RI's Insurance Commissioner the authority for hospital rate review negotiations, and PC and behavioral health spending for statewide accountability. Several committee members encouraged more accountability to be built into the Cost Board recommendations to better ensure compliance.

Presentation: Increased Medicaid reimbursement for primary care

Kahlie Dufresne, Special Assistant for Health Policy & Programs, HCA

Medicaid typically reimburses less than Medicare for the same services, while commercial plans tend to reimburse more. The hypothesis for the Medicaid rate increase and how to contribute to increasing total spend uses a logic model of higher Medicaid reimbursement rates could invenctivize more providers to participate in Medicaid, accepting Medicaid patients, which results in better access to PC and more PC spend.

As of 2019, 12 states had PC Medicaid FFS rates at or above 90% of Medicare. Only Alaska, Montana, Delaware, and North Dakota had rates at or above 100% of Medicare for PC fee schedules. The Centers for Medicare & Medicaid Services (CMS) has been requiring states to review the benchmark of fee schedules relative to Medicare for PC services and other core service categories. CMS requires states achieve a certain benchmark as a condition of approval for 1115 waivers. Washington has been steadily implementing increases in PC payment rates for the past few years. There is mixed evidence on the relationship between PC rates and provider participation in Medicaid. Evidence of a strong relationship shows 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. Evidence of a weaker relationship comes from the 2014-2015 "fee bump" under the Affordable Care Act which showed no effect on provider participation in Medicaid. Now, nuanced assessments are available showing how setbacks and delays of the fee bump implementation effected provider engagement.

Additional factors impacting payment rates and provider participation include patient coverage mix, provider perception, administrative burden, and referral pathways. Another consideration is how inequitable payment can contribute to racial disparities in outcomes and access to care. There are multiple reasons to consider that the Medicaid reimbursement change can do. Concerning the potential administrative burden of implementing these changes, there are things to consider. This includes the multiple billing guides providers need to be familiar with to know which services to bill under what reimbursement structure. In an effort to increase the Medicaid PC rate, it is important to not create another PC fee schedule and review existing ones while considering the disparities between the Medicaid and Medicare payment rates. Better access to PC can prevent the need for expensive specialty and acute care, particularly unnecessary emergency department visits. It can also increase the use of specialty and acute care when the PC provider identifies conditions or issues that need additional treatment. The context, content, and timing of increased primary care utilization can have an impact on the overall spend ratio.

The recommendation under consideration is for HCA to increase Medicaid rates for PC services to parity with the Medicaid fee schedule. To mitigate adminsitrative burden, implementing the increase could use existing fee schedules. HCA is working on this effort and encourages the committee's support.

A committee member asked how Washington PC Medicaid rates compare to national benchmarks. Kahlie responded it's about 70% of Medicare, but will be reanalyzed in light of recent increases. The analysis will also separate the price comparison taking utilization mix into account. Kahlie will look into Washington Medicaid rates in comparison to other states. Another committee member cautioned that time is needed to see how PC numbers increase, especially with speciality providers. A member questioned how the policy recommendation will impact the fee schedule given the different service rates between Medicare and Medicaid afforded to providers. Kahlie said that the recommendation might be oversimplified due to differentials in provider types and services paid above the benchmark that would not be decreased to meet Medicare parity. A committee member questioned if there is legislative funding provided, and there are is currently an under-supply of PC providers, how will the broader issues fit into the recommendation? Kahlie mentioned the other policy options that could address workforce numbers and said there could be an argument about dwindling supply of providers because prices are so low. In terms of the budget, this could be costly and an analysis will be completed after the new fees are in place.

Presentation & discussion: Incentivizing and measuring non-fee for-service payment

Karen Johnson, Vice President, Advancement Academy of Family Physicians (AAFP)

Well-designed PC payment should include FFS and non-FFS payment. FFS alone does not work well for PC because of undervalued payments, burdensome documentation, and PC is not a discrete service. A report shows PC would benefit from a hybrid payment model retaining FFS for incentives and more general services. AAFP developed a practice and payment policy using six principles. More practical data is needed to determine the impacts of hybrid payment models.

