Advisory Committee on Primary Care meeting

Washington State Health Care Authority

Washington State Health Care Authority

Advisory Committee on Primary Care
Meeting Materials

September 28, 2023
2:00 p.m. – 4:00 p.m.

(Hybrid Attendance)

Meeting materials

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Advisory Committee on Primary Care

September 28, 2023
2:00 p.m. – 4:00 p.m.
Hybrid Meeting

AGENDA

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

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome, roll call, and agenda review	1	Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
2:05-2:10 (5 min)	Approval of August meeting summary	2	Jean Marie Dreyer, Committee Facilitator Washington State Health Care Authority
2:10-2:25 (15 min)	Public Comment	3	
2:25-3:00 (35 min)	Making Care Primary overview	4	Kahlie Dufresne, Washington State Health Care Authority
3:00-3:55 (55 min)	Presentation and discussion: Primary care data collection and reporting	5	Shane Mofford, Center for Evidence-based Policy (CEbP)
3:55-4:00 (5 min)	Wrap-up and adjournment		Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority

Tab 2

Advisory Committee on Primary Care Meeting Summary

August 31, 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

Kristal Albrecht
Sharon Brown
Tony Butruille
Michele Causley
Tray Corgiat
D.C. Dugdale
Sharon Eloranta
Meg Jones
Katina Rue
Jonathan Staloff
Linda Van Hoff
Shawn West
Maddy Wiley

Members absent

Judy Zerzan-Thul
Nancy Connolly
David DiGiuseppe
Gregory Marchand
Chandra Hicks
Sheryl Morelli
Lan H. Nguyen
Mandy Stahre
Kevin Phelan
Eileen Ravella
Sarah Stokes
Staici West
Ginny Weir

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

Committee member and co-chair, Jonathan Staloff, reviewed the meeting's agenda and led roll call.

Approval of July meeting summary

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

Topics for Today

The main topics were a presentation on primary care payment reform strategies, a presentation on and discussion of primary care policy context, and a presentation on United Healthcare's experience with the primary care target in Rhode Island.

Public Comment

There were no public comments.

Presentation: Primary care payment reform strategies

Summer Boslaugh, Transformation Analyst, Oregon Health Authority (OHA)

Summer Boslaugh presented Oregon's primary care payment reform policies, its value-based payment (VBP) compact, primary care VBP model, and lessons learned. In 2015, Oregon passed Senate Bill 231 which required OHA and the Department of Consumer and Business Services to report annually on health care expenditures allocated to primary care by Medicaid, public employee benefit plans, and commercial health plans. OHA also added Medicare Advantage (MA) to the collected data. The annual report is public and used as a tool for policymakers and other interested parties to track primary care spending by payer. The bill directed OHA to establish the Primary Care Payment Reform Collaborative, which is a multi-stakeholder advisory group charged with increasing investment in primary care, improving payment methods, and aligning payment across payers and purchasers. The Collaborative has over 30 members and has convened since 2016.

In 2017, the Oregon Legislature passed another bill, Senate Bill 934 to further specify previous requirements. The bill required all payers to allocate at least 12 percent of health care expenditures to primary care by 2023. Payers failing to meet the target must submit a plan on how they will increase primary care expenditures by at least one percent each year. The 12 percent target was based on national research indicating that current primary care expenditure allocation is around seven percent. Senate Bill 934 also further defined the charge to include the use of VBP methods, to support behavioral and physical health integration and metric alignment. The end date of the Collaborative was extended to 2027.

Oregon's VBP Compact began in 2021 and grew out of Oregon's focus on the creation of a sustainable cost growth target. The Compact represented a voluntary commitment by payers and providers across the state to increase VBP through specific targets across all settings of care. There are 47 signatories in the Compact including commercial, all Medicaid payers, health systems and clinics, and MA, representing 73 percent of Oregonians in state. The Compact includes provider organizations like Oregon Family Physicians, the Oregon Hospital Association, the Oregon Medical Association, and the Oregon Primary Care Association. The purpose of the Compact was to lower the rate of cost growth, foster health equity, and improve quality and outcomes.
There were several lessons learned from Oregon's primary care reform process. It was important to establish an active relationship between the Collaborative and the primary care spending report. Both the Collaborative and

the report arose from the same legislation and the report is presented to the Collaborative, but the Collaborative doesn't own the report. Going forward, it would be helpful to have this relationship more well-defined. The rule defining primary care for the report wasn't developed directly by the Collaborative.

