Advisory Committee on Primary Care meeting

Washington State Health Care Authority

Washington State Health Care Authority

Advisory Committee on Primary Care
Meeting Materials

April 27, 2023
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting materials

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Advisory Committee on Primary Care

April 27, 2023
2:00 p.m. – 4:00 p.m.
Zoom Meeting

AGENDA

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

Time	Agenda Items	Tab	Lead
2:00-2:10 (10 min)	Welcome, roll call, and agenda review	1	Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
2:10-2:15 (5 min)	Approval of March meeting summary	2	Jean Marie Dreyer, Committee Manager Washington State Health Care Authority
2:15-2:30 (15 min)	Public comment	3	Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
2:30-3:30 (60 min)	Presentation on and discussion of committee charges and proposed amendment to the primary care definition	4	Shane Mofford and Amy Clary, Consultants, Center for Evidence-Based Policy (CEbP)
3:30-3:55 (25 min)	Discussion and voting on remaining code-sets		Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
3:55-4:00 (5 min)	Wrap-up and adjournment		Jean Marie Dreyer, Committee Manager Washington State Health Care Authority

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.

Tab 2

Advisory Committee on Primary Care Meeting Summary

March 30, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

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

Members present

Judy Zerzan-Thul, Chair
Chandra Hicks
David DiGiuseppe
D.C. Dugdale
Ginny Weir
Gregory Marchand
Katina Rue
Kristal Albrecht
Lan H. Nguyen
Linda Van Hoff
Madeline Wiley
Mandy Stahre
Nancy Connolly
Sharon Eloranta
Staici West
Shawn West
Tony Butruille
Tracy Corgiat

Members absent

Jonathan Staloff
Eileen Ravella
Kevin Phelan
Meg Jones
Michele Causley
Sarah Stokes
Sharon Brown
Sheryl Morelli

Call to order

Chair Dr. Judy Zeran-Thul called the meeting to order at 2:02 p.m.

Agenda items

Welcome, roll call, and agenda review

Dr. Judy Zerzan-Thul, Health Care Authority (HCA)

Approval of January meeting summary

The committee voted to adopt the Meeting Summary from the February 2023 meeting.

Topics for Today

The main topics were a presentation on progress to date and a review of discussion goals, as well as a code-level discussion of primary care services.

Public Comment

Katerina LaMarche, Washington State Hospital Association (WSHA), noted that members of the Advisory Committee of Health Care Providers and Carriers were unable to give additional feedback on the primary care definition because their most recent meeting was cancelled. The definition should include the *why* of primary care. Ensuring primary care and outpatient services are adequately supported is critical to maintaining a cost-effective system. It is imperative that the work of the committees and the board is structured so that members' expertise can be exercised before decisions are made.

Presentation of Progress-to-date and Review of Discussion Goals

Amy Clary and Shane Mofford, Center for Evidence-Based Policy (CEbP)

Amy Clary provided a recap of the Advisory Committee on Primary Care's (the Committee's) work on the definition of primary care. Decisions were made at previous meetings related to the *who* and the *where* and discussion had begun at the February meeting to determine a code level set of primary care services. The goal of today's meeting is to finalize the code-level list of primary care services. The Committee also reviewed the general definition of primary care created by the Committee that was approved by the Board in February.

Amy Clary explained the ground rules for today's meeting: 1) the primary care definition needs to account for the intersection of the *who*, the *where*, and the *what*; 2) this is a "working" definition; 3) there will be no changes to existing statutory categories; 4) future data analysis may inform refinements of the final definition.

The Committee reviewed the list of facilities and providers approved at prior meetings. These may be revisited based on data analysis. For providers, the Committee chose to add Advanced Practice Registered Nurses (APRN), internal medicine pediatrics, and Physician Assistant (PA) to the narrow list. The Committee added psychiatric mental health APRNs and psychiatric mental health PAs to the broad category and removed homeopaths from either of the lists.

Dr. Judy Zerzan-Thul led a motion to approve the facilities and providers list. There will be another review of these lists after initial data analysis is performed.

Committee member Madeline Wiley cited a question from Linda Van Hoff about listing Advanced Registered Nurse Practitioners as APRNs. Legally, they are abbreviated as ARNPS. Dr. Zerzan-Thul responded that both could be included to sufficiently cover the different notations.

Committee member David DiGiuseppe asked whether the overlap between primary care providers and specialists had been addressed at previous meetings. Dr. Zerzan-Thul responded that it hadn't. There are some codes that include general practice that suggest surgical versus medical. The Committee planned to use medical rather than surgical for PAs. There is more nuance with APRN categories, and less for PAs. David DiGiuseppe pointed out that at some point, someone will have to code in the claims data to identify primary care, which is more complex than the discussion at this level. Dr. Zerzan-Thul noted that the Washington Health Alliance has a good provider list. The Committee may want to discuss something like that for tagging specific people as primary care on an annual basis.

Committee member Nancy Connolly asked how the Committee would handle a home care visit. A home isn't typically a facility, primary care can happen there. Additionally, how is the Committee considering the team-based component of the definition as it relates to these chosen categories of providers and facilities? Dr. Zerzan-Thul clarified that the Committee hasn't thought about how the team-based component will function with specific coding. For codes, home visits are included. Telehealth usually uses a facility to bill home visits. The visits might happen from home but are billed from an office at some point. Staff can investigate how home visits are billed for a future meeting.

Committee member Tracy Corgiat asked if the group had discussed pharmacists. Dr. Zerzan-Thul stated that the group hadn't discussed pharmacists. Tracy Corgiat asked if there would be an opportunity to do that. Dr. Zerzan-Thul said there could be. Other states haven't included pharmacists. The Committee needs to find the bulk of primary care, not identify every single service. If there's a place for future investment, this work will guide that. Tracy Corgiat cautioned against limiting inclusion of pharmacists in the future. Pending future data analysis allows for conditional approval today. The Committee can look at future data to see the level of inclusion with pharmacists. Committee member Shawn West moved to approve the current facilities and providers list, pending future data analysis. The motion was seconded and passed.

Discussion of Primary Care Services

Shane Mofford, CEbP

Shane Mofford reviewed a comparison between the Office of Financial Management's (OFM's) primary care services included in their 2019 report versus those services included in the Bree Collaborative's 2020 report. Care coordination and urgent care were included in Bree, but not in OFM. For today's meeting, codes have been put into discrete categories. If a service doesn't get included by this Committee for measurement, providers will still be reimbursed. Both the Primary Care Transformation Model (PCTM) and this Committee's statutory work aim to increase primary care spending while decreasing total health care spending. Today's discussion will focus on the *what* of primary care services. The intersection of all three – *who, where,* and *what* – will determine what's included for the 12 percent target.

For today's discussion: 1) The group doesn't need to capture every possible code that might be rendered; 2) the focus is ensuring the final code set includes services predominantly provided by primary care; 3) future analyses can identify services for future consideration that are frequently provided to be approved by the committee.

Each category of code sets will undergo a recommendation approval process. Each cluster will have a formal motion, followed by discussion. Motions pass by simple majority. If there's a no, then there's an amendment process.

The first category the Committee reviewed was preventive medicine services (Part 1). All codes in this set had 100 percent prevalence across other definitions and were recommended by HCA leadership for inclusion. A motion was made to vote on the category. The motion passed with 17 yeas, and no nays. The second category was preventive medicine services (Part 2). A motion was made to adhere to the recommendation to include all the codes in this set. The motion passed with 16 yeas and no nays. The third category was immunizations. The recommendation for the set was to include all codes.

Committee member Sharon Eloranta asked what other states who didn't include the codes were thinking, as the prevalence in other definitions was less than 100 percent across other states. Dr. Zerzan-Thul wasn't sure but explained that HCA clinical staff started with those codes that had broad agreement among states. Some immunizations happen in pharmacies. Shane Mofford added that this current level of analysis isn't looking at location or provider type. Dr. Zerzan-Thul noted that Washington is the only state that includes a location for analytical purposes. The Committee may want to revisit this code set based on future data analysis.

Madeline Wiley asked how the Committee knows it isn't leaving something out in a category. Dr. Zerzan-Thul clarified that these are the most common codes that have been used in anyone's definition. The Committee shouldn't do an exhaustive search. Shawn West pointed out that the Committee is capturing most codes. There will always be additions and subtractions.

A member of the public stated that if a vaccine is state-supplied, providers aren't billing using the immunization codes from this set, they're billing and adding an "SL" code to determine that it's an administrative charge. Dr. Zerzan-Thul said it will show up in the data analysis if providers don't bill for immunizations. The Committee can evaluate existing billing practices. Tracy Corgiat explained that most pediatric vaccines are state supplied and should be captured. Dr. Zerzan-Thul clarified that providers should be billing using the immunization administration codes in this set because they get paid more that way. This is why the Committee isn't including individual vaccines but the administration of vaccines. Katina Rue noted that there is also a SL state code for administration. The Committee should check to see if it needs the SL or can capture without. Dr. Zerzan-Thul responded that the current codes should capture all subvariants, but staff can double check. A motion was made to approve the immunization code set. There was no further discussion. The motion passed with 15 yeas, and no nays.

The next code set was special services, procedures, and reports (Part 1). Only Colorado included the first few, but HCA recommends inclusion of all codes in the set. Committee member Kristal Albrecht cautioned that office emergency care could add up quickly and reiterated that the codes should reflect true primary care. The Committee can vote to exclude a single code while keeping the remaining codes when voting on the set.

Tracy Corgiat asked if there is an option for further consideration to gain more context on lower percentages that were not as prevalent across other definitions. Committee member Tony Butruille noted that Washington's process is different from other states because Washington uses both the *who* and the *where*. The Committee should be more inclusive based on the three intersections the Committee has chosen. Dr. Zerzan-Thul expressed hesitation around making Washington's codes more like other states versus adopting a more state specific method of measurement. Washington's inclusion of facilities may narrow the definition. Kristal Albrecht voiced support for aligning with other states since the Committee had chosen to be fairly liberal with which facilities to include.

Tracy Corgiat recommended erring on the side of greater inclusion. Dr. Zerzan-Thul noted that some facilities are broader, such as on-site hospital clinics and multi-specialty. David DiGiuseppe stated a preference not to be overly expansive for what services to include and asked for further clarification on the voting process. Shane Mofford explained that if the group votes no on a category, then it should make amendments to the list for what to include or exclude, and re-vote. The Committee could add a question to the data analysis around prevalence. What is the alignment with other states? Tracy Corgiat asked whether someone could voice an amendment or had to wait until it's a no. Shane Mofford responded that if there is not currently a movement to approve, a member could propose a change to the recommendation before the formal vote. Tracy Corgiat made a motion to only include the codes at 100 percent in the special services, procedures, and reports (Part 1) set. The motion was seconded. There were 12 yeas and 3 nays.

The next code set was special services, procedures, and reports (Part 2). Committee member Staici West asked whether all of the office visits in this set would be captured working in multi-specialty clinics. OFM used a formula of 60 percent of PA services and asked Mandy Stahre if OFM limited their calculations to general or surgical. Committee member Mandy Stahre responded that there were three categories. Madeline Wiley stated that surgical wasn't included. Mandy Stahre further explained that the 60 percent was based on literature reviews. Shane Mofford noted that checking the percentage of PA office visits would be a good follow-up item. David DiGiuseppe noted that there are specialty and taxonomy codes that can be used to address some of these issues. Dr. Zerzan-Thul responded that taxonomy codes will be used for physicians. These codes are narrower but still reasonable for APRNs, with 10 to 15 codes. For PAs, there are only three codes. A motion was made to include all codes in the Part 2 special services set. The motion passed with 14 yeas, and 1 nay.

The next code set category was special evaluation and management services. All codes except remote monitoring were recommended for inclusion. Tracy Corgiat asked about the difference between remote psychological monitoring and other codes in the set. Committee member Ginny Weir noted that disability exams also didn't show a high prevalence across other definitions but had been recommended for inclusion. These could also be excluded for consistency. Sharon Eloranta added that remote initial and programming are primary care. Tracy Corgiat recommended changing the remote monitoring codes to be included.

David DiGiuseppe asked about the percentages and dollars associated with low prevalence codes. If the Committee reaches 20 percent because it included low prevalence codes, that's a different situation. Tracy Corgiat added that the Committee is currently only taking one data point to include or exclude and suggested maybe there should be more. The Committee should include all codes and then report back by groupings on the impact of inclusion.

