Washington State Health Care Authority

# Advisory Committee on Primary Care

September 28, 2022

Washington State Health Care Authority

# Advisory Committee on Primary Care
# Meeting Materials

**September 28, 2022**
**11:30 a.m. – 1:00 p.m.**

**(Zoom Attendance Only)**

## Meeting materials


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# Agenda

# TAB 1

Washington State Health Care Authority

# Advisory Committee on Primary Care

**September 28, 2021**
**11:30 a.m. – 1:00 p.m.**
**Zoom Meeting**

## AGENDA

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

| Time | Agenda Items | Lead |
|---|---|---|
| 11:30-11:35<br>(5 min) | Welcome and call to order | Dr. Judy Zerzan-Thul, Chair, Medical Director<br>Washington State Health Care Authority |
| 11:35-12:00<br>(25 min) | Agenda review; committee member and staff introductions | Jean Marie Dreyer, Committee Facilitator<br>Health Care Authority |
| 12:00-12:20<br>(20 min) | Introduction to committee workplan and primary care | Dr. Judy Zerzan-Thul, Chair, Medical Director<br>Washington State Health Care Authority |
| 12:20-12:40<br>(20 min) | Presentation on OFM and Bree primary care definitions | Mandy Stahre, Office of Financial Management<br>Ginny Weir, Bree Collaborative |
| 12:40-12:50<br>(10 min) | Public comments | Dr. Judy Zerzan-Thul, Chair, Medical Director<br>Health Care Authority |
| 12:50-12:55<br>(5 min) | Next Steps | Dr. Judy Zerzan-Thul, Chair, Medical Director<br>Health Care Authority |
| 12:55-1:00<br>(5 min) | Wrap-up and adjournment | Jean Marie Dreyer, Committee Facilitator |

*Subject to Section 5 of the Laws of 2022, Chapter 115, also known as HB 1329, the Board has agreed this meeting will be held via Zoom without a physical location.*

# Committee member and staff introductions

# TAB 2

# Committee Member and Staff Introductions

- Introduce yourself and where you work
- Questions
  1) Share your interest in primary care and this committee.
  2) What is a holiday meal you like to enjoy?

# Introduction to committee workplan and primary care

# TAB 3

# Advisory Committee on Primary Care

Dr. Judy Zerzan-Thul

CMO, HCA

Washington State Health Care Authority

# Senate Bill 5589: Statute and Directive

- **Statute**: In 2022, the Washington State Legislature passed Senate Bill 5589

- **Directive:** Health Care Cost Transparency Board directed to "measure and report on primary care expenditures and the progress toward increasing to 12% of total health care expenditures (THC)."

# Senate Bill 5589: Inclusion of Prior Work

- **Work to include**:
  - December 2019 report from the Office of Financial Management (OFM)
  - 2020 Bree Collaborative report
  - Research from other states
  - Research from Milbank memorial fund
  - Research from the National Academy of Sciences, Engineering, and Medicine (NASEM)
  - Health Care Authority efforts to strengthen primary care within state purchased health care

# Senate Bill 5589: Legislative Report

- **Preliminary legislative report:** Due on December 1, 2022, which includes recommendations on:
  - How to define primary care
  - Measurement considerations
  - How to increase primary care spending to 12 percent of total health care expenditures

# Health Care Cost Transparency Board (HCCTB)- Function and Purpose

- Created to identify trends in health care cost growth
- Responsible for establishing a health care cost growth benchmark/target for percentage growth
- Measures total health care expenditures (THCE)
  - THCE definition: All health care expenditures in Washington State by public and private sources, including:
    - Payments to providers for claims and non-claims-based payments
    - All cost-sharing paid by Washington residents, including copayments, deductibles, and coinsurance
    - The net cost of private health insurance
- HCCTB's two advisory committees provide built-in stakeholdering for advisory committee on primary care
- Part of coordinated cost growth monitoring efforts with other states
  - Existing Peterson Milbank sustainability grant work with other states will also involve primary care committee work

# Advisory Committee on Primary Care

- Chaired by CMO, Dr. Judy Zerzan, HCA
- Administrative support from HCA staff
- Membership subject to review and appointment by the Health Care Cost Transparency Board
- Reports to and advises the Health Care Cost Transparency Board on Primary Care Recommendations
- Primary care committee recommendations reviewed by two peer subcommittees:
  - Advisory Committee of Providers and Carriers
  - Advisory Committee on Data Issues

# Advisory Committee on Primary Care: Our Work

- The committee will advise the Health Care Cost Transparency Board and its subcommittees on recommendations for adoption:

  1) Recommend a ***definition of primary care***

  2) Recommend ***measurement methodologies*** to ***assess claims-based spending***

  3) Recommend ***measurement methodologies*** to ***assess non-claims-based spending***

  4) Report on ***barriers to access and use of primary care data*** and ***how to overcome them***

# Additional Legislative Directives for Primary Care Work

- Report annual progress needed for primary care expenditures to reach 12 percent of total health care expenditures
- Track accountability for annual primary care expenditure targets
- Recommend methods to incentivize achievement of the 12 percent target
- Recommend specific practices and methods of reimbursement to achieve and sustain primary care expenditure targets

# Advisory Committee on Primary Care: Meetings

- Regular meetings, beginning in September
  - Schedule coming soon
- Meetings will continue until required recommendations are:
  - Completed and;
  - Submitted to HCCTB
- Committee member term length
  - Currently undefined
  - Hope to be done within two years
- Virtual meetings for now - eventually hybrid?
- All materials will be distributed electronically and recorded with video placed on the Board website
- Contact email for questions: hcahcctboard@hca.wa.gov

# Advisory Committee on Primary Care: Decision making

- Four initial recommendations:
  - Two to be developed by the end of 202 and included in December 1, 2022 legislative report
  - Two more will be developed in 2023 for inclusion in August legislative report
- Next steps for this year:
  - Today's meeting will focus on the first recommendation- defining primary care
    - Discussion to continue during October 25 meeting
  - October 25 meeting:
    - Finish discussion on first recommendation and;
    - Begin discussion of recommendation two - measurement of claims-based spending
  - November 21 meeting will finalize recommendations
- Recommendations will be subject to a motion and vote by committee members
- If necessary, recommendations will be determined by a majority

# Overview of Primary Care Spending

Dr. Judy Zerzan-Thul
Chief Medical Officer, HCA

Washington State Health Care Authority

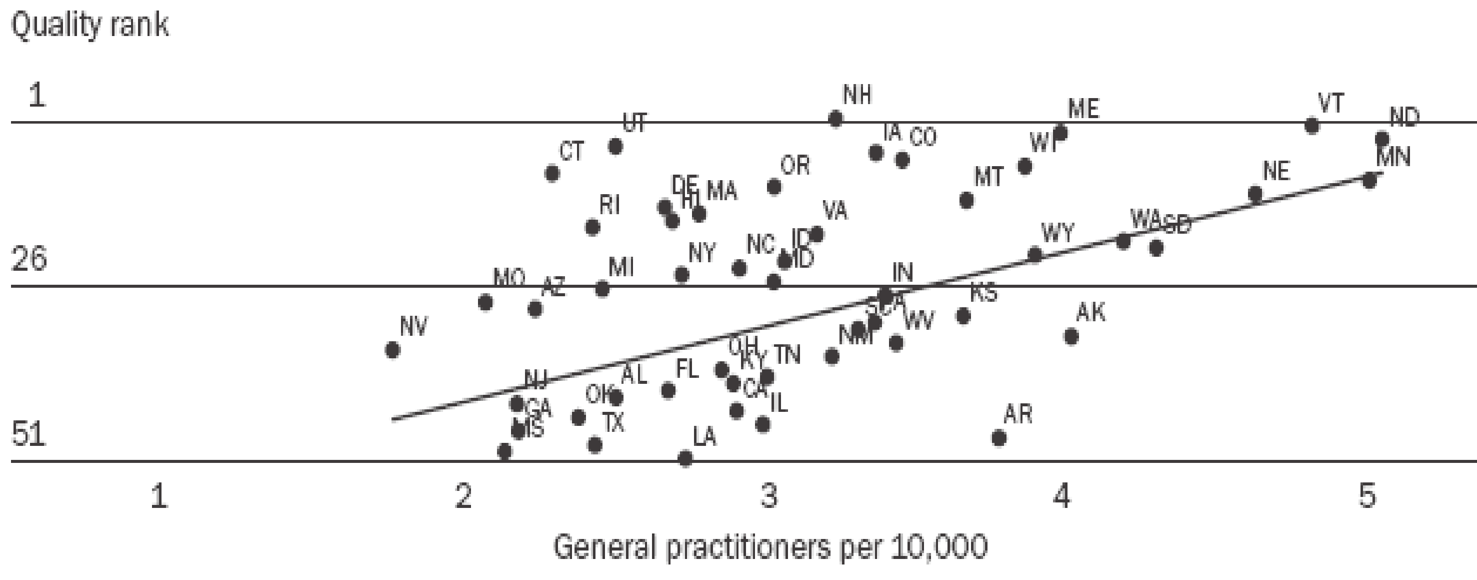
# Overview

- Why is increasing primary care spending to 12% important?
- 12% target challenges
  - Current spending levels
  - Definition impact
  - New data
- What existing efforts will we need to consider for our recommendations?
  - Bree
  - OFM
  - NASEM
  - Milbank
  - Others

# Why does the 12% primary care spending target matter?

- Over time, expectations of primary care have steadily increased
- Resources have not increased commensurate with expectations, leading to a crisis in primary care (workforce, access, etc.)
- Strong evidence supports the value of resourcing primary care better

# Primary Care Associated with Higher Quality




Several slides adapted with permission from Chris Koller, Milbank Fund

Source: Baicker & Chandra, Health Affairs, April 7, 2004

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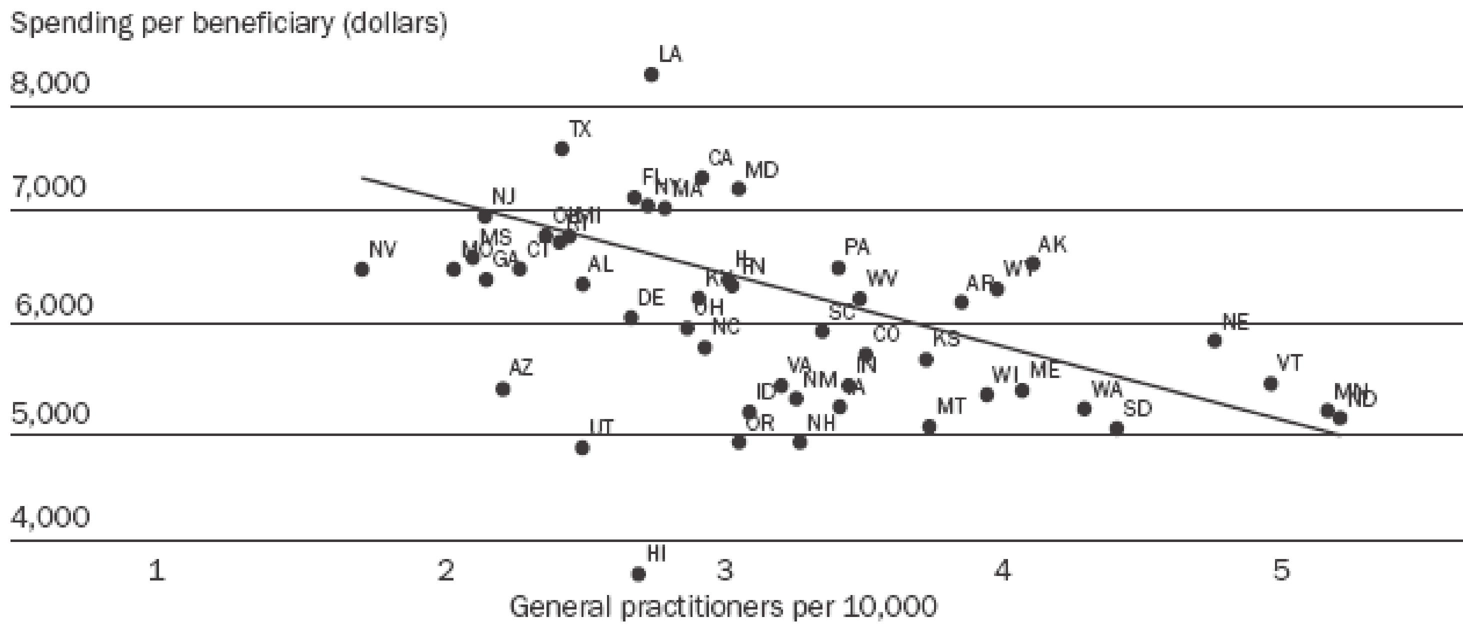
# Primary Care Associated with Lower Total Costs

**EXHIBIT 9**

**Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000**




**SOURCES:** Medicare claims data; and Area Resource File, 2003.
**NOTE:** Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004

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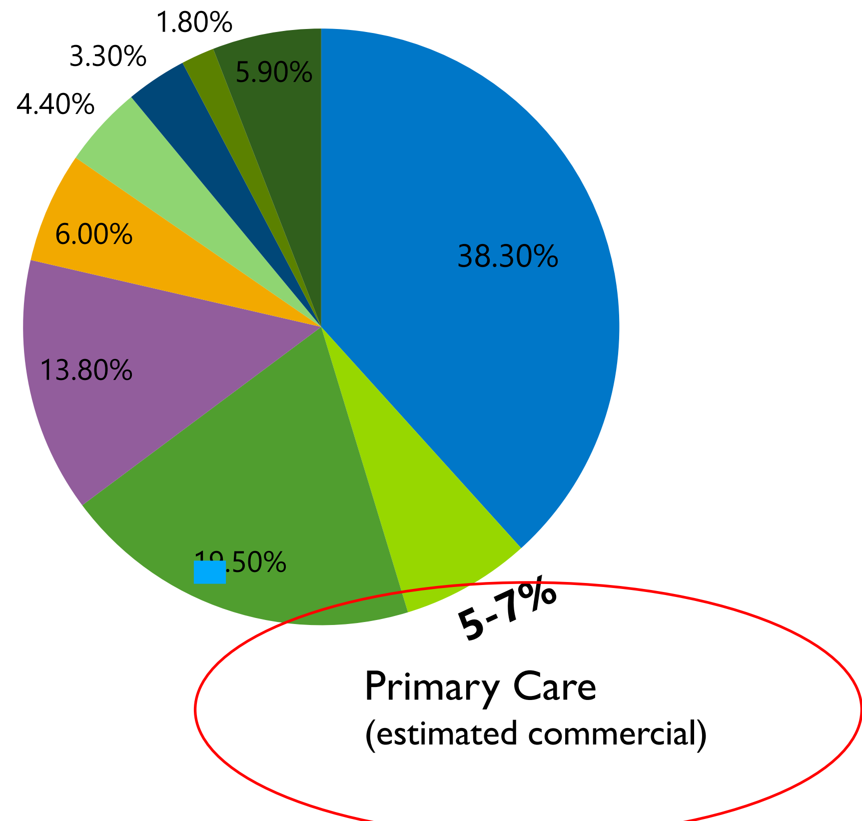
# Overall Spending Remains Low

- Hospital Care
- All Other Physician and Professional Services
- Prescription Drugs and Other Medical Nondurables
- Nursing Home Care
- Dental Services
- Home Health Care
- Medical Durables
- Other Health, Residential, and Personal Care




Source: CMS Actuary. All Payments

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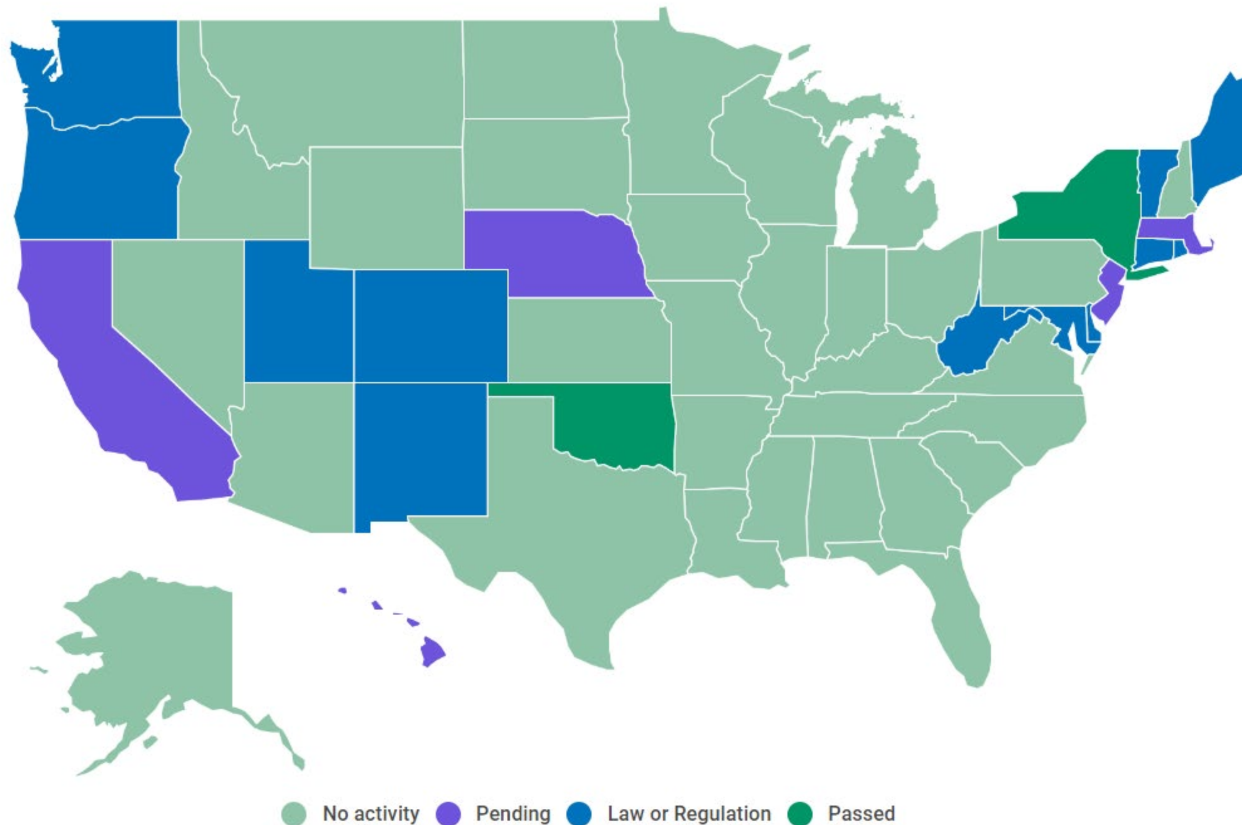
# Measuring Primary Care Spending: States with Statutory or Regulatory Action

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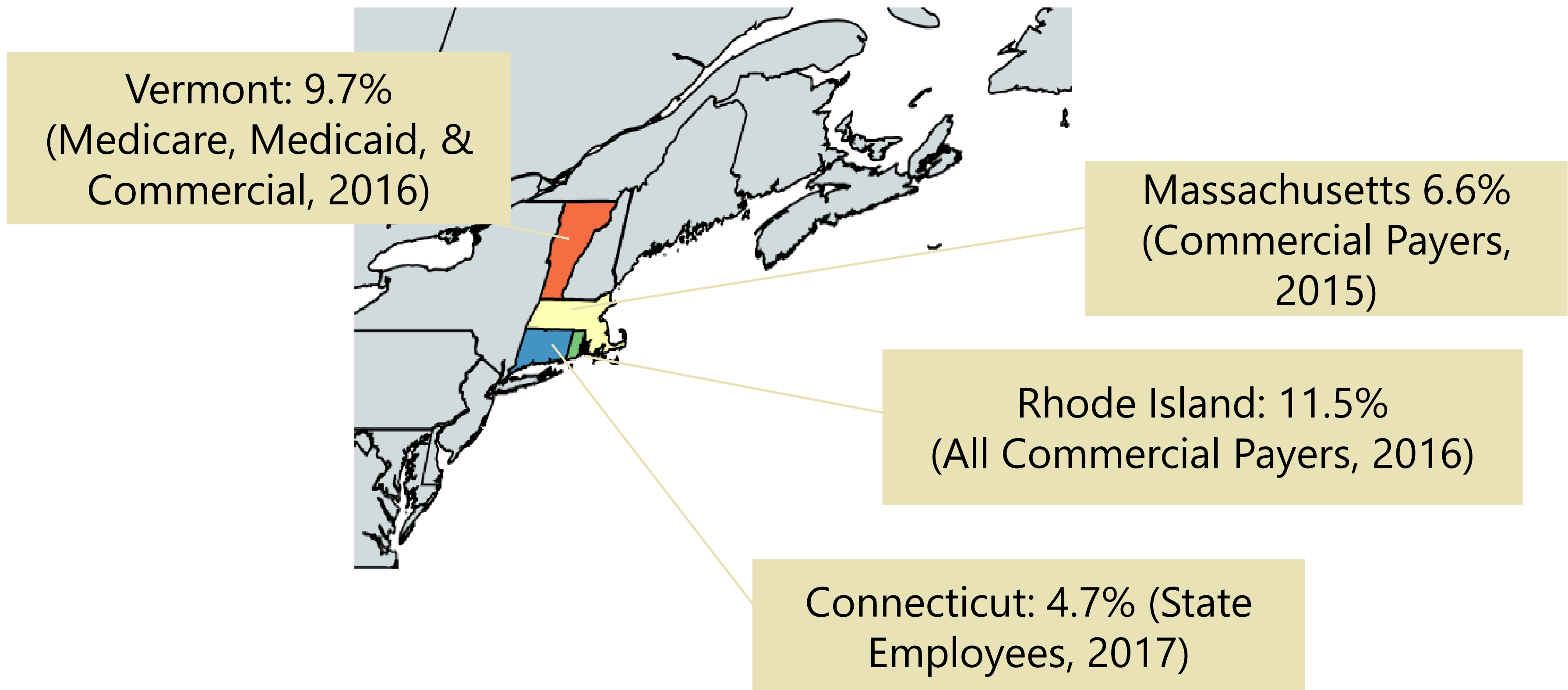
# Some Baseline Data (Note that Definitions Vary)




Source: NESCSO Primary Care Workgroup Presentation, 18 October 2018

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# Primary Care Spending: 12% Target Challenges

- Must increase current spending levels – 4.4% to 5.6% - to 12% of total health care expenditures
- Chosen definition will impact percentage – aim to be more inclusive, not less
- Will include data not currently incorporated i.e., non-claims-based data

# Existing Washington Primary Care Definitions

- RCW 74.09.010
  - "General practice physician, family practitioner, internist, pediatrician, osteopathic physician, naturopath, physician assistant, osteopathic physician assistant, and advanced registered nurse practitioner"
- OFM
  - In 2019, OFM was charged by legislature (Chapter 415) to assess primary care expenditures
- **Bree Collaborative**
  - The Bree Collaborative convened a workgroup in 2020 on primary care and developed a report

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# Existing Measurement of Washington State Primary Care Spending: OFM

- 2019 OFM report
  - Claims-based, All-Payer Claims Database (APCD) data, OFM definitions
  - For 2018, primary care expenditures were 4.4% ($838M) based on narrow definition and 5.6% (about $1B) based on broad definition
  - Data refresh with same definitions 2022 (not a full report)

# Existing Measurement of Washington State Primary Care Spending: HCA

- HCA carrier reporting
  - Contract requirement in Apple Health MCO contracts, PEBB and SEBB contracts, and Cascade Care contracts, phased in starting with 2020 payments
  - HCA has supplied template for HCA carriers to self-report
  - Claims definitions largely based on OFM report, with additional non-claims categories derived from national sources
  - Self-report percentages range from 5 to 14%
    - Note: interpretations of non-claims spend varied, and no audit of self report

# Primary care spending recommendations: Definition and measurement

- Recommendation 1: Defining Primary Care
  - *Who?*
    - Which providers/provider types are included?
  - *What?*
    - Which services are included?
- Recommendation 2: Claims-based spending
  - *How is spend measured?*
    - Claims-based
- Recommendation 3: Non-claims-based spending
  - *How is spend measured?*
    - Non-claims-based

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# Introduction of Primary Care Subject Matter Experts

- Mandy Stahre, Managing Director of Forecasting and Research, Office of Financial Management
  - Helped develop OFM's 2019 report on primary care expenditures as a percent of total medical expenditures by carrier

- Ginny Weir, Chief Executive Officer, Foundation for Health Care Quality, Bree Collaborative
  - Helped develop Bree Collaborative's 2020 report on a statewide-definition of primary care to support multi-payor payment reform

# Presentation on OFM and Bree primary care definitions

# TAB 4

# Office of Financial Management (OFM) and Bree Collaborative: Primary Care Definitions

Mandy Stahre, Office of Financial Management

Ginny Weir, Bree Collaborative

Washington State Health Care Authority

# OFM: 2019 Primary Care Report Process

- 2019 report developed with multi-stakeholder workgroup including:
  - OFM staff
  - ARNPs
  - Family physicians
  - Pediatricians
  - UW workforce researchers
  - UW global health expert
  - HCA staff
- OFM used WA-APCD claims data to measure primary care expenditures
- Separate definitions used for primary care providers and primary care services
- Narrow and broad definitions used for both providers and services
- Providers identified using taxonomy codes
- Services identified using CPT/HCPC codes

# OFM Primary Care Provider Definition: Narrow

- **Narrow:** Representing providers who traditionally perform roles contained within strict definitions of primary care.