Committee members expressed interest in hearing more details about the VBP model. Summer Boslaugh provided a high-level overview of the model. The primary care VBP model is a prospective capitated payment model that also includes fee-for-service (FFS) payments for all other covered services. There are infrastructure payments including a required base payment tied to the patient center primary care home (PCPCH) tier with additional tiers for specific high-value services. The prospective payments cover about 85 to 95 percent of primary care services with variation by payer and age group. Some codes paid on an FFS basis were preserved to include utilization: behavioral health codes, home visits, prenatal visits, after hour codes, and others.

Summer Boslaugh reviewed the participation, attribution, and payment rates of the model, as well as risk adjustment, performance-based incentives, infrastructure payments, and the model's focus on equity. Currently, Oregon is seeking to promote the VBP model with multiple audiences. OHA is reviewing its role as a purchaser to incorporate the model in its contracts with Coordinated Care Organizations (CCOs), Medicaid organizations, and public employee benefit and Oregon educator benefit board plans.

Shane Mofford asked whether there were other unintended consequences that Oregon would want to account for if they were repeating the process of creating the target. Oregon's primary care definition is partially defined by statute and partially defined in rule. There needs to be support and consensus across all aspects of how primary care is defined because those aspects feed into the target. Oregon's methodology shifts year to year to account for code changes. It's difficult to change the statutory definition – it hasn't been changed since the bill was passed in 2015 despite feedback asking for change from advocates.

Committee member questions and answers:

What statutory or regulatory authorities does Oregon have in place to hold payers accountable for the investment piece? What consequences arise from failing to meet a target? For Medicaid CCOs and public employee or educator plans, OHA has greater authority to modify contracts based on performance. Commercial plans must submit a plan on how to improve if they fail to meet the target, but OHA lacks an accountability mechanism to enforce compliance. Currently, any proposed improvement plans are folded into the annual primary care spending report, but future accountability mechanisms haven't been determined.

Did OHA feel the primary care definition was too broad or too narrow, and which groups caused the most difficulty in the selection process? One of the key sticking points was provider type – Oregon included obstetricians and gynecologists (OBGYNs) and psychiatry – but there was a strong perception from the provider community that those two types didn't belong. Behavioral health providers felt clinical social workers should be included when they were excluded. There was also negative feedback for excluding pharmacy from the definition.

Are there any requirements that recipients of the primary care funds use them exclusively for primary care services or providers, or is that left to the discretion of the organization? Fund use is left to the discretion of the recipients. Spending could occur on the system level but that doesn't mean that individual clinician rates were increased.
How were analytics used to assess the primary care data resourced? Resourcing took a lot more time and funding than originally anticipated to hire senior analytics staff. The all-payer all claims database captures both claims and

non-claims spending through the same system but it's time intensive to stratify the data. Every year, there's one analyst who spends six months working solely on processing the data. There are no external contractors, only state of Oregon staff. Oregon has no statewide provider directory, which makes identifying individual providers difficult.

What outcomes, patient and fiscal, occurred from implementation of the primary care spending target? There was no impact on rates due to target implementation. For patient outcomes, there is no direct way to assess the relationship between achieving the spending target and improved quality outcomes. When looked at collectively on average, CCOs and Medicaid plans meet the target, but at the individual level, there are plans that deviate sharply from the target.

What consideration has been given to workforce components of primary care investment? Oregon recently passed several bills increasing workforce investment, e.g., loan repayment assistance to certain provider groups to increase provider retention. There hasn't been a direct effort to address workforce related to the primary care spending target or the VBP model.

Presentation and discussion: Primary care policy context continued

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

Shane Mofford reviewed the committees' introductory conversations related to how to achieve the 12 percent spending target. More information is needed to frame the reasonability of targets over time and statewide spending estimates using the new primary care definition, which won't be available until after the 2024 data call. The committee is continuing to review outcomes in other states that have implemented similar primary care spending policies. In general, other states have used three levers to achieve spending targets, including executive orders, legislative mandates, and actions taken by insurance commissioners.