Shane Mofford clarified that if single data points on prevalence aren't significant to the group, the Committee could accept the current recommendation and do further refinement when the analysis comes back. The Committee could use the current recommendation process and could add codes later as dictated by further analysis. Or the Committee could include everything now and refine the list to be potentially narrower in the future. Dr. Zerzan-Thul suggested that having a smaller code set might be more helpful in the future to assess the target. The Legislature could use this as a place to target primary care reimbursement. It may not be worth it to have low volume codes because the Committee should focus on the main parts of primary care. Kristal Albrecht suggested looking only at codes with 75 to 100 percent prevalence to get through the sets more quickly.

Tracy Corgiat asked whether voting to include a code enables the data analysis or whether the analysis is already underway. There is not currently enough information for selection. If the Legislature is making decisions on payments based on this, the group needs better ground for choosing. The data analysis depends on Dr. Zerzan-

Thul's preference. Dr. Zerzan-Thul clarified that there are very few data analysis resources and no analysis is happening right now. The plan is to pull the data once, analyze it, and make necessary refinements. The data will come from cost board solicited health plan data. Ideally, a final code set would be included in July reporting for carriers, but there may not be enough time for that to happen this year. There needs to be a stable point of measurement for future comparison.

Tony Butruille expressed a strong desire to lean towards more inclusivity. There is an intersection between primary care and specialty. It would be bad to disincentivize primary care from doing more complicated procedures (injections, excisions, etc.) because then more services/procedures will be sent to specialty. Dr. Zerzan-Thul responded that people do varied things with different roles. There isn't a code if a family physician, internal medicine physician, or pediatrician works in the Emergency Room. Locations don't necessarily place a provider in a primary care clinic. A motion was made to approve all codes in the special evaluation and management services set – changing two excluded codes to include. This motion was approved with 12 yeas, and 3 nays.

The next code set for consideration was care plan oversight services. The recommendation for this set was to include all codes. Shane asked the group whether they wanted to continue with the current recommendation approval process considering today's conversations about prevalence. David DiGiuseppe asked if services could be bucketed into narrow and broad like the providers were. Dr. Zerzan-Thul said this might be possible. Jean Marie Dreyer noted that only Washington used narrow and broad categories to assess primary care services.

Nancy Connolly brought up the issue of teams-based delivery again. Dr. Zerzan-Thul reiterated that there's no way of knowing via coding whether a provider is part of a team. The Committee could account for the team-based aspect when assessing non-claims-based payments. Jean Marie Dreyer added that this could be a qualitative analysis the group does later after running initial numbers. Dr. Zerzan-Thul added that Oregon has a certification for primary care with self-attestation. Shane Mofford suggested that the teams-based aspect could be evaluated as part of a secondary level of analysis after the initial analysis is completed. The first level analysis looks to see if a provider, place, or service counts as primary care. The second analysis would investigate how a service is delivered. Nancy Connolly reminded the group that if a team member is doing something in a primary care team setting, then any provider in that setting should be included. Dr. Zerzan-Thul clarified that there wasn't broad agreement on that. The Committee will run the risk of diluting certain services if everyone gets included. Dr. Zerzan-Thul made a motion to approve the current set of care plan oversight services. The motion was seconded. There was no further discussion. The motion passed with 14 yeas, and no nays.

The next category for consideration was consultation services. All codes in this set were recommended for inclusion and the prevalence was 83 percent. A motion to approve the set was proposed, seconded, and passed with 14 yeas, and no nays.

The next code set was home health services, which Dr. Zerzan-Thul noted should be titled home visits. All codes in the set were recommended for inclusion and had a prevalence of 92 percent across other definitions. A motion to approve the set was made, seconded, and passed with 14 yeas, and no nays.

The next code set was complex chronic care coordination services. All codes were recommended for inclusion and all but one had a prevalence above 50 percent. A motion to approve the set was made, seconded, and passed with 14 yeas, and no nays.

The next code set was non-face-to-face physician and non-physician services. A motion to approve the set was made, seconded, and passed with 14 yeas, and no nays.

The next code set was nursing facility services. All codes in the set had 25 percent prevalence and were recommended for exclusion. A motion to approve the excluded codes was made and seconded.

Nancy Connolly asked about a primary care physician who has checked their patient into a Skilled Nursing Facility (SNF). Dr. Zerzan-Thul explained that can happen through billing but wouldn't count in this measurement process. Tracy Corgiat expressed concern if this category were used for billing. Dr. Zerzan-Thul explained that none of these codes will be excluded from regular business. Nancy Connolly worried that excluding these codes could discourage a primary care doctor from following their patient. Dr. Zerzan-Thul clarified that the choice to exclude these codes won't discourage care coordination and physicians who follow their patients will still get paid. Rarer services aren't worth including because they're such a small percentage and won't affect the outcome one way or another. If in 10 years this practice changes and more doctors follow patients into nursing facilities, this group can update the process. A motion was made to exclude the code set from measurement. The motion was seconded and passed with 13 to yeas and one nay.

The next code set was domiciliary, rest home, or custodial care services. All codes were recommended for inclusion. Tony Butruille asked if the set refers to assisted living more than nursing homes. Dr. Zerzan-Thul was not sure. Tony Butruille added that assisted living is supposed to be mobile enough for office visits. Nursing facilities are in-house with their own providers. Jean Marie Dreyer will do more research on this topic. The group decided to refrain from voting on the domiciliary set until a later time.

The final code set was osteopathic manipulative treatment. There was a low prevalence in other definitions, but all codes were recommended for inclusion. A motion was made to approve the included osteopathic codes. The motion was seconded and passed with 9 yeas, and 2 nays.

At the next meeting, the Committee will finish reviewing the code sets. Senate Bill 5589 also requires the Committee to discuss barriers to access, how and by whom it should be determined whether the primary care target is being met, methods to achieve the desired levels of primary care, and methods of reimbursement to achieve sustained levels. Staff will send the legislative language for members to review. There is a report due in the early summer. In May, the group will hear presentations on non-claims-based spending.

Adjournment

The meeting adjourned at 4:00 p.m.

Next meeting

March 30, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Washington State Health Care Authority

HCCTB Advisory Committee on Primary Care

Written Comments

Received Since Last Meeting

Written Comments Submitted by Email

No Additional Comments Were Received at the March Committee Meeting

- The Zoom video recording is available for viewing here: https://youtu.be/oEk_JvnTaE8

Delivered via e-mail

March 30, 2023

Dear Director Birch and Members of the Health Care Cost Transparency Board (Board),

Please consider the following feedback on the Advisory Committee on Primary Care's definition of primary care as you finalize the Board's legislative report. It is our understanding that the Board voted in favor of the current definition of primary care at its last meeting, but that there is room for additional input.

We appreciate the Board's robust discussion on the definition of primary care. **The current definition only addresses the *what*** – that primary care is team-based care acting as a patient's primary contact with the larger system, providing a comprehensive array of services to create and maintain a continuous relationship. As it stands, **the definition does not address the *why*** of primary care, which is integral for community members to fully understand the purpose of primary care and what this care aims to achieve.

To that end, please accept the below amendment to the definition.

"Team-based care led by an accountable primary care clinician that serves as a person's source of primary contact with the larger healthcare system. Primary care includes a comprehensive array of equitable, evidence-informed services to create and maintain a state of overall health and wellness for each individual, through a continuous relationship over time. This array of services is coordinated by the accountable primary care clinician but may exist in multiple care settings or be delivered in a variety of modes."

Thank you for the opportunity to provide feedback on the definition of primary care in an effort to strengthen it. Please let us know if you have any questions.

Sincerely,

Mika Sinanan, MD, PhD
Past President
Washington State Medical Association

Mike Marsh
President & CEO
Overlake Medical Center & Clinics

From: Vidaurri, Veronica
To: HCA HCCT Board
Subject: FW: March HCCTB Advisory Committee on Primary Care meeting coming up
Date: Thursday, March 30, 2023 3:04:37 PM
Attachments: image002.png

External Email

Immunizations do not account for admin codes for State supplied vaccines. EPSDT Program Billing Guide (wa.gov)

What vaccines are free from the Department of Health (DOH) for clients age 18 and younger?

No-cost immunizations from DOH are available for clients age 18 and younger. See the Professional Administered Drug Fee Schedule for a list of immunizations that are free from DOH. Therefore, HCA pays only for administering the vaccine.

- In a nonfacility setting:
  - Bill for the vaccine by reporting the procedure code for the vaccine given with modifier SL (e.g., CPT® 90707 SL). HCA covers the administrative cost

Washington State Health Care Authority

for those vaccines that are free from DOH and are billed with modifier SL (e.g., CPT® 90707 SL).

- DO NOT bill CPT® codes 90460-90461 or CPT® 90471-90472 for the administration.
- To bill for the administration of vaccines in an outpatient hospital or hospital-

Verónica Vidaurri, MHA
President and CEO
Highline Medical Services Organization
C 509.492.7146
F 206.834.6000

From: Washington Health Care Authority <WaHCA@public.govdelivery.com>
Sent: Friday, March 24, 2023 2:15 PM
To: Vidaurri, Veronica <veronica.t@hmsoinc.org>
Subject: March HCCTB Advisory Committee on Primary Care meeting coming up

HCA Logo (White on Transparent Background)

March 24, 2023

March HCCTB Advisory Committee on Primary Care meeting coming up

On Thursday, March 30, the Advisory Committee on Primary Care will meet on Zoom. During this meeting, the committee will discuss:

- The committee's progress to date
- A review of previously discussed goals
- Code level discussion of primary care services

Meeting details

Thursday, March 30, 2023
2-4 p.m.

Meet on Zoom (no registration required)

Live captioning may be available: Communication Access Real-time Transcription (CART) services, or live closed captioning, may be available for this event, on demand. To request this accommodation, please submit a request to addie.augsburger@hca.wa.gov as soon as possible. We will make every effort to accommodate this request but cannot guarantee that a CART writer will be available.

What's the Advisory Committee on Primary Care?

This advisory committee will develop recommendations related to the state's 12 percent primary care spending target for the board's review. The committee will begin their work by recommending a definition of primary care and standards for reporting and measuring claims- and non-claims-based spending. View our roster or visit our website to learn more.

Can I provide public comment or testimony?

Yes. Every committee meeting will have a designated time for public comment. To sign up to provide public comment, please contact us at hcahcctboard@hca.wa.gov by **5 p.m. on March 29.** You can also submit comments in writing at any time.

Tab 4

Washington State Health Care Authority

HCCTB Advisory Committee on Primary Care Meeting

April 27, 2023

Agenda

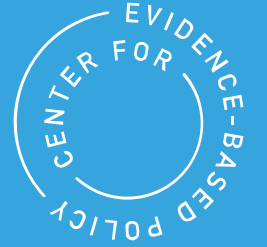
Time	Topic	Facilitator/Presenter
2:00	Call to order and roll call	Dr. Judy Zerzan-Thul (HCA)
2:10	Agenda and goals	Jean Marie Dreyer (HCA)
2:15	Approve prior meeting minutes	
2:15	Public comment	
2:30	Workgroup charges	
2:35	Primary care definition	
2:45	Data to support primary care	Shane Mofford (CEbP)
3:15	Policies to increase and sustain primary care	Gretchen Morley (CEbP)
TBD	Continue code-level definition of primary care	Dr. Judy Zerzan-Thul (HCA)
4:00	Adjourn	

Goals

- Finalize general definition of primary care
- Begin discussion of data, incentives, and payment model workgroup charges
- Complete review of remaining code sets

Public Comment

Definition, data, and policy Workgroup charges



HCCTB Advisory Committee on Primary Care Charges

- **Primary Care Definition**
  - Recommend a definition of primary care
  - Recommend measurement methodologies to assess claims-based spending
  - Recommend measurement methodologies to assess non-claims-based spending

- **Data To Support Primary Care**
  - Report on barriers to access and use of primary care data and how to overcome them
  - 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

- **Policies to Increase and Sustain Primary Care**
  - 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

Primary Care Definition

HCCTB Advisory Committee on Primary Care Charges

- Primary Care Definition
  - Recommend a definition of primary care
  - Recommend measurement methodologies to assess claims-based spending
  - Recommend measurement methodologies to assess non-claims-based spending

- Data To Support Primary Care
  - Report on barriers to access and use of primary care data and how to overcome them
  - 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

- Policies to Increase and Sustain Primary Care
  - 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

Current definition

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

Proposed amendment

- Current definition only addresses the “what” of primary care and does not include the “why.”