- **Includes:**
  - Family medicine
  - Internal medicine
  - Federally qualified health centers (FQHCs)
  - General practice
  - Naturopath
  - Pediatrics
  - Preventive medicine
  - Nurse practitioners
  - Physician assistant
  - Primary care clinic providers
  - Rural health centers (RHCs)

# OFM Primary Care Provider Definition: Broad

- **Broad:** Representing providers who perform roles not traditionally contained within a strict definition of primary care
- **Includes:**
  - Behavioral health providers
  - Clinical nurse specialists
  - Registered nurses (RNs)
  - Midwives
  - Obstetricians and gynecologists
  - Family medicine and pediatric subspecialists
  - Homeopaths
  - Psychiatrists and neurologists
  - Psychologists
  - Social workers

# OFM Primary Care Services: Definition

- Modeled definition after other national efforts to define primary care (narrow and broad definition)
- Utilized claims data
  - Focused on billing
  - Didn't capture EMR information
- Claims do not always capture the location of services
- Services provided by NPs and PAs had to be imputed

# Bree Collaborative: 2020 Primary Care Report Process

- Collaborative workgroup comprised of primary care practitioners with representation from:
  - Washington State Department of Labor and Industries
  - Confluence Health
  - Haborview Medical Center
  - Washington State Hospital Association
  - Healthcare plans
  - Private companies: e.g., Microsoft and Boeing
  - SEIU 775 Benefits Group
  - Washington State Health Care Authority
  - Others
- Philosophical framework
- Principle-based
- Definition based on function/role as well as taxonomy

# Bree Definition: Primary Care

"***Team-based*** care led by an ***accountable*** provider that serves as a person's source of ***first contact*** with the larger healthcare system and coordinator of services that the person receives. Primary care includes a ***comprehensive*** array of appropriate, evidence-informed services to foster a ***continuous*** relationship over time. This array of services is ***coordinated*** by the accountable primary care provider but may exist in multiple care settings or be delivered in a variety of modes."

# Bree Definition: Elements of Primary Care

- **Accountable**: Team and/or provider includes physical health, behavioral health, and care coordination.
  - Practitioners include:
    - Doctors of medicine (general, family, internal, geriatrics, general pediatrics, adolescent medicine)
    - Doctor of osteopathy (same subcategories as DOM)
    - Advanced registered nurse practitioner (general, family, adult, pediatric, women's health)
    - Physician assistant (same categories as ARNP)
    - Osteopathic physician assistant (same categories as PA)
    - Other team members **can include but are not limited to**: Naturopath, psychologist, psychiatrist, social worker, registered nurse, medical assistant, care coordinator, etc.

# Bree: Elements of Primary Care Continued

- **First Contact:** Does the team assess, triage, and direct a person's health or health care issues as they first arise?
- **Comprehensive:** Does the team care for the whole person and provide services that address multiple organ systems and behavioral health as well as recommended screening and preventive services?
- **Continuous:** Does the team maintain or attempt to develop a longitudinal relationship?
- **Coordinated:** Does the team take responsibility for a person's care through managing a care plan in coordination with a multidisciplinary team and/or with offsite referrals?
- **Appropriate:** Does the team provide evidence-based, person-centered medicine that includes behavioral health?

# Bree: Primary Care Services

- Care coordination
- Integrated behavioral health
- Disease prevention and screening
- Chronic condition management
- Medication management
- Health promotion
- Person-centered care that considers physical, emotional, and social needs

# Comparison: Broadest Level of Primary Care Providers

| OFM Primary Care Providers (Broad) | Bree Primary Care Providers |
|---|---|
| Behavioral health providers | Behavioral health providers |
| Registered nurses | Registered nurses |
| Obstetricians and gynecologists | Women's health |
| Midwives | Women's health |
| Psychiatrists and neurologists | Psychiatrists |
| Psychologists | Psychologists |
| Social workers | Social workers |
| Homeopath | |
| Clinical nurse specialists | Advanced registered nurse practitioners (ARNPs) |
| Family medicine and pediatric subspecialists | Geriatrics and adolescent medicine |
| | Care coordinators |

# Comparison: Primary Care Services

| OFM Primary Care Services (Broad) | Bree Primary Care Services |
|---|---|
| Excludes ED visits | Excludes ED and Urgent Care |
| | Care coordination |
| Integrated behavioral health | Integrated behavioral health |
| Disease prevention and screening | Disease prevention and screening |
| Chronic condition management | Chronic condition management |
| Medication management | Medication management |
| Person-centered care that includes physical, emotional, and social needs | Person-centered care that includes physical, emotional, and social needs |

# Comparison: Approaches to Defining Primary Care

- Solving for different problems:
  - OFM created definitions for measurement tool
  - Bree's created definitions to drive quality improvements in a primary care-centered system

- Definition type:
  - OFM technical definitions for data applications
  - Bree theoretical definitions for health policy applications

# Public comment

# Next Steps

# TAB 5

# Next Steps for our Committee

Dr. Judy Zerzan-Thul

Chief Medical Officer, HCA

Washington State Health Care Authority

# Next meeting: Starting Point

- Bree and OFM definitions already reviewed during September 28 meeting
- Will get a summary in advance of the meeting that covers other work on primary care definitions from:
  - NASEM
  - Milbank
  - Other states
- Will discuss and approve recommendation 1: Defining primary care
  - Who
  - What
- Will begin discussion of recommendation 2: Claims-based measurement

# Guiding Principles for Approval of Recommendation 1: Defining Primary Care

- Adoption of Bree principles
  - Accountable
  - First Contact
  - Comprehensive
  - Continuous
  - Coordinated
  - Appropriate
- Flexible approach to coding given OFM's narrow and broad definitions
- Adherence to NASEM definition of primary care

# Index – CA healthcare foundation study

# TAB 6

POPULATION HEALTH MANAGEMENT > PRIMARY CARE

# Study Links Primary Care Spending, Quality Improvement in Medi-Cal

California Health Care Foundation analysis finds statistical relationship between Medicaid managed care plans with higher primary care spending and those that scored higher on a composite measure of overall care quality

David Raths

July 25, 2022

A study encompassing 5.4 million Californians enrolled in Medi-Cal managed care in 2019 finds that

LATEST IN PRIMARY CARE

Primary Care

**HHS Awards $115...**

Janette Wider July 5,

greater investment in primary care is associated with better quality of care, patient experience, and plan rating.

Plans that spend a higher percentage on primary care were statistically more likely to get a better rating from the National Committee for Quality Assurance. NCQA evaluates health plans on the quality of care that patients receive, how patients experience their care, and health plans' efforts to keep improving.

The research is based on an analysis prepared by Edrington Health Consulting, a Health Management Associates Company, for the California Health Care Foundation (CHCF).

"Increasing emphasis on primary care in Medi-Cal is essential to improving health and well-being and reducing health disparities," said Kathryn E. Phillips, CHCF senior program officer, in a statement. "This study provides an important baseline for understanding how greater investment in primary care can improve performance."

Primary care providers administer critical first-line care for physical and behavioral health needs. Supported by teams that include community health workers, nurses, behavioral health staff, and others, they help patients diagnose symptoms, prevent disease, manage chronic illness, and overcome social stressors that impact health, such as violence or food insecurity. They also help coordinate care, such as testing and specialist care.

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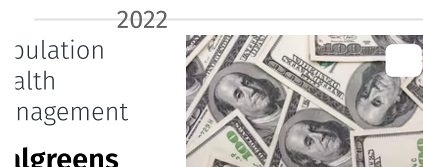
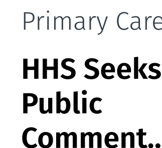


Primary Care
HHS Seeks Public Comment...
Janette Wider June 28, 2022




'rimary Care
IHS
Announces
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anette
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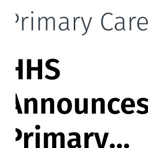


'rimary Care
New York to
Establish
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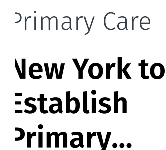
David
Raths June 5, 2022



Medi-Cal is the state's health insurance program for Californians with low incomes, including over 40 percent of all children, half of those with disabilities, over a million seniors, and one in five workers. About 80 percent of all Medi-Cal enrollees get their care through a Medi-Cal managed care plan, which are contracted with the state.

The study, which evaluated primary care spending data from 13 Medi-Cal managed care plans, found wide variation in the level of primary care investment by plan and population. Spending on primary care across plans ranged from $8.85 to $61.24 per member per month. This translates to roughly 11 percent of total healthcare dollars being spent on primary care, ranging from 5 percent to 19 percent.

A significant statistical relationship was observed between plans with higher primary care spending percentages and those that scored higher on a composite measure of overall care quality, which included the percentage of plan members who complete well-child visits, receive immunizations, have control of their diabetes, and receive recommended cancer screenings, among other quality measures. When individual measures of quality were studied, plans with a higher percentage of spending on primary care performed better on 9 of 11 measures. Three of these measures met criteria for statistical significance and align with state priorities: receipt of recommended cancer screenings and two measures of management of medications for depression.

Medi-Cal covers a third of all Californians, and nearly half of all children. It serves those facing health challenges shaped by poverty, housing and food insecurity, pollution, and racial discrimination. Due to these systemic injustices, Californians enrolled in Medi-Cal are twice as likely to have poor health overall. About two-thirds of all Medi-Cal enrollees are people of color. Medi-Cal care quality remained stagnant at best in the decade leading up to 2019. A focus on primary care is an opportunity to move these measures in the right direction.

Medi-Cal serves 34 percent of California's Latinos/x, 28 percent of Black Californians, and 15 percent of the Asian American community. Given that, the study points to an important opportunity to improve health equity for all Californians through greater emphasis on primary care.

The study comes as California and several other states are making a push toward requiring primary care teams, including physicians, nurse practitioners, physician assistants, community health workers, behavioral health staff, and others, to play a greater role in the health care delivery system.

As part of efforts to transform Medi-Cal, beginning in 2024, the California Department of Health Care Services (DHCS) will require all Medi-Cal managed care plans to report on primary care expenditures. This heightened focus on strengthening primary care will impact the more than 10.8 million Medi-Cal enrollees served by Medi-Cal managed care plans and align

California with other states seeking to strengthen primary care as a lever to improve quality, improve value,  and advance equity.

“DHCS is committed to reducing the stark racial and ethnic disparities in access to primary care. These include maternity outcomes and children’s preventive services, as well as improving maternal and adolescent depression screenings. This study will serve as a benchmark among Medi-Cal managed care plans as we seek to achieve these and other bold goals,” said Palav Babaria, M.D., M.H.S., chief quality officer and deputy director of Quality and Population Health Management at DHCS, in a statement.

California established a new Office of Health Care Affordability to measure and promote a sustained systemwide investment in primary care in the state budget enacted just weeks ago.

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# Index – 2019 OFM primary care expenditures report

# TAB 7

# Primary Care Expenditures

## Summary of current primary care expenditures and investment in Washington

### Report to the Legislature

As required by Chapter 415, Laws of 2019

**Forecasting and Research**
Office of Financial Management
December 2019

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# Executive summary

This is the first comprehensive analysis of annual primary care medical expenditures in Washington. In the 2019–21 biennial budget, the Legislature directed the Office of Financial Management to determine annual primary care medical expenditures as a percentage of total medical expenditures by carrier. This report summarizes the approach and data sets used to calculate these expenditures, compares and contrasts the methods and results with other state and national reports on primary care medical expenditures, and discusses limitations to current data sources.

OFM, working with key stakeholders representing different areas of primary care practitioners, created a definition for primary care providers and services that takes into account the range of interpretations of primary care. A narrow and broad definition of providers and services were created, and then claims meeting the service and provider definitions were used to calculate primary care expenditures. This approach ensured expenditures attributed to primary care services were incurred by primary care providers. Expenditures were calculated using cost information from the Washington All-Payer Health Care Claims Database.

**In Washington for 2018, primary care expenditures as a percentage of total medical expenditures ranged from 4.4% (about $838 million) to 5.6% (about $1 billion) based on either a narrow or broad definition, respectively, of primary care. Primary care spending as a percentage of total spending was highest for people under 18 years and lowest in people 65 years and older.**

With respect to market sector: Similar percentages of primary care spending were seen in public employee, Medicaid managed care and commercial coverage. Medicare Advantage had the lowest percentage, reflecting differences already seen by age. Differences in primary care spending by health care company and market sector vary considerably and could be influenced by the needs of the population covered (average age, sex, comorbidity and geography).

This report's estimates for the proportion of medical expenditures attributable to primary care appears smaller than estimates calculated in other reports. Because there is no national standard for how to measure primary care expenditures, however, these estimates cannot be compared directly because of differences in data sets, methodologies and definitions of primary care. When comparing Washington's proportion of primary care spending with reports from Oregon and Rhode Island, the differences in approaches and definitions of primary care make these types of comparisons challenging. For instance, Washington included pharmacy claims in its total medical expenditures while Oregon did not. Washington and Oregon also differed in their methods for capturing costs of primary care services. Oregon and Rhode Island included non-claims-based expenditures in their total primary care spending which are not included in Washington's estimates. An overview of the non-claims-based expenditures collected by Oregon and Rhode Island is included in this report, in addition to examples for future consideration in data collection efforts for Washington.

This report highlights a low rate of investment in primary care in Washington and, as a baseline, can be used to monitor future spending. Research has shown health care systems with higher proportions of investments oriented toward primary care have better health outcomes and lower costs. Monitoring the impact of policies and system performance will be key to successfully strengthening Washington's primary care system.

## Background

In the 2019–21 biennial operating budget, Chapter 415, Laws of 2019,[1] the Legislature directed the Office of Financial Management to conduct a study to determine annual primary care medical expenditures as a percentage of total medical expenditures in Washington (Appendix A). Having an estimate of primary care expenditures, in addition to reports on the primary care workforce, enhances the state's understanding of the current level of investment in primary care (Yen, 2018). With a baseline of primary care spending, the state will have better:

- Benchmarking of spending and investments on primary care;
- Tracking of efforts to increase primary care spending;
- Measurement of the impacts of payment reform;
- Focus of interventions to increase patient access to primary care; and
- Information to compare to other states' efforts to increase primary care spending.

Similar reports have been completed in Oregon and Rhode Island; efforts are underway in other states to understand primary care spending levels to guide new investments.

As required in the proviso, OFM convened a group of stakeholders (Appendix B) representing family practice, general internal medicine, general pediatrics and the state Health Care Authority to advise on the parameters for estimating primary care expenditures for the state.

The stakeholder group worked with OFM to answer the following questions:

- Who are primary care providers?
- What are primary care services?
- What percentage of total health care expenditures is currently allocated to primary care?
- How does this percentage differ by health insurance carrier?
- What information about primary care is not captured by current data sources?

OFM also contacted researchers in Oregon and Rhode Island, and from other institutions who worked on similar primary care expenditure reports, to discuss methodology and gather advice for pursuing the Washington report.

The goals for Washington's primary care expenditure report are to:

- Conduct a transparent process for determining what providers and services are considered primary care;
- Develop a transparent and detailed methodology that can be replicated to measure trends and changes in primary care spending in future years;
- Discuss differences between Washington's methodology and results compared with other estimates and reports;
- Identify barriers to accurately estimating primary care expenditures; and
- Provide suggestions and guidance for future tracking of primary care spending and iterations of this type of report.

OFM intends for this report to be the baseline for tracking and monitoring new investments and initiatives to increase primary care spending in Washington. This report can help frame discussions

[1] http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1109-S.SL.pdf

on what additional information will be beneficial for understanding primary care needs and how to measure outcomes of increasing primary care spending.

But first, we must start with a definition of primary care.

## What is primary care?

Primary care as defined by the National Academy of Medicine (formerly the Institute of Medicine): "… is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs including physical, mental, emotional, and social concerns, developing a sustained partnership with patients, and practicing in the context of family and community (Donaldson, M.S., Yordy, K.D., Lohr, K.N., & Vanselow, N.A., 1996)."

This definition has been used to measure how well four main features of primary care services are fulfilled (Starfield, B., Shi, L., Macinko, J., 2005):

- First-contact access (into the health care system) for each new need
- Long-term person- (not disease-) focused care (also referred to as continuous care)
- Comprehensive care for most health needs
- Coordinated care when it must be sought elsewhere

Investing in primary care and ensuring access to primary care can reduce health care costs by lowering rates of preventable emergency department visits, hospital admissions and specialist visits (Friedberg, Hussey, & Schneider, 2010; Glass, Kanter, Jacobsen, & Minardi, 2017; Starfield, B., Shi, L., Macinko, J., 2005). Primary care helps to achieve health equity by providing access to health services and promotes care at the most appropriate level (Starfield, 1998) and, as a result, can reduce premature mortality (Basu et al., 2019; Starfield, B., Shi, L., Macinko, J., 2005). Internationally, health systems with higher proportions of health care spending on primary care have better health outcomes and lower health care costs (Friedberg et al., 2010; Jabbarpour, Y., Greiner, A., Jetty, A., Coffman, M., Jose, C., Petterson, S., 2019; OECD, 2017).

Many states are implementing strategies to improve primary care investment by adopting patient-centered medical home incentives or other value-based care models; focusing on social determinants of health; expanding the primary care workforce and infrastructure; or increasing rates for primary care providers.

# Approach to estimate primary care spending

OFM contracted with Onpoint Health Data to estimate primary care expenditures using the state-run Washington All-Payer Health Care Claims Database, or WA-APCD. Onpoint Health Data is the data vendor for the WA-APCD, which was established by OFM through legislation passed in 2014. Launched in the summer of 2018, the WA-APCD contains pharmacy, medical and dental claims along with eligibility information. It is the most comprehensive source of claims data in the state with more than 6 million covered lives from more than 50 commercial, Medicaid and Medicare payers. Self-insured (not covered by state public employee benefits), federal insurance and Veterans Benefits Administration claims are not included in the database. The WA-APCD contains cost information, including billed, allowed and paid amounts that allow for calculations of total and primary care expenditures. Data from 2014 through the third quarter of 2019 are included in the database; submissions from carriers are completed on a quarterly basis and validated on a yearly basis. Data from calendar year 2018 were used for this report.

## Inclusion and exclusion criteria

As per the budget proviso, total medical expenditures excluded dental care, but included costs of prescription drugs. The proviso also called for vision care to be excluded, but it was unclear what types of vision services should be excluded (e.g., eyeglasses, cataract surgery, glaucoma testing). Many commercial insurance plans lack vision coverage, but because vision services are not submitted separately from medical claims to the WA-APCD (unlike dental claims that are a separate submission), it was determined for this report to leave vision services as part of total medical expenditures.

Only claims paid using the member's primary insurance are included in the calculations for expenditures. Claims paid using a secondary insurance or payer were not included to avoid double counting expenditures. Only members who had a medical or pharmacy claim paid in 2018 are included in the analysis, limiting the members who are included. According to the National Health Interview Survey, about 16% of adults did not have contact with a doctor or other health care professional in the past year (Centers for Disease Control and Prevention, 2019).

Additionally, Medicare fee-for-service data were excluded from this report because the 2018 data will not be available until 2020. Medicaid fee-for-service data were excluded due to errors in submission to the WA-APCD, and health care claims from Coordinated Care for Medicaid managed care were excluded because labeling of its claims in the submission process made it difficult to distinguish if claims were paid as a primary or secondary payer.

Oregon and Rhode Island included estimates of non-claims-based expenditures for primary care, which are usually self-reported by the individual insurance carriers in the state, in their reports on primary care spending. Currently, there is no process in Washington to collect this type of information from all commercial carriers. The Health Care Authority collects information from the Medicaid managed care organizations and the public employee benefits carriers for managed care rate development, and is developing processes to collect non-claims information for future contracts. OFM was unable to access this information for this report. Suggestions for future data collection of non-claims-based expenditures are outlined later in this report.

## Defining primary care claims

Identifying primary care services in claims data is not straightforward. Most analyses of primary care expenditures using claims data must construct a definition for primary care provider and primary care services. There are several reasons for this approach:

- Identifying primary care clinics or offices in claims data is difficult because there is no field or value that indicates primary care as a setting of care.
- Providers who list primary care as their specialty may work in a variety of places, some of which would not be considered a traditional primary care setting (e.g., hospitalists in in-patient settings or nurse practitioners working in a specialist's office) or may be delivering nonprimary care services.
- Some primary care services may be delivered by specialists or others who would not be defined as a primary care provider (e.g., a cardiologist ordering a basic lab test).
- Some institutions (e.g., Federally Qualified Health Center) may submit both a facility and professional claim for primary care services depending on the health insurance company, and the provider identification on these types of claims may be different.

As a first step for this analysis, separate definitions of primary care provider and primary care services were determined and then claims meeting both definitions were included as primary care expenditures. This approach follows the concepts of the Primary Care Spend Model to narrow primary care services to those that are performed specifically by primary care providers (Baillieu et al., 2019).

## Primary care providers

Washington does not have a roster or other data source identifying individual providers who are practicing in primary care settings. Some health insurance companies may have a listing of providers delivering primary care, but it is not included in claims submissions to the WA-APCD. There is also no agreed-upon definition used in the literature to define primary care providers. Some of the variation in definition is due to the availability of different data sources that may or may not include certain types of providers (e.g., homeopaths).