Shane Mofford presented three concepts to provide further context for primary care policies, using thought exercises rather than real data. The first concept was how an increase in the percent spent on primary care as a percent of total expenditures affects changes in primary care reimbursement. Holding total expenditures and primary care utilization constant, increasing primary care spending from five to 12 percent would require a 140 percent increase in primary care reimbursement. This example represents an aggregate-level perspective across all payers. Each payer would contribute to the total differently depending on their current payment policies and utilization patterns. Oregon's increase went from seven to 12 percent, representing a 72 percent increase, which translates to around a 14 percent annual increase over a five-year period. The second concept used to frame the primary care target was how the payer mix determines the size of the impact of policies when targeting individual payers. Policies focused on individual payer types will have proportionally smaller impacts on aggregate spending totals. Most policies apply differently to different payer types depending on current payment levels. As an example, if Medicaid reimburses at 65 percent of Medicare, and increases reimbursement to 100 percent of Medicare, because Medicaid is estimated at 31 percent of total primary spending, the 54 percent increase in reimbursement would result in only a relative 17 percent increase in total primary care reimbursement in aggregate (from 5 to 5.8 percent). The third framing concept was how price and utilization patterns vary for different primary care services. Expenditure trends differ by different categories, e.g., inpatient, outpatient, pharmacy, and physician services. The 12 percent spending target occurs in a dynamic environment, making it difficult to achieve the target when other spending areas change significantly, e.g., hospital costs.

To illustrate the general magnitude of reimbursement increases, there are three factors that must be considered: 1) underlying utilization patterns over time for both primary care and other services, 2) the underlying rate of

price changes for other services, and 3) policy-driven expected changes to utilization of primary care and other services. Small increases in the percent of total spending require significant increases in primary care reimbursement when holding utilization and total expenditures constant. Ideally, increasing primary care reimbursement would increase utilization of primary care services and increasing primary care access would decrease utilization of other service categories (e.g., emergency, inpatient). Any implementation of payment changes will vary by payer.

The committee reviewed future considerations for choosing a broad versus narrow primary care definition. To achieve the 12 percent target under a narrower definition, investments would be focused on the narrower set of providers. The magnitude of investment directed to a narrower set of providers would have to be greater to move the aggregate statistics. If the committee uses a narrow definition, the distance to the target will be greater. Results will change with the updated primary care definition and with the inclusion of non-claims-based expenditures. The chosen definition will directly impact investment strategies i.e., whether increases occur under a blanket FFS scheme or under an alternative payment model (APM). It's unknown the extent to which the chosen definition will differ from prior measurement efforts.

The committee was reminded about the Making Care Primary (MCP) model. The model supports VBP and equitable access through additional investments in primary care and focuses on improving care management, coordination, and integration. It will run for a 10.5-year period with the same cohort of providers maintained for the duration of the program. Applications are being accepted from September 4 through November 30 with a one-time onboarding to the program.

Presentation: United Healthcare plan perspective on primary care target in Rhode Island

Michele Causley, Vice President of Health Plan Operations, United Healthcare

Committee member Michele Causley gave an overview of United Healthcare's efforts to achieve the primary care target in Rhode Island. Rhode Island increased their primary care spend from around six percent to 10.7 percent. At least 9.7 percent of the target goes towards direct reimbursement to providers. The remaining one percent goes towards administrative fees. Most achievement of the target occurred through shared savings and care coordination payments embedded in VBP models. Practices were offered grants to meet the target. Rhode Island's target includes pharmacy net of rebates. Including pharmacy in the denominator can lead to significant fluctuation in primary care investment, making it more difficult for payers to meet the target. Rhode Island also controls hospital cost trends through caps. There was no definitive decline seen in total cost of care because of the primary care spending target, but there were increases in the use of VBP models and an increase in downside-risk models. Without direct offsets for other spending categories, it's hard to bring down the total cost of care. VBP models as a whole focus more on mitigating cost trends rather than lowering costs.

Adjournment

The meeting adjourned at 4:00 p.m.