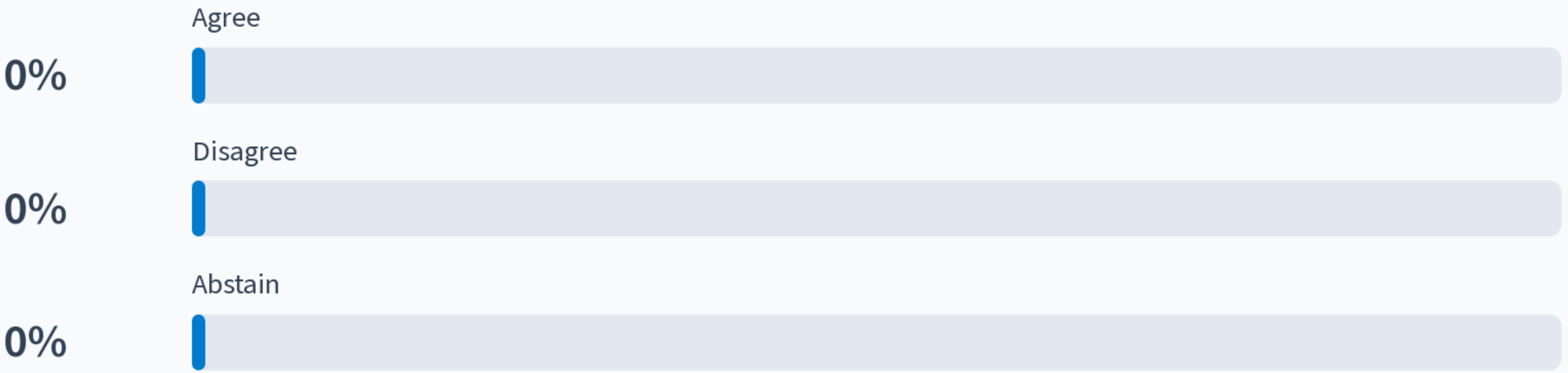
- It is important for community members to understand the purpose of primary care.

- The definition could be amended to state the goal of primary care – what primary care is trying to achieve.

Proposed amendment

"Team-based care led by an accountable primary care clinician that serves as a person's source of primary contact with the larger healthcare system. Primary care includes a comprehensive array of equitable, evidence-informed services to create and maintain a state of overall health and wellness for each individual, through a continuous relationship over time. This array of services is coordinated by the accountable primary care clinician but may exist in multiple care settings or be delivered in a variety of modes."

I support the proposed amendment to the primary care definition.



Data to Support Primary Care

HCCTB Advisory Committee on Primary Care Charges

- Primary Care Definition
  - Recommend a definition of primary care
  - Recommend measurement methodologies to assess claims-based spending
  - Recommend measurement methodologies to assess non-claims-based spending
- Data to Support Primary Care
  - Report on barriers to access and use of primary care data and how to overcome them
  - 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
- Policies to Increase and Sustain Primary Care
  - 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

National Academy for Sciences, Engineering, and Medicine (NASEM) Primary Care Committee

NASEM developed a set of recommendations for CMS and other federal entities to support primary care.

These recommendations are shared today as examples of potential policies and general context as we move forward with the “Data to support Primary Care” and “Policies to Increase and Sustain Primary Care” bodies of work.

NASEM Recommendation Development

- 5 meetings, a webinar, and many conference calls
- 3 public information-gathering sessions
- 3 commissioned papers: the historical evolution of primary care; the effects of the pandemic; and payment reform
- Literature review (~6,000 articles) and synthesis of findings and conclusions
- Recommendations driven by consensus
- External peer-review by 16 experts in a variety of disciplines

NASEM Primary Care Committee:
Five objectives for achieving high-quality primary care

1) Pay for primary care teams to care for people, not doctors to deliver services.
2) Ensure that high quality primary care is available to every individual and family in every community.
3) Train primary care teams where people live and work.
4) Design information technology that serves the patient, family, and interprofessional team.
5) Ensure that high quality primary care is implemented in the U.S.

Overcoming barriers – meaningful exchange of data

NASEM Recommendations

- Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare and Medicaid (CMS) should plan for and adopt a comprehensive aggregate patient data system to enable primary care clinicians and interprofessional teams to easily access comprehensive patient data needed to provide whole-person care. This could be accomplished through:
  - A centralized data warehouse,
  - Individual health data card, or
  - Distributed sources connected by a real-time, functional health information exchange.

Washington Context

- Washington should continue to leverage existing state health information technology investments:
  - Clinical Data Repository (CDR), which contains clinical data from electronic health records, through additional investment and regulation allowing all providers to submit data;
  - Washington All-Payer Claims Database (WA-APCD) which contains claims data for Medicaid, Medicare, and Commercial clients, through encouraging self-funded payers to submit data;
  - Washington's Health Information Exchange (HIE) operated by One Health Port, through additional investment and directing future state initiatives to leverage the HIE infrastructure; and
  - Washington's Master Person Index (MPI), through the use of a uniform identifier that facilitates delivery of public services.

Overcoming barriers – digital health

NASEM Recommendations

- Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare and Medicaid (CMS) should develop the next phase of digital health, including electronic health record certification standards to:
  - Align with the functions of primary care supporting the relationship between clinicians, care teams, and patients;
  - Ensure base products meet certification standards with minimal need for local modification to meet requirements; and
  - Hold state health information technology vendors financially responsible for failing to achieve benchmarks.

Washington Context

- Washington should support the use of standard digital health technologies through adoption of certified electronic health records (EHR) systems:
  - Invest in and support HCA's EHR-as-a-Service initiative which will provide access to a certified EHR for behavioral health, small, and rural providers;
  - HCA should hold its EHR-as-a-Service provider accountable for meeting certification standards with minimal need for local modification; and
  - Invest in and support HCA's Electronic Consent Management (ECM) initiative which will capture and make visible clients' consent to share their sensitive health information.

Which data policies would you initially recommend for measurement and support of primary care?

Washington should invest in and support HCA's Electronic Consent Management (ECM) initiative.

0 0

HCA should hold EHR-as-a-Service providers accountable for meeting certification standards.

0 0

Washington should invest in and support HCA's EHR-as-a-Service initiative.

0 0

Continue to leverage Washington's Master Person Index (MPI).

Policies to Increase and Sustain Primary Care

HCCTB Advisory Committee on Primary Care Charges

- Primary Care Definition
  - Recommend a definition of primary care
  - Recommend measurement methodologies to assess claims-based spending
  - Recommend measurement methodologies to assess non-claims-based spending

- Data Focused to support primary care
  - Report on barriers to access and use of primary care data and how to overcome them
  - 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

- Policies to Increase and Sustain Primary Care
  - 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

Foreword

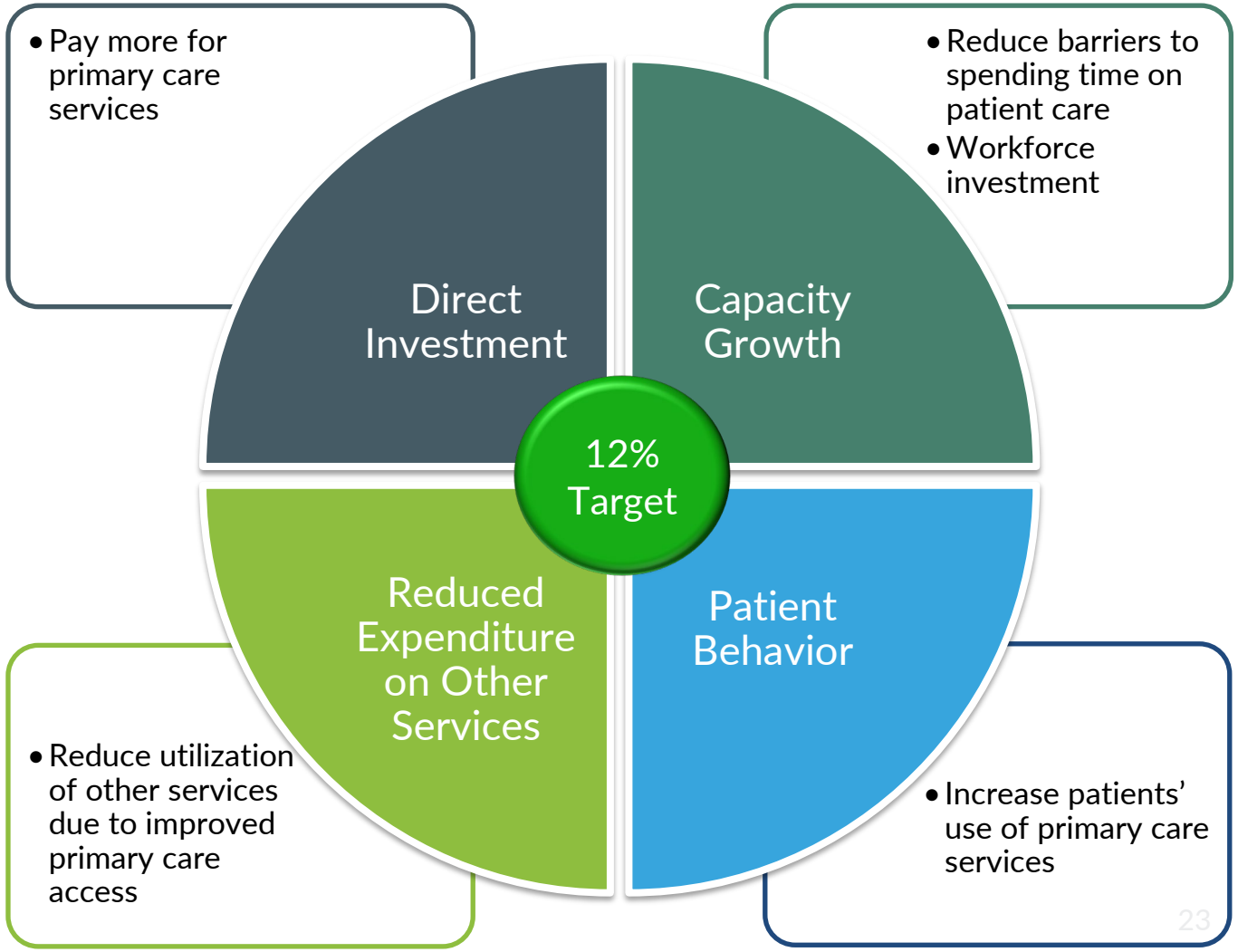
We will be discussing different strategies to drive toward the 12% expenditure target and then polling preferences.

Consider jotting down ideas that resonate with you as you will need that when we get to the discussion and polling section.

Policies to increase and sustain primary care – 12% in context

Four key dynamics that influence the primary care expenditure statistics:

- Direct investment
- Capacity Growth
- Patient Behavior
- Reduced Expenditure on Other Services



Actors -> Levers -> Strategies

Examples:

- Oregon SB 17-934 – requires increases in primary care spend until carrier achieves 12% target
- Oklahoma SB 22-1337 – Requires managed care entities to report on primary care expenditures and increase primary care expenditures to a minimum of 11% within four years
- Nationwide common practice – adjustments to Medicaid reimbursement rates through legislative action

Key Actors	Primary Levers
State Legislature	• Appropriate funding • Legislation
State Executive Branch	• Marketplace policies • Public insurance policies
Purchasers	• Reimbursement rates • Payment innovations
Payers	• Reimbursement rates • Payment innovations
Federal Government	• Fund additional investment through payment reform models

Capacity Growth

Actors -> Levers -> Strategies

Examples:

- Minnesota Rural Physician Loan Forgiveness Program
- CMS creation of the Office of Burden Reduction and Health Informatics
- Multistate adoption of telehealth as compensable services during the pandemic
- Indiana – initiative through community colleges to encourage CNAs to continue their education and become nurses
- WA PCTM – model that provides combination of provider support and payment models

Actors	Levers
State Legislature	• Workforce Investments • Legislation
State Executive Branch	• Marketplace policies • Public insurance policies • Licensure requirements
Purchasers	• Admin requirements • Provider supports
Payers	• Admin requirements • Provider supports
Providers	• Process/staffing changes
Federal Government	• Workforce Investment • Admin requirements

NASEM strategies that support sustainability

NASEM Recommendations

- Payers—Medicaid, Medicare, commercial insurers, and self-insured employers using a fee-for-service (FFS) payment model for primary care should shift primary care payment toward hybrid (part FFS, part capitated) models, making them the default method for primary care teams over time.

- States could use authority to facilitate multi-payer collaboration on primary care payment and fee schedules.

Washington Context

- Payers and purchasers currently offer a variety of payment models to practices that incentivize performance, offer financial flexibility, or both. Model offerings and requirements vary from plan to plan.

- Payers, purchasers, and providers have been collaborating to develop a new framework to support primary care in Washington through payment models, collaboration on providers supports, aligned policies to reduce administrative burden, and consistent standards and expectations for practices.