The Health Care Payment Learning & Action Network (HCP-LAN) was created under the Affordable Care Act to advance multi-stakeholder payment reforms to enable coordinated health care that achieves better health, equity, and affordability. The four categories of the HCP-LAN Alternative Payment Framework helps standardize and measure a hybrid-payment model. For non-FFS PC services, Comprehensive Population-Based payment under Category 4B fits best. Payment incentives matter but can be complicated and not easily separated between one-patient-at-a-time and value-based care. Using the HCP-LAN model, value-based payment is layered atop FFS payments and includes doing it all. It's important to try to understand what's happening as payment changes, what form it's taking, and how it moves from FFS towards population-based payments. HCP-LAN collects information through a survey instrument, with payers submitting data to track nationwide progress, published in an annual report. Individual plan data is strictly confidential, likely lending to high participation from payers. Using the HCP-LAN data from the 2015-2022 annual report, AAFP tracked an upward trend for category 4 payment models. Overall, about 40% is FFS only, approximately 50% is an alternative payment model using an FFS foundation, and around 10% is non-FFS. AAFP formally requested HCP-LAN track how much of the shift in non-FFS payment is from PC, separate from specialty care. This could show what non-FFS in PC could look like and how to drive change in Washington.

Increasing investment through non-FFS payments can help strengthen accountability and engagement between patients and PCPs by asking members and patients to choose where they want to get their PC to accurately direct non-FFS payments. It could also increase more flexible revenue streams to practices, allowing for investment in people and infrastructure. Reducing burdens associated with payment, which can improve physician and team well-being and sustain much-needed primary care workforce, is also a possible benefit.

Comprehensive Primary Care Plus (CPC+) was a national advanced primary care medical home model aimed to strengthen PC through regionally-based multi-payer payment reform and care delivery transformation. Before CPC+, about 3% of patients provided non-FFS from payer partners. Over the next four performance years, the numbers increased to almost 20%, mostly supported by CMS providing alternative payments with little change to the percentage of payer partners. The payer partners voluntarily participated in CPC+ and already engaged in non-FFS practices. AAFP is working with Colorado, Delaware, OR, CA, and Massachusetts using a PC investment toolkit on non-FFS measurement and investment.

Presentation: Tie primary care spending to alternative payment models

Kahlie Dufresne, Special Assistant for Health Policy & Programs, HCA

HCA defines value-based payment (VBP) models using categories 2C through 4C of the HCP-LAN Alternative Payment Framework for Washington. Starting in 2016, the annual Paying for Values survey is one of the main trackers to show the state's VBP adoption over time with FFS decreasing as VBP are utilized more. As of 2022, PC providers represent most of the providers engaged in alternative payment methods (APM). This could be in connection with HCA's incentives for PC services. There may not be room to expand VBP within PC, but there could be opportunities to change the types of arrangements for PC providers. The 2024 Primary Care Expenditure report will provide more detail about APMs by asking PC to report their spending by category.

Other states are leveraging APMs to reach their PC spending targets. States including Delaware, CA, 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. Massachusetts requires PC providers that participate in its Medicaid accountable care organizations to shift to a per-member-per-month model that supports team-based care. Colorado, Delaware, and RI also have policies aimed at increasing rates overall with an emphasis on claims payments. As a

recommendation, the committee could annually review adoption of APM by HCP-LAN Category and by Making Care Primary alignment.

A committee member said to consider requiring Medicaid prospective payment or capitation by a certain date with the understanding of the nuance behind the requirement.

Primary Care Committee 2024 wrap-up

Chair Dr. Judy Zerzan-Thul, Medical Director, HCA

Chair Zerzan-Thul shared an overview of the seven policy recommendations presented to the committee:

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%.

The goal is to narrow the selection down to the top two or three choices, to present to the Cost Board for consideration, as presenting all seven would be overwhelming. Two or three recommendations increases the likelihood of action and implementation.

The June 26, 2024, meeting will be the last committee meeting for the year. There will be a meeting scheduled for next year to review the PC spend data (claims and non-claims-based spending) and the policy recommendations to see if there is anything that needs updating.

