Washington State Hospital Association

August 7, 2020

Re: WSHA Comments on Multi-payer Primary Care Model

On behalf of our 106 hospital and health system members, the Washington State Hospital Association (WSHA) values the opportunity to comment on the proposed multi-payor primary care model.

WSHA supports the overall concept and general direction of the proposed model. The model includes components that primary care groups and insurers have been working on for several years. We believe the emphasis on alignment of payment and quality measures between payors that are part of the model will help the adoption of these efforts. We believe the conceptual framework and direction of the model is sound, but the development of the specific details will be critical in ensuring the adoption and success of the model. As it moves forward, we recommend that HCA broaden its workgroups to ensure it includes members with expertise in each subject area and that represent various types and sizes of primary care entries. We also recommend that primary care entities be given the opportunity to voluntarily participate in the new model. We also recommend that to the degree possible, the details of the model reflect the work already done and arrangements already in place between payers and primary care provider entities. Broad workgroup representation will help identify commonalities between existing initiatives that can be incorporated in the details of the model.

We ask that HCA consider the following as it works through the specific details of the model:

Payment

The model represents a significant transition from the existing model, by giving the primary care provider greater role in coordinating care that previously was the responsibility of the health plan. Under the proposed model, primary care providers will be required to provide, procure, and coordinate a range of services they have not done previously. The payment for primary care must be adequate to support the services provided, as well as the additional infrastructure costs for the care coordination that will be needed. The payment must be enough to ensure the viability or primary care providers in rural areas. At a minimum, payments to rural health clinics should equal or exceed what they receive under existing RHC payment and expand as needed to reflect the costs of expanded coordination and services.

Availability of services

The model assumes availability of a range of social services and other services to be available. While we expect these services to be available in many areas, we believe that there will some areas that will lack many of these services due to geography or population. We recommend the model allow modification of requirements according to the availability of services for each primary care entity.

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Cost

We support the model provisions that would require payors to increase their investment in primary care as a proportion of their total spend on medical services. We believe investment in primary care can ultimately provide significant savings by reducing avoidable utilization of acute care services through better access to preventive services and improved care coordination of care for chronic conditions. While the amount of acute care may be reduced, the average acuity will likely increase over time. We recommend the model ensure that health plans do not meet the primary care funding requirement by cutting rates or network adequacy to other needed services

Risk.

The model is essentially a capitation model with transitional payments and quality incentive. While similar models have been used historically with larger provider groups, safeguards must be put into place to minimize risk for smaller provider groups.

Attribution

We understand the quality and utilization risk components of the model will involve some form of attribution of patients to provider groups. Attribution works well when a patient stays with the same provider over a longer time period but there can be issues allocating responsibility accurately when patients frequently move among providers. This is a particular concern for Washington Apple Health, as patients can change their managed care health plan, and by consequence their primary care provider on a monthly basis. We recommend the model include safeguards to ensure providers bear financial risk only for patients that have been assigned to them for a minimum duration.

Utilization and Quality Risk

Most projections of expected quality and utilization are based upon a relatively normal time period. With the COVID emergency, it is unclear when health care will return to the type of normalcy we have experienced in the past. As a result, it may be difficult to project with accuracy what normal utilization rates will be for specific services and the COVID crisis will likely continue to result in swings of utilization that are largely out the control of the provider. During an emergency, utilization of some services will increase. On the other hand, other services, such as preventive care and immunizations may decrease if patients are afraid to seek health care. This could adversely affect the quality scores for the provider, even though largely out of his or her control. We recommend the specifics of the model reflect this reality. We encourage the use of telehealth where indicated, and support efforts to ensure services via telehealth “count” toward meeting any necessary quality components.

Thank you again for the opportunity to comment. If you have questions, please contact Andrew Busz, WSHA Policy Director, Finance at (206) 216-2533 or andrewb@wsha.org.

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