Next meeting

September 28, 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

Tab 4

Washington State Health Care Authority

CMMI model overview: Making Care Primary

Health Care Cost Transparency Board-
Advisory Committee on Primary Care
September 28, 2023

Washington State Health Care Authority

Agenda

- "Making Care Primary" model overview
- Multi-payer participation
- Eligibility for participation in Medicare FFS demo
- Payment model overview
  - Tracks
  - Payment approach
  - Specialty integration
- Quality performance measures
- Timeline
- Resources

Making Care Primary (MCP) Summary

Goals

- 10.5 years
- Cost neutral
- Improve quality
- Sustainable transformation
- Pathway for more practices to enter in value-based care arrangements

Care Teams

- Care management & coordination
- Specialty care integration
- BH integration
- Address health related social needs and equity

Flexible Payment

- Progression to prospective payment
- Progression in accountability
- Specialty integration payments
- Reward quality outcomes

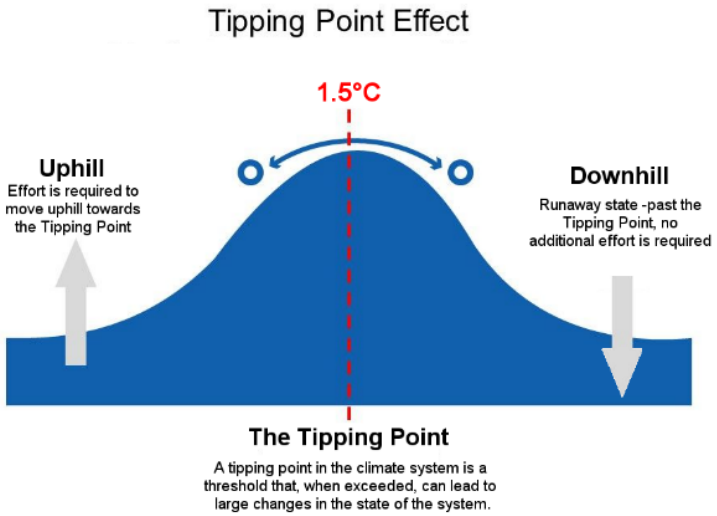
Multi-payer alignment can support transformation

Transformation "tipping point"

- Practice transformation is burdensome
- Meaningful alignment across payers necessary to justify participant effort

Build upon existing efforts in Washington to implement an evidence-based primary care transformation model to improve primary care by providing additional Medicare resources.

Illustrate commitment to primary care investment, increasing appeal as payers to participating primary care providers.



Payer Partnership is Core to the Success of MCP

CMS Innovation Center will partner with public and private payers to implement MCP. Through these partnerships, CMS will foster alignment in areas to reduce clinician burden and provide flexibility to encourage increased payer participation.

Directional Alignment

- CMS will work with payers in MCP states to encourage close alignment in areas that directly reduce burden on clinicians:
  - Performance measurement and reporting
  - Moving primary care payment away from FFS to prospective basis
  - Timely and consistent data sharing
  - Leveraging Technical Assistance
- CMS is partnering with State Medicaid Agencies (SMAs) and other payers to streamline primary care reform and reduce fragmentation to help practices focus on care.

Local Implementation

- CMS, SMAs, and payer partners will make practice- and patient-level data available to participants through data sharing efforts within the state
- CMS will provide flexibility for payers to include additional measures that reflect local priorities for their patient population(s)

HCA Participation in Making Care Primary

- Traditional ("original", or "FFS") Medicare is testing this model in Washington.

- HCA is interested in aligning w/the Medicare model principles
  - Comparable to the Primary Care Transformation Model (PCTM) efforts, with Medicare at the table
  - Make the investments worthwhile for practices

- HCA does not yet have funding or legislative direction to require participation in its PEBB/SEBB or Medicaid populations. Our contracted carriers could choose to launch this model anytime.

Eligibility to Participate *for Medicare FFS Demo*

Organizations that provide primary care services to patients may be eligible to apply to MCP. Due to MCP's payment and quality reporting design, certain organizations are not eligible to participate in MCP.