Next Steps for Primary Care Committee

Gretchen Morley, Center for Evidence-based Policy (CEbP)

HCA staff will send the committee the full list of primary care policies for committee members to review. Further input about the policies will be due on June 7, 2024. Members are encouraged to think about how to prioritize the list of policies at the June 26, 2024 meeting. CEbP will facilitate the discussion as committee members rank-order all seven policies and finalize the top two or three recommended policies to share with the Cost Board for consideration at their July 2024 meeting.

A committee member asked about the process for considering suggestions for the final recommended policies. Gretchen responded that CEbP will ensure everyone's input is reflected in the conversation. The input received before the meeting could determine the method of how it is presented to members, particularly if policies could be combined. Chair Zerzan-Thul added if there is something that might have been missed, it can also be discussed during the meeting. Gretchen said that there will be a poll to rank each option for everyone to have a direct vote.

Adjournment

Meeting adjourned at 3:43 p.m.

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Washington Association for Community Health
Community Health Centers Advancing Quality Care for All

May 29, 2024

Health Care Cost Transparency Board
Advisory Committee on Primary Care
Washington State Health Care Authority
626 8th Ave SE
Olympia, WA 98501

RE: Legislative Recommendations – Proposed Alternatives to 12 Percent Primary Care Spend Target

Dear Chair Zerzan-Thul and Members of the Advisory Committee on Primary Care:

The Washington Association for Community Health (Association) welcomes this opportunity to provide public comment on the Advisory Committee on Primary Care's (Committee's) potential policy recommendation on primary care expenditure target measurement. The Association represents Washington's 28 Federally Qualified Health Centers (FQHCs), which collectively provide comprehensive primary medical, dental, and behavioral health services to over 1.2 million patients annually, forming the largest primary care network in our state. The work of the Health Care Cost Transparency Board (Board) and its advisory committees are of special interest to FQHCs and their patients, approximately 88 percent of whom live at or below 200 percent of Federal Poverty Guidelines.[i] The Board's policy recommendations are certain to have a disproportionate impact on access to affordable care for the low-income and underserved individuals, families, and communities that FQHCs have been established to serve.

Passed in 2022, SB 5589 directed the Board to track expenditures on primary care, establishing a goal of increasing the share spent on primary care to 12 percent of total health care expenditures annually. In considering this legislation, the Legislature heard testimony that primary care is the only part of the continuum of care where "an increased supply is associated with better population health and more equitable outcomes."[ii] Additionally, increasing the proportion of total health care costs directed to primary care means putting more resources into monitoring and maintaining the health of an individual, increasing the potential for early detection of and timely intervention for emerging health challenges as well as managing chronic conditions in a sustainable and patient-directed fashion, with the effect of bringing down global health care costs.

During its April 28 meeting, the Committee was briefed on the option of recommending an alternative to this 12 percent target, considering instead establishing a per-member-per-month (PMPM) or per-capita primary care expenditure target. As outlined by staff for the Committee, this would enable the state to target spending to the "actual needs of primary care," rather than tethering the measure to spending in other sectors of the

health care system. In illustrating this concept, staff noted the possibility that a significant innovation in health care delivery or a major price control could drive down the state's total cost of care in other areas, meaning that even increasing primary care's share to 12 percent could mean fewer total resources invested in primary care. Indeed, this would be particularly problematic if such an innovation or price control does not impact the real and rising cost of delivering primary care services.

Nevertheless, adopting such an approach to primary care expenditure targets – in isolation – fails to account for two key factors in the broader conversation around greater investment in primary care. First, historical trends indicate that an absolute reduction in global health care costs, such that the total resources invested in primary care would be reduced even if the 12 percent target were achieved, is unlikely to materialize in the short- to medium-term. Second, the Legislature appears to have established the 12 percent target precisely because it wishes to increase investment in primary care relative to other parts of the health care system, both because it holds the promise of long-term savings and because of its demonstrated effectiveness in improving overall population health.

Instead, the Association suggests that the Committee recommend that the state maintain its 12 percent primary care expenditure target while also tracking a secondary PMPM or per-capita target. This additional data would allow the state to account for confounding shifts – upward or downward – in total health care costs, including any delivery innovations or price controls. Furthermore, as staff noted in the briefing on the proposal, establishing a supplementary PMPM or per-capita target would entail an assessment of "provider costs, population health status, and clinical best practice" – an assessment which would be extremely useful for informing the Committee and the Board as it works to drive further investment in primary care in pursuit of both the 12 percent target and a capitated target, and perhaps influence other policy recommendations as well. Finally, in the event that global health care spending trends quickly upward, making it more difficult to achieve a firm 12 percent primary care spending share, it would enable the state to demonstrate progress relative to the established baseline.