NASEM strategies that support sustainability - workforce

- Health care organizations, local, and state agencies could expand and **diversify the primary care workforce**, particularly in federally designated shortage areas, to strengthen interprofessional teams and better align the workforce with the communities they serve.
  - Public and private health care organizations could ensure inclusion, support, and training for family caregivers, community health workers, and other informal caregivers as members of the interprofessional primary care team.
  - State and local government, and health care systems could **redesign and implement economic incentives,** including loan forgiveness and salary supplements, to ensure that interprofessional care team members, especially those who reflect the diverse needs of the local community, are encouraged to enter primary care in rural and underserved areas.
- States could redeploy or augment funding to **support interprofessional training in community-based, primary care practice environments**. The revised funding model could be sufficient in size to improve access to primary care and ensure that training programs can adequately support primary care pipeline needs of the future.

Patient Behavior

Actors -> Levers -> Strategies

Examples:

- Affordable Care Act – grants to 10 states in the amount of $85 million to test the use of financial rewards for preventive care and management of chronic disease
- NH and MA - Minuteman Health - $50 incentives for members to have a minimum of 1 PCP visit annually
- Insurance carriers - partnering with community organizations – discounts on studios, gyms, fitness gear, and patient education
- Oregon CCOs – targeted education campaigns supported by respiratory therapists to implement asthma action plans

Actors	Levers
State Executive Branch	• Public education • Public insurance policy
Purchasers	• Patient incentives and education • Influence patient choice
Payers	• Patient incentives and education
Providers	• Patient relationships and empowerment
Patients	• Engagement in care
Federal Government	• Public education • Cost sharing structures

NASEM Strategies Impacting Patient Behavior

- Reinforce patient/physician relationship
  - Request all covered individuals declare a usual source of primary care annually
  - Assign non-responding enrollees using established methods
    - Track this information
    - Use it for payment and accountability measures
  - Health centers, hospitals, and primary care practices could assume and document an ongoing clinical relationship with the uninsured people they are treating

Factoring in other service categories when setting targets with policy

- As primary access grows, utilization of other services will likely be impacted, too
  - Less Emergency Department
  - More testing
  - Less hospitalization
  - More pharmacy
- Because these other services contribute to the denominator of the 12% formula, direct investment of a 1% primary care spending equivalent could have a greater than 1% impact.
- Moving forward, we'll have to think through not just the direct policy implications, but the indirect effects as well.

Which strategies would you initially recommend WA prioritize to support achieving the primary care expenditure target?

Capacity Growth - Payer focus on reducing administrative buren/costs for providers

0 0

Capacity Growth - Multipayer collaboration to develop and implement payment models that offer greater financial flexibility and incentives while growing access and improving quality.

0 0

Capacity Growth - State funded expansion of loan forgiveness opportunity.

0 0

Code Review Finalization

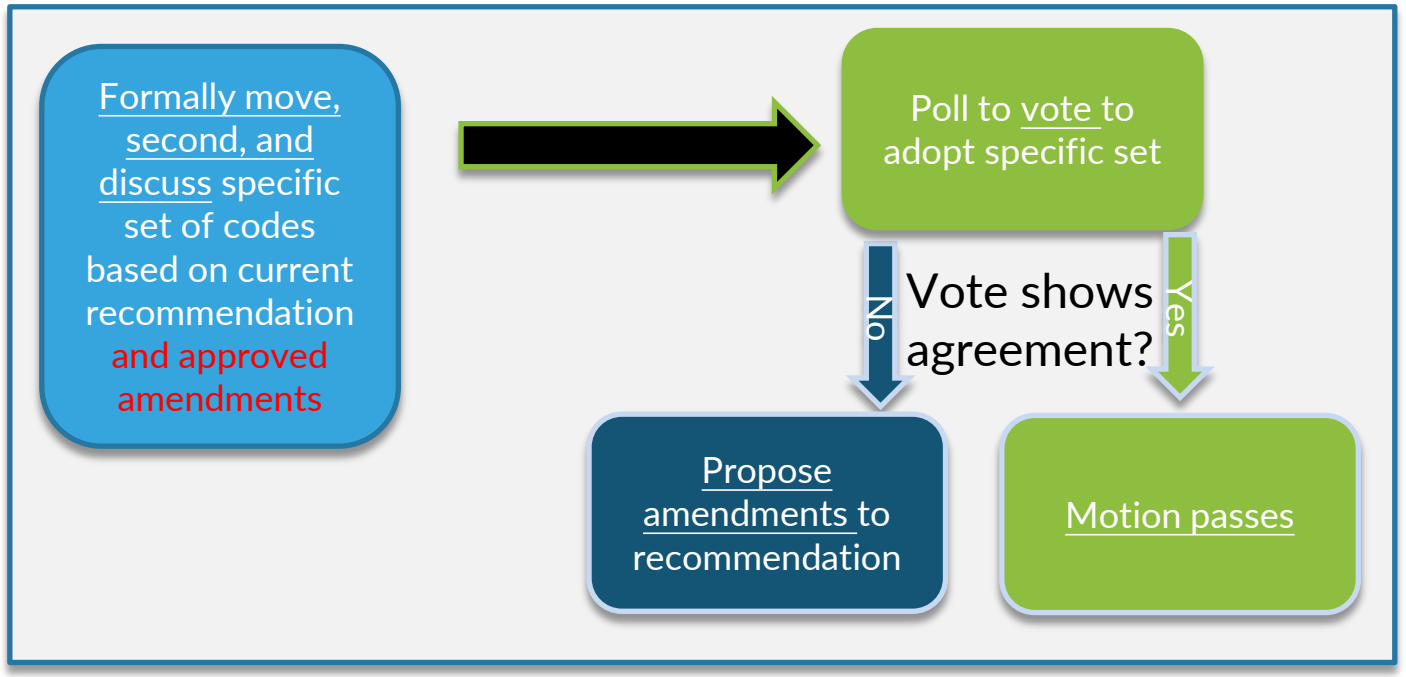
HCCTB Advisory Committee on Primary Care Charges

- Primary Care Definition
  - Recommend a definition of primary care
  - Recommend measurement methodologies to assess claims-based spending
  - Recommend measurement methodologies to assess non-claims-based spending

- Data Focused to support primary care
  - Report on barriers to access and use of primary care data and how to overcome them
  - 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

- Policies to Increase and Sustain Primary Care
  - 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

Recommendation approval process



Domiciliary, Rest Home or Custodial Care Services

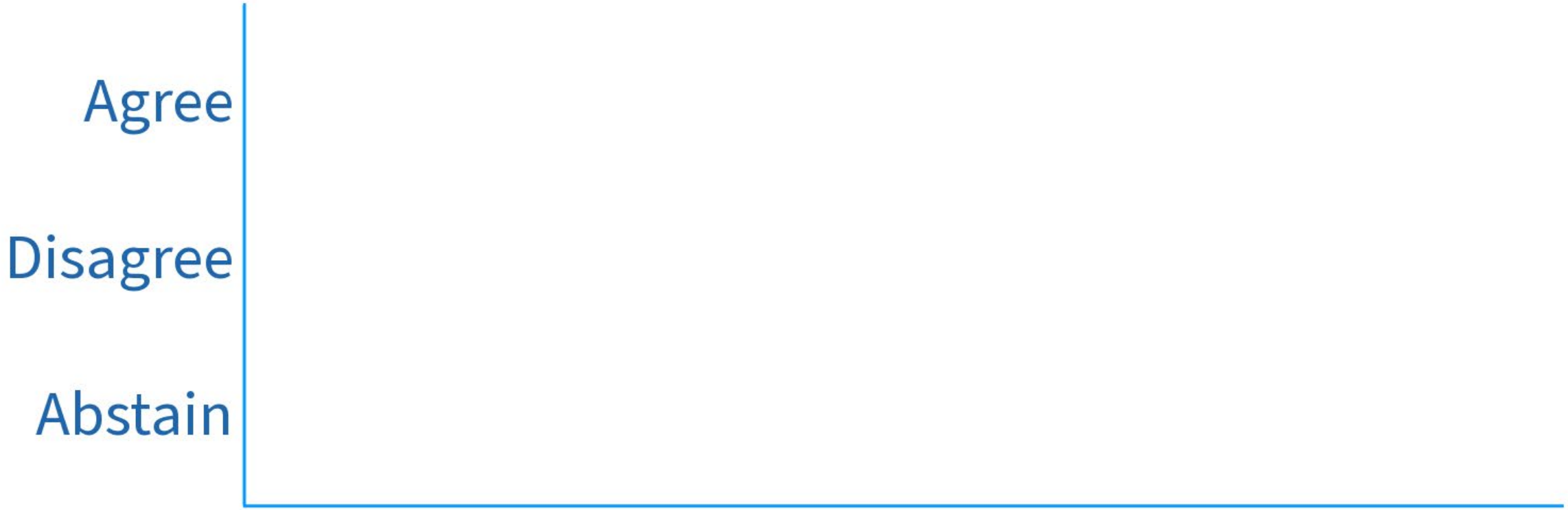
CPT codes 99324-99337 are used to report evaluation and management (E/M) services to **individuals residing in a facility which provides room, board, and other personal assistance services, generally on a long-term basis**. These codes are used to report E/M services in facilities assigned places of service (POS) codes 13 (Assisted Living Facility), 14 (Group Home), 33 (Custodial Care Facility), and 55 (Residential Substance Abuse Facility). The codes were introduced in 2006 and replaced the CPT codes 99321-99333.

99339: **Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multi-disciplinary care modalities** involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

Domiciliary, Rest Home or Custodial Care Services

Codes	Description	Prevalence in Other Definitions	Recommendation
99339	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 15-29 Min	83%	Include
99324	Domiciliary Or Rest Home Custodial Care 20 Min	42%	Include
99325	Domiciliary Or Rest Home Custodial Care 30 Min	42%	Include
99326	Domiciliary Or Rest Home Custodial Care 45 Min	42%	Include
99327	Domiciliary Or Rest Home Custodial Care 60 Min	42%	Include
99328	Domiciliary Or Rest Home Custodial Care 75 Min	42%	Include
99334	Domiciiary Or Rest Home Evaluation 15 Min	50%	Include
99335	Domiciliary Or Rest Home Evaluation 25 Min	42%	Include
99336	Domiciliary Or Rest Home Evaluation 40 Min	50%	Include
99337	Domiciliary Or Rest Home Evaluation 60 Min	50%	Include

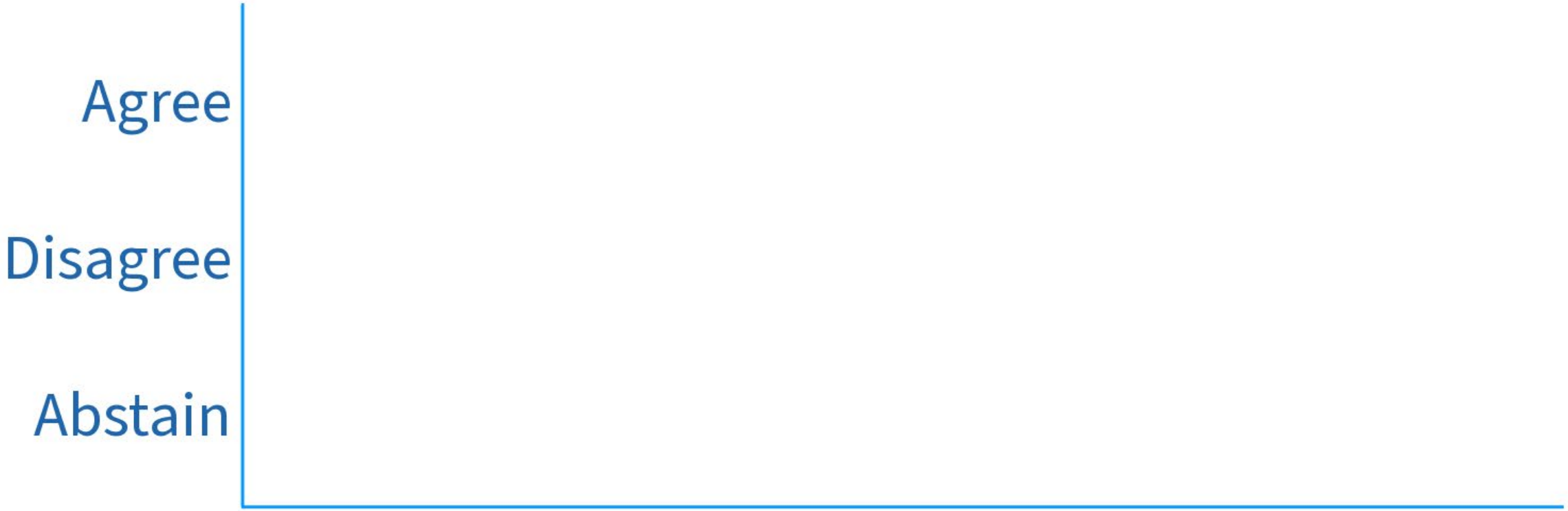
Domiciliary, Rest Home or Custodial Care Services: I support the current recommendations for inclusion/exclusion of codes in this set