The stakeholder group began by reviewing taxonomy codes, which are used to categorize health care providers by their specialization, and descriptions included in the 2019 Primary Care Spending in Oregon report (Oregon Health Authority and the Department of Consumer and Business Services, 2019). The stakeholder group decided upon two groups of providers (Appendix C):

- Narrow definition: representing providers who traditionally perform roles contained within strict definitions of primary care
- Broad definition: representing providers who perform roles not traditionally contained within a strict definition of primary care (e.g., obstetricians)

This approach is similar to other reports on primary care expenditures (Bailit, Friedberg, & Houy, 2017; Jabbarpour, Y., Greiner, A., Jetty, A., Coffman, M., Jose, C., Petterson, S., et al., 2019; Reid, Damberg, & Friedberg, 2019), but was not the approach taken in the Oregon report. Results for both the narrow and broad definitions of primary care providers are included in this report. Taxonomy codes for the narrow definition of primary care provider are family medicine, internal medicine, Federally Qualified Health Center, general practice, naturopath, pediatrics, preventive medicine, nurse practitioner, physician assistant, primary care clinic and rural health clinic. The broad definition of providers included behavioral health providers, clinical nurse specialist, registered nurse, midwives, obstetrics and gynecology, family medicine and pediatric subspecialties, homeopath, psychiatry and neurology, psychologist, registered nurse and social worker.

## Primary care services

Primary care procedures or services were defined using the American Medical Association's Current Procedure Terminology, or CPT, and the Healthcare Common Procedure Coding System, or HCPCS. For this report, the stakeholder group began by reviewing the list of primary care procedure codes included in the Oregon report and added services (e.g., additional preventive medicine screenings) based on various works stakeholders had completed in other areas. Both a narrow and broad list of services were considered for estimating primary care. Many of the services included in the broad definition reflected services that were specific to provider taxonomies included in the broad definition of primary care provider (e.g., obstetricians and care following a cesarean delivery). Inpatient visits billed by primary care providers using a CPT or HCPC inpatient code were not included in either the broad or narrow definition of primary care services. The stakeholder group did not feel that these types of visits represented traditional primary care (e.g., first-contact access, continuous, comprehensive, coordinated) or getting people the right care in the right setting. In many instances, it's difficult to identify which services on claims were performed by a primary

care provider in inpatient hospital settings. Emergency department visits billed by a primary care practitioner were also not included for similar reasons.

Other reports on primary care expenditures have used one definition for primary care services cross-walked with different definitions for primary care providers (Bailit et al., 2017; Jabbarpour, Y., Greiner, A., Jetty, A., Coffman, M., Jose, C., Petterson, S., 2019). Reid et al (Reid et al., 2019) used both a narrow and broad definition for primary care providers in combination with a narrow definition for primary care services and then again with all professional services.

This report contains the results from both the narrow and broad definition of primary care services. Examples of primary care procedure codes are those for routine medical exams, preventive medicine services, screening for diseases, vaccine administration and newborn care services (Appendix D).

## Expenditure calculations

Expenditures for health care services were calculated using the total allowed amount submitted on claims to the WA-APCD. The total allowed amount includes the health insurance plan paid amount plus any deductibles, coinsurance or copays paid by the patient. For insurance companies that pay providers using capitated payment arrangements (e.g., a per-member per-month payment), the fee-for-service equivalent amount is submitted to the WA-APCD and used as the paid amount for that health care service.

Total health care expenditures comprised all medical claims (including in-patient hospitalizations) and pharmacy claims. With respect to immunizations: Although vaccines are included in the total health care expenditures calculations, only the costs associated with administering the vaccine, if administered by a primary care provider, were included in primary care expenditures. Expenditures for primary care services provided by primary care providers were aggregated by provider specialty and then summed across all provider groupings to estimate total primary care expenditures. Although Appendix C (List of Providers) lists a large number of behavioral health specialist taxonomy codes, when primary care service codes were applied, most claims and associated expenditures for these providers were not included in primary care expenditures.

All nurse practitioner and physician assistant taxonomy codes were included in this report. Adjustments were made to the total primary care expenditures calculated for these providers. These adjustments (41% for nurse practitioners and 34% for physician assistants) were needed because many nurse practitioners and physician assistants may have a provider taxonomy code included in the definition for a primary care provider, but actually provide care in other settings (e.g., surgical). Because claims data do not indicate if a health care setting is primary care, the adjustment factors were needed to avoid overestimating primary care expenditures by counting services for nurse practitioners or physician assistants that were not conducted in primary care settings. These adjustments were based on recommendations from the stakeholder group and studies conducted by the Washington State University College of Nursing (Kaplan & Gill, 2018) and the Washington Medical Commission (Washington Medical Commission, 2019).

Primary care services for people without insurance and services paid with cash by patients who did not file an insurance claim were not included in the analyses.

## Calculations for carriers

More than 50 commercial, Medicare and Medicaid data suppliers submit claims data to the WA-APCD. Data are submitted either at the company level or at the individual health insurance plan level, depending upon how the company's claims processing system is set up and the number of

health insurance plans issued in the state. Plans were first grouped by market sector (commercial, public employee benefits, Medicaid managed care organizations and Medicare Advantage) and then rolled up to the company level. Primary care and total expenditures were calculated at the company level within each market sector. Companies that had fewer than 1,000 covered persons were excluded from analyses. Dental companies were also excluded, and only medical and pharmacy claims from 2018 were used.

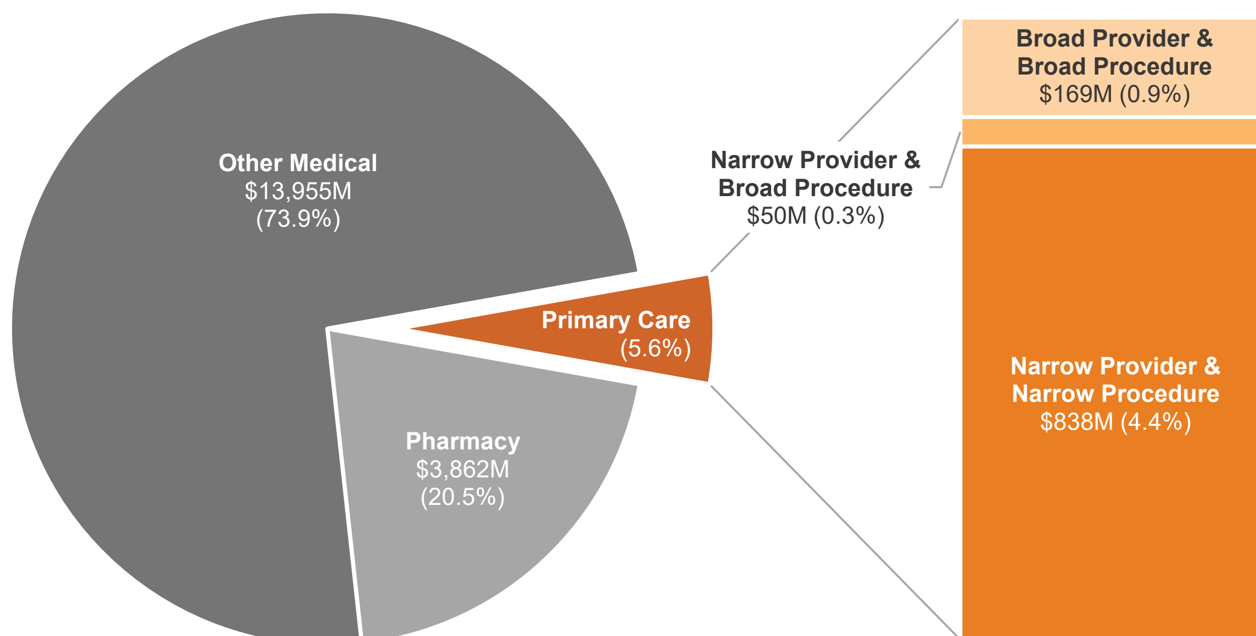
# Results

## Monthly enrollment

Included in this report is claims information for more than 1.2 million Medicaid managed care organization members, more than 1.1 million commercial members, and more than 300,000 public employees and 300,000 Medicare Advantage members. The total amount of health care spending captured in the WA-APCD for this report for 2018 was almost $19 billion, 21% of which was for pharmacy claims.

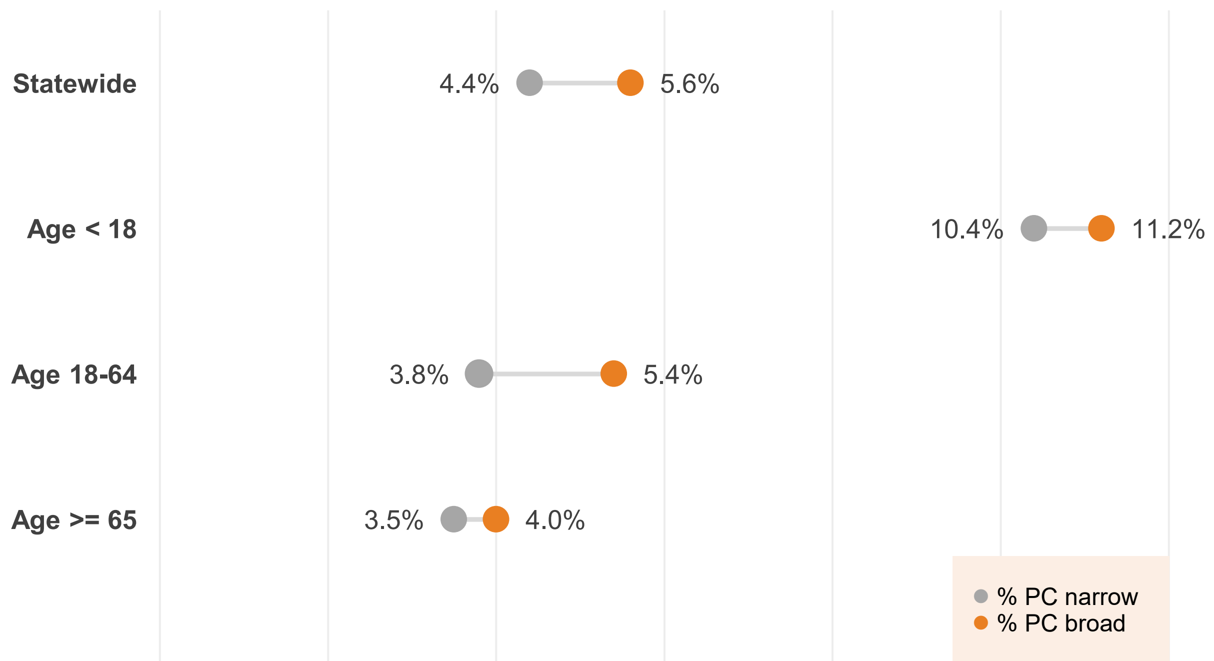
In 2018, overall investments in primary care as a total of all medical expenditures for Washington ranged from 4.4% to 5.6%, depending on whether a narrow or broad definition of providers and services were used (Figure 1). Limiting the definition of primary care providers and procedures to narrow definitions each resulted in approximately $838 million in claims. Including the broad category of procedures resulted in about $50 million more and an increase in the primary care share to 4.7% of total medical expenditures. Including a broad definition of providers, in addition to a broad definition of procedures, increased primary care expenditures by about $169 million and resulted in a 19% increase in primary care expenditures, but overall, the total percentage of all health care expenditures specific to primary care was only 5.6%.

**Figure 1. Summary of Medical Expenditures in Washington State, 2018**



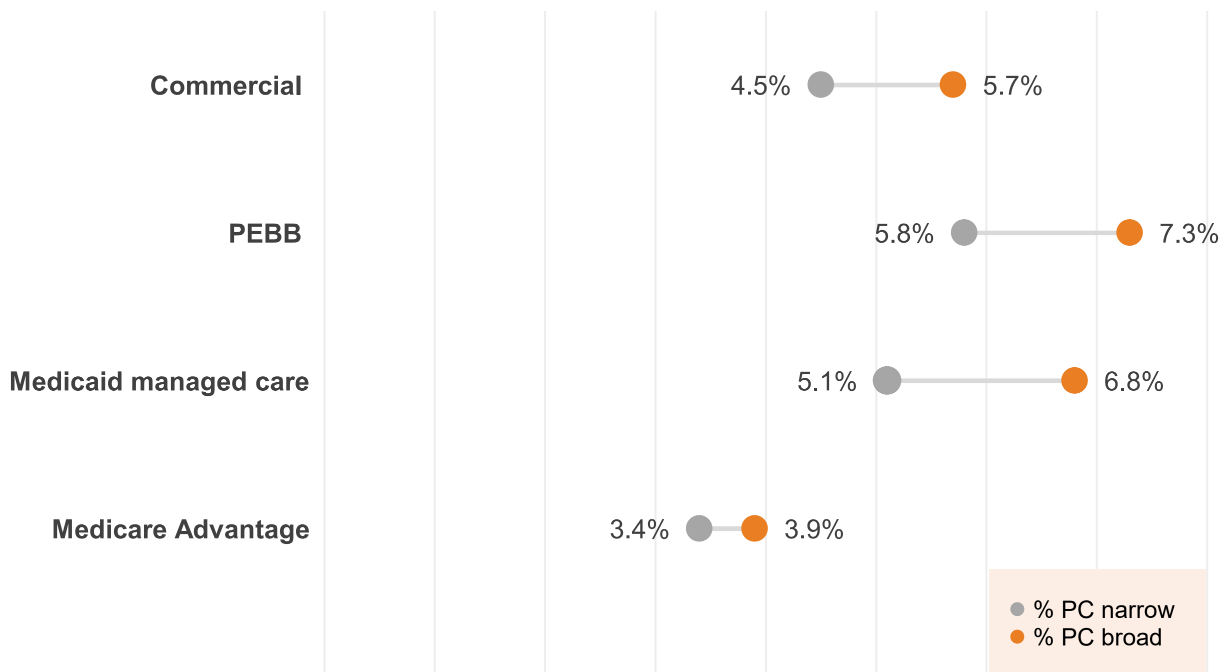
This highest percentage of primary care spending was for individuals younger than 18 years, ranging from 10.4% to 11.2% of about $2 billion in total medical expenditures for the narrow (narrow definition of providers and narrow definition of procedures) and broad (broad definition of providers and broad definition of procedures) definitions of primary care, respectively (Figure 2). Of working age adults aged 18 to 64 years, the percentage of primary care spending ranged from 3.8% to 5.4% of about $11 billion in total medical expenditures. It should be noted that this age group could be affected the most by the inclusion of obstetrics in the broad definition of primary care. For adults aged 65 and older, primary care spending was 3.5% to 4% of about $5.5 billion in total medical spending. Older adults have a higher rate of hospital inpatient stays and other costs outside of primary care because of the higher prevalence of chronic and comorbid conditions and greater use of specialists.

**Figure 2. Primary Care as Percentage of Total Expenditures by Age**



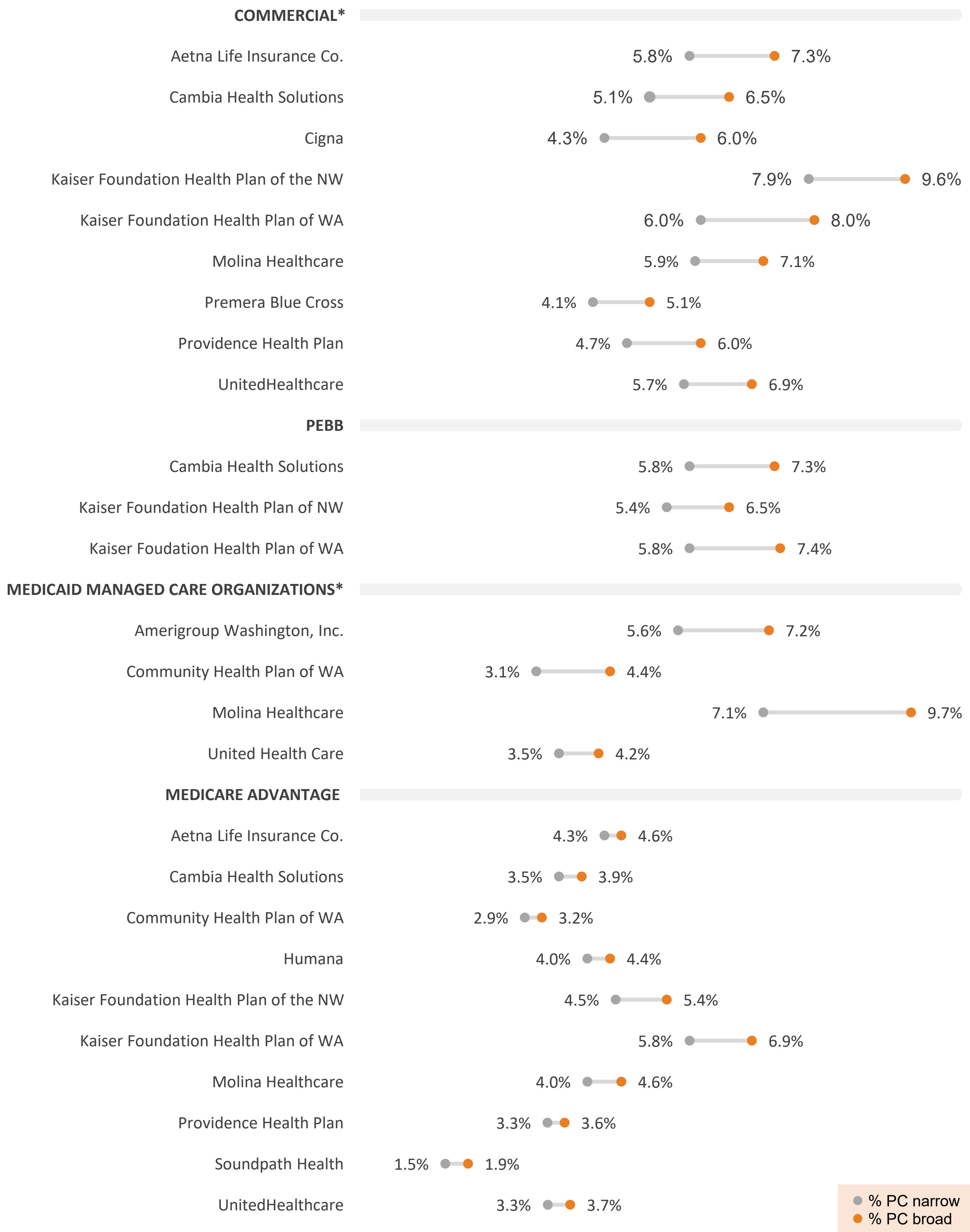
Considering primary care expenditures by market sector, public employee coverage had the highest percentage of primary care spending, ranging from 5.8% to 7.3% of about $1.8 billion in 2018 (Figure 3). Medicaid managed care organizations ranged between 5.1% to 6.8% of about $4 billion in 2018; commercial plans ranged between 4.5% and 5.7% of about $8 billion; and Medicare Advantage plans ranged from 3.4% to 3.9% of about $5 billion in total claims. Some of these differences in primary care spending reflect differences in patient characteristics between market sectors. Additionally, primary care spending for public employee coverage may be overestimated because many of the pharmacy claims were not designated for public employees when submitted to the WA-APCD. This would result in lower total expenditures for this group.

**Figure 3. Primary Care as Percentage of Total Expenditures by Market Sector**




Of commercial plans, the percentage of primary care investment as a total of all medical expenditures ranged from 4.1% to 5.1% for Premera Blue Cross to 7.9% to 9.6% for Kaiser Foundation Health Plan of the Northwest. For public employee plans in the Public Employee Benefits Board program, the range of primary care spending was very similar among the three companies. For Medicaid managed care plans, the percentage of primary care spending as a total of all medical expenditures ranged from 3.1% to 4.4% for Community Health Plan of Washington to 7.1% to 9.7% for Molina Healthcare. For Medicare Advantage plans, the percentage of primary care investment was less than 7% for all plans (Figure 4). Even within market sector, caution should be exercised in comparing expenditures by health plan or company because of differences in characteristics of enrollees that are not adjusted for in these analyses.

**Figure 4. Primary Care as Percentage of Total Expenditures by Carrier or Company**




* Data for Coordinated Care are not listed due to data issues.

## Previous research on primary care

There have been a number of efforts to estimate primary care spending as a proportion of total health care spending. While Washington's estimates might appear low, these estimates cannot be compared directly with other published studies. Indeed, there is no national standard for how to measure primary care expenditures. As a result, estimates between reports may differ as a result of different definitions of primary care, different data sets used in analyses, different populations included in data sets and different methodologies to estimate primary care spending.

The Robert Graham Center, using survey data from the Medical Expenditure Panel Survey, or MEPS, estimated that Washington spends between 5.9% and 10.1% of health care expenditures on primary care (depending on whether a narrow or broad definition of primary care provider is used) (Jabbarpour, Y., Greiner, A., Jetty, A., Coffman, M., Jose, C., Petterson, S., 2019). While this study used a standardized measure (MEPS data) to compare primary care spending across states, it does have some limitations. The definition of primary care used in the analysis was based only on the taxonomy of the provider without taking into account the particular health care services performed, which may have resulted in an overestimate of actual primary care spending. Furthermore, nurses, nurse practitioners and physician assistants were included as primary care providers irrespective of whether they practiced in primary care settings because that information cannot be ascertained in the MEPS data. In addition, some MEPS data is self-reported and may be subject to recall bias.

The Milbank Memorial Fund undertook a proof-of-concept study to assess the feasibility of calculating primary care spending using commercial claims data (Bailit et al., 2017). The study used national data and found that 7.1% to 8.6% of total health care spending was specifically primary care-related. Differing interpretations of how to calculate primary care spending may have occurred, however, because each health insurance carrier calculated and submitted its data independently.

A recent report in the Journal of the American Medical Association Internal Medicine using claims data estimated about 2% to 4% of total medical and prescription drug spending for Medicare fee-for-service beneficiaries was for primary care (Reid et al., 2019). In comparison, while this report does not include Medicare fee-for-service beneficiaries, it does include Medicare Advantage members; these estimates as a market sector were between 3.4% and 3.9%.

Oregon and Rhode Island routinely produce reports estimating primary care spending. For 2017, Oregon estimated the percentage of total medical spending for primary care was:

- 16.5% for coordinated care organizations
- 13.4% for commercial carriers
- 12.2% for Medicare Advantage
- 10.6% for public employees and educators benefits

Rhode Island estimated primary care spending for its commercial plans to be close to 9.1% (in 2012), an increase of 3.5% from 2008.

It is difficult to compare Washington's proportion of primary care spending to Oregon's or Rhode Island's estimates due to differences in approaches and definitions of primary care. For example, Oregon did not include any health care spending by patients such as copay, coinsurance or deductibles while these were included in Washington's estimates. Oregon also excluded prescription drugs from its estimates of total claims-based payments or total medical expenditures. Per the budget proviso, this report included all pharmacy claims costs in total medical expenditures, which would make the percentage of primary care spending in Washington appear smaller than if these

claims had been excluded. For this report, only claims paid by the primary payer are included in the calculations to avoid any duplications of cost. It is not clear whether Oregon and Rhode Island employed this same strategy.