Thank you for reviewing these comments. The Association looks forward to further engagement with the policy recommendations of the Committee and the work of the Board. If you have questions or concerns, please contact me by email at bmarsalli@wacommunityhealth.org or by phone at (360) 786-9722.

Sincerely,

Bob Marsalli
Chief Executive Officer
Washington Association for Community Health

[i] https://data.hrsa.gov/tools/data-reporting/program-data/state/WA, accessed 5.28.2024
[ii] https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bill%20Reports/Senate/5589%20SBR%20HLTC%20OC%2022.pdf?q=20240529085757, accessed 5.28.2024

Tab 4

Washington State Health Care Authority

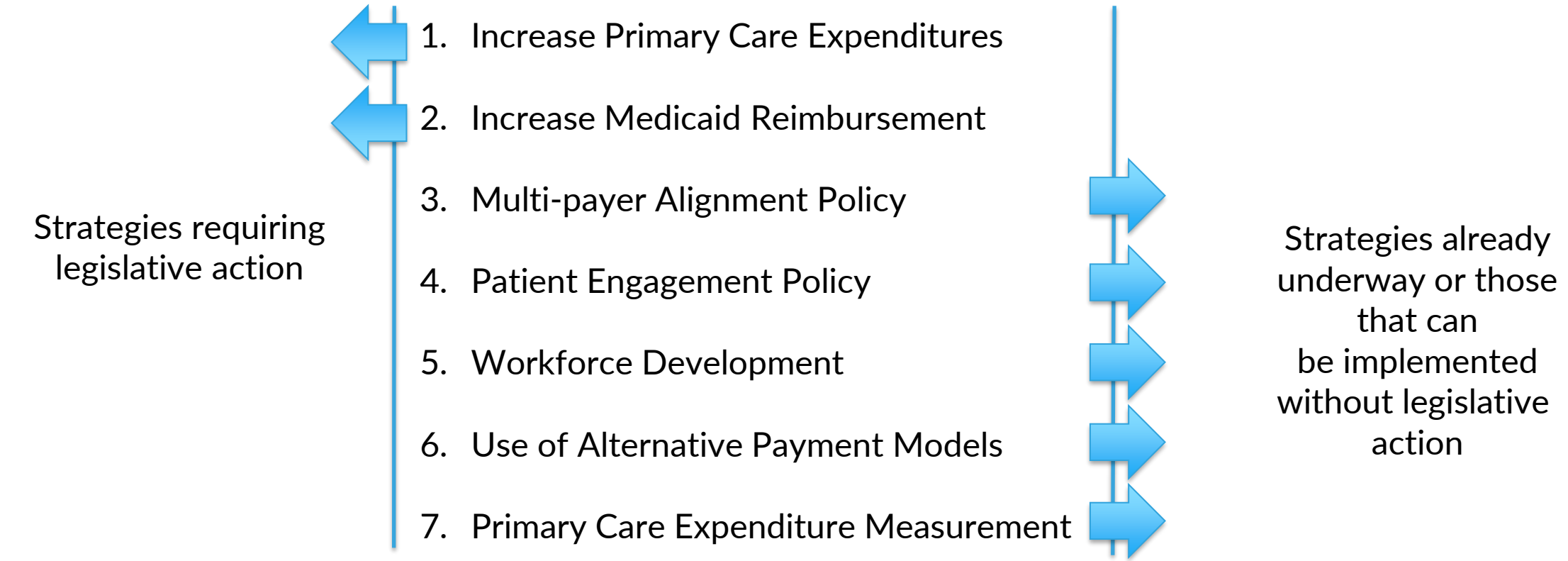
Policy Prioritization
(you will be voting on policies in these sections)