Prolonged Services

Codes	Description	Prevalence in Other Definitions	Recommendation
99354	Prolonged Service OutPt 60 Min	42%	Include
99355	Prolonged Service OutPt Add 30 Min	42%	Include
99356	Prolonged Service Requiring Unit/Floor 60 Min	17%	Include
99357	Prolonged Service Requiring Unit/Floor Add 30 Min	17%	Include
99358	Prolong Service W/O Contact	67%	Include
99359	Prolong Serv W/O Contact Add 30 Min	67%	Include
99360	Standby Service	42%	Include

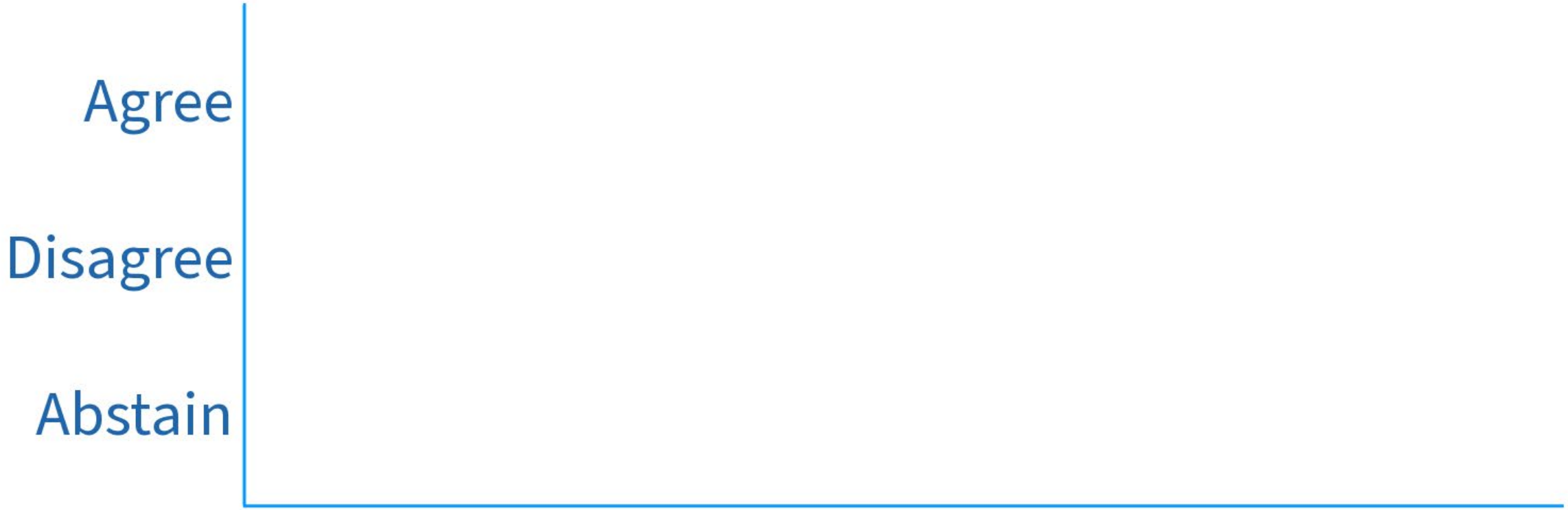
Prolonged Services: I support the current recommendations for inclusion/exclusion of codes in this set



Lab Testing and Supplies (Part 1)

Codes	Description	Prevalence in Other Definitions	Recommendation
*81000	Urinalysis Dip Stick/Tablet Reagnt Non-Auto Micrscpy	0%	Exclude
*81001	Urinalysis Dip Stick/Tablet Reagent Auto Microscopy	0%	Exclude
*81025	Urine Pregnancy Test Visual Color Comparison	0%	Exclude
82044	Urine Albumin Semiquantitative	0%	Exclude
82270	Blood Occult Peroxidase Actv Qual Feces 1 Determination	0%	Exclude
82272	Blood Occult Peroxidase Actv Qual Feces 1-3 Spec Determination	0%	Exclude
82465	Cholesterol Serum/Whole Blood Total	0%	Exclude
82947	Glucose Quantitative Blood Xcpt Reagent Strip	0%	Exclude
82948	Glucose Blood Reagent Strip	0%	Exclude
82950	Glucose Post Glucose Dose	0%	Exclude
82962	Gluc Bld Glucouse Device Spec Home Use	0%	Exclude
83655	Assay Of Lead	0%	Exclude

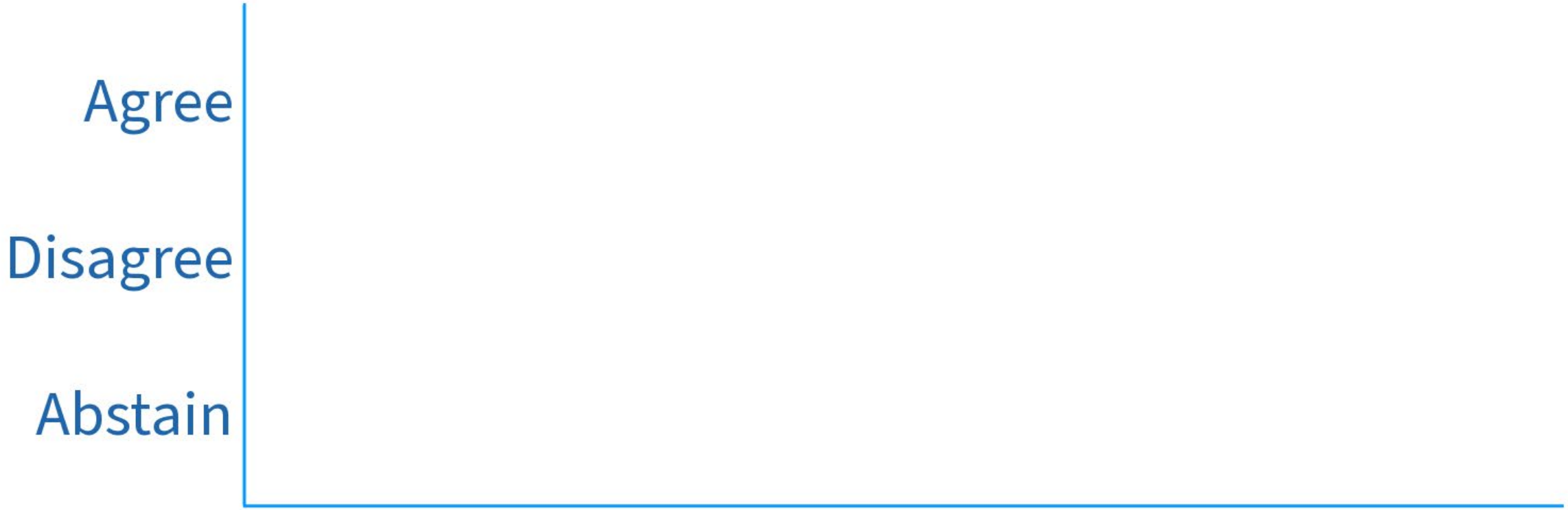
Lab Testing and Supplies (Part 1): I support the current recommendations for inclusion/exclusion of codes in this set



Lab Testing and Supplies (Part 2)

Codes	Description	Prevalence in Other Definitions	Recommendation
83718	Lipoprotein Dir Meas High Density Cholesterol	0%	Exclude
85013	Blood Count Spun Microhematocrit	0%	Exclude
85014	Blood Count Hematocrit	0%	Exclude
85018	Blood Count Hemoglobin	0%	Exclude
*86580	Skin Test Tuberculosis Intradermal	0%	Exclude
*87205	Smr Prim Src Gram/Giemsa Stain Bct Fungi/Cel	0%	Exclude
*87880	Immunoassay Streptococcus Group A	0%	Exclude

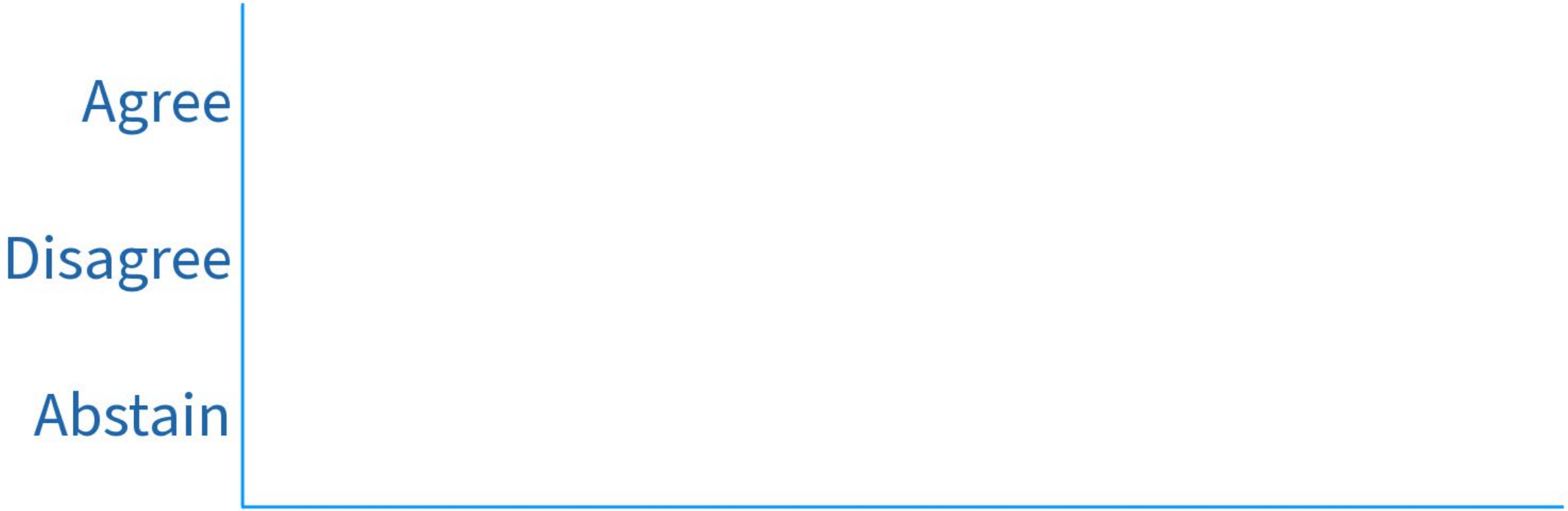
Lab Testing and Supplies (Part 2): I support the current recommendations for inclusion/exclusion of codes in this set



Temporary Codes (Part 1)

Codes	Description	Prevalence in Other Definitions	Recommendation
G0008	Admin Influenza Virus Vaccine	92%	Include
G0009	Admin Pneumococcal Vaccine	92%	Include
G0010	Admin Hepatitis B Vaccine	75%	Include
G0101	Cancer Screen; Pelvic/Breast Exam	58%	Include
G0102	Prostate Cancer Screening; Digital Rectal Examination	58%	Include
G0179	Phys Re-Cert Mcr-Covr Hom Hlth Srvc Re-Cert Prd	25%	Include
G0180	Phys Cert Mcr-Covr Hom Hlth Srvc Per Cert Prd	25%	Include
G0181	Home/Nursing Facility Visits W/Out Pt Medicare Approved	25%	Include
G0182	Hospice Facility Visits Medicare Approved	25%	Include
G0396	Alcohol/Subs Misuse Intervention 15-30 Min	67%	Include
G0397	Alcohol/Subs Misuse Intervention 30 Min <	67%	Include
G0402	Welcome to Medicare visit	58%	Include
G0403	Ekg For Initial Prevent Exam	17%	Include