Additionally, Washington's estimates do not include non-claims-based expenditures, which are included in estimates for Oregon and Rhode Island. When limiting Oregon's primary care spending to just claims-based, the estimated percentage of total medical spending for primary care for 2017 was closer to Washington's estimates:

- 6.6% for coordinated care organizations
- 7.3% for commercial carriers
- 3.6% for Medicare Advantage
- 8% for public employees and educators benefits

Excluding non-claims-based estimates from this report produces a smaller overall estimate for Washington, although some of these included in other states may not be exclusive to primary care. For Oregon, many of the non-claims-based expenditures were capitated salaries for primary care or provider incentive payments. Because Washington uses a fee-for-service equivalent for capitated payments, the methods used in this report could be capturing some of the non-claims-based payments that Oregon reported separately in its total.

## Non-claims-based expenditures

Many services and activities are needed to fulfill the four main features of primary care services (first-contact, continuous, comprehensive and coordinated care). These activities are not always captured in fee-for-service expenditures submitted on health care claims. Non-claims-based expenditures may occur in a provider's office, be delivered by health care companies or be part of government initiatives. Because of the broad nature of these types of activities, these investments may not be specific to primary care (e.g., health information technology) or may be unique to certain health care systems and populations. Collecting non-claims-based primary care expenditure information in a standard way across payers will be difficult with current data sources. Clear guidelines, definitions and reporting requirements, along with a critical examination of what non-claims-based investments will benefit the delivery of primary care specifically (versus the cost of business), should be included in future discussions on primary care expenditures.

Oregon and Rhode Island included a variety of non-claims-based expenditures in their primary care spending estimates. Originally, Rhode Island had a requirement from its Office of the Health Insurance Commissioner's Affordability Standards that all commercial insurers allocate at least 35% of their total spending on primary care to non-claims-based (Rhode Island referred to these as non-fee-for-service) payments increasing to 40% in 2014. While these targets were retired in 2015, the aggregate value of non-fee-for-service investments in primary care has continued to increase (King, 2019).

Non-claims-based expenditures included incentive payments to providers or practices, health information technology investments such as health insurance exchanges, expansion of primary care workforce with supplemental staff and other investments. Oregon and Rhode Island collected this information directly from their health plans using Excel templates. Oregon included in rule the definitions for non-claims-based primary care expenditures[2] and gave additional guidance in its

[2] https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=260735 Accessed Oct 2019.

reporting templates on how to consider what expenditures to report. Rhode Island's Office of the Health Commissioner collects the non-claims-based information through its Affordability Standards program, which aims to lower costs and improve quality. This program includes investment requirements like patient-centered medical homes, but also allows for insurance companies to submit expenditures for other types of investments for primary care (e.g., loan repayment).

Washington has no process to collect non-claims-based information from all plans that submit claims to the WA-APCD, nor has the state developed any universal guidance or definitions of non-claims-based expenditures. Some information outside of fee-for-service payments is submitted through the Medicaid managed care rate development process for Medicaid and the Public Employees Benefit Board. The Health Care Authority is developing a process to collect information related to primary care for these programs, but OFM was not able to obtain this information for this report.

For future primary care expenditures reports, Washington may want to consider developing a standardized process to collect, across payers, a variety of non-claims-based investments. Outlined below are several such areas and examples.

## Provider incentives

Provider incentives such as those to encourage providers to adopt certain behaviors or pay providers based on performance are often included in non-claims-based investments in primary care. Oregon includes retrospective incentive payments "to primary care providers or practices based on their performance at decreasing cost or improving value for a defined population" and prospective incentive payments "to providers or practices aimed at developing capacity for improving care for a defined population of patients." [3] For example, Oregon collects information on bonus payments to providers when they meet a target for vaccination rates. Rhode Island collects information on incentive distributions under shared savings contracts.

Washington should consider how to collect information on provider incentives, including:

- Carrier-specific quality improvement programs aimed at specific in-network providers.
- State-sponsored quality improvement initiatives such as pay for performance metrics or other bonus payments to providers.
- Federal quality improvement initiatives such as the Centers for Medicare and Medicaid Services Merit-Based Incentive Payment System.

## Patient-Centered Medical Home Models

According to the American College of Physicians, a Patient-Centered Medical Home, or PCMH, is a care delivery model whereby treatment is coordinated through the patient's primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand. The Agency for Healthcare Research and Quality defines the core functions of the medical home as follows:[4]

- comprehensive care
- patient-centered
- coordinated care

[3] Ibid.
[4] https://pcmh.ahrq.gov/page/defining-pcmh Accessed Oct 2019.

- accessible services
- quality and safety

Oregon and Rhode Island collect information from carriers on investments in PCMH models (in addition to provider incentives). Oregon has a Patient-Centered Primary Care Home program that allows for the inclusion of the per-member per-month payment based upon a practice's tier level. Rhode Island hosts a Care Transformation Collaborative, called CTC-RI, which brings together key care stakeholders to promote care for patients with chronic disease through the PCMH model. Rhode Island's only multi-payer PCMH initiative, it helps practices apply for national PCMH recognition, hire on-site care management/coordination to improve the health of patients with the highest needs, and enhance data capabilities to manage and improve population health.[5] Additionally, Oregon and Rhode Island collect information on investments from carriers on other PCMH initiatives.

Washington should consider how to collect information on practice and provider PCMH payments and how to include this information in future reports, e.g., carrier-specific investments or aggregated payments at the state level.

## Investments in technology

Oregon and Rhode Island collect information on investments in primary care related to health information technology. These investments include payments to providers to adopt electronic medical records or payments for providers' license fees. Additionally, Rhode Island, which requires health insurance companies to invest in the state health information exchange called CurrentCare, includes this investment in insurers' non-claims-based expenditures.

In deciding which technology to include in primary care investments, Washington stakeholders should consider not only the four main features of primary care (first-contact, continuous, comprehensive and coordinated), but also technology advances that improve health equity. Below are ideas for the types of technology investments that stakeholders in Washington may want to consider:

- Technology to promote interoperability of electronic health records between providers and facilities.
- Telehealth services including secure online chat tools for members to speak with primary care providers and for video visits with providers.
- Texting services for reminders of appointments, lab test results or provider communication.
- Mobile applications to access medical records, pay bills or order refills on medications.
- E-consults between providers through electronic medical record platforms.
- Transcription services or talk-to-text services to help input information directly into electronic medical records.
- Investments in OneHealthPort to improve the state's health information exchange.
- Grants from state programs or federal programs to promote the exchange of health information.

[5] https://www.ctc-ri.org/about-us/what-ctc-ri Accessed Oct 2019.

Many of the investments in technology previously mentioned may not be exclusive to primary care, and care should be taken if these types of investments are counted toward future primary care investments.

## Workforce expenditures

In addition to typical staffing of primary care offices for administrative roles or billing, many of the non-claims-based initiatives already mentioned — investments in technology, provider incentives and PCMH models — require supplemental primary care staff and activities. Oregon and Rhode Island collect non-claims-based primary care expenditures for certain workforce investments such as practice coaches, patient educators, patient navigators and nurse case managers. Embedding supplemental staff, including registered nurses and practice coaches, in primary care supports the "whole person" model, will be in greater demand as the prevalence of multiple chronic conditions increases and can improve patient health outcomes (Bauer & Bodenheimer, 2017; Grumbach, K., Bainbridge, E., and Bodenheimer, T., 2012).

Examples of how supplemental staff can benefit a primary care setting are:

- Implementing electronic medical records or a health information exchange.
- Providing technical support for technology enhancements in care delivery.
- Supporting adoption of new models of care delivery and continuous quality improvement.
- Helping patients change or adapt unhealthy behaviors (e.g., weight loss or smoking cessation).
- Improving care of chronic conditions, including medication adherence.
- Connecting patients with social services.
- Improving cultural competence among clinic staff.
- Integrating behavioral health services.
- Managing continuity of care.

In addition to investments in supplemental staff, investments in primary care providers is needed to maintain enough providers to support Washington's growing population. Baicker and Chandra (2004) found that states where more physicians are general practitioners have greater use of high-quality care and lower cost per beneficiary (among Medicare patients).

Although there are numerous ways to increase and maintain the primary care provider workforce in Washington — preventing provider burnout, increasing the number of residency slots in primary care, increasing the funding for primary care provider education — this report will focus only on one area, loan repayment, because Rhode Island has useful experience from which Washington can draw information.

The Washington Student Achievement Council and the Department of Health administer two programs to help health professionals pay back student loan debt. The median amount of that debt is about:

- $200,000 for medical school (for class of 2018) (American Association of Medical Colleges, 2018)
- $112,500 for physician assistants (for class of 2018) (National Commission on Certification of Physician Assistants, 2019)
- $40,000 to $55,000 for graduate nursing education (class of 2016, most recent year available) (American Association of Colleges of Nursing, 2017)

The Federal-State Loan Repayment Program, or FSLRP, awards $70,000 for loan reimbursement with federal and state funds in return for two years of full-time work at an approved site. The Health Professional Loan Repayment Program, or HPLRP, is a state-funded award that reimburses $75,000 of loans for three years of full-time employment (or five years for less than full-time employment). This program requires the approved site to meet the definition of providing comprehensive primary care services: comprehensive outpatient, ambulatory and primary health care services. This definition includes critical access or rural hospitals but excludes all other hospitals. (Program-specific criteria are available from the WSAC website.[6]) In the last cycle (funds obligated in fiscal year 2015–16 and disbursed in fiscal years 2016–18 for FSLRP and fiscal years 2016–19 for HPLRP), 72 primary care providers (who also matched the definition of primary care used in this study) were awarded more than $4.4 million in student loan debt relief.

### Other investments

Additional types of investments that Oregon or Rhode Island collected and included in its non-claims (or non-fee-for-service) primary care expenditure calculations included:

- Vaccine clinics (specifically for influenza vaccines)
- Integration of behavioral health services (outside of supplemental staff)
- Risk-based reconciliation
- Capitated or salaried expenditures not captured in claims

In considering the broad context of primary care, investments in evaluation and research on primary care services, community-based programs to address social determinants of health and activities undertaken by community health workers could all be counted as primary care expenditures although they may not be part of the direct delivery of primary care services. Understanding and defining the sphere in which primary care is taking place outside of the fee-for-service system is essential for capturing non-claims-based investments in primary care (Baillieu et al., 2019). In addition to what has already been mentioned about caveats to collecting non-claims-based investments or expenditures for primary care, future reports will want to consider mechanisms to evaluate these types of expenditures and how to allow for their inclusion over time.

## Limitations of current report

This is the first comprehensive analysis of annual primary care expenditures in Washington using claims data from the WA-APCD. Although future reports may continue to use claims data extracted from the WA-APCD or other sources, there are inherent limitations to health care claims data from any data source. The gaps in data identified during the study included the following:

### Procedure codes

The stakeholder group conducted an extensive review of primary care procedure codes. This report included all procedures from various reports on primary care (Bailit et al., 2017; Oregon Health Authority and the Department of Consumer and Business Services, 2019; Reid et al., 2019) and additional codes the stakeholder group identified as services performed in primary care settings by primary care providers. Even with the exhaustive list of codes, there could still be procedures that were not included in this report, but are billed for by primary care providers (e.g., hospice visits,

[6] https://wsac.wa.gov/sites/default/files/2019.FSLRP.HPLRP.Guide.pdf Accessed Sept 2019.

charges for vaccines). Caution should be used when comparing this report to other reports that do not use the same codes.

## No primary care location indicator

We were not able to identify if the setting for the primary care service was a primary care clinic or other type of health care setting; this information is not captured on claims submitted to the WA-APCD. It is unclear if this underestimated or overestimated the true level of primary care expenditures for the state. OFM is working on solutions to gather the primary care location information for future reports.

## No primary care provider roster or consensus on definition

Without a roster or other continually updated source for primary care providers for Washington, stakeholder groups will need to determine and define who is a primary care provider outside of relying on just the taxonomy code. This is especially important for nurse practitioners and physician assistants: It is unclear from the methods used to define primary care and the adjustment used for nurse practitioners and physician assistants if we over- or under-estimated primary care providers for the state. Additionally, not all reports have included obstetrics and behavioral health as primary care providers. Without a national standard or consensus on definition of primary care providers, it will continue to be difficult to compare estimates between reports.

## Bundled payment services

As health care services move to bundled payments for services (e.g., obstetrics), it becomes difficult to carve out which services are attributable or defined as primary care (e.g., prenatal visits). Future reports should consider possible adjustments to methodology to identify and capture primary care services within bundled payments.

## Federally Qualified Health Centers and rural health centers

Claims submitted by Federally Qualified Health Centers or rural health centers may be submitted by the facility or by the individual provider. Because this practice varies by location, an accurate estimate of primary care services delivered at or by these facilities cannot be determined.

## Integrated delivery systems

Some health insurance carriers are part of integrated delivery systems or use capitated payments. These type of systems do not follow the traditional fee-for-service model when paying for health care services. Although the methodology in this report used the fee-for-service equivalent in claims data for capitated payments, there could still be an underestimate of primary care expenditures for these services that could result in an underestimate of the true primary care investment by these health insurance carriers.

## Medicaid fee-for-service and Medicare fee-for-service claims

Neither Oregon nor Rhode Island, nor the current report for Washington include Medicaid fee-for-service or Medicare fee-for-service primary care expenditures. These results could be inferred from results calculated for Medicare Advantage and Medicaid managed care organizations, but these results would not take into account differences in population characteristics, health status or reimbursement rates between the fee-for-service groups and the managed care groups. Future reports may want to consider including these health insurance claims to better understand how investments in primary care differ among these populations.

### Non-claims-based expenditures

As discussed previously in this report, there is no standardized statewide system in place to collect non-claims-based expenditures from health insurance carriers in Washington. Although not all primary care reports have used this type of data, Oregon and Rhode Island used it in their reports. Without non-claims-based expenditures, estimates of primary care spending will appear lower in Washington compared with states that collect these data.

## Future considerations

This report provides a baseline estimate of primary care spending in Washington. This estimate can be used to monitor primary care spending and to compare the impacts of new investments and initiatives. Future reports should continue to evaluate limitations to evolving methodology and measurements. However, if future iterations of this report update or add codes or services, any changes in spending results could be due to these changes in methodology and may not be the result of any policy or behavior change. Oregon updated its inclusion of costs and primary care service codes between its reports released in 2018 and 2019 (Oregon Health Authority and the Department of Consumer and Business Services, 2019). There was no discussion on how this may have influenced its primary care expenditure results between reports.

Because primary care utilization is heavily influenced by needs of the population, future reports may include more detailed stratifications of population characteristics (e.g., sex, comorbidity, geography) to better understand variations in primary care spending. These population characteristics could help explain differences in primary care spending by market sector and by carriers outside of provider networks and business agreements.

This report cannot differentiate how spending among carriers in different market sectors correlates with quality of services, patient and provider satisfaction, or population health outcomes. If additional population characteristics are included in future reports, additional indicators previously mentioned should also be considered for collection

If non-claims-based expenditures are to be collected and included in future iterations of this report, care should be given on whether to consider these types of investments as spending in addition to what is identified from claims and fee-for-service expenditures.

## Conclusion

This primary care spending report provides not only a baseline to compare new investments or initiatives, but also caveats and considerations for how to continue to measure primary care expenditures.

The results in this report highlight a low rate of investment in primary care in Washington. Based on current research, the health care system would benefit from increased primary care investments. To ensure the best results, decisions should be guided by additional research into best practices based on current evidence, available data and broad stakeholder input. Monitoring the impact of policies and system performance will be key to successfully strengthening Washington's primary care system (Center for Health Care Strategies and State Health Access Data Assistance Center, 2014).

Future stakeholders should pose the following questions suggested by Koller et al (Koller, C.F., Khullar, 2017):

- What is the right level of primary care spending based on evidence?
- How large of an improvement in care outcomes could be expected with a unit increase in primary care spending?
- How does the effect of additional spending on primary care vary with the patient population being served?

State-level efforts to control costs and increase primary care spending are possible. Rhode Island's efforts to control costs have resulted in decreased overall spending among commercial insurers through lower prices while increasing primary care spending without affecting quality or utilization (Baum et al., 2019).

## References


American Association of Colleges of Nursing. (2017). *The Numbers Behind the Degree: Financing Graduate Nursing Education*. Retrieved from https://www.aacnnursing.org/Policy-Advocacy/View/ArticleId/20715/AACN-Releases-2017-Graduate-Nursing-Student-Debt-Report

American Association of Medical Colleges. (2018). October 2018 Medical Student Education: Debt, Costs, and Loan Repayment Fact Card. Retrieved October 17, 2019, from https://store.aamc.org/downloadable/download/sample/sample_id/240/

Baicker, K., & Chandra, A. (2004). Medicare spending, the physician workforce, and beneficiaries' quality of care. *Health Affairs*, *23*(SUPPL.), 184–197. https://doi.org/10.1377/hlthaff.W4.184

Bailit, M. H., Friedberg, M. W., & Houy, M. L. (2017). *Standardizing the Measurement of Commercial Health Plan Primary Care Spending*. Retrieved from www.milbank.org

Baillieu, R., Kidd, M., Phillips, R., Roland, M., Mueller, M., Morgan, D., … Bazemore, A. (2019). The Primary Care Spend Model: A systems approach to measuring investment in primary care. *BMJ Global Health*, *4*(4). https://doi.org/10.1136/bmjgh-2019-001601

Basu, S., Berkowitz, S. A., Phillips, R. L., Bitton, A., Landon, B. E., & Phillips, R. S. (2019). Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. *JAMA Internal Medicine*, *179*(4), 506–514. https://doi.org/10.1001/jamainternmed.2018.7624

Bauer, L., & Bodenheimer, T. (2017). Expanded roles of registered nurses in primary care delivery of the future. *Nursing Outlook*, *65*(5), 624–632. https://doi.org/10.1016/j.outlook.2017.03.011

Baum, A., Song, Z., Landon, B. E., Phillips, R. S., Bitton, A., & Basu, S. (2019). Health care spending slowed after Rhode Island applied affordability standards to commercial insurers. *Health Affairs*, *38*(2), 237–245. https://doi.org/10.1377/hlthaff.2018.05164

Center for Health Care Strategies & State Health Access Data Assistance Center. (2014). *Multi-Payer Investments in Primary Care: Policy and Measurement Strategies*. Trenton, NJ.

Centers for Disease Control and Prevention. (2019). *Tables of Summary Health Statistics for U.S. Adults: 2018 National Health Interview* (Vol. 0). Retrieved from http://www.cdc/gov/nchs/nhs/SHS/tables.htm

Donaldson, M.S., Yordy, K.D., Lohr, K.N., & Vanselow, N. A. (Ed.). (1996). *Primary Care: America's Health in a New Era*. https://doi.org/10.1002/clc.4960190202

Friedberg, M. W., Hussey, P. S., & Schneider, E. C. (2010). Primary care: A critical review of the evidence on quality and costs of health care. *Health Affairs*, *29*(5), 766–772. https://doi.org/10.1377/hlthaff.2010.0025

Glass, D. P., Kanter, M. H., Jacobsen, S. J., & Minardi, P. M. (2017). The impact of improving access to primary care. *Journal of Evaluation in Clinical Practice*, *23*(6), 1451–1458. https://doi.org/10.1111/jep.12821

Grumbach, K., Bainbridge, E., and Bodenheimer, T. (2012). Facilitating Improvement in Primary Care: The Promise of Practice Coaching. *Commonwealth Fund*, *15* (pub. 1605). Retrieved from https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2012_jun_1605_grumbach_facilitating_improvement_primary_care_practice_coaching.pdf

Jabbarpour, Y., Greiner, A., Jetty, A., Coffman, M., Jose, C., Petterson, S. et al. (2019). *Investing in primary care: A state-level analysis*. Retrieved from https://www.pcpcc.org/resource/evidence2019

Kaplan, L., & Gill, J. (2018). *2018 Washington State Advanced Registered Nurse Practitioner Survey Data Report*. Vancouver, WA.

King, C. (2019). *Email Communication*.

Koller, C.F., Khullar, D. (2017). Primary Care Spending Rate – A Lever for Encouraging Investment in Primary Care. *New England Journal of Medicine*, *377*(18), 1709–1711.

National Commission on Certification of Physician Assistants. (2019). *2018 Statistical Profile of Recently Certified Physician Assistants: An Annual Report of the National Commission on Certification of Physician Assistants*. Retrieved from http://www.nccpa.net

OECD. (2017). *Health at a Glance 2017: OECD Indicators*. Retrieved from http://dx.doi.org/10.1787/health_glance-2017-en

Oregon Health Authority and the Department of Consumer and Business Services. (2019). *Primary Care Spending in Oregon: A Report to the Oregon Legislature*. Retrieved from https://www.oregon.gov/oha/HPA/ANALYTICS/Documents/SB-231-Report-2019.pdf

Reid, R., Damberg, C., & Friedberg, M. W. (2019, July 1). Primary Care Spending in the Fee-for-Service Medicare Population. *JAMA Internal Medicine*, Vol. 179, pp. 977–980. https://doi.org/10.1001/jamainternmed.2018.8747

Starfield, B., Shi, L., Macinko, J. (2005). Contribution of primary care to health systems and health. *Milbank Quarterly*, *83*(3), 457–502.

Starfield, B. (1998). *Primary Care: Balancing Health Needs, Services, and Technology*. New York, NY: Oxford University Press.

Washington Medical Commission. (2019). *Physician Assistant Demographic Census Aggregate Report*. Retrieved from https://wmc.wa.gov/sites/default/files/public/PAReportOctober2019.pdf

Yen, W. (2018). *2016 Physician Supply*. Retrieved from https://www.ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/workforce/physician_supply_2016.pdf

# Appendix A: Budget proviso

**ESHB 1109, Section 131(9)**

(9) $110,000 of the general fund—state appropriation for fiscal year 2020 is provided solely for the office of financial management to determine annual primary care medical expenditures in Washington, by insurance carrier, in total and as a percentage of total medical expenditure. Where feasible, this determination must also be broken down by relevant characteristics such as whether expenditures were for in-patient or out-patient care, physical or mental health, by type of provider, and by payment mechanism.

(a) The determination must be made in consultation with statewide primary care provider organizations using the state's all payer claims database and other existing data.

(b) For purposes of this section:

(i) "Primary care" means family medicine, general internal medicine, and general pediatrics.

(ii) "Primary care provider" means a physician, naturopath, nurse practitioner, physician assistant, or other health professional licensed or certified in Washington state whose clinical practice is in the area of primary care.

(iii) "Primary care medical expenditures" means payments to reimburse the cost of physical and mental health care provided by a primary care provider, excluding prescription drugs, vision care, and dental care, whether paid on a fee-for-service basis or as a part of a capitated rate or other type of payment mechanism.

(iv) "Total medical expenditure" means payments to reimburse the cost of all health care and prescription drugs, excluding vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment mechanism.

(c) By December 1, 2019, the office of financial management shall report its findings to the legislature, including an explanation of its methodology and any limits or gaps in existing data which affected its determination.