Recommendations to increase and sustain investment in primary care

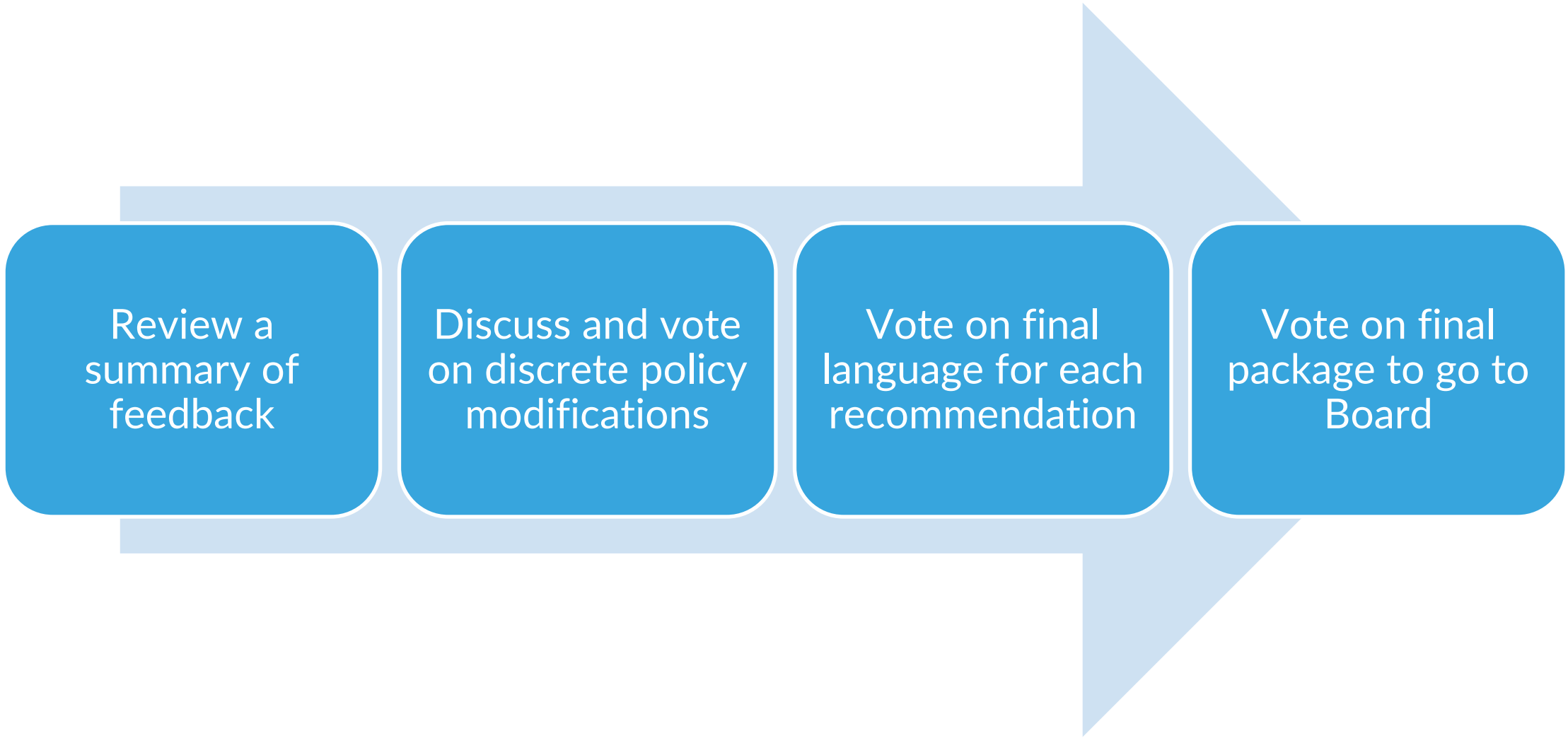
1. **Increase primary care expenditures** as a percentage of total health care spending by one percentage point annually until a primary care expenditure ratio of 12% is achieved.
2. **Increase Medicaid reimbursement** for primary care to no less than 100% of Medicare no later than 2028.
3. **Multi-payer 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% of total health expenditures.

Potential Proposal Advancement Strategy

Staff recommendation: Instead of prioritizing 2-3 action items out of the 7, consider submitting a package where there are 2-3 action items and a suite of endorsements for other policies. The final recommendations and feedback have created a natural delineation between the two categories.