Organizations Eligible for MCP

- Independent or solo primary care practices
- Group practices
- Federally Qualified Health Centers (FQHCs)
- Health Systems
- Indian Health Programs
- Certain CAHs
- Organizations operating in the listed MCP states
- Organizations with at least 125 attributed Medicare FFS beneficiaries

Organizations Not Eligible for MCP

- Rural Health Clinics
- Concierge practices
- Grandfathered Tribal FQHCs
- Primary Care First (PCF) practices and ACO REACH Participant Providers active as of 5/31/23
- Organizations not operating in the listed MCP states
- In general, organizations enrolled in CMMI models (such as MSSP and ACO REACH) will not be allowed to simultaneously participate in MCP, with the exception of bundled payment models

Other payers can adopt model with pediatric practices, RHCs, etc.

Participation Track Options Overview

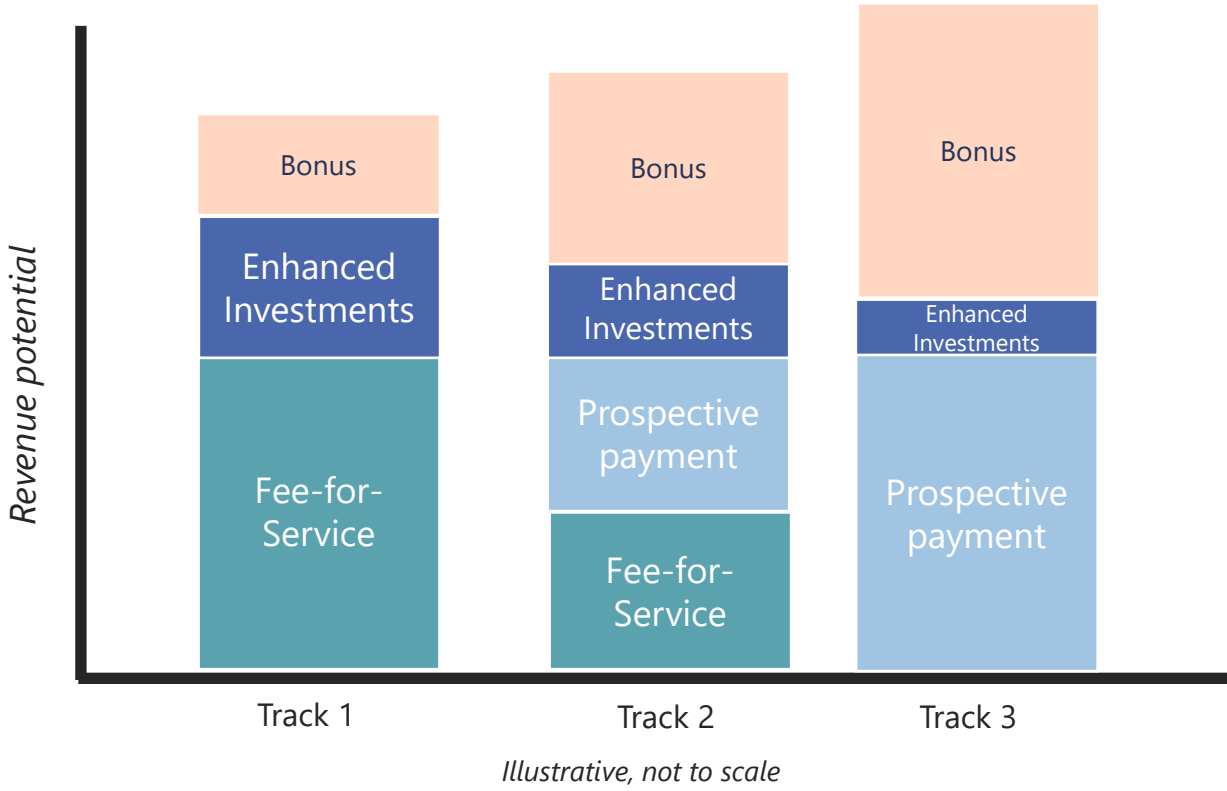
MCP includes three tracks that health care organizations can select from when applying to the model. An organization's prior experience with VBC will determine their eligibility for individual Tracks. The Tracks provide opportunities for organizations with differing levels of care delivery and value-based payment experience to enter the model at a point that matches their capabilities at the start.