# Appendix B: Primary Care Expenditures Stakeholder Group

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# Appendix C: List of providers

## Narrow definition of primary care provider

| Taxonomy Code | Description |
|---|---|
| 207Q00000X | Family Medicine |
| 207QA0000X | Family Medicine, Adolescent Medicine |
| 207QA0505X | Family Medicine, Adult Medicine |
| 207QG0300X | Family Medicine, Geriatric Medicine |
| 261QF0400X | Federally Qualified Health Center |
| 208D00000X | General Practice |
| 207R00000X | Internal Medicine |
| 207RG0300X | Internal Medicine, Geriatric Medicine |
| 175F00000X | Naturopath |
| 208000000X | Pediatrics |
| 2080A0000X | Pediatrics, Adolescent Medicine |
| 2083P0500X | Preventive Medicine, Preventive Medicine/Occupational Environmental Medicine |
| 261QP2300X | Primary care clinic |
| 261QR1300X | Rural health clinic |

## Nurse practitioner and physician assistant definitions

| Taxonomy Code | Description |
|---|---|
| 363L00000X | Nurse Practitioner |
| 363LA2100X | Nurse Practitioner, Acute Care |
| 363LA2200X | Nurse Practitioner, Adult Health |
| 363LC1500X | Nurse Practitioner, Community Health |
| 363LC0200X | Nurse Practitioner, Critical Care Medicine |
| 363LF0000X | Nurse Practitioner, Family |
| 363LG0600X | Nurse Practitioner, Gerontology |
| 363LN0000X | Nurse Practitioner, Neonatal |
| 363LN0005X | Nurse Practitioner, Neonatal, Critical Care |
| 363LX0001X | Nurse Practitioner, Obstetrics & Gynecology |
| 363LX0106X | Nurse Practitioner, Occupational Health |
| 363LP0200X | Nurse Practitioner, Pediatrics |
| 363LP0222X | Nurse Practitioner, Pediatrics, Critical Care |
| 363LP1700X | Nurse Practitioner, Perinatal |
| 363LP2300X | Nurse Practitioner, Primary Care |
| 363LP0808X | Nurse Practitioner, Psychiatric/Mental Health |
| 363LS0200X | Nurse Practitioner, School |
| 363LW0102X | Nurse Practitioner, Women's Health |
| 363A00000X | Physician Assistant |
| 363AM0700X | Physician Assistant, Medical |
| 363AS0400X | Physician Assistant, Surgical |

### Broad definition of primary care provider

| Taxonomy Code | Description |
|---|---|
| 367A00000X | Advanced Practice Midwife |
| 106E00000X | Assistant Behavior Analyst |
| 106S00000X | Behavior Technician |
| 103K00000X | Behavioral Analyst |
| 103G00000X | Clinical Neuropsychologist |
| 364S00000X | Clinical Nurse Specialist |
| 163W00000X | Registered Nurse |
| 101Y00000X | Counselor |
| 101YA0400X | Counselor, Addiction (Substance Use Disorder) |
| 101YM0800X | Counselor, Mental Health |
| 101YP1600X | Counselor, Pastoral |
| 101YP2500X | Counselor, Professional |
| 101YS0200X | Counselor, School |
| 207QA0401X | Family Medicine, Addiction Medicine |
| 207QB0002X | Family Medicine, Bariatric Medicine |
| 207QH0002X | Family Medicine, Hospice and Palliative Medicine |
| 207QS1201X | Family Medicine, Sleep Medicine |
| 207QS0010X | Family Medicine, Sports Medicine |
| 175L00000X | Homeopath |
| 207RA0401X | Internal Medicine, Addiction Medicine |
| 106H00000X | Marriage & Family Therapist |
| 176B00000X | Midwife |
| 207V00000X | Obstetrics & Gynecology |
| 207VG0400X | Obstetrics & Gynecology, Gynecology |
| 2080P0006X | Pediatrics, Developmental – Behavioral Pediatrics |
| 2080P0008X | Pediatrics, Neurodevelopmental Disabilities |
| 2084A0401X | Psychiatry & Neurology, Addiction Medicine |
| 2084P0802X | Psychiatry & Neurology, Addiction Psychiatry |

### Broad definition of primary care provider

| Taxonomy Code | Description |
|---|---|
| 2084P0804X | Psychiatry & Neurology, Child & Adolescent Psychiatry |
| 2084F0202X | Psychiatry & Neurology, Forensic Psychiatry |
| 2084P0805X | Psychiatry & Neurology, Geriatric Psychiatry |
| 2084P0005X | Psychiatry & Neurology, Neurodevelopmental Disabilities |
| 2084P0800X | Psychiatry & Neurology, Psychiatry |
| 2084P0015X | Psychiatry & Neurology, Psychosomatic Medicine |
| 102L00000X | Psychoanalyst |
| 103T00000X | Psychologist |
| 103TA0400X | Psychologist, Addiction (Substance Use Disorder) |
| 103TA0700X | Psychologist, Adult Development & Aging |
| 103TC0700X | Psychologist, Clinical |
| 103TC2200X | Psychologist, Clinical Child & Adolescent |
| 103TB0200X | Psychologist, Cognitive & Behavioral |
| 103TC1900X | Psychologist, Counseling |
| 103TE1000X | Psychologist, Educational |
| 103TE1100X | Psychologist, Exercise & Sports |
| 103TF0000X | Psychologist, Family |
| 103TF0200X | Psychologist, Forensic |
| 103TP2701X | Psychologist, Group Psychotherapy |
| 103TH0004X | Psychologist, Health |
| 103TH0100X | Psychologist, Health Service |
| 103TM1700X | Psychologist, Men & Masculinity |
| 103TM1800X | Psychologist, Mental Retardation & Developmental Disabilities |
| 103TP0016X | Psychologist, Prescribing (Medical) |
| 103TP0814X | Psychologist, Psychoanalysis |
| 103TP2700X | Psychologist, Psychotherapy |
| 103TR0400X | Psychologist, Rehabilitation |

### Broad definition of primary care provider

| Taxonomy Code | Description |
|---|---|
| 103TS0200X | Psychologist, School |
| 103TW0100X | Psychologist, Women |
| 104100000X | Social Worker |
| 1041C0700X | Social Worker, Clinical |
| 1041S0200X | Social Worker, School |

# Appendix D: Procedure codes

## Narrow definition of procedures

| HCPCs or CPT codes | Procedure Category | Procedure Long Description |
|---|---|---|
| 99497 | Advance Care Planning Evaluation & Management Services | ADVANCE CARE PLANNING FIRST 30 MINS |
| 99498 | Advance Care Planning Evaluation & Management Services | ADVANCE CARE PLANNING EA ADDL 30 MINS |
| 99450 | Basic Life and/or Disability Exam | BASIC LIFE AND/OR DISABILITY EXAMINATION |
| 99455 | Basic Life and/or Disability Exam | WORK RELATED/MED DBLT XM TREATING PHYS |
| 99456 | Basic Life and/or Disability Exam | WORK RELATED/MED DBLT XM OTH/THN TREATING PHYS |
| 99366 | Case Management Services | TEAM CONFERENCE FACE-TO-FACE NONPHYSICIAN |
| 99367 | Case Management Services | TEAM CONFERENCE NON-FACE-TO-FACE PHYSICIAN |
| 99368 | Case Management Services | TEAM CONFERENCE NON-FACE-TO-FACE NONPHYSICIAN |
| 99487 | Chronic Care Management Services | CMPLX CHRON CARE MGMT W/O PT VST 1ST HR PER MO |
| 99489 | Chronic Care Management Services | CMPLX CHRON CARE MGMT EA ADDL 30 MIN PER MONTH |
| 99490 | Chronic Care Management Services | CHRON CARE MANAGEMENT SRVC 20 MIN PER MONTH |
| G0506 | Chronic Care Management Services | COMP ASMT OF & CARE PLNG PT RQR CC MGMT SRVC |
| 99241 | Consultation Services | OFFICE CONSULTATION NEW/ESTAB PATIENT 15 MIN |
| 99242 | Consultation Services | OFFICE CONSULTATION NEW/ESTAB PATIENT 30 MIN |
| 99243 | Consultation Services | OFFICE CONSULTATION NEW/ESTAB PATIENT 40 MIN |
| 99244 | Consultation Services | OFFICE CONSULTATION NEW/ESTAB PATIENT 60 MIN |
| G0438 | Counseling, Screening, & Prevention Services | ANNUAL WELLNESS VISIT; PERSONALIZ PPS INIT VISIT |
| G0439 | Counseling, Screening, & Prevention Services | ANNUAL WELLNESS VST; PERSONALIZED PPS SUBSQT VST |
| G0442 | Counseling, Screening, & Prevention Services | ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES |
| G0443 | Counseling, Screening, & Prevention Services | BRIEF FACE-FACE BEHAV CNSL ALCOHL MISUSE 15 MIN |
| 99324 | Domiciliary, Rest Home or Custodial Care | DOMICIL/REST HOME NEW PT VISIT LOW SEVER 20 MIN |
| 99325 | Domiciliary, Rest Home or Custodial Care | DOMICIL/REST HOME NEW PT VISIT MOD SEVER 30 MIN |
| 99326 | Domiciliary, Rest Home or Custodial Care | DOMICIL/REST HOME NEW PT HI-MOD SEVER 45 MINUTES |
| 99327 | Domiciliary, Rest Home or Custodial Care | DOMICIL/REST HOME NEW PT VISIT HI SEVER 60 MIN |

### Narrow definition of procedures

| HCPCs or CPT codes | Procedure Category | Procedure Long Description |
|---|---|---|
| 99328 | Domiciliary, Rest Home or Custodial Care | DOM/R-HOME E/M NEW PT SIGNIF NEW PROB 75 MINUTES |
| 99334 | Domiciliary, Rest Home or Custodial Care | DOM/R-HOME E/M EST PT SELF-LMTD/MINOR 15 MINUTES |
| 99335 | Domiciliary, Rest Home or Custodial Care | DOM/R-HOME E/M EST PT LW MOD SEVERITY 25 MINUTES |
| 99336 | Domiciliary, Rest Home or Custodial Care | DOM/R-HOME E/M EST PT MOD HI SEVERITY 40 MINUTES |
| 99337 | Domiciliary, Rest Home or Custodial Care | DOM/R-HOME E/M EST PT SIGNIF NEW PROB 60 MINUTES |
| 99078 | Educational Service Group Setting | PHYS/QHP EDUCATION SVCS RENDERED PTS GRP SETTING |
| G0466 | FQHC Visits | FEDERALLY QUALIFIED HEALTH CENTER VISIT NEW PT |
| G0467 | FQHC Visits | FEDERALLY QUALIFIED HEALTH CENTER VISIT ESTAB PT |
| G0468 | FQHC Visits | FEDERALLY QUALIFIED HEALTH CENTER VISIT IPPE/AWV |
| G0469 | FQHC Visits | FED QUAL HEALTH CNTR VISIT MENTAL HEALTH NEW PT |
| G0470 | FQHC Visits | FED QUAL HEALTH CNTR VST MENTAL HEALTH ESTAB PT |
| T1015 | FQHC Visits - T1015 | CLINIC VISIT/ENCOUNTER ALL-INCLUSIVE |
| 96160 | Health Risk Assessment & Screenings | PT-FOCUSED HLTH RISK ASSMT SCORE DOC STND INSTRM |
| 96161 | Health Risk Assessment & Screenings | CAREGIVER HLTH RISK ASSMT SCORE DOC STND INSTRM |
| 99339 | Health Risk Assessment & Screenings | INDIV PHYS SUPVJ HOME/DOM/R-HOME MO 15-29 MIN |
| 99340 | Health Risk Assessment & Screenings | INDIV PHYS SUPVJ HOME/DOM/R-HOME MO 30 MIN/> |
| 99483 | Health Risk Assessment & Screenings | ASSMT & CARE PLANNING PT W/COGNITIVE IMPAIRMENT |
| G0396 | Health Risk Assessment & Screenings | ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT 15-30 MIN |
| G0397 | Health Risk Assessment & Screenings | ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT >30 MIN |
| G0444 | Health Risk Assessment & Screenings | ANNUAL DEPRESSION SCREENING 15 MINUTES |
| G0505 | Health Risk Assessment & Screenings | COGN & FUNCT ASMT USING STD INST OFF/OTH OP/HOME |
| 99341 | Home Health Services | HOME VISIT NEW PATIENT LOW SEVERITY 20 MINUTES |
| 99342 | Home Health Services | HOME VISIT NEW PATIENT MOD SEVERITY 30 MINUTES |
| 99343 | Home Health Services | HOME VST NEW PATIENT MOD-HI SEVERITY 45 MINUTES |
| 99344 | Home Health Services | HOME VISIT NEW PATIENT HI SEVERITY 60 MINUTES |
| 99345 | Home Health Services | HOME VISIT NEW PT UNSTABL/SIGNIF NEW PROB 75 MIN |

### Narrow definition of procedures

| HCPCs or CPT codes | Procedure Category | Procedure Long Description |
|---|---|---|
| 99347 | Home Health Services | HOME VISIT EST PT SELF LIMITED/MINOR 15 MINUTES |
| 99348 | Home Health Services | HOME VISIT EST PT LOW-MOD SEVERITY 25 MINUTES |
| 99349 | Home Health Services | HOME VISIT EST PT MOD-HI SEVERITY 40 MINUTES |
| 99350 | Home Health Services | HOME VST EST PT UNSTABLE/SIGNIF NEW PROB 60 MINS |
| 99374 | Home Health Services | SUPVJ PT HOME HEALTH AGENCY MO 15-29 MINUTES |
| 99375 | Home Health Services | SUPERVISION PT HOME HEALTH AGENCY MONTH 30 MIN/> |
| 99376 | Home Health Services | CARE PLAN OVERSIGHT/OVER |
| G0179 | Home Health Services | PHYS RE-CERT MCR-COVR HOM HLTH SRVC RE-CERT PRD |
| G0180 | Home Health Services | PHYS CERT MCR-COVR HOM HLTH SRVC PER CERT PRD |
| G0181 | Home Health Services | PHYS SUPV PT RECV MCR-COVR SRVC HOM HLTH AGCY |
| G0463 | Hospital Outpatient Clinic Visit | HOSPITAL OUTPATIENT CLIN VISIT ASSESS & MGMT PT |
| 90460 | Immunization Administration for Vaccines/Toxoids | IM ADM THRU 18YR ANY RTE 1ST/ONLY COMPT VAC/TOX |
| 90461 | Immunization Administration for Vaccines/Toxoids | IM ADM THRU 18YR ANY RTE ADDL VAC/TOX COMPT |
| 90471 | Immunization Administration for Vaccines/Toxoids | IM ADM PRQ ID SUBQ/IM NJXS 1 VACCINE |
| 90472 | Immunization Administration for Vaccines/Toxoids | IM ADM PRQ ID SUBQ/IM NJXS EA VACCINE |
| 90473 | Immunization Administration for Vaccines/Toxoids | IM ADM INTRANSL/ORAL 1 VACCINE |
| 90474 | Immunization Administration for Vaccines/Toxoids | IM ADM INTRANSL/ORAL EA VACCINE |
| G0402 | Initial Services for Medicare Enrollment | INIT PREV PE LTD NEW BENEF DUR 1ST 12 MOS MCR |
| 96372 | Injections | THERAPEUTIC PROPHYLACTIC/DX INJECTION SUBQ/IM |
| 11055 | Minor Procedures and Tests | PARING/CUTTING BENIGN HYPERKERATOTIC LESION 1 |
| 11056 | Minor Procedures and Tests | PARING/CUTTING BENIGN HYPERKERATOTIC LESION 2-4 |
| 11200 | Minor Procedures and Tests | REMOVAL SKN TAGS MLT FIBRQ TAGS ANY AREA UPW/15 |
| 11201 | Minor Procedures and Tests | REMOVAL SK TGS MLT FIBRQ TAGS ANY AREA EA 10 |

## Narrow definition of procedures

| HCPCs or CPT codes | Procedure Category | Procedure Long Description |
|---|---|---|
| 11719 | Minor Procedures and Tests | TRIMMING NONDYSTROPHIC NAILS ANY NUMBER |
| 11720 | Minor Procedures and Tests | DEBRIDEMENT NAIL ANY METHOD 1-5 |
| 11721 | Minor Procedures and Tests | DEBRIDEMENT NAIL ANY METHOD 6/> |
| 11740 | Minor Procedures and Tests | EVACUATION SUBUNGUAL HEMATOMA |
| 11900 | Minor Procedures and Tests | INJECTION INTRALESIONAL UP TO & INCLUD 7 LESIONS |
| 11901 | Minor Procedures and Tests | INJECTION INTRALESIONAL >7 LESIONS |
| 15851 | Minor Procedures and Tests | REMOVAL SUTURES UNDER ANESTHESIA OTHER SURGEON |
| 16020 | Minor Procedures and Tests | DRS&/DBRDMT PRTL-THKNS BURNS 1ST/SBSQ SMALL |
| 17110 | Minor Procedures and Tests | DESTRUCTION BENIGN LESIONS UP TO 14 |
| 17111 | Minor Procedures and Tests | DESTRUCTION BENIGN LESIONS 15/> |
| 24640 | Minor Procedures and Tests | CLTX RDL HEAD SUBLXTJ CHLD NURSEMAID ELBW W/MANJ |
| 30300 | Minor Procedures and Tests | REMOVAL FOREIGN BODY INTRANASAL OFFICE PROCEDURE |
| 36415 | Minor Procedures and Tests | COLLECTION VENOUS BLOOD VENIPUNCTURE |
| 36416 | Minor Procedures and Tests | COLLECTION CAPILLARY BLOOD SPECIMEN |
| 43760 | Minor Procedures and Tests | CHANGE GASTROSTOMY TUBE PERCUTANEOUS W/O GDNCE |
| 51702 | Minor Procedures and Tests | INSJ TEMP NDWELLG BLADDER CATHETER SIMPLE |
| 54150 | Minor Procedures and Tests | CIRCUMCISION W/CLAMP/OTH DEV W/BLOCK |
| 57170 | Minor Procedures and Tests | DIAPHRAGM/CERVICAL CAP FITTING W/INSTRUCTIONS |
| 69200 | Minor Procedures and Tests | RMVL FB XTRNL AUDITORY CANAL W/O ANES |
| 69210 | Minor Procedures and Tests | REMOVAL IMPACTED CERUMEN INSTRUMENTATION UNILAT |
| 81000 | Minor Procedures and Tests | URINLS DIP STICK/TABLET REAGNT NON-AUTO MICRSCPY |
| 81001 | Minor Procedures and Tests | URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY |
| 81002 | Minor Procedures and Tests | URNLS DIP STICK/TABLET RGNT NON-AUTO W/O MICRSCP |
| 81025 | Minor Procedures and Tests | URINE PREGNANCY TEST VISUAL COLOR CMPRSN METHS |
| 82044 | Minor Procedures and Tests | URINE ALBUMIN SEMIQUANTITATIVE |
| 82270 | Minor Procedures and Tests | BLOOD OCCULT PEROXIDASE ACTV QUAL FECES 1 DETER |

### Narrow definition of procedures

| HCPCs or CPT codes | Procedure Category | Procedure Long Description |
|---|---|---|
| 82272 | Minor Procedures and Tests | BLOOD OCCULT PEROXIDASE ACTV QUAL FECES 1-3 SPEC |
| 82465 | Minor Procedures and Tests | CHOLESTEROL SERUM/WHOLE BLOOD TOTAL |
| 82947 | Minor Procedures and Tests | GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP |
| 82948 | Minor Procedures and Tests | GLUCOSE BLOOD REAGENT STRIP |
| 82950 | Minor Procedures and Tests | GLUCOSE POST GLUCOSE DOSE |
| 82962 | Minor Procedures and Tests | GLUC BLD GLUC MNTR DEV CLEARED FDA SPEC HOME USE |
| 83718 | Minor Procedures and Tests | LIPOPROTEIN DIR MEAS HIGH DENSITY CHOLESTEROL |
| 85013 | Minor Procedures and Tests | BLOOD COUNT SPUN MICROHEMATOCRIT |
| 85014 | Minor Procedures and Tests | BLOOD COUNT HEMATOCRIT |
| 85018 | Minor Procedures and Tests | BLOOD COUNT HEMOGLOBIN |
| 86580 | Minor Procedures and Tests | SKIN TEST TUBERCULOSIS INTRADERMAL |
| 87205 | Minor Procedures and Tests | SMR PRIM SRC GRAM/GIEMSA STAIN BCT FUNGI/CELL |
| 87880 | Minor Procedures and Tests | IAADIADOO STREPTOCOCCUS GROUP A |
| 92551 | Minor Procedures and Tests | SCREENING TEST PURE TONE AIR ONLY |
| 92567 | Minor Procedures and Tests | TYMPANOMETRY |
| 93000 | Minor Procedures and Tests | ECG ROUTINE ECG W/LEAST 12 LDS W/I&R |
| 93005 | Minor Procedures and Tests | ECG ROUTINE ECG W/LEAST 12 LDS TRCG ONLY W/O I&R |
| 93010 | Minor Procedures and Tests | ECG ROUTINE ECG W/LEAST 12 LDS I&R ONLY |
| 93040 | Minor Procedures and Tests | RHYTHM ECG 1-3 LEADS W/INTERPRETATION & REPORT |
| 93268 | Minor Procedures and Tests | XTRNL PT ACTIV ECG TRANSMIS W/R&I </30 DAYS |
| 93270 | Minor Procedures and Tests | XTRNL PT ACTIVATED ECG RECORD MONITOR 30 DAYS |
| 93272 | Minor Procedures and Tests | XTRNL PT ACTIVTD ECG DWNLD W/R&I </30 DAYS |
| 93784 | Minor Procedures and Tests | AMBL BLD PRESS W/TAPE&/DISK 24/> HR ALYS I&R |
| 94010 | Minor Procedures and Tests | SPMTRY W/VC EXPIRATORY FLO W/WO MXML VOL VNTJ |
| 94060 | Minor Procedures and Tests | BRNCDILAT RSPSE SPMTRY PRE&POST-BRNCDILAT ADMN |
| 94640 | Minor Procedures and Tests | PRESSURIZED/NONPRESSURIZED INHALATION TREATMENT |