Policy Finalization Process



Recommendation #1: Increase Primary Care Expenditures

Recommendation #1: Increase Primary Care Expenditures Prior Draft Language

- Recommend the Legislature codify a goal to increase primary care spending by 1 percentage point per year.
- Recommend the Legislature require agencies to publicly report primary care expenditure ratios of all carriers (HCA, HBE, OIC)

Recommendation #1: Increase Primary Care Expenditures Feedback Summary

Committee Amendment Suggestions:

- Expand authority of the Insurance Commissioner to be able to enforce targets
- Create a new role: Health Insurance Commissioner within OIC
- (3+) Include specific consequences for not achieving targets
- (2) Increase 1% or 2%

Requests for Additional Information:

- How will this policy impact premiums?
  - Each plan could have a different strategy for achieving the goal. Different strategies may have different premium impacts, or no premium impact at all in aggregate.
  - We heard from Oregon that they did not need to make explicit rating adjustments in Medicaid to support achieving targets, but they saw early success regardless

Recommendation #1: Increase Primary Care Expenditures Proposed Revised Language

- Recommend the Legislature codify a goal to increase primary care spending by **one [or two]** percentage point(s) per year.
- Recommend the Legislature require agencies to publicly report primary care expenditure ratios of all carriers (HCA, HBE, OIC)
- **Recommend that the Office of the Insurance Commissioner (OIC) should submit a report to the Legislature by 2026 describing how payers will be held accountable for achieving primary care expenditure targets. This report should include making recommendations for changes to the OIC's regulatory oversight authority if necessary.**

Recommendation #1: Vote 1 – 1 or 2 percentage points

Vote: The percentage target should increase 1% (or 2%) annually.

Recommendation #1: Vote 2 – Recommendation Related to the Office of Insurance Commissioner

Vote: Recommend that the Office of the Insurance Commissioner (OIC) should submit a report to the Legislature by 2026 describing how payers will be held accountable for achieving primary care expenditure targets. This report should include making recommendations for changes to the OIC's regulatory oversight authority if necessary.

Recommendation #1: Increase Primary Care Expenditures Final Language

- Recommend that the Legislature codify a goal to increase primary care spending by **one [or two]** percentage point(s) per year.
- Recommend that the Legislature require agencies t publicly report primary care expenditure ratios of all carriers (HCA, HBE, OIC)
- **Recommend that the Office of the Insurance Commissioner (OIC) should submit a report to the Legislature by 2026 describing how payers will be held accountable for achieving primary care expenditure targets. This should include making recommendations for changes to the OIC's regulatory oversight authority if necessary.**

Recommendation #2: Increase Medicaid Reimbursement

Recommendation #2: Increase Medicaid Reimbursement Prior Draft Language

- HCA should increase Medicaid reimbursement for primary care services to no less than Medicare rates by 2028.
- HCA should implement the increase using existing enhanced fee schedules to minimize confusion.

Recommendation #2: Increase Medicaid Reimbursement Proposed Revised Language

- The Legislature should increase Medicaid reimbursement for primary care services to no less than Medicare rates by **2028**.
- **The Legislature should direct HCA to:**
  - **Implement the increase by using the Enhanced Adult Primary Care and Enhanced Pediatric fee schedules.**
  - **Revise those fee schedules to more closely align with the service codes in the Cost Board's adopted definition of primary care services.**
- **The payment rate for any services on the enhanced fee schedules already reimbursed at or above Medicare equivalent rates should not be changed.**
- The Legislature should implement the fee schedule increase no later than **2028**.

Recommendation #2: Increase Medicaid Reimbursement Feedback Summary

Committee Amendment Suggestions:

- Increases in Medicaid reimbursement should apply more broadly and not just to primary care
- (2) Medicaid reimbursement for primary care services should target 100% of Medicare by 2026
- Add greater specificity to reflect how the policy would be implemented
- Reference legislative appropriations

Requests for Additional Information:

- Verify that mandated increases in primary care reimbursement can be reflected in managed care capitation rates
  - Managed care capitation rates can be adjusted to reflect policy changes as rates are required to be actuarially sound.
  - The rate adjustment might not be a dollar-for-dollar depending on the expected impact of the policy change on utilization or cost of other services.
- Request to know how much this policy would advance the state toward 12% goal

Recommendation #2: Vote 2026 instead of 2028

Vote: Should the recommendation change from 2028 to 2026?