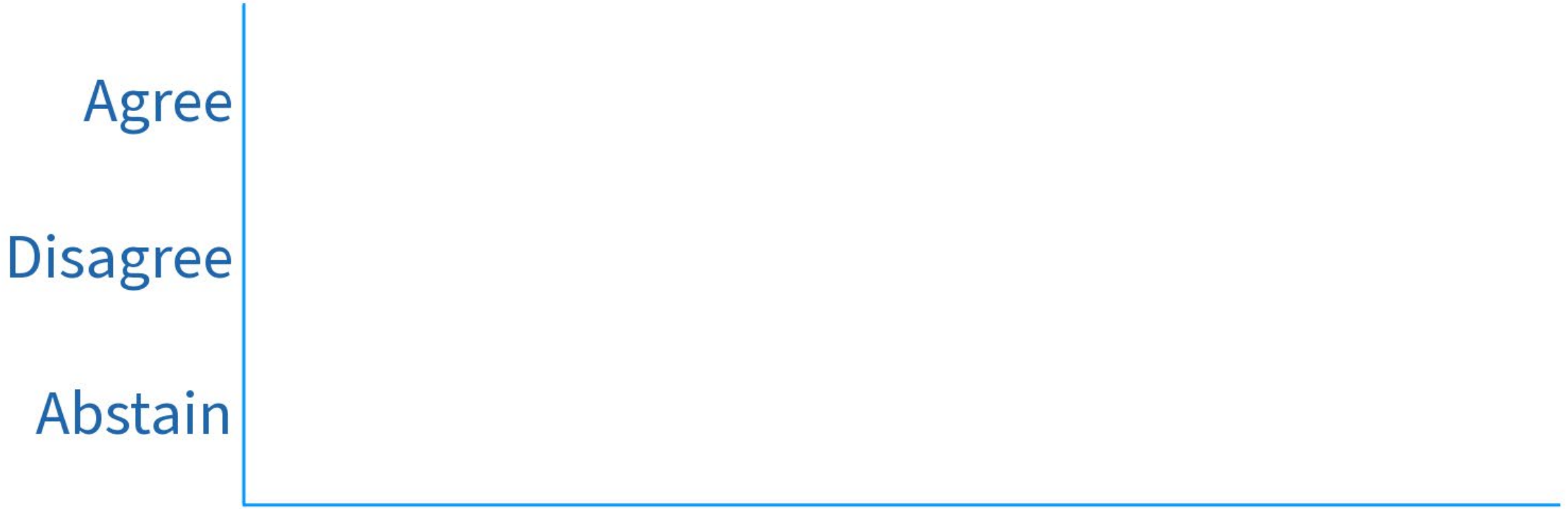
Temporary Codes (Part 1): I support the current recommendations for inclusion/exclusion of codes in this set



Temporary Codes (Part 2)

Codes	Description	Prevalence in Other Definitions	Recommendation
G0404	Ekg Tracing For Initial Prev	17%	Include
G0405	Ekg Interpret & Report Preve	17%	Include
G0438	Ppps, Initial Visit	92%	Include
G0439	Ppps, Subseq Visit	92%	Include
G0442	Annual Alcohol Screen 15 Min	83%	Include
G0443	Brief Alcohol Misuse Counsel	83%	Include
G0444	Depression Screen Annual 15 Min	75%	Include
G0404	Ekg Tracing For Initial Prev	17%	Include
G0405	Ekg Interpret & Report Preve	17%	Include
G0438	Ppps, Initial Visit	92%	Include
G0439	Ppps, Subseq Visit	92%	Include
G0442	Annual Alcohol Screen 15 Min	83%	Include
G0443	Brief Alcohol Misuse Counsel	83%	Include

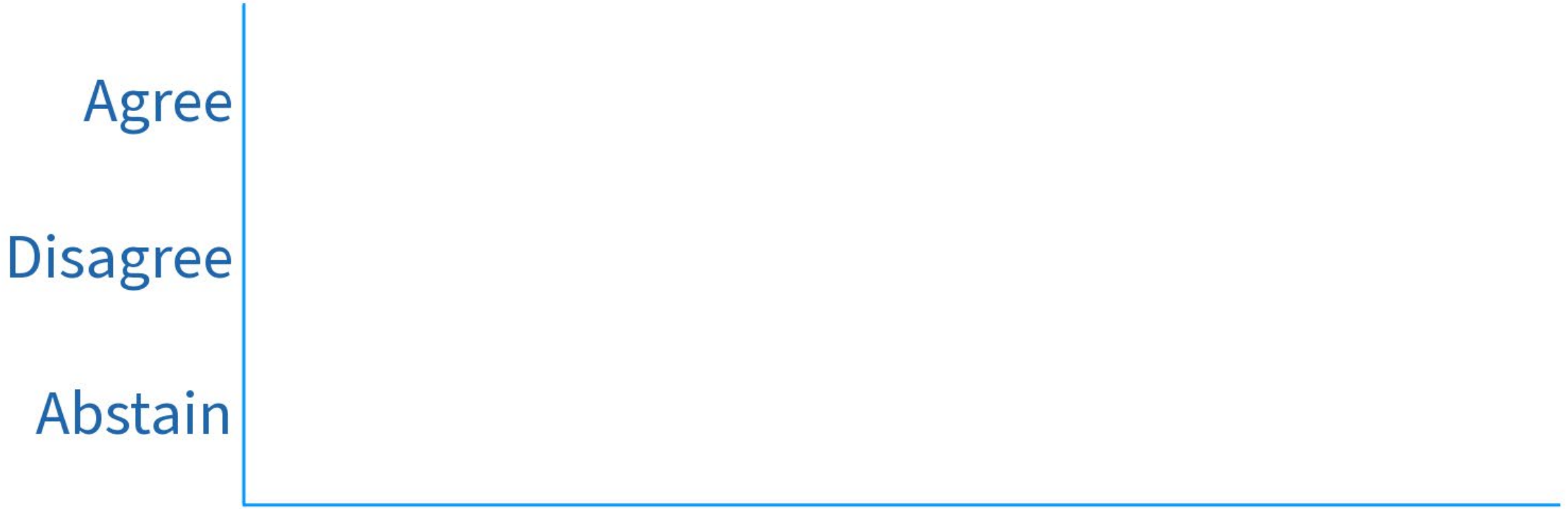
Temporary Codes (Part 2): I support the current recommendations for inclusion/exclusion of codes in this set



Temporary Codes (Part 3)

Codes	Description	Prevalence in Other Definitions	Recommendation
G0463	Hospital Outpt Clinic Visit	58%	Include
G0466	FQHC Visit, New Pt	58%	Include
G0467	FQHC Visit, Established Pt	58%	Include
G0468	FQHC Preventive Visit	58%	Include
G0469	FQHC Visit, Mh New Pt	8%	Include
G0470	FQHC Visit, Mh Estab Pt	8%	Include
G0506	Comprehensive Asses Care Plan Chronic Care Mgmt Services	75%	Include
G0513	Prolong Preventative Services, First 30 Min	67%	Include
G0514	Prolonged Preventive Service Addl 30 Min	67%	Include
*J1050	Injection Medroxyprogesterone Acetate 1 Mg	0%	Exclude
Q0091	Obtaining Screen Pap Smear	33%	Include
*S8100	Holding Chamb/Spacr W/Inhal/Nebulizr; W/O Mask	0%	Exclude
*S8101	Holding Chamb/Spacr W/An Inhal/Nebulizr; W/Mask	0%	Exclude
T1015	Clinic Service All-Inclusive	58%	Include

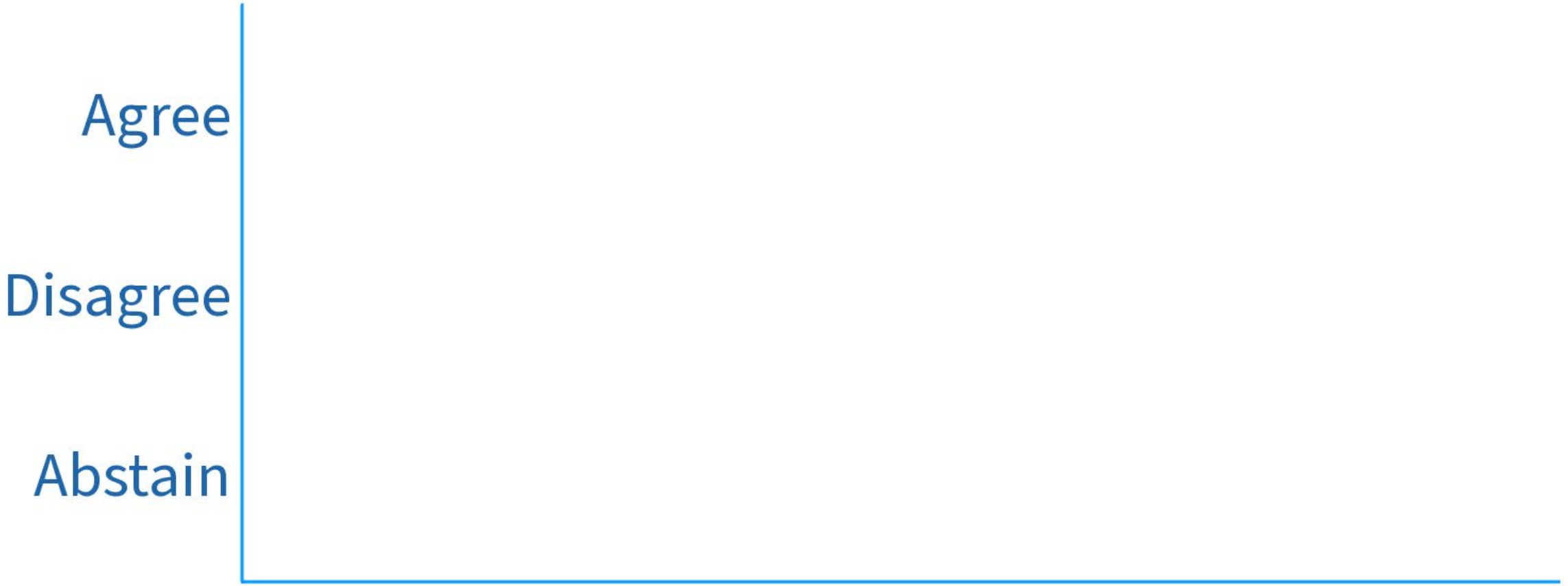
Temporary Codes (Part 3): I support the current recommendations for inclusion/exclusion of codes in this set



Supervision

Codes	Description	Prevalence in Other Definitions	Recommendation
99340	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 30 Min	83%	Include
99377	Supervision Hospice Patient/Month 15-29 Min	25%	Include
99378	Supervision Hospice Patient/Month 30 Minutes/>	25%	Include
*99379	Supervision Nurs Facility Pt Mo 15-29 Min	0%	Exclude
*99380	Supervision Nurs Facility Pt Month 30 Min/>	0%	Exclude

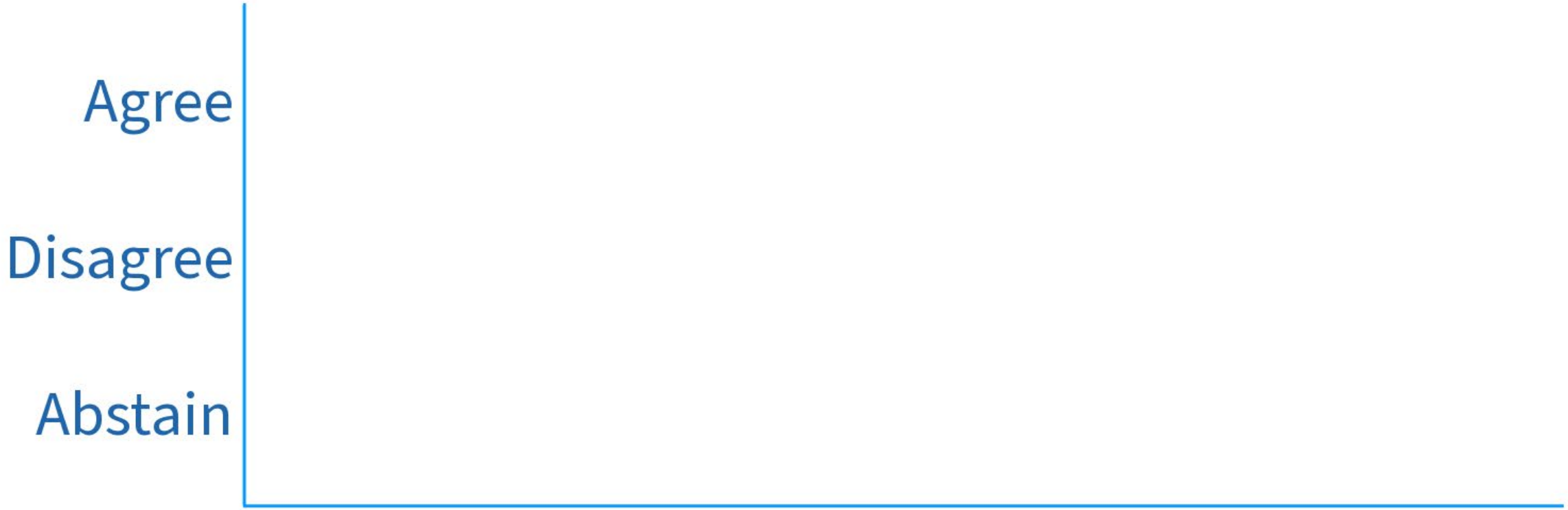
Supervision: I support the current recommendations for inclusion/exclusion of codes in this set