	Track 1 Building Infrastructure	Track 2 Implementing Advanced Primary Care	Track 3 Optimizing Care and Partnerships
Focus Area	 Building capacity to offer advanced services, such as risk stratification, data review, identification of staff, and HRSN screening and referral	 Transitioning between FFS and prospective, population-based payment	 Optimizing advanced primary care services and specialty care integration enabled by prospective, population-based payment
Level of VBC Experience			
Duration	Participants who enter* in Track 1 can remain in Track 1 for 2.5 years before progressing to Track 2	Participants who enter* in Track 2 can remain in Track 2 for 2.5 years before moving to Track 3	Participants who enter* in Track 3 can remain for the entirety of the MCP

**Organizations that start in Track 1, 2, or 3 will have an additional 6 months (or half of a year) in that track, given the mid-year start date for the model. A participant's length of time in a track depends on which track they started in.*

Payment Approach

- **Prospective Primary Care Payment** (PPCP) **increases** over time, while Fee-for-Service *decreases*, to support the interprofessional team.
- **Enhanced Services Payments** (ESP) ***decrease*** over time as practices become more advanced, and potential for payments tied to quality performance increases.
- **Performance Incentive Payment** (PIP) *potential* greatly **increases** over time to make up for decreases in guaranteed payments.



MCP Payment Types

MCP will introduce six (6) payment types to support MCP participants as they work to reach their patient care goals.

Prospective Primary Care Payment (PPCP)

Track 1 | **Track 2** | **Track 3**

Quarterly per-beneficiary-per-month (PBPM) payment (calculated based on historical billing) to support a gradual progression from FFS payment to a population-based payment structure

Enhanced Services Payment (ESP)

Track 1 | **Track 2** | **Track 3**

Non-visit-based per-beneficiary-per-month (PBPM) payment that is adjusted to reflect the attributed population's level of clinical (CM-HCC) and social (ADI) risk to provide proportionally more resources to organizations that serve high-needs patients.

Performance Incentive Payment (PIP)

Track 1 | **Track 2** | **Track 3**

Upside-only performance incentive payment designed to reward MCP participants for improvements in patient outcomes and quality measures. Structured to maximize revenue stability (half of estimated PIP will be paid in the first quarter of performance year).

Upfront Infrastructure Payment (UIP)

Track 1 | Track 2 | Track 3

One-time payment for select Track 1 participants to support organizations with fewer resources to invest in staffing, SDOH strategies, and HIT infrastructure.

MCP E-Consult (MEC)

Track 1 | **Track 2** | **Track 3**

Ambulatory Co-Management (ACM)

Track 1 | Track 2 | **Track 3**

Payments to support specialty integration strategy to support communication and collaboration for longitudinal primary care and short-term specialized care for chronic conditions. MEC code billable by MCP primary care clinicals, while ACM is billable by specialty care partners.

Specialty Care Integration Strategy

MCP provides participants with payment mechanisms, as well as data, learning tools, and peer-to-peer learning opportunities to support the Specialty Integration Care Delivery requirements, focused on coordination and improving patient care.

Payment: Once MCP participants enter Tracks 2 and 3, they are expected to implement e-consults as part of their care delivery requirements.

Data: CMS will provide participants with performance data on specialists in their region, prioritizing measures related to cardiology, pulmonology, and orthopedics.

Learning Tools: CMS will partner with stakeholders, state Medicaid programs, and other payer partners to connect MCP participants with each other, specialty practices, and CBOs.

Peer-to-Peer Learning: CMS will provide a collaboration platform and other forums to help participants learn from each other.

Payment Details

MCP will feature two payment types to encourage specialty care integration and support participants as they take on care delivery requirements:

	MCP eConsult (MEC) Code *Billable by MCP Primary Care Clinicians*	**Ambulatory Co-Management (ACM) Code** *Billable by Specialty Care Partners*
Goal	Address current barriers to eConsult billing, including its inclusion of post-service time to implement the specialist's recommendation	Support ongoing communication and collaboration of shared MCP patients who require both longitudinal primary care and also short-term specialized care to stabilize an exacerbated chronic condition
Eligibility	Participants in Tracks 2 and 3 *(These codes are absorbed into the capitated prospective primary care payments (PPCPs) in Track 3).*	Rostered Specialty Care Partner clinicians *(whose TIN has a Collaborative Care Arrangement (CCA) in place with an MCP Participant)*
Potential Amount	$40 per service (subject to geographic adjustment)*	$50 per month (subject to geographic adjustment)*