Recommendation #2: Increase Medicaid Reimbursement Final Language

- The Legislature should increase Medicaid reimbursement for primary care services to no less than Medicare rates by **2026 or 2028 as determined by the Committee**.
- **The Legislature should direct HCA to:**
  - **Implement the increase by using the Enhanced Adult Primary Care and Enhanced Pediatric fee schedules.**
  - **Revise those fee schedules to more closely align with the service codes in the Cost Board's adopted definition of primary care services.**
- **The payment rate for any services on the enhanced fee schedules already reimbursed at or above Medicare equivalent rates should not be changed.**
- The Legislature should implement the fee schedule increase no later than **2026 or 2028 determined by the Committee**.

Recommendation #3: Multipayer Alignment

Recommendation #3: Multipayer Alignment
Prior Draft Language

Committee support for:

- The Multi-payer Collaborative's work in aligning standards, quality metrics, practice supports, and payment models.
- The Collaborative's efforts to align the Primary Care Transformation Model with the federal Making Care Primary program.
- Legislature advance multi-payer primary care alignment efforts, particularly for state-funded plans to participate in a Making Care Primary aligned transformation model.

Recommendation #3: Multipayer Alignment Feedback Summary

Committee Amendment Suggestions:

- Endorse the state's Multipayer Collaborative adopted policy design

Requests for Additional Information:

- N/A

Recommendation #3: Multipayer Alignment Final Language

The Committee **endorses**:

- The Multi-payer Collaborative's work in aligning standards, quality metrics, practice supports, and payment models.
- The Collaborative's efforts to align the Primary Care Transformation Model with the federal Making Care Primary program.
- Legislature advance multi-payer primary care alignment efforts, particularly for state-funded plans to participate in a Making Care Primary aligned transformation model.

Recommendation #4: Patient Engagement

Recommendation #4: Patient Engagement
Prior Draft Language

- Payer and purchasers provide education and incentives to promote utilization of primary care and preventive services
- 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.
- Legislature should fund a study to conduct an opportunity analysis of patient incentive programs that could be implemented to increase engagement with primary care providers while improving patient's health. Promising, feasible opportunities should be pursued through the appropriate authority and operational processes.

Recommendation #4: Patient Engagement Feedback Summary

Committee Amendment Suggestions:

- Appropriate agencies should allow for incentives to promote utilization of primary care services

Requests for Additional Information:

- N/A

Recommendation #4: Patient Engagement
Final Language

The Committee **endorses**:

- 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.
- **Any state agency efforts to support availability of employee or member incentives to access primary care services.**

Recommendation #5: Workforce Development

Recommendation #5: Workforce Development
Prior Draft Language

The Legislature should prioritize funding for state primary care workforce initiatives as collaboratively identified through the Health Workforce Council.

Recommendation #5: Workforce Development Feedback Summary

Committee Amendment Suggestions:

- Support recommendations from the Health Workforce Council (HWC)

Requests for additional information:

What recommendations does the HWC have that would support primary care?

- The following are general recommendations from HWC apply more broadly than primary care, but may also support the primary care workforce:
  - **Additional Funds for WA Health Corps:** Allocate more funds to support loan repayment awards for both behavioral health and other health professionals through the WA Health Corps.
  - **Evaluation of Loan Repayment Programs:** Provide funds for a third-party evaluation of the outcomes of loan repayment programs, with directives to relevant agencies to share necessary data for tracking the progress of applicants and awardees.
  - **Support Access to Public Service Loan Forgiveness:** Eligible healthcare employers should provide educational materials about the Public Service Loan Forgiveness (PSLF) program when hiring new employees, annually thereafter, and at the time of employee separation.
  - **Address Access to Child Care, Housing, and Transportation:** Address access to essential community resources such as childcare, housing, and transportation to support healthcare workers.

Source: Health-Workforce-Council-Annual-Report-2023.pdf (wa.gov)

Recommendation #5: Workforce Development
Final Language

The Committee endorses Health Workforce Council recommendations that would increase access to primary care services.