### Narrow definition of procedures

| HCPCs or CPT codes | Procedure Category | Procedure Long Description |
|---|---|---|
| 94664 | Minor Procedures and Tests | DEMO&/EVAL OF PT UTILIZ AERSL GEN/NEB/INHLR/IP |
| 94760 | Minor Procedures and Tests | NONINVASIVE EAR/PULSE OXIMETRY SINGLE DETER |
| 94761 | Minor Procedures and Tests | NONINVASIVE EAR/PULSE OXIMETRY MULTIPLE DETER |
| 95115 | Minor Procedures and Tests | PROF SVCS ALLG IMMNTX X W/PRV ALLGIC XTRCS 1 NJX |
| 95117 | Minor Procedures and Tests | PROF SVCS ALLG IMMNTX X W/PRV ALLGIC XTRCS NJXS |
| 97597 | Minor Procedures and Tests | DEBRIDEMENT OPEN WOUND 20 SQ CM/< |
| 97602 | Minor Procedures and Tests | RMVL DEVITAL TISS N-SLCTV DBRDMT W/O ANES 1 SESS |
| 99000 | Minor Procedures and Tests | HANDLG&/OR CONVEY OF SPEC FOR TR OFFICE TO LAB |
| 99050 | Minor Procedures and Tests | SERVICES PROVIDED OFFICE OTH/THN REG SCHED HOURS |
| 99051 | Minor Procedures and Tests | SVC PRV OFFICE REG SCHEDD EVN WKEND/HOLIDAY HRS |
| 99058 | Minor Procedures and Tests | SVC PRV EMER BASIS IN OFFICE DISRUPTING SVCS |
| A4627 | Minor Procedures and Tests | SPACR BAG/RESRVOR W/WO MASK W/METRD DOSE INHAL |
| A6448 | Minor Procedures and Tests | LT COMPRS BANDGE ELAST WDTH < 3 IN PER YARD |
| A6449 | Minor Procedures and Tests | LT COMPRS BANDGE ELAST WDTH >/= 3 & <5 IN PER YD |
| A7003 | Minor Procedures and Tests | ADMN SET SM VOL NONFILTR PNEUMAT NEBULIZR DISPBL |
| A7015 | Minor Procedures and Tests | AREO MASK USED W/ DME NEB |
| G0403 | Minor Procedures and Tests | ECG RTN ECG W/12 LEADS SCR INIT PREVNTV PE W/I&R |
| G0404 | Minor Procedures and Tests | ECG RTN ECG W/12 LEADS TRACING ONLY W/O I&R |
| G0405 | Minor Procedures and Tests | ECG RTN ECG W/12 LEADS INTERPR & REPORT ONLY |
| S8100 | Minor Procedures and Tests | HOLDING CHAMB/SPACR W/INHAL/NEBULIZR; W/O MASK |
| S8101 | Minor Procedures and Tests | HOLDING CHAMB/SPACR W/AN INHAL/NEBULIZR; W/MASK |
| 99460 | Newborn Care Services | 1ST HOSP/BIRTHING CENTER CARE PER DAY NML NB |
| 99461 | Newborn Care Services | 1ST CARE PR DAY NML NB XCPT HOSP/BIRTHING CENTER |
| 99462 | Newborn Care Services | SUBQ HOSPITAL CARE PER DAY E/M NORMAL NEWBORN |
| 99463 | Newborn Care Services | 1ST HOSP/BIRTHING CENTER NB ADMIT & DSCHG SM DAT |
| 98969 | Non-Face-to-Face Non-Physician Services | NONPHYSICIAN ONLINE ASSESSMENT AND MANAGEMENT |

### Narrow definition of procedures

| HCPCs or CPT codes | Procedure Category | Procedure Long Description |
|---|---|---|
| 99441 | Non-Face-to-Face Physician Services | PHYS/QHP TELEPHONE EVALUATION 5-10 MIN |
| 99442 | Non-Face-to-Face Physician Services | PHYS/QHP TELEPHONE EVALUATION 11-20 MIN |
| 99443 | Non-Face-to-Face Physician Services | PHYS/QHP TELEPHONE EVALUATION 21-30 MIN |
| 99444 | Non-Face-to-Face Physician Services | PHYS/QHP ONLINE EVALUATION & MANAGEMENT SERVICE |
| 99446 | Non-Face-to-Face Physician Services | NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5-10 MIN |
| 99447 | Non-Face-to-Face Physician Services | NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 11-20 MIN |
| 99448 | Non-Face-to-Face Physician Services | NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 21-30 MIN |
| 99449 | Non-Face-to-Face Physician Services | NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 31/> MIN |
| 99451 | Non-Face-to-Face Physician Services | NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5/> MIN |
| 99452 | Non-Face-to-Face Physician Services | NTRPROF PHONE/NTRNET/EHR REFERRAL SVC 30 MIN |
| 99453 | Non-Face-to-Face Physician Services | REM MNTR PHYSIOL PARAM 1ST SET UP PT EDUCAJ EQP |
| 99454 | Non-Face-to-Face Physician Services | REM MNTR PHYSIOL PARAM 1ST DEV SUPPLY EA 30 D |
| 99457 | Non-Face-to-Face Physician Services | REMOTE PHYSIOLOGIC MONITORING 20 MIN+ PER MONTH |
| 98966 | Non-Physician Telephone Services | NONPHYSICIAN TELEPHONE ASSESSMENT 5-10 MIN |
| 98967 | Non-Physician Telephone Services | NONPHYSICIAN TELEPHONE ASSESSMENT 11-20 MIN |
| 98968 | Non-Physician Telephone Services | NONPHYSICIAN TELEPHONE ASSESSMENT 21-30 MIN |
| 99201 | Office/Other Outpatient Services | OFFICE OUTPATIENT NEW 10 MINUTES |
| 99202 | Office/Other Outpatient Services | OFFICE OUTPATIENT NEW 20 MINUTES |
| 99203 | Office/Other Outpatient Services | OFFICE OUTPATIENT NEW 30 MINUTES |
| 99204 | Office/Other Outpatient Services | OFFICE OUTPATIENT NEW 45 MINUTES |
| 99205 | Office/Other Outpatient Services | OFFICE OUTPATIENT NEW 60 MINUTES |
| 99211 | Office/Other Outpatient Services | OFFICE OUTPATIENT VISIT 5 MINUTES |
| 99212 | Office/Other Outpatient Services | OFFICE OUTPATIENT VISIT 10 MINUTES |
| 99213 | Office/Other Outpatient Services | OFFICE OUTPATIENT VISIT 15 MINUTES |
| 99214 | Office/Other Outpatient Services | OFFICE OUTPATIENT VISIT 25 MINUTES |
| 99215 | Office/Other Outpatient Services | OFFICE OUTPATIENT VISIT 40 MINUTES |

### Narrow definition of procedures

| HCPCs or CPT codes | Procedure Category | Procedure Long Description |
|---|---|---|
| 98925 | Osteopathic Manipulation | OSTEOPATHIC MANIPULATIVE TX 1-2 BODY REGIONS |
| 98926 | Osteopathic Manipulation | OSTEOPATHIC MANIPULATIVE TX 3-4 BODY REGIONS |
| 98927 | Osteopathic Manipulation | OSTEOPATHIC MANIPULATIVE TX 5-6 BODY REGIONS |
| 98928 | Osteopathic Manipulation | OSTEOPATHIC MANIPULATIVE TX 7-8 BODY REGIONS |
| 98929 | Osteopathic Manipulation | OSTEOPATHIC MANIPULATIVE TX 9-10 BODY REGIONS |
| 11981 | Preventive Medicine Services | INSJ NON-BIODEGRADABLE DRUG DELIVERY IMPLANT |
| 11982 | Preventive Medicine Services | REMOVAL NON-BIODEGRADABLE DRUG DELIVERY IMPLANT |
| 11983 | Preventive Medicine Services | RMVL W/RINSJ NON-BIODEGRADABLE DRUG DLVR IMPLT |
| 58300 | Preventive Medicine Services | INSERTION INTRAUTERINE DEVICE IUD |
| 83655 | Preventive Medicine Services | ASSAY OF LEAD |
| 99173 | Preventive Medicine Services | SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT |
| 99381 | Preventive Medicine Services | INITIAL PREVENTIVE MEDICINE NEW PATIENT <1YEAR |
| 99382 | Preventive Medicine Services | INITIAL PREVENTIVE MEDICINE NEW PT AGE 1-4 YRS |
| 99383 | Preventive Medicine Services | INITIAL PREVENTIVE MEDICINE NEW PT AGE 5-11 YRS |
| 99384 | Preventive Medicine Services | INITIAL PREVENTIVE MEDICINE NEW PT AGE 12-17 YR |
| 99385 | Preventive Medicine Services | INITIAL PREVENTIVE MEDICINE NEW PT AGE 18-39YRS |
| 99386 | Preventive Medicine Services | INITIAL PREVENTIVE MEDICINE NEW PATIENT 40-64YRS |
| 99387 | Preventive Medicine Services | INITIAL PREVENTIVE MEDICINE NEW PATIENT 65YRS&> |
| 99391 | Preventive Medicine Services | PERIODIC PREVENTIVE MED ESTABLISHED PATIENT <1Y |
| 99392 | Preventive Medicine Services | PERIODIC PREVENTIVE MED EST PATIENT 1-4YRS |
| 99393 | Preventive Medicine Services | PERIODIC PREVENTIVE MED EST PATIENT 5-11YRS |
| 99394 | Preventive Medicine Services | PERIODIC PREVENTIVE MED EST PATIENT 12-17YRS |
| 99395 | Preventive Medicine Services | PERIODIC PREVENTIVE MED EST PATIENT 18-39 YRS |
| 99396 | Preventive Medicine Services | PERIODIC PREVENTIVE MED EST PATIENT 40-64YRS |
| 99397 | Preventive Medicine Services | PERIODIC PREVENTIVE MED EST PATIENT 65YRS& OLDER |
| 99401 | Preventive Medicine Services | PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 15 MIN |

## Narrow definition of procedures

| HCPCs or CPT codes | Procedure Category | Procedure Long Description |
|---|---|---|
| 99402 | Preventive Medicine Services | PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 30 MIN |
| 99403 | Preventive Medicine Services | PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 45 MIN |
| 99404 | Preventive Medicine Services | PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 60 MIN |
| 99406 | Preventive Medicine Services | TOBACCO USE CESSATION INTERMEDIATE 3-10 MINUTES |
| 99407 | Preventive Medicine Services | TOBACCO USE CESSATION INTENSIVE >10 MINUTES |
| 99408 | Preventive Medicine Services | ALCOHOL/SUBSTANCE SCREEN & INTERVEN 15-30 MIN |
| 99409 | Preventive Medicine Services | ALCOHOL/SUBSTANCE SCREEN & INTERVENTION >30 MIN |
| 99411 | Preventive Medicine Services | PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 30 M |
| 99412 | Preventive Medicine Services | PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 60 M |
| 99420 | Preventive Medicine Services | ADMN & INTERPJ HEALTH RISK ASSESSMENT INSTRUMENT |
| 99429 | Preventive Medicine Services | UNLISTED PREVENTIVE MEDICINE SERVICE |
| G0101 | Preventive Medicine Services | CERV/VAGINAL CANCER SCR; PELV&CLIN BREAST EXAM |
| G0102 | Preventive Medicine Services | PROS CANCER SCREENING; DIGTL RECTAL EXAMINATION |
| G0436 | Preventive Medicine Services | SMOKE TOB CESSATION CNSL AS PT; INTRMED 3-10 MIN |
| G0437 | Preventive Medicine Services | SMOKING & TOB CESS CNSL AS PT; INTENSIVE >10 MIN |
| J1050 | Preventive Medicine Services | INJECTION MEDROXYPROGESTERONE ACETATE 1 MG |
| Q0091 | Preventive Medicine Services | SCREEN PAP SMEAR; OBTAIN PREP &C ONVEY TO LAB |
| G0513 | Prolonged Preventive Services | PRLNG PREV SRVC OFC/OTH O/P RQR DIR CTC;1ST 30 M |
| G0514 | Prolonged Preventive Services | PRLNG PREV SRVC OFC/OTH O/P DIR CTC;EA ADD 30 M |
| 99354 | Prolonged Services | PROLNG E&M/PSYCTX SVC OFFICE O/P DIR CON 1ST HR |
| 99355 | Prolonged Services | PROLNG E&M/PSYCTX SVC OFFICE O/P DIR CON ADDL 30 |
| 99358 | Prolonged Services | PROLNG E/M SVC BEFORE&/AFTER DIR PT CARE 1ST HR |
| 99359 | Prolonged Services | PROLNG E/M BEFORE&/AFTER DIR CARE EA 30 MINUTES |
| 99360 | Prolonged Services | PHYS STANDBY SVC PROLNG PHYS ATTN EA 30 MINUTES |
| 99495 | Transitional Care Management Services | TRANSITIONAL CARE MANAGE SRVC 14 DAY DISCHARGE |
| 99496 | Transitional Care Management Services | TRANSITIONAL CARE MANAGE SRVC 7 DAY DISCHARGE |

### Narrow definition of procedures

| HCPCs or CPT codes | Procedure Category | Procedure Long Description |
|---|---|---|
| G0008 | Vaccine Administration | ADMINISTRATION OF INFLUENZA VIRUS VACCINE |
| G0009 | Vaccine Administration | ADMINISTRATION OF PNEUMOCOCCAL VACCINE |
| G0010 | Vaccine Administration | ADMINISTRATION OF HEPATITIS B VACCINE |

### Broad definition of procedure codes

| HCPCs or CPT codes | Procedure Category | Procedure Long Description |
|---|---|---|
| 59510 | Cesarean Delivery Procedures | OB ANTEPARTUM CARE CESAREAN DLVR & POSTPARTUM |
| 59515 | Cesarean Delivery Procedures | CESAREAN DELIVERY ONLY W/POSTPARTUM CARE |
| 59610 | Delivery Procedures After Previous Cesarean Delivery | ROUTINE OB CARE VAG DLVRY & POSTPARTUM CARE VB |
| 59614 | Delivery Procedures After Previous Cesarean Delivery | VAGINAL DELIVERY & POSTPARTUM CARE VBAC |
| 59618 | Delivery Procedures After Previous Cesarean Delivery | ROUTINE OBSTETRICAL CARE ATTEMPTED VBAC |
| 59622 | Delivery Procedures After Previous Cesarean Delivery | CESAREAN DLVRY & POSTPARTUM CARE ATTEMPTED VBA |
| 99464 | Delivery/Birthing Room Attendance & Resuscitation Services | ATTN AT DELIVERY 1ST STABILIZATION OF NEWBORN |
| 99465 | Delivery/Birthing Room Attendance & Resuscitation Services | DELIVERY/BIRTHING ROOM RESUSCITATION |
| 99377 | Hospice Services | SUPERVISION HOSPICE PATIENT/MONTH 15-29 MIN |
| 99378 | Hospice Services | SUPERVISION HOSPICE PATIENT/MONTH 30 MINUTES/> |
| G0182 | Hospice Services | PHYS SUPV PT UNDER MEDICARE-APPROVED HOSPICE |
| 99304 | Nursing Facility Services | INITIAL NURSING FACILITY CARE/DAY 25 MINUTES |
| 99305 | Nursing Facility Services | INITIAL NURSING FACILITY CARE/DAY 35 MINUTES |
| 99306 | Nursing Facility Services | INITIAL NURSING FACILITY CARE/DAY 45 MINUTES |
| 99307 | Nursing Facility Services | SBSQ NURSING FACILITY CARE/DAY E/M STABLE 10 MIN |
| 99308 | Nursing Facility Services | SBSQ NURSING FACIL CARE/DAY MINOR COMPLJ 15 MIN |
| 99309 | Nursing Facility Services | SBSQ NURSING FACIL CARE/DAY NEW PROBLEM 25 MIN |
| 99310 | Nursing Facility Services | SBSQ NURS FACIL CARE/DAY UNSTABL/NEW PROB 35 MIN |

**Broad definition of procedure codes**

| HCPCs or CPT codes | Procedure Category | Procedure Long Description |
| --- | --- | --- |
| 99315 | Nursing Facility Services | NURSING FACILITY DISCHARGE MANAGEMENT 30 MINUTES |
| 99316 | Nursing Facility Services | NURSING FACILITY DISCHARGE MANAGEMENT 30 MINUTES |
| 99318 | Nursing Facility Services | E/M ANNUAL NURSING FACILITY ASSESS STABLE 30 MIN |
| 99379 | Nursing Facility Services | SUPERVISION NURS FACILITY PATIENT MO 15-29 MIN |
| 99380 | Nursing Facility Services | SUPERVISION NURS FACILITY PATIENT MONTH 30 MIN/> |
| 99484 | Psychiatric Care Management | CARE MGMT SERVICES BEHAVIORAL HLTH COND 20 MINS |
| 99492 | Psychiatric Care Management | 1ST PSYCHIATRIC COLLAB CARE MGMT 1ST 70 MINS |
| 99493 | Psychiatric Care Management | SBSQ PSYCHIATRIC COLLAB CARE MGMT 1ST 60 MINS |
| 99494 | Psychiatric Care Management | 1ST/SBSQ PSYCH COLLAB CARE MGMT EA ADDL 30 MINS |
| G0502 | Psychiatric Care Management | INIT PS CCM 1ST 70 MIN 1ST CAL MO BEH HC MGR AC |
| G0503 | Psychiatric Care Management | SUBSQT PS CCM 1ST 60 MIN SUBSQT MO BEH HC MGR AC |
| G0504 | Psychiatric Care Management | INIT/SUBSQ PS CCM EA ADD 30 MN CAL MO BHC MGR AC |
| G0507 | Psychiatric Care Management | CARE MGMT BH COND AL 20 MIN CL STAFF TM P CAL MO |
| 59400 | Vaginal Delivery, Antepartum & Postpartum Care Procedures | OB CARE ANTEPARTUM VAG DLVR & POSTPARTUM |
| 59410 | Vaginal Delivery, Antepartum & Postpartum Care Procedures | VAGINAL DELIVERY ONLY W/POSTPARTUM CARE |
| 59425 | Vaginal Delivery, Antepartum & Postpartum Care Procedures | ANTEPARTUM CARE ONLY 4-6 VISITS |
| 59426 | Vaginal Delivery, Antepartum & Postpartum Care Procedures | ANTEPARTUM CARE ONLY 7/> VISITS |
| 59430 | Vaginal Delivery, Antepartum & Postpartum Care Procedures | POSTPARTUM CARE ONLY SEPARATE PROCEDURE |

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# Index – 2020 Bree collaborative report on primary care

# TAB 8

Working together to improve health care quality, outcomes, and affordability in Washington State.

# Primary Care Report and Recommendations

2020

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## Executive Summary

*Primary care access and quality impact all 329 million Americans. Geographic access varies significantly and is often lower in areas with a higher proportion of people of color, adding to health disparities.*

Primary care, widely identified as the cornerstone of the health care system, is the usual source of health promotion, disease prevention, and care for a population's acute and chronic health problems. The definition of primary care starts with a broad scope of services and general attributes and is often described in contrast to health care services provided for urgent needs or within a hospital or surgical setting.

Access to regular, high-quality care is a challenge for many. These issues are influenced and compounded by low reimbursement for primary care compared to specialty care and hospital care. Low reimbursement leads to not enough time being spent with an individual patient in the visit. Compounding the issue of low reimbursement is the fact that many of the activities expected of a high-performing primary care practice are not reimbursed by traditional fee-for-service payment approaches.

To address issues of limited access and uncertain definitions, the Bree Collaborative elected to develop standards to develop a state-wide definition for primary care to support multi-payor payment reform. The workgroup met through 2020 to recommend system- and individual-level changes to build a healthcare system that truly meetings the needs of a diverse population. The workgroup's goal is to foster a common understanding of primary care through defining primary care, discussing measurement of primary care, and outlining components of primary care that are impactful on population health.

This report outlines the benefits of accessing primary care for a population as well as the issues with current reimbursement models on page 3 and the focus areas for these recommendations on page 5. Pages 6-11 include checklists for primary care, for health plans, for people receiving care, and for employer groups to support the focus areas. Must have infrastructure elements for primary care are listed on page 6 including those around team-based, evidence-informed, and whole-person care; available behavioral health; patient panels; accessible care; and supportive health information technology. Primary care is further defined on pages 13-14 including a philosophical framework of being accountable, first contact, comprehensive, continuous, coordinated, and appropriate. Content of care visits is discussed on page 15 and approaches to reimbursement including measurement on page 18.



Adopted by the Bree Collaborative January 27, 2021.

## Dr. Robert Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 *"…to provide a mechanism through which public and private healthcare stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State."* The Bree Collaborative was named in memory of Dr. Robert Bree, a leader in the imaging field and a key member of previous healthcare quality improvement collaborative projects.

Members are appointed by the Washington State Governor and include public healthcare purchasers for Washington State, private healthcare purchasers (employers and union trusts), health plans, physicians and other healthcare providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying healthcare services annually with substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each healthcare service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing healthcare providers or health carriers as to the price or specific level of reimbursement for healthcare services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private healthcare purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Healthcare Authority for review and approval. The Healthcare Authority (HCA) oversees Washington State's largest healthcare purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, healthcare service quality, and the affordability of healthcare for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

The Bree Collaborative elected to develop standards to develop a state-wide definition for primary care to support multi-payor payment reform. The workgroup met from January to XXX 2020 to recommend system- and individual-level changes to build a healthcare system that truly meetings the needs of a diverse population.

See **Appendix B** for the Primary Care Workgroup charter and a list of members.

## Background

Primary care, widely identified as the cornerstone of the health care system, is the usual source of health promotion, disease prevention, and care for a population's acute and chronic health problems.[1] Efforts to define primary care often start with a broad scope of services, general attributes in an outpatient or ambulatory care setting, and are often described in contrast to health care services provided for acute or urgent needs or within a hospital or surgical setting. The delivery of comprehensive primary care services is also frequently associated with certain types of providers that are trained to provide first contact, comprehensive, continuous, and coordinated care – the hallmarks of primary care.

### *Access and Outcomes*

In a report from the Primary Care Collaborative, the authors note that "*consistent and growing evidence shows that primary care-oriented systems achieve better health outcomes, more health equity, and lower costs.*"[2] A lack of a sufficient primary care workforce is a growing issue that impacts accessibility in Washington State as well as nationally.[3]

Access to primary care depends on multiple factors: availability, accessibility or how close a delivery site is to where a person lives or works, convenience or the hours that the delivery site operates and the modes in which care is offered such as in-person or virtually, affordability or cost of care, and acceptability or how well the care that is offered matches a person's individual needs and preferences such as through the availability of care in different languages.[4] Accessibility, defined as physical proximity, is the most well-studied factor associated with individual and population health, consistently showing a positive impact when compared with populations farther away from primary care.[5] Early studies in the 1990s found an association between a higher ratio of primary care physicians at a state-level and population-level health outcomes such as lower all-cause mortality and mortality from heart disease, cancer, stroke, as well as infant mortality.[6] Presence of primary care providers is also associated with increased life span, reduction in infant low birth weight, better overall patient experience, and a person's self-rated health.[7,8,9]

Access to regular, high-quality care is a challenge for many. Analysis of urban census tracts show lower levels of access to primary care for specific populations, such as areas with a higher proportion of Black Americans.[10] Those living in rural areas also have lower levels of access to primary care.[11] A primary care delivery site may be located in close geographic proximity but may not be of high quality, may have hours that render it inaccessible, or the providers may not be taking new patients.