Cardiac and Pulmonary Testing/Procedures

Codes	Description	Prevalence in Other Definitions	Recommendation
*93000	Ecg Routine Ecg W/Least 12 Lds W/I&R	0%	Exclude
*93005	Ecg Routine Ecg W/Least 12 Lds Trcg Only W/O I&R	0%	Exclude
*93010	Ecg Routine Ecg W/Least 12 Lds I&R Only	0%	Exclude
*93040	Rhythm Ecg 1-3 Leads W/Interpretation & Report	0%	Exclude
*93268	Xtrnl Pt Activ Ecg Transmis W/R&I </30 Days	0%	Exclude
*93784	Ambl Bld Press W/Tape&/Disk 24/> Hr Alys I&R	0%	Exclude
*94010	Spirometry	8%	Exclude
*94060	Bronchodilation Responsiveness	8%	Exclude
*94640	Pressurized/Nonpressurized Inhalation Treatment	0%	Exclude
*94664	Demo&/Eval Of Pt Utiliz Aersl Gen/Neb/Inhlr/Ip	0%	Exclude
*94760	Noninvasive Ear/Pulse Oximetry Single Deter	0%	Exclude
*94761	Noninvasive Ear/Pulse Oximetry Multiple Deter	0%	Exclude

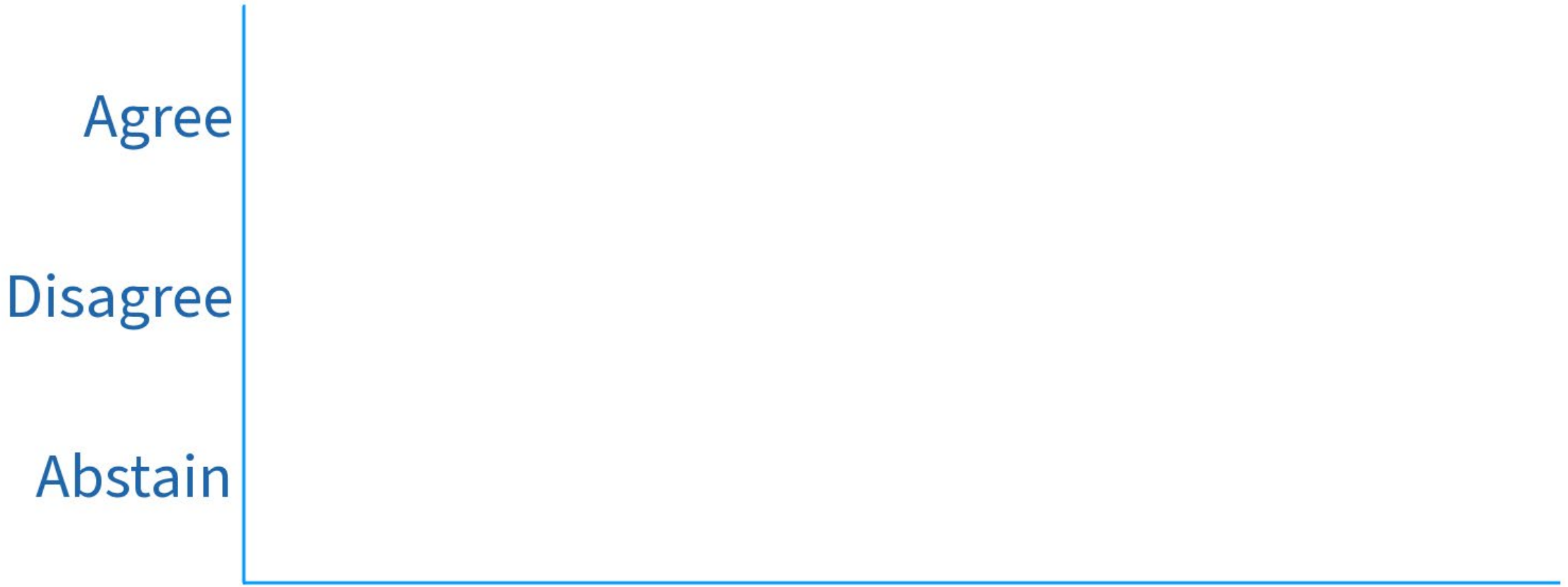
Cardiac and Pulmonary Testing/Procedures: I support the current recommendations for inclusion/exclusion of codes in this set



Dermatological

Codes	Description	Prevalence in Other Definitions	Recommendation
11055	Trim Skin Lesion Single	8%	Exclude
11056	Trim Skin Lesions 2 To 4	8%	Exclude
*11200	Removal Of Skin Tags <W/15	8%	Exclude
*11201	Remove Skin Tags Add-On	8%	Exclude
11719	Trimming Nondystrophic Nails Any Number	0%	Exclude
11720	Debride Nail 1-5	8%	Exclude
11721	Debride Nail 6+	0%	Exclude
11740	Evacuation Subungual Hematoma	0%	Exclude
11900	Inject Skin Lesions </W 7	8%	Exclude

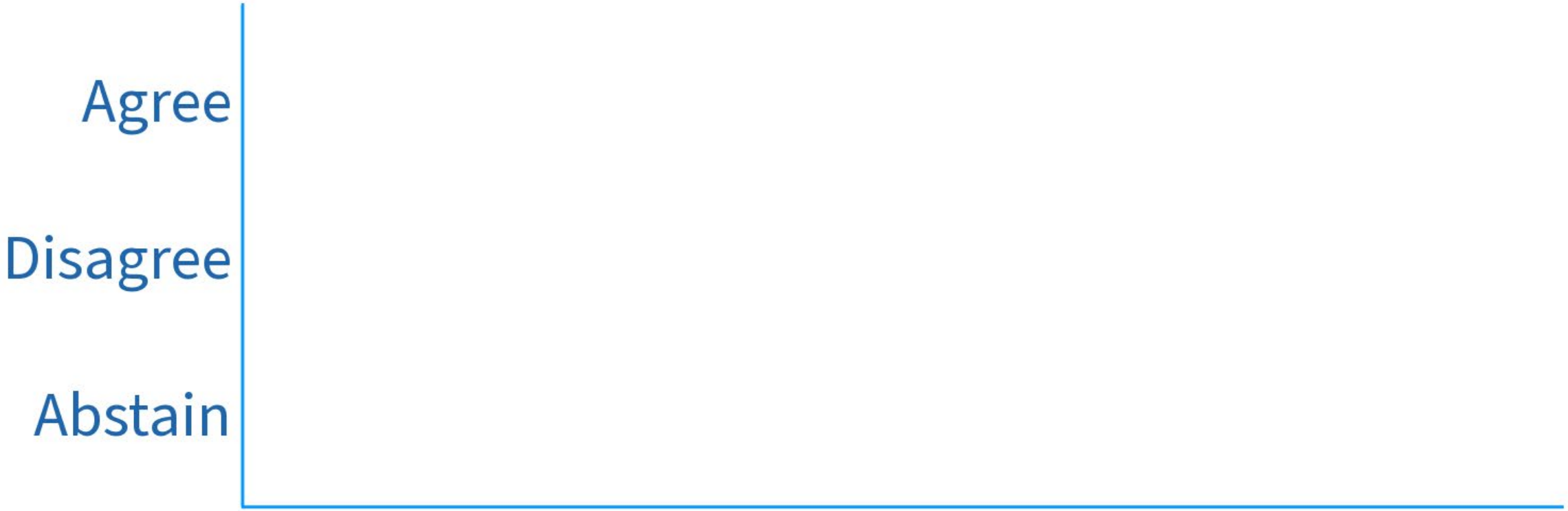
Dermatological: I support the current recommendations for inclusion/exclusion of codes in this set



Newborn care services

Codes	Description	Prevalence in Other Definitions	Recommendation
*99460	Initial Evaluation And Management Of Newborn At Hospital	25%	Exclude
*99461	Initial Evaluation And Management Of Newborn Outside Of Hospital	25%	Exclude
*99462	Evaluation And Menagement Of Normal Newborn At Hospital	25%	Exclude
*99463	Evaluation And Menagement Of Normal Newborn Hospital Same Day Admittance And Discharge	25%	Exclude
*99464	Attendance At Delivery And Initial Stabilization Of Newborn	25%	Exclude
*99465	Delivery/Birthing Resuscitation	25%	Exclude

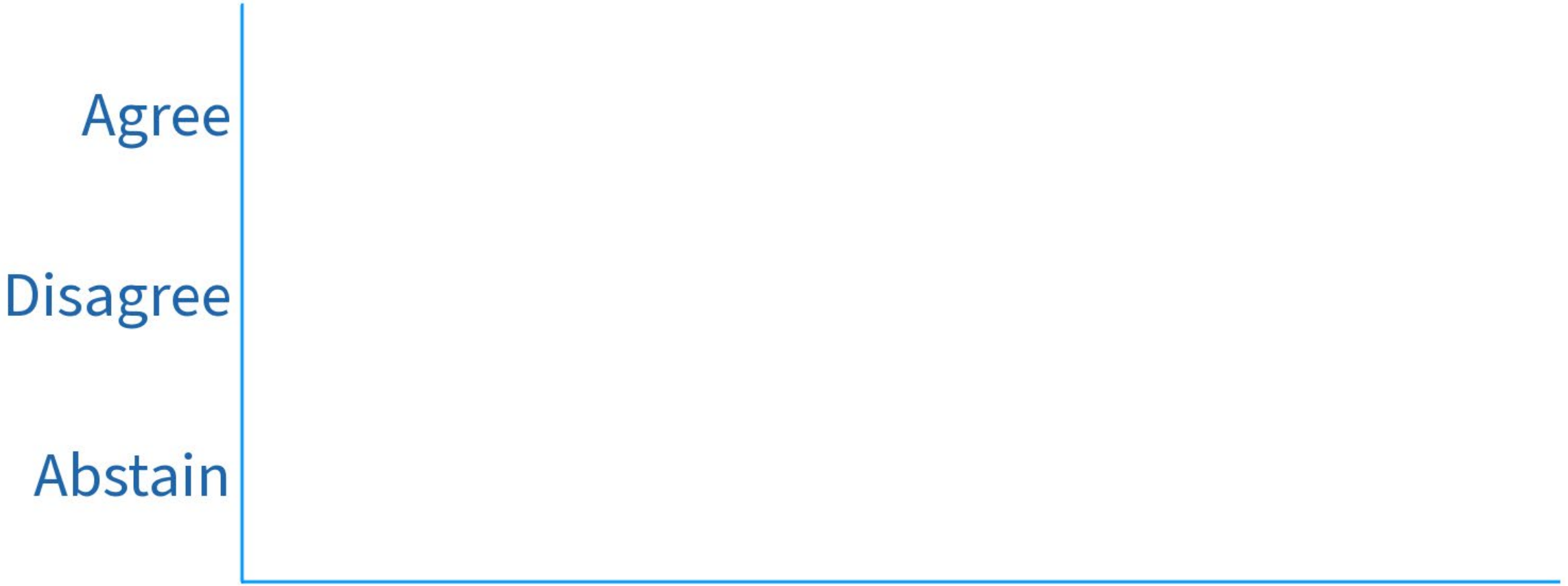
Newborn care services: I support the current recommendations for inclusion/exclusion of codes in this set



Obstetrics

Codes	Description	Prevalence in Other Definitions	Recommendation
*59400	Obstetrical Care	36%	Exclude
*59410	Veginal Delivery + Postpartum Care	25%	Exclude
*59425	Antepartum Care Only 4-6 Visits	17%	Exclude
*59426	Antepartum Care Only 7< Visits	17%	Exclude
*59430	Postpartum Care Only	17%	Exclude
*59510	Routine Ob Care	36%	Exclude
*59515	Cesarean Delivery Only + Postpartum Care	27%	Exclude
*59610	Routine Obstetric Care After Prevs C-Section	30%	Exclude
*59614	Vaginal Delivery Only After Prevs C-Section + Postpartum Care	27%	Exclude
*59618	Routine Ob Care Post Vaginal Delivery After Prev C-Section	36%	Exclude
*59622	C-Section Only, After Attempted Vaginal Delivery After Prev C- Section + Postpartum Care	27%	Exclude