Recommendation #6: Use of Alternative Payment Models

Recommendation #6: Use of Alternative Payment Models Prior Draft Language

Following the 2024 reporting of primary care expenditures by the Health Care Payment Learning & Action Network (HCP-LAN) category, the committee may make recommendations to the Cost Board for the portion of primary care expenditure that should be tied to alternative payment methodologies for expenditures to count towards the expenditure growth target.

Recommendation #6: Use of Alternative Payment Models Feedback Summary

Committee Amendment Suggestions:

- 50% of payments should be through 4b by 2030
  - Category 4b specifically involves integrated payment and delivery systems where payments are designed to support comprehensive, coordinated care across multiple settings, which may include shared financial risk and population-based payments

Requests for Additional Information:

- N/A

Payment Model APM Framework (hcp-lan.org)

Recommendation #6: Use of Alternative Payment Models Final Language

Endorse HCA efforts to track primary care expenditures using the HCPLAN Alternative Payment Model Framework categories and to make future recommendation on modifications to the expenditure targets based on related findings. This could include setting a minimum percentage of primary care expenditures that must be paid through more advanced payment models for the primary care expenditures to count towards the annual expenditure target.

Recommendation #7: Measurement Strategy

Recommendation #7: Measurement Strategy
Prior Draft Language

- The Health Care Cost and Transparency Board should evaluate the feasibility and appropriateness of using a primary care expenditure target based on aggregate per capita or per-member-per-month (PMPM) expenditures instead of an aggregate expenditure ratio of 12%.
- If the Board determines a PMPM or per capita target is feasible and desirable and targets are identified, the Board should make recommendations to the Legislature to replace the 12% primary care expenditure target with the revised PMPM or per capita target.

Recommendation #7: Measurement Strategy Feedback Summary

Committee Amendment Suggestions:

- Measure using both strategies, but maintain the percent of total spend as primary

Requests for Additional Information:

- N/A

Recommendation #7: Measurement Strategy
Final Language

The Committee endorses an effort by HCA to measure expenditures both on a PMPM or per capita basis and primary care expenditures as a percent of total expenditures and to make future recommendations to improve primary care expenditure tracking based on any findings.

Tab 5

Washington State Health Care Authority

Recommendation Package

Committee Recommendation Package

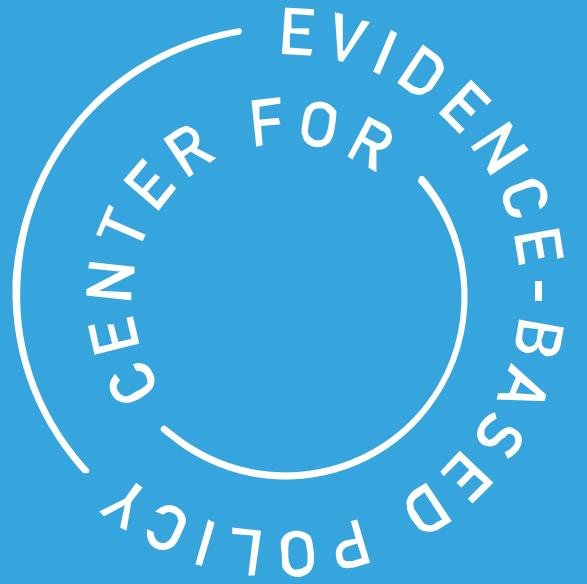
Policy Recommendations

Committee Endorsements

Strategies requiring legislative action

1. Increase Primary Care Expenditures
1. Increase Medicaid Reimbursement
2. Multi-payer Alignment Policy
3. Patient Engagement Policy
4. Workforce Development
5. Use of Alternative Payment Models
6. Primary Care Expenditure Measurement

Strategies already underway, or that can be implemented without legislative action


CENTER FOR EVIDENCE-BASED POLICY

Tab 6

Washington State Health Care Authority

Wrap Up & Next Steps

- Policy recommendations from today will be brought to the Cost Board meeting on July 30th
- Today is the last meeting for 2024 for the Advisory Committee on Primary Care
- 2025 meeting schedule will be emailed to committee members when it becomes available
- If you have any updates / changes to your contact information, please send to hcahcctbprimarycareadvisorycommittee@hca.wa.gov

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

Washington State Health Care Authority