These issues are influenced and compounded by low reimbursement for primary care compared to specialty care and hospital care, with the United States spending between 5-7% of total health care expenditure on primary care and Washington State spending between 4.4% to 5.6% of total expenditure on primary care.[12] Low reimbursement leads to fewer physicians choosing to practice in primary care, opting instead for higher reimbursed and thus higher paying specialty care, and to not enough time being spent with an individual patient during primary care visits. Many argue that there is not currently

enough time in a clinical visit to deliver all the services recommended by the US Preventive Services Task Force (USPSTF) to a complete panel of patients without reducing panel size by half.[13]

Compounding the issue of low reimbursement is the fact that many of the activities expected of a high-performing primary care practice are not reimbursed by traditional fee-for-service payment approaches. Examples of these activities that are frequently identified as features of high-performing or "advanced" models of primary care are included here:

- Proactive outreach to patients with upcoming or overdue preventive tests or screenings
- Ongoing engagement with patients who have complex or multiple chronic conditions to ensure adherence to agreed upon care plan
- Active management
- Daily team huddles that consider the needs of all patients– those on the visit schedule for the day as well as those not on the schedule
- Health information technology implementations that support population and individual health analytics to properly resource and manage the patient panel while also meeting individual care needs

## Recommendation Framework

The workgroup's goal is to foster a common understanding of primary care to increase primary care accessibility and availability.

| Focus Area | Definition |
|---|---|
| **Defining Primary Care** | Team-based care led by an accountable provider that serves as a person's source of first contact with the larger healthcare system and coordinator of services that the person receives. Primary care includes a comprehensive array of appropriate, evidence-informed services to foster a continuous relationship over time. This array of services is coordinated by the accountable primary care provider but may exist in multiple care settings or be delivered in a variety of modes. |
| **Components of Primary Care with Large Impact** | • Care coordination<br>• Integrated behavioral health<br>• Disease prevention and screening<br>• Chronic condition management<br>• Medication management<br>• Health promotion<br>• Person-centered care that considers physical, emotional, and social needs |
| **Measuring Primary Care** | Based in claims, care delivered in an ambulatory setting by a predefined group of providers and team members as a proportion of total cost of care |

## Stakeholder Checklists

### *Primary Care Site Checklist*

**Must have elements:**

- ☐ Team-based care strategies (e.g., huddles, care management meetings, high-risk patient panel review) are consistently used through co-located or integrated models. The team can include the clinical team including nursing, social services, community services, and home-based care.
- ☐ Behavioral health provider(s) are part of the care team through co-located or integrated models
- ☐ Active patients are assigned or attributed to a primary care provider or team for advanced clinical judgment, the primary care team may/may not reside in the same physical setting and does not need to have the same organizational affiliation to act as a team
- ☐ Care is evidence-based or evidence informed
- ☐ Services that address the whole person (multiple organ systems) are regularly offered including:
  - ☐ Active management of chronic diseases
  - ☐ Acute care for minor illnesses and injuries
  - ☐ Office-based procedures and diagnostic tests
  - ☐ Preventive services including USPSTF recommended cancer screenings
  - ☐ Patient education
  - ☐ Self-management support
  - ☐ Medication management
  - ☐ Chronic condition management
  - ☐ Behavioral health support
- ☐ Convenient and flexible care options allow easy access to the right care in the right setting when needed.
  - ☐ At least one alternative to traditional physical and behavioral health office visits is offered (e.g., e-visits, phone visits, group visits, home visits, alternate location visits)
  - ☐ Site also offers expanded hours (e.g., early mornings, evenings, weekends)
- ☐ Health information technology is in place that supports management of the patient panel at a population health level while also supporting optimal care at the individual patient level. To be effective, the primary care provider must be "connected" to the broader healthcare ecosystem through some mechanism that supports interoperability, such as a Health Information Exchange (HIE) that supports a longitudinal patient-centric record and near/real time alerts to support

**The following are strongly recommended for high quality primary care**

**Infrastructure**

- ☐ Forms and protocols (e.g., mission statement, employee materials) reflect that the delivery site has an open and affirming environment that includes non-discrimination in hiring practices
- ☐ Age-appropriate and culturally inclusive reading materials and audiovisual aids are available in the reception area and examination rooms

**Access**

- ☐ The site is physically accessible to those with mobility issues including entering/exiting, moving within the facility, and during the clinical encounter such as seating within an exam room.
- ☐ Translation services for languages common among the patient population are available. This can include providers who speak a patient and family's language, presence of a certified interpreter, or a telephonic interpreter. Family or friends are **not** used to translate during a clinical encounter
- ☐ Patient-facing forms and information:
  - ☐ Are readable at an $8^{th}$ grade reading level
  - ☐ Are available in languages that reflect the patient population
  - ☐ Are available in accessible formats (e.g., braille, large print, audio)
  - ☐ Use inclusive, non-stigmatizing language
  - ☐ Reaffirm the confidentiality of information

**Information**

- ☐ Health record for each active patient contains at least the following and is updated as needed during a visit:
  - ☐ Problem list
  - ☐ Medication list
  - ☐ Surgical history
  - ☐ Allergies
  - ☐ Race and ethnicity (if disclosed by the person)
  - ☐ Preferred language
  - ☐ Sexual orientation
  - ☐ Gender identity, chosen pronouns, and chosen name
  - ☐ BMI/BMI percentile/growth chart as appropriate
  - ☐ Immunization
  - ☐ Parenting intention in the next year, if applicable
  - ☐ Advance directive or other advance care plan including goals, preferences, needs
  - ☐ Other care needs (e.g., oral health, behavioral health)
- ☐ Care plan is coordinated, documented, and accessible to all members of the primary care team, regardless of their physical location or organizational affiliation, and others as needed
- ☐ Risk stratification process is in place for all empaneled patients that includes:
  - ☐ Medical need
  - ☐ Behavioral diagnoses
  - ☐ Health-related social needs
- ☐ At least every two years, site post-visit surveys to measure patient reported outcomes are sent to people who have accessed care including questions on access to care, provider or health team communication, coordination of care, and staff helpfulness
- ☐ Whole person needs are identified at a population level and processes are developed to meet needs

- Quality and effectiveness of care improve over time
- Patient visits with assigned clinician or team are tracked and reported to health plans
- Capacity to query and use data to support clinical and business decisions

**Referrals**

- Agreements or contracts among providers, plans, and other organizations to coordinate transitions are in place including:
    - Emergency department and inpatient visits
    - Residential and partial treatment facility stays
    - Stays at substance abuse treatment facilities
    - Community resources to support non-medical social needs that impede health improvement
- Referrals to offsite services are tracked
    - Overdue referrals prompt outreach to the patient
- Referral patterns are identified and adjusted to improve patient outcomes and reduce cost and unnecessary care
- Hospitals and EDs responsible for most patients' hospitalizations and ED visits are identified
    - Timeliness of notification and information transfer is assessed
- Opportunities to work with ACHs to improve community supports are identified

**Content of Care**

- People are screened at least annually using a validated instrument for:
    - Depression
    - Anxiety
    - Suicidality
    - Tobacco use
    - Alcohol
    - Other drug use
        - → Process for follow-up of brief intervention, brief treatment or referral to treatment is documented
- Coordination of care and meeting care needs (e.g., dentists who may be prescribing)
- During a clinical visit, patients and providers engage in:
    - Self-management support
    - Shared decision making
    - Motivational interviewing for behavior change

*Patients and Family Members Checklist*

- ☐ Select a primary care provider who meets your needs
- ☐ Think about your broad health and wellness-related goals and how your provider and care team might help you meet these goals
- ☐ In situations where different options are available, give your provider(s) information about your values and preferences, and discuss options, tradeoffs, and implications of a decision together
- ☐ Consider your primary care provider/team your first point of contact to the larger health system for all non-emergent care needs

*Health Plan Checklist*

- ☐ Members receive information about the value of primary care, how to access primary care within the network, and are asked or otherwise encouraged to select a primary care provider/team at enrollment
- ☐ Members select or are paneled to a primary care provider/team through a claims-based attribution process or other assignment mechanism that is transparent to the purchaser (employer/union), as well as to the individual member.
- ☐ Members are notified when a primary care provider is held accountable for their care through a claims-based attribution process or other assignment mechanism. Members should be able to change this by notifying the health plan of their preferred primary care provider within the available network.
- ☐ Data from care delivery sites is collected and aggregated to understand variation in care and look for underlying issues such as disparities in access or services provided within and across:
    - Race and ethnicity
    - Language
    - Sex
    - Screening for relevant cancers of the sexual and reproductive health system
    - Prenatal care utilization
    - Perinatal care outcomes reported for those who are Black, indigenous, and people of color
- ☐ Health plan records accurately reflect a person's gender, pronouns, and chosen name. If gathered at a health plan level such as upon enrollment, this is communicated to care delivery sites with the required permissions to do so in place at the member/individual level
- ☐ A payment mechanism supports primary care features that are not reimbursed through traditional fee-for-service payments. These mechanisms include value-based reimbursement such as fee-for-service enhancements or prospective payments made in the form of per member per month (PMPM) payments that could include incentives for transformation, performance-based incentives, or more expansive forms of capitation
    - Multipayor models to increase consistency and reduce unnecessary administrative complexity are prioritized
    - Health plans partner with providers and practices to share relevant information including cost (e.g., services, medication)
    - Payment mechanisms are clearly articulated to employers with the stipulation that the qualifications for payment eligibility and the measures of success are clearly understood and openly shared

### *Employer/Purchaser Checklist*

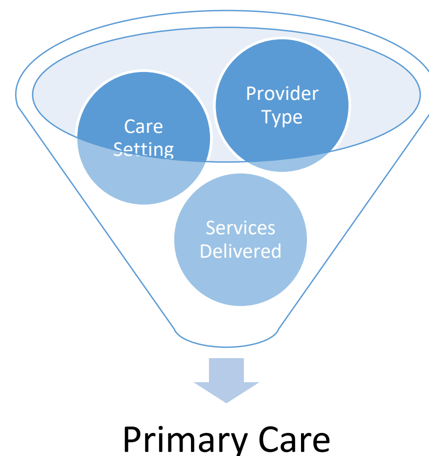
- ☐ Those who are covered under the selected plan(s) receive information about the value of primary care, how to access primary care within the available plan options, and are asked or encouraged to select a primary care provider/team at enrollment
- ☐ Benefit designs are structured to encourage the use of primary care including Value-Based Insurance Design (VBID) mechanisms tied to primary care, such as:
    - $0 cost for specified in-person or virtual care services delivered by the individual's named primary care provider (that provider is named by the individual or assigned through an attribution or other mechanism)
    - Lower out-of-pocket cost for specialty care accessed after seeing one's primary care provider/team
    - When qualified high deductible health plans with Health Savings Accounts (HSA's) are in place, the new rules allowing for first dollar coverage under an expanded definition of "preventive services" have been incorporated.
- ☐ Agree to support non-fee-for-service payment mechanisms for primary care in partnership with other purchasers to reduce administrative complexity. Non-fee-for-service forms of primary care payment must be clearly articulated by health plans and supported by employers with the stipulation that the qualifications for payment eligibility and the measures of success are also clearly understood and openly shared.
- ☐ Contracts with health plans and/or directly with delivery systems require:
    - Measurement of primary care spend
    - Total cost of care
    - Measurement of quality of care
    - Measurement of disparities in care outcomes by race
    - Reporting of primary care spend
    - Targets for primary care spend
    - Requirement that consumers select or be paneled to a primary care provider or team
    - When individual selection is not in place, the primary care provider/team to whom the individual is assigned is clearly communicated and the individual has the ability to change that assignment
    - Penalties for indicators of not-managed and not-coordinated care, like avoidable hospital readmissions or avoidable ED

## Defining Primary Care

The concept of primary care was first introduced in the 1920s and described by the Institute of Medicine (IOM) in 1978 as being "*accessible, comprehensive, coordinated, continuous, and accountable*."[14] Barbara Starfield further describes primary care as being characterized by first-contact care and being longitudinal and comprehensive.[15] Primary care can further be defined as including advocacy, taking place in the context of a community and family, including goal-oriented care and health promotion, being integrated, and being based on a relationship.[16] In many studies, primary care is defined by four Cs: **first-contact care** that is **comprehensive** in addressing a wide variety of issues from sprains to behavioral health to prenatal care, is **continuous** with multiple touch-points over time, and is **coordinated**. In order to know whether primary care spend is increasing in the state, Washington must first develop an agreed upon definition of primary care that will allow for accurate measurement.

The IOM categorizes possible definitions into care provided by certain clinicians, a particular set of activities, a level or setting of care, the attributes themselves, or as a strategy for organizing a system.[17] More simply, primary care can be defined broadly as consisting of the care provided by a subgroup of medical providers, the set of functions that providers within and outside of that subgroup perform, and/or a general orientation of a health delivery system.[18] A family medicine physician may order a thyroid test which would be considered part of primary care while an endocrinologist ordering that same test may not necessarily be considered primary care. These provider, service, and system categories have been expanded by Milbank into:[19]

- Provider: All the services delivered by pre-defined primary care providers in an ambulatory setting.
- Service: Services that meet particular definitions including being: comprehensive, first-contact for a wide variety of (not limited) conditions, coordinated, and taking place over time (longitudinal).
- Service: All office visits and preventative services within a category independent of the provider type.
- Service and Provider: Based in claims, specific set of pre-defined services delivered by pre-defined primary care providers not limited to an ambulatory setting.
- Health systems: Primary care delivered at a system level, useful for capitated systems but most difficult to measure.




In Washington State, primary care provider is defined as "a general practice physician, family practitioner, internist, pediatrician, osteopathic physician, naturopath, physician assistant, osteopathic physician assistant, and advanced registered nurse practitioner licensed under Title 18 RCW."[20] The workgroup sought to operationalize

the four Cs described above to develop a standardized definition: Team-based care led by an accountable provider that serves as a person's source of first contact with the larger healthcare system and coordinator of the health care services that the person receives. Primary care includes a comprehensive array of appropriate, evidence-informed services to foster a continuous relationship over time.

**If yes to ALL of the following, then is primary care:**

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1. **Accountability** through a team and/or provider that includes physical health, behavioral health, and care coordination. Advanced clinical judgement for a person's care/panel of patients lies with one of the following:
    - Doctor of Medicine – General practice, Family Medicine, General Internal Medicine, Geriatrics, General Pediatrics, Adolescent Medicine
    - Doctor of Osteopathic Medicine - General practice, Family Medicine, General Internal Medicine, Geriatrics, General Pediatrics, Adolescent Medicine
    - Advance Registered Nurse Practitioner – General Practice, Family, Adult, Pediatric, Women's Health
    - Physician Assistant – General Practice, Family, Adult, Pediatric, Women's Health
    - Osteopathic Physician Assistant – General Practice, Family, Adult, Pediatric, Women's Health

    Other team members can include but are not limited to: naturopath, psychologist, psychiatrist, social worker, registered nurse, medical assistant, care coordinator, etc.

2. **First Contact** – Does the team assess, triage, and direct a person's health or health care issues as they first arise?
3. **Comprehensive** – Does the team care for the whole person and provide services that address multiple organ systems including active management of chronic physical (e.g., COPD, diabetes) and behavioral health (e.g., depression, anxiety, substance use disorder) conditions as well as USPSTF recommended screening and preventive services?
4. **Continuous** – Does the team maintain or attempt to develop a longitudinal relationship?
5. **Coordinated** – Does the team take responsibility for a person's care through managing a care plan in coordination with a multidisciplinary team and/or with offsite referrals?
6. **Appropriate** – Does the team provide evidence-based, person-centered medicine that includes behavioral health?

**Figure 1: Example of Care Provided Over the Course of a Person's Life**

## Content of Care

### *Disease Identification or Screening and Disease Treatment*

Primary care practices screen for both communicable diseases and non-communicable diseases likely to be present in an individual or which are common within a patient population. Screening for non-communicable diseases such as cardiovascular diseases, diabetes mellitus, and cancer are done based on risk such as a person's age. Screening for communicable disease should also be done on risk and possible exposure.

Cancer screening is a key component of preventative health. Approximately 39.3% of people will be diagnosed with cancer in their lifetime.[21] The most common types of cancer are breast, lung and bronchus, prostate, colorectal, and melanoma and skin cancer. For example, the USPSTF recommends **(not an exhaustive list)**

- **Breast** "biennial screening mammography for women aged 50 to 74 years."[22]
- **Prostate** "For men aged 55 to 69 years, the decision to undergo periodic prostate-specific antigen (PSA)-based screening for prostate cancer should be an individual one. Before deciding whether to be screened, men should have an opportunity to discuss the potential benefits and harms of screening with their clinician and to incorporate their values and preferences in the decision. Screening offers a small potential benefit of reducing the chance of death from prostate cancer in some men. However, many men will experience potential harms of screening, including false-positive results that require additional testing and possible prostate biopsy; overdiagnosis and overtreatment; and treatment complications, such as incontinence and erectile dysfunction. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms on the basis of family history, race/ethnicity, comorbid medical conditions, patient values about the benefits and harms of screening and treatment-specific outcomes, and other health needs. Clinicians should not screen men who do not express a preference for screening."[23]
- **Colorectal** "starting at age 50 years and continuing until age 75 years. [24]
- **Cervical** "screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting)."[25]

### *Health Promotion*

Clinical care typically focuses on disease or illness identification and management or treatment; however, the function of preventing disease and promoting health broadly is equally or more important in a person's and in a population's health. Health promotion within primary care includes educating and motivating a person about a healthy lifestyle (e.g., exercise, tobacco cessation), assessing needs or preferences and readiness for any lifestyle change as well as chronic care management, medication management, and vaccinations against common diseases. As almost half of all Americans have a chronic disease including heart disease, stroke, cancer, diabetes, respiratory conditions, and arthritis, promoting health is paramount to managing the health of a population.[26]

The American Medical Association proposes that health promotion be collaborative and that providers:[27]

- "*Keep current with preventive care guidelines that apply to their patients and ensure that the interventions they recommend are well supported by the best available evidence.*
- *Educate patients about relevant modifiable risk factors.*
- *Recommend and encourage patients to have appropriate vaccinations and screenings.*
- *Encourage an open dialogue regarding circumstances that may make it difficult to manage chronic conditions or maintain a healthy lifestyle, such as transportation, work and home environments, and social support systems.*
- *Collaborate with the patient to develop recommendations that are most likely to be effective.*
- *When appropriate, delegate health promotion activities to other professionals or other resources available in the community who can help counsel and educate patients.*
- *Consider the health of the community when treating their own patients and identify and notify public health authorities if and when they notice patterns in patient health that may indicate a health risk for others.*
- *Recognize that modeling health behaviors can help patients make changes in their own lives*."

Health promotion can often include motivational interviewing, "a patient-centered approach to counseling for guiding behavior change, usually when a patient feels ambivalent, e.g., about lifestyle choices or adherence to medication."[28] Motivational interviewing can occur due to the person receiving care not understanding the impact of a choice, competing values and priorities, or other reasons. The clinician then attempts to identify and reconcile these conflicts to achieve desired goals

### *Care Coordination*

Coordinating or synchronizing a person's engagements with the broad health care system has been associated with lower inpatient care utilization and better health outcomes.[29] Care coordination for those with complex care needs or multiple comorbidities is even more important. Specifically, building relationships with care partners, supporting people as they transition between care sites, and information exchange are positively associated with lower inpatient care utilization.[30] AHRQ defines care coordination as "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care."[31]

The mechanisms through which care coordination is achieved can take many forms, be conducted by different types of staff, clinical and non-clinical, and is not typically reimbursed in a fee-for-service

environment. For care coordination to be truly successful, the person's social needs must also be considered along with their medical needs including needs around transportation, access to food, and housing security.[32]

Care coordination efforts vary from low to high intensity based on the need of an individual and are often also offered by specialty care such as for treatment of cancer. Within primary care, examples of care coordination include:[33]

- "*Easy access to a range of health care services and providers*
- *Good communications and effective care plan transitions between providers*
- *A focus on the total health care needs of the patient*
- *Clear and simple information that patients can understand*"

### *Integrated Behavioral Health*

Mental illness and substance use disorders, together called behavioral health, are common, with an estimated 46% of adults experiencing mental illness or a substance abuse disorder at some point in their lifetime, 25% in a year.[34] Patients with chronic medical conditions and behavioral health issues have an estimated two to three times higher health care costs.[35] Depression is especially common among those with a chronic illness, such as diabetes, resulting in lower adherence to clinical recommendations, worse physical functioning, and higher cost.[36]

On average, 80 million Americans visit an ambulatory care center with major depressive disorder as their primary diagnosis, indicating potential to impact patient outcomes through treatment within the context of primary care.[37] Primary care providers have reported preferring integrated care, reporting more effective communication and lower stigma about mental health and substance use for patients.[38] Research has consistently shown healthier patients and populations including decreased depression, anxiety, and positive impacts on medical conditions including diabetes, increases in quality of life, and higher patient satisfaction.[39,40]

### *Person-Centered Care*

The person receiving care is at the heart of every care relationship. Shared decision making, where appropriate, is a key component of person-centered care. This is a, "*process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences*."[41] Motivational interviewing is behavioral change achieved through identifying patient values and motivators and using these to drive progress toward a desired health outcome.

Shared decision making for preference-sensitive conditions has been shown to help people gain knowledge about their health condition(s) and possible outcomes of care and to have more confidence in their decisions.[42,43] The process has also been associated with improved patient satisfaction with care, improved health outcomes, and with better appropriateness of care.[44,45]

## Strengthening Primary Care Through New Payment Models

A key mechanism to strengthening primary care is changing how we pay for primary care. Current spending in Washington State, ranges from 4.4%-5.6% of total health spending on primary care services. This low reimbursement for primary care services coupled with fact that traditional fee-for-service payment approaches do not reimburse many of the activities to support high-performing primary care practices (i.e. care coordination, population health) has created a need create new payment models to improve primary care delivery.

To understand how to create new primary care payment models, the Workgroup has organized the discussion to include:

- A description of the range of payment types available, including the central features of each
- A discussion of initiatives under way across the country to change the primary care mechanism to inform efforts in Washington State. This discussion includes the identification of features central to these efforts, including practice transformation and patient attribution/assignment considerations.
- The implications for measurement based on the system as it is today (primarily fee-for-service) and as may be envisioned under a new payment model(s) that support the transformation of primary care in Washington state with non-fee-for service mechanisms.

### *Primary Care Payment Types*

Like most other forms of health care delivered in Washington State and across the country, the predominant form of payment is fee-for-service. While there have been many efforts to enhance fee-for-service with various value-based incentives tied to cost and/or quality measures, the underlying payment for the services delivered to patients continues to be fee-for-service.

It has already been noted that many of the important components of primary care described in the previous section are not directly reimbursable through a fee-for-service payment mechanism. This represents an obstacle to strengthening primary care in the best of circumstances. The Workgroup writes these recommendations at a time when the impact of COVID-19 cannot be ignored – particularly as it relates to primary care. The Larry Green Center, in collaboration with the Primary Care Collaborative has been surveying primary care practices weekly to assess the impact that COVID-19 is having on primary care practices since mid-March. In the latest survey report published on their website, they state that *"The primary care platform is shrinking. The low level and time limited support offered through previous federal relief efforts are ill-matched with the magnitude of COVID-19 challenges."* Their survey results indicate that "2% of practices have closed, another 2% are considering bankruptcy, and 10% are unable to be certain of their solvency 4 weeks out" and that "1 in 5 clinicians are now considering leaving primary care and 13% could not answer that question either way." When basic services are not being delivered, primary care practices, that operate on thin margins in the best of

circumstances, cannot survive. This also means that, in many cases, basic health care needs of individuals are not being met.

The range of primary care payment mechanisms available are described at a very high level in the table below. There are many iterations and variations within each of these categories. This table is intended to ground the discussion around measurement of primary care spending by describing the broad payment types included in this table and used as terms throughout this document.