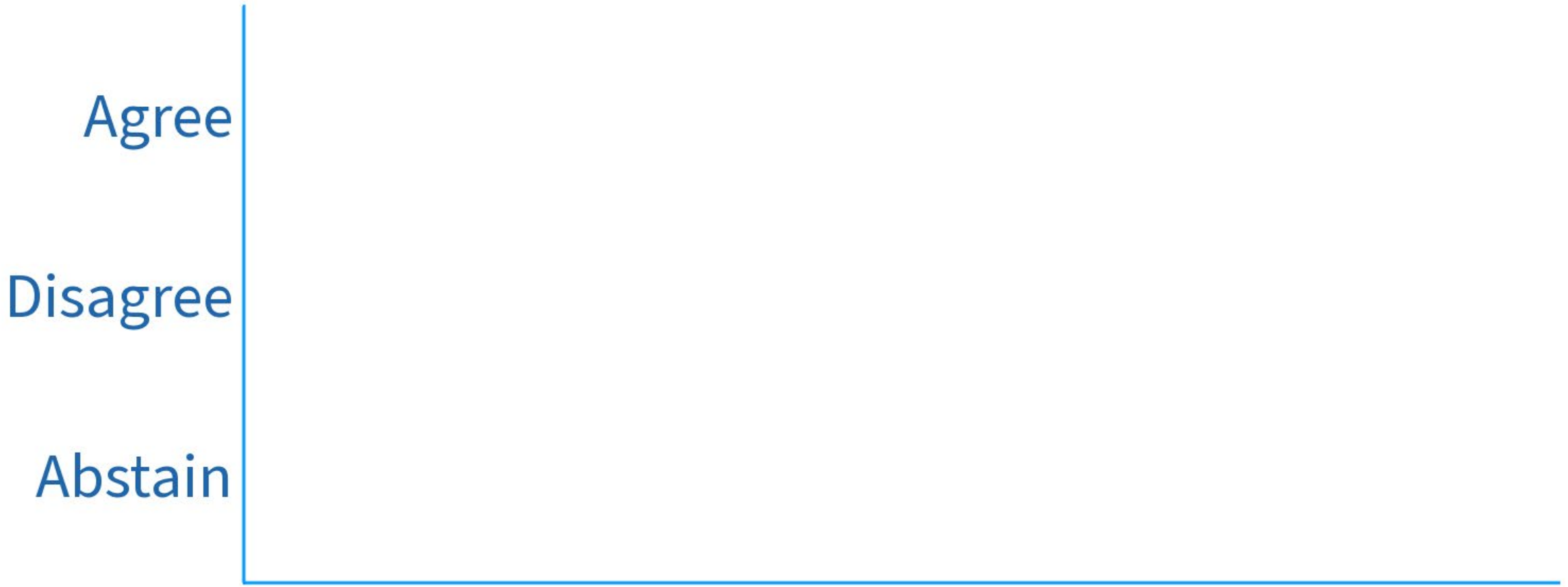
Obstetrics: I support the current recommendations for inclusion/exclusion of codes in this set



Otology Services

Codes	Description	Prevalence in Other Definitions	Recommendation
*69200	Clear Outer Ear Canal W/Out Anesthesia	8%	Exclude
*69210	Remove Impacted Ear Wax Instruments	8%	Exclude
*92551	Pure Tone Hearing Test Air	8%	Exclude
*92567	Tympanometry	8%	Exclude

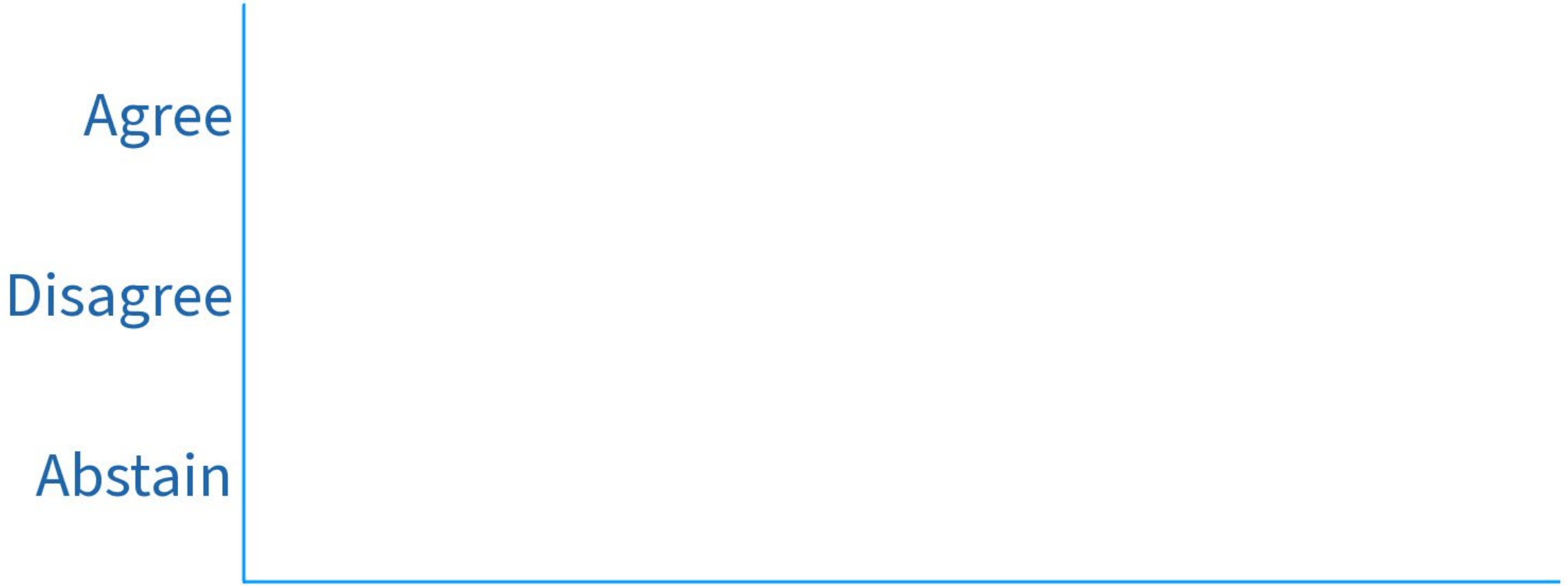
Otology Services: I support the current recommendations for inclusion/exclusion of codes in this set



Other (Part 1)

Codes	Description	Prevalence in Other Definitions	Recommendation
*36415	Routine Venipuncture	8%	Exclude
*36416	Capillary Blood Draw	8%	Exclude
11976	Remove Contraceptive Capsule	8%	Include
11981	Insert Drug Implant Device	33%	Include
11982	Remove Drug Implant Device	33%	Include
11983	Remove W/ Insert Drug Implant	33%	Include
15851	Removal Sutures Under Anesthesia Other Surgeon	0%	Exclude
16020	Dressings&/Dbrdmt Prtl-Thkns Burns 1St/Sbsq Small	0%	Exclude
17110	Destroy B9 Lesion 1-14	8%	Exclude
17111	Destroy B9 Lesion 15 Or More	8%	Exclude
*24640	Closed Treat Radial Head Sublx Child	0%	Exclude
*30300	Removal Foreign Body Intranasal Office Procedure	0%	Exclude
*51702	Insj Temp Indwellg Bladder Catheter Simple	0%	Exclude

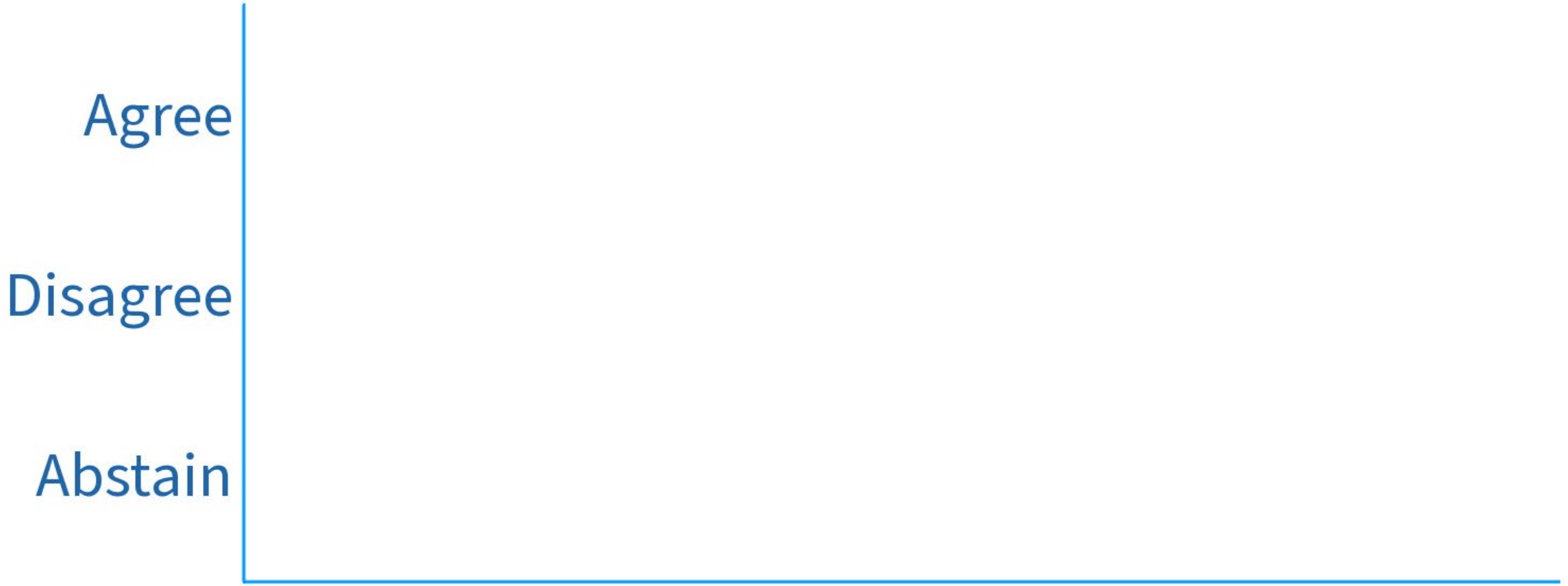
Other (Part 1): I support the current recommendations for inclusion/exclusion of codes in this set



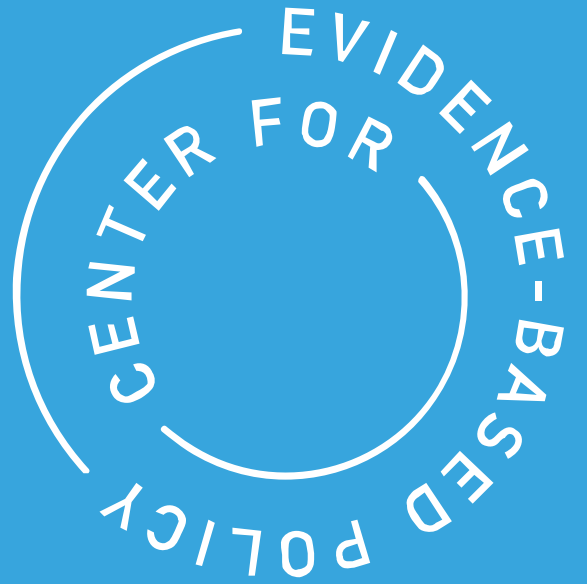
Other (Part 2)

Codes	Description	Prevalence in Other Definitions	Recommendation
*54150	Circumcision W/Clamp/Oth Dev W/Block	0%	Exclude
57170	Fitting Of Diaphragm/Cap	33%	Include
58300	Insert Intrauterine Device	33%	Include
*95115	Prof Services Allergen Immutherapy Single Injection	0%	Exclude
*95117	Prof Services Allergen Immutherapy Multiple Injection	0%	Exclude
96372	Ther/Proph/Diag Inj Sc/Im	50%	Include
*A4627	Spacr Bag/Resrvor W/Wo Mask W/Metrd Dose Inhal	0%	Exclude
*A6448	Light Comprs Bandge Elast Wdth < 3 In Per Yard	0%	Exclude
*A6449	Light Comprs Bandge Elast Wdth >/= 3 & <5 In Per Yd	0%	Exclude
*A7003	Admn Set Sm Vol Nonfiltr Pneumat Nebulizr Dispbl	0%	Exclude
*A7015	Areo Mask Used W/ Dme Neb	0%	Exclude
99495	Trans Care Mgmt 14 Day Disch	92%	Include
*97597	Debridement Open Wound 20 Sq Cm/<	0%	Exclude
*97602	Rmvl Devital Tiss N-Slctv Dbrdmt W/O Anes 1 Sess	0%	Exclude
96110	Developmental screening including autism screening	25%	Exclude
96127	Brief behavioral screening screening	17%	Exclude

Other (Part 2): I support the current recommendations for inclusion/exclusion of codes in this set



Thank you!


CENTER FOR EVIDENCE-BASED POLICY

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

Washington State Health Care Authority