**Table 1: Reimbursement Model Comparison**

| | **Fee-for-Service** | **Fee-for-Service-Based Incentives** | **Non-Fee-for-Service Prospective Payments** |
|---|---|---|---|
| **What triggers payment?** | Delivery of a Service | Achievement of threshold for cost, quality, experience measures | Matching a patient to a qualified provider |
| **How is payment made?** | A discrete payment made as services are delivered | In a variety of ways: enhanced ffs, lump sums, quarterly bonuses, etc. | Typically on a PMPM monthly basis, but may be quarterly |
| **What is covered by the payment?** | The actual services delivered | Performance on a wide range of quality measures – cost, clinical, experience | Enhanced or "advanced" components of primary care not covered by ffs |
| **Does the payment reflect the intensity of the services delivered?** | Yes, if FFS coding is accurate | Unknown | Yes, if risk adjusted accurately at the individual patient level |

It is not within the scope of the workgroup to recommend a specific payment type. However, the workgroup believes that noting the inadequacy of a fee-for-service payment mechanism to support the implementation of primary care as defined or envisioned by this workgroup. The workgroup strongly encourages the adoption of non-fee-for-service payment mechanisms in a manner that aligns key healthcare stakeholders – providers, payers, and purchasers. These recommendations are reflected in the Stakeholder Checklists.

### *Primary Care Payment Initiatives*

The Centers for Medicare and Medicaid Services (CMS) launched Comprehensive Primary Care Plus (CPC+), a multi-payer primary care improvement initiative in 2017, the largest single primary care payment demonstration model in the US. CPC+ builds on the learnings derived from a smaller five-year Comprehensive Primary Care Plus (CPC) demonstration. Alignment across the commercial and Medicaid plans that voluntarily participate in CPC+ is an important point of emphasis in CPC+. The 18 CPC+ regions

were selected based on the number and strength of private payers (commercial, Medicaid MCOs and Medicare Advantage) and state agencies willing to work together on a regional basis to do the following:

- Compensate primary care practices using prospective PMPM payment mechanisms (with or without fee-for-service; the specific approach is left to each organization and payment levels are not discussed across payers or specified by CMS/CMMI)
- Align with CMS and other payers in the region on quality measurement – both the identification of key metrics and to aggregate the data used for measurement and evaluation of participating primary care practices
- Work in collaboration with other payers in the region to support practice transformation through learning collaboratives, shared resources, such as practice transformation consultants, etc.

The evidence on how well CPC+ is working is mixed. CMS has retained Mathematica to conduct its evaluation of CPC+ based on its impact in the Medicare population. The impact on the lives covered by the private payers is not included in Mathematica's evaluation. The evidence for how well this is working in the private sector has been less robust but is starting to emerge. Recently, the most significant payer in the Arkansas region which has been a part of CPC and CPC+ published a white paper that reports significant savings in the total cost of care for patients whose primary care provider is in the CPC+ model vs. those that are not. Similar evidence from other regions is beginning to emerge in conference settings but has not yet been published.

Independently and prior to CPC+, the Oregon Health Authority developed and established the Patient Centered Primary Care Home Program due to state legislation in 2009. The program sets standards, certifies individual practices, and works to incentivize the population's use of the certified primary care homes.[46] Core attributes of the program include: access to care; accountability; comprehensive, whole-person care; continuity; and person and family-centered care with 11 must-pass standards such as offering advice through telephone and five possible tiers.[21] All of the following are able to become a certified primary care home: Physical health providers; Behavioral, addictions and mental health care providers with integrated primary care services; Solo practitioners; Group practices; Community mental health centers with integrated primary care services; Rural health clinics; Federally qualified health centers; and School-based health centers.

Key learnings from these and other primary care payment initiatives underscores the importance of non-fee-for-service payments and a multi-payer approach. Specific considerations around implementation of these models is best supported when there are common understandings and approaches to implementation across payers to support practice transformation.

### Attribution

Decisions for attribution include: unit of analysis (patient versus episode of care); signal for responsibility (professional costs versus number of evaluation and management visits); number of clinicians that can be assigned responsibility (single physician versus multiple); and minimum threshold for assigning responsibility (majority of visits or costs versus plurality of visits or costs).[47]

### *Measurement*

The workgroup recommends that annual primary care spend initially be measured with claims data such that the numerator includes all services delivered in an ambulatory setting by a predefined group of providers and team members and the denominator is the total cost of care including ambulatory and non-ambulatory care services, laboratory tests, drug costs, imaging, and other fees.

Accurate measurement of primary care depends on availability of data and how primary care is defined. Claims data, derived from fee-for-service payment, has been used imperfectly to measure the attributes of the four Cs (first contact, comprehensive, continuous, and coordinated). However, billable codes do not necessarily capture all elements of this framework including members of the primary care team accountable for care but who do not bill separately from a provider. Further, the lack of a nationally accepted definition of primary care is a major impediment to assessing and increasing the primary care expenditures uniformly across states.

Despite issues with attribution and definition of providers, several studies have developed strategies to estimate primary care spending including:

- Milbank Memorial Fund's Report Standardizing the Measurement of Commercial Health Plan Primary Care Spending
- The Center for Disease Control and Prevention's Interpretation of Health Claims Data
- Reid R, Damberg C, Friedberg MW. Primary Care Spending in the Fee-for-Service Medicare Population. JAMA Intern Med. 2019 Jul 1;179(7):977-980.
- Reiff J, Brennan N, Fuglesten Biniek J. Primary Care Spending in the Commercially Insured Population. JAMA. 2019 Dec 10;322(22):2244-2245.

In 2019, Washington State Office of Financial Management (OFM) was mandated by legislation to develop a report on primary care spend. The report notes that comparisons between Washington's percent expenditure and national averages or other states' averages depend on different definitions. Also, this 2019 report does not include non-claims-based care such care coordination activities. Reports from the states of Oregon and Rhode Island include non-claims care that may artificially lower Washington's numbers.[12]

To develop a proxy measure for primary care spend, groups have operated on various assumptions. If defined by provider, the assumption is that a group of subspecialists (i.e., family medicine) always offers primary care and that other groups of subspecialists never provide primary care (i.e., emergency medicine). This assumption holds true for some but not all disciplines. Advance registered nurse practitioners (ARNPs) and physician assistants (PAs) practice in a multitude of settings, including surgical care, which may not be adequately captured based on limitations of what is captured in claims data. The 2019 OFM report adjusted the total claims from ARNPs and PAs by 41% and 34%, respectively.

The OFM report presents narrow and broad definitions of primary care, differing based the types of providers who are assumed to be providing primary care. The narrow definition only includes providers who are traditionally considered to perform primary care while the broad definition includes a wider range of provider taxonomy codes includes behavioral health providers, clinical nurse specialists, registered nurses, midwives, and a host of other providers who are not typically considered general

practitioners.[12] The OFM stakeholder group also reviewed procedure codes and created both narrow and broad definitions of services qualifying as primary care. Only claims which met both the provider and service definitions of primary care were counted toward the state's total health care expenditure, with the narrow definition yielding 4.4% and the broad 5.6%.[12]

However, the OFM report noted that deficiencies inherent to the Washington All Payor Claims Database claims database, combined with lack of a firm definition for primary care, limit the report's accuracy in some regards. Claims data does not capture, for example, whether or not the location of services provided was a primary care clinic. As was mentioned earlier, Washington lacks a way to measure non-claims-based expenditures. The OFM report mentions a number of other systemic impediments to accurate measurement that may need to be addressed in order to calculate an accurate primary care expenditure percentage for the state.[12]

## Appendix A: Bree Collaborative Members

| Member | Title | Organization |
|---|---|---|
| Susie Dade, MS | | |
| Gary Franklin, MD, MPH | Medical Director | Washington State Department of Labor and Industries |
| Stuart Freed, MD | Chief Medical Officer | Confluence Health |
| Richard Goss, MD | Medical Director | Harborview Medical Center – University of Washington |
| Darcy Jaffe, MN, ARNP, NE-BC, FACHE | Senior Vice President, Safety & Quality | Washington State Hospital Association |
| Sonja Kellen | Global Benefits Director | Microsoft |
| Dan Kent, MD | Chief Medical Officer, Community Plan | UnitedHealthcare |
| Wm. Richard Ludwig, MD | Chief Medical Officer, Accountable Care Organization | Providence Health and Services |
| Greg Marchand | Director, Benefits & Policy and Strategy | The Boeing Company |
| Robert Mecklenburg, MD | Medical Director, Center for Health Care Solutions | Virginia Mason Medical Center |
| Kimberly Moore, MD | Associate Chief Medical Officer | Franciscan Health System |
| Carl Olden, MD | Family Physician | Pacific Crest Family Medicine, Yakima |
| Drew Oliveira, MD | Executive Medical Director | Regence BlueShield |
| Mary Kay O'Neill, MD, MBA | Partner | Mercer |
| John Robinson, MD, SM | Chief Medical Officer | First Choice Health |
| Jeanne Rupert, DO, PhD | Provider | One Medical |
| Angela Sparks, MD | Medical Director Clinical Knowledge Development & Support | Kaiser Permanente Washington |
| Hugh Straley, MD (Chair) | Retired | Medical Director, Group Health Cooperative; President, Group Health Physicians |
| Shawn West, MD | | |
| Laura Kate Zaichkin, MPH | Director of Health Plan Performance and Strategy | SEIU 775 Benefits Group |
| Judy Zerzan, MD, MPH | Chief Medical Officer | Washington State Health Care Authority |

## Appendix B: Primary Care Charter and Roster

### Problem Statement

Primary care is widely identified as the cornerstone of the health care system, serving as a usual source of care that is focused on acute and chronic disease detection, management, treatment, and prevention.[48] While provision of primary care has been shown to contribute to population-level reductions in morbidity and mortality, access to regular, high-quality care is a challenge for many people in Washington State.[49] Further, reimbursement for primary care is low compared to specialty care, with the United States spending between 5-7% of total health care expenditure on primary care and Washington between 4.4% to 5.6% of total expenditure.[50,51]

### Aim

To foster a common understanding of primary care in order to increase primary care accessibility and availability.

### Purpose

To propose evidence-based recommendations to the full Bree Collaborative on:

- A common definition, current and aspirational, for primary care services including behavioral health (i.e., providers of, components of, locations of service)
- Components of primary care with the largest impact on individual and population health
- A mechanism for measuring primary care spend

### Duties & Functions

The Primary Care workgroup will:

- Research evidence-based and expert-opinion informed guidelines and best practices (emerging and established).
- Consult relevant professional associations and other stakeholder organizations and subject matter experts for feedback, as appropriate.
- Meet for approximately ten-twelve months, as needed.
- Provide updates at Bree Collaborative meetings.
- Post draft report(s) on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.
- Present findings and recommendations in a report.
- Recommend data-driven and practical implementation strategies including metrics or a process for measurement.
- Create and oversee subsequent subgroups to help carry out the work, as needed.
- Revise this charter as necessary based on scope of work.

### Structure

The workgroup will consist of individuals confirmed by Bree Collaborative members or appointed by the chair of the Bree Collaborative or the workgroup chair. The chair of the workgroup will be appointed by

the chair of the Bree Collaborative. The Bree Collaborative program director and program assistant will staff and provide management and support services for the workgroup.

Less than the full workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to send to the Bree Collaborative.

## Meetings

The workgroup will hold meetings as necessary. The program director will conduct meetings along with the chair, arrange for the recording of each meeting, and distribute meeting agendas and other materials prior to each meeting. Additional workgroup members may be added at the discretion of the workgroup chair.

| Name | Title | Organization |
|---|---|---|
| Judy Zerzan, MD, MPH (Chair) | Chief Medical Officer | Washington State Health Care Authority |
| Patricia Auerbach, MD, MBA | Senior Medical Director | United Health Care |
| Cynthia Burdick, MD | Medical Director, Medicare and Medicaid | Kaiser Permanente Washington |
| Tony Butruille, MD | Chair, Primary Care Investment Task Force | Washington Academy of Family Physicians |
| Jason Fodeman, MD | Associate Medical Director | Washington State Department of Labor and Industries |
| Bianca Frogner, PhD | Associate Professor, Family Medicine; Director of Center for Health Workforce Studies | University of Washington School of Medicine |
| Ingrid Gerbino, MD, FACP | Chief, Department of Primary Care | Virginia Mason |
| Karen Johnson, PhD, MHSA | Director of Performance Improvement and Innovation | Washington Health Alliance |
| Louise Kaplan, PhD, ARNP, FNP-BC, FAANP, FAAN | Associate Professor, Associate Academic Director | Washington State University Vancouver College of Nursing |
| Cat Mazzawy, RN, MSN, CPPS | Sr. Director for Safety & Quality | Washington State Hospital Association |
| Carl Olden, MD | Family Physician | Virginia Mason Memorial |
| Julie Osgood, DrPH | VP Clinic Operations | Valley Medical Center |
| Mary Kay O'Neill, MS, MBA | Partner | Mercer |
| Ashok Reddy, MD, MS | Assistant Professor, Medicine | University of Washington School of Medicine, Veterans Administration |
| Keri Waterland, PhD, MAOB | Division Director, Division of Behavioral Health and Recovery | Health Care Authority |
| Laura Kate Zaichkin, MPH | Director, Health Plan Performance and Strategy | SEIU 775 Benefits Group |

*Thank you to Susie Dade.*

## Appendix C: Practice Transformation for Implementation

The Knoster model for managing complex change argues that for a successful change to occur, a system needs vision, skills, incentives, resources, and an action plan.[52] The lack of any of these elements leads to confusion, anxiety, resistance, frustration, or false starts, respectively.

- Vision – Outlined in these Bree Collaborative recommendations (needed to overcome confusion)
- Skills – Already exist (needed to overcome anxiety)
- Incentives – Multi-Payer Approach to non-fee-for service payment, such as Transformation of Care Fee (needed to overcome resistance)
- Resources – Payor-agnostic resources to reduce the administrative burden placed on practices dealing with multiple payment mechanisms, misaligned quality incentives and/or data collection mechanisms (needed to overcome frustration)
- Action Plan – Outlined in these recommendations as Stakeholder Checklists (needed to overcome false starts)

## References

[1] Blewett LA, Johnson PJ, Lee B, Scal PB. When a usual source of care and usual provider matter: adult prevention and screening services. *J Gen Intern Med*. 2008;23(9):1354–1360.
[2] Primary Care Collaborative. Investing in Primary Care: A State-Level Analysis. www.pcpcc.org/resource/evidence2019
[3] Schwartz MD. Health care reform and the primary care workforce bottleneck. J Gen Intern Med. 2012;27(4):469-472.
[4] Penchansky R, Thomas JW. The concept of access: definition and relationship to consumer satisfaction. Med Care. 1981;19(2):127-140. 1
[5] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502.
[6] Shi L. Primary care, specialty care, and life chances. Int J Health Serv. 1994; 24(3):431-58.
[7] Vogel RL, Ackermann RJ. Is primary care physician supply correlated with health outcomes? Int J Health Serv. 1998; 28(1):183-96.
[8] Levine DM, Landon BE, Linder JA. Quality and Experience of Outpatient Care in the United States for Adults With or Without Primary Care [published correction appears in JAMA Intern Med. 2019 May 1;179(5):733
[9] Macinko J, Starfield B, Shi L. Quantifying the health benefits of primary care physician supply in the United States. Int J Health Serv. 2007;37(1):111-126.
[10] Brown EJ, Polsky D, Barbu CM, Seymour JW, Grande D. Racial Disparities In Geographic Access To Primary Care In Philadelphia. Health Aff (Millwood). 2016;35(8):1374-1381.
[11] Access to Rural Health Care – A Literature Review and New Synthesis. Available: www.rupri.org/Forms/HealthPanel_Access_August2014.pdf
[12] Washington State Office of Financial Management. Primary Care Expenditures Report Summary of current primary care expenditures and investment in Washington. December 2019.
[13] Yarnall KS, Pollak KI, Østbye T, Krause KM, Michener JL. Primary care: is there enough time for prevention?. Am J Public Health. 2003;93(4):635-641. doi:10.2105/ajph.93.4.635
[14] Institute of Medicine (IOM) A Manpower Policy for Primary Health Care. Washington, D.C.: National Academy of Sciences; 1978. IOM Publication 78-02.
[15] Starfield 1992
[16] Etz RS, Zyzanski SJ, Gonzalez MM, Reves SR, O'Neal JP, Stange KC. A New Comprehensive Measure of High-Value Aspects of Primary Care. Ann Fam Med. 2019;17(3):221-230.
[17] Institute of Medicine (US) Committee on the Future of Primary Care; Donaldson MS, Yordy KD, Lohr KN, et al., editors. Primary Care: America's Health in a New Era. Washington (DC): National Academies Press (US); 1996. 2, Defining Primary Care. Available from: https://www.ncbi.nlm.nih.gov/books/NBK232631/
[18] Friedberg MW, Hussey PS, Schneider EC. Primary care: a critical review of the evidence on quality and costs of health care. Health Aff (Millwood). 2010;29(5):766-772.
[19] Bailit MH, Friedberd MW, Houy ML. Standardizing the Measurement of Commercial Health Plan Primary Care Spending. Milbank Memorial Fund. July 2017.
[20] RCW 74.09.010. Available: https://app.leg.wa.gov/rcw/default.aspx?cite=74.09.010
[21] Cancer Stat Facts: Cancer of Any Site. https://seer.cancer.gov/statfacts/html/all.html
[22] US Preventive Services Task Force. Final Recommendation Statement Breast Cancer: Screening. January 11, 2016. Available: www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening
[23] US Preventive Services Task Force. Final Recommendation Statement Prostate Cancer: Screening. May 08, 2018. Available: www.uspreventiveservicestaskforce.org/uspstf/recommendation/prostate-cancer-screening
[24] US Preventive Services Task Force. Final Recommendation Statement Colorectal Cancer: Screening. June 15, 2016. Available: www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening
[25] US Preventive Services Task Force. Final Recommendation Statement Cervical Cancer: Screening. August 21, 2018. www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening
[26] Schmidt H. Chronic Disease Prevention and Health Promotion. 2016 Apr 13. In: H. Barrett D, W. Ortmann L, Dawson A, et al., editors. Public Health Ethics: Cases Spanning the Globe [Internet]. Cham (CH): Springer; 2016. Chapter 5. Available from: https://www.ncbi.nlm.nih.gov/books/NBK435779/
[27] American Medical Association. Health Promotion and Preventive Care. Code of Medical Ethics Opinion 8.11. www.ama-assn.org/delivering-care/ethics/health-promotion-and-preventive-care

[28] Elwyn G, Dehlendorf C, Epstein RM, Marrin K, White J, Frosch DL. Shared decision making and motivational interviewing: achieving patient-centered care across the spectrum of health care problems [published correction appears in Ann Fam Med. 2014 Jul-Aug;12(4):301]. Ann Fam Med. 2014;12(3):270-275.
[29] Leff B, Reider L, Frick KD, Scharfstein DO, Boyd CM, Frey K, Karm L, Boult C. Guided care and the cost of complex healthcare: a preliminary report. Am J Manag Care. 2009 Aug;15(8):555-9. PMID: 19670959.
Copy
[30] Wagner EH, Sandhu N, Coleman K, Phillips KE, Sugarman JR. Improving care coordination in primary care. Med Care. 2014 Nov;52(11 Suppl 4):S33-8.
[31]Care Coordination. Content last reviewed August 2018. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/ncepcr/care/coordination.htm
[32] Phillips C. Care Coordination for Primary Care Practice. J Am Board Fam Med. 2016 Nov 12;29(6):649-651.
[33] NEJM Catalyst. What Is Care Coordination? January 1, 2018. Available: https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0291
[34] Kessler RC, Wang PS. The descriptive epidemiology of commonly occurring mental disorders in the United States. Annu Rev Public Health. 2008;29:115-29.
[35] Melek S. Milliman. Bending the Medicaid healthcare cost curve through financially sustainable medical-behavioral integration. July 2012. Available: www.milliman.com/uploadedFiles/insight/health-published/pdfs/bending-medicaid-cost-curve.pdf.
[36] Ciechanowski PS, Katon WJ, Russo JE. Depression and diabetes: impact of depressive symptoms on adherence, function, and costs. Arch Intern Med. 2000 Nov 27;160(21):3278-85.
[37] National Center for Health Statistics. FastStats Homepage Depression. Centers for Disease Control and Prevention. April 2016. Accessed: July 2016. Available: www.cdc.gov/nchs/fastats/depression.htm.
[38] Gallo JJ, Zubritsky C, Maxwell J, Nazar M, Bogner HR, Quijano LM, Syropoulos HJ, Cheal KL, Chen H, Sanchez H, Dodson J, Levkoff SE; PRISM-E Investigators. Primary care clinicians evaluate integrated and referral models of behavioral health care for older adults: results from a multisite effectiveness trial (PRISM-e). Ann Fam Med. 2004 Jul-Aug;2(4):305-9.
[39] Butler M, Kane RL, McAlpin D, Kathol R, Fu SS, Hagedorn H, et al. Integration of Mental Health/Substance Abuse and Primary Care No 173 (Prepared by Minnesota Evidence-based Practice Center, Minneapolis, Minnesota under contract 290-02-0009). Agency for Healthcare Research and Quality Publication Number 09-E003. Rockville, MD: Agency for Healthcare Research and Quality, October 2008. Available: www.ahrq.gov/sites/default/files/wysiwyg/research/findings/evidence-based-reports/mhsapc-evidence-report.pdf.
[40] Tice JA, Ollendorf DA, Reed SJ, Shore KK, Weissberg J, Pearson SD. Integrating Behavioral Health into Primary Care: A Technology Assessment. Institute for Clinical And Economic Review. June 2, 2015. https://icer-review.org/wp-content/uploads/2016/01/BHI_Final_Report_0602151.pdf
[41] Washington State Health Care Authority. Shared Decision Making. 2018. Accessed: November 2018. Available: www.hca.wa.gov/about-hca/healthier-washington/shared-decision-making.
[42] Elwyn G, Scholl I, Tietbohl C, Mann M, Edwards AG, Clay C, et al. "Many miles to go …": a systematic review of the implementation of patient decision support interventions into routine clinical practice. *BMC Med Inform Decis Mak*. 2013;13 Suppl 2:S14.
[43] Shay LA, Lafata JE. Where is the evidence? A systematic review of shared decision making and patient outcomes. *Med Decis Making.* 2015;35:114–31.
[44] Arterburn D, Wellman R, Westbrook E, Rutter C, Ross T, McCulloch D, et al. Introducing decision aids at Group Health was linked to sharply lower hip and knee surgery rates and costs. *Health Aff (Millwood).* 2012 Sep;31(9):2094-104.
[45] Stacey D, Légaré F, Col NF, Bennett CL, Barry MJ, Eden KB, et al. Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev.* 2014 Jan 28;(1):CD001431.
[46] https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/TA-Guide.pdf
[47] Mehrotra A, Adams JL, Thomas JW, McGlynn EA. The effect of different attribution rules on individual physician cost profiles. Ann Intern Med. 2010;152(10):649-654
[48] Blewett LA, Johnson PJ, Lee B, Scal PB. When a usual source of care and usual provider matter: adult prevention and screening services. *J Gen Intern Med*. 2008;23(9):1354–1360. doi:10.1007/s11606-008-0659-0 When a Usual Source of Care and Usual Provider Matter: Adult Prevention and Screening Services
[49] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502.

[50] Primary Care Collaborative. Investing in Primary Care: A State-Level Analysis. https://www.pcpcc.org/resource/evidence2019
[51] Washington State Office of Financial Management. Primary Care Expenditures Report Summary of current primary care expenditures and investment in Washington. December 2019.
[52] Change Management Strategies. The Learning Accelerator. Accessed: June 2020. Available: https://practices.learningaccelerator.org/strategies/tool-knoster-model-for-managing-complex-change