**To account for regional cost differences, MCP will apply a geographic adjustment factor (GAF) to the MEC and ACM.*

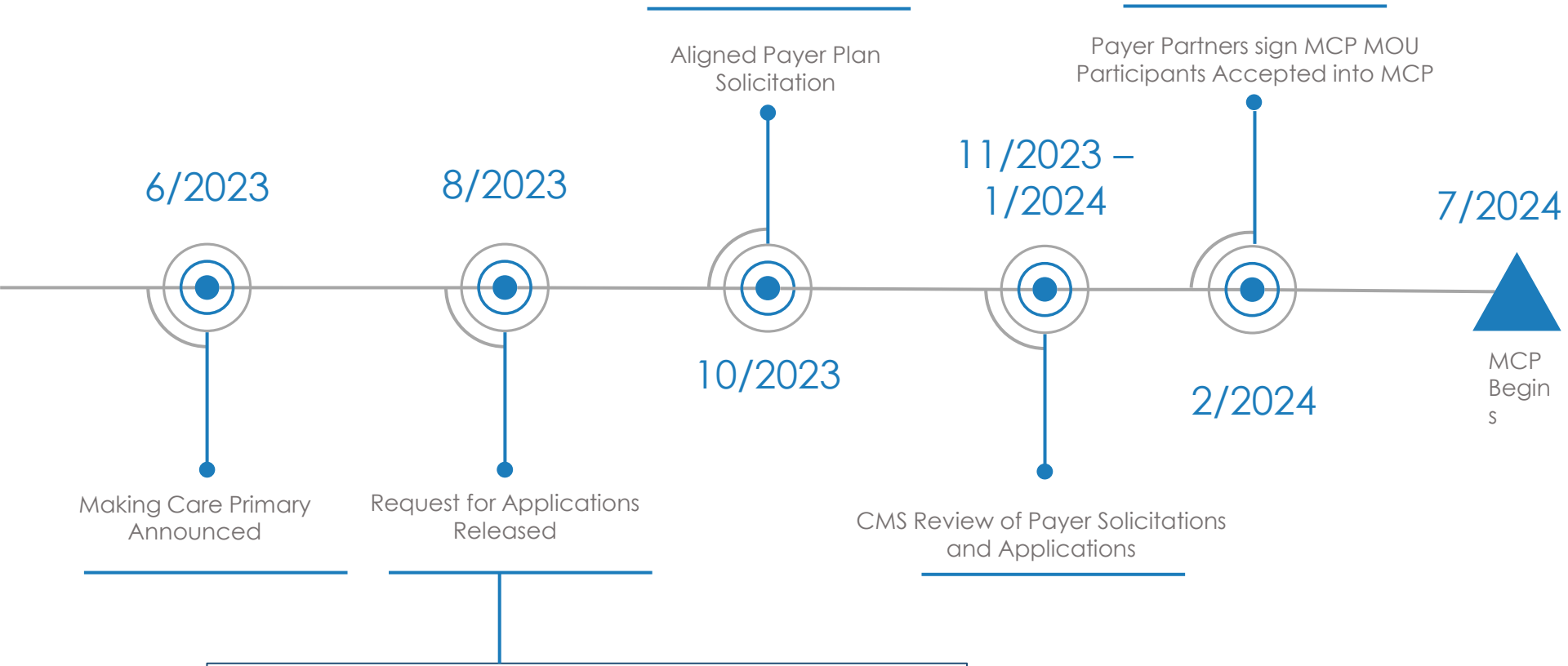
Performance Measures

Mirroring CMS's broader quality measurement strategy, measures for Medicare were selected to be actionable, clinically meaningful, and aligned with other CMS quality programs, including the Universal Foundation Measure Set *(as indicated below with an asterisk "*")*, Quality Payment Program (QPP) and other existing measure sets. **Payer Partners may adapt measure set below to target their population health needs.**

Focus	Measure	Mode	Track		
			1	2	3
Chronic Conditions	Controlling High Blood Pressure*	eCQM	X	X	X
	Diabetes Hba1C Poor Control (>9%)*	eCQM	X	X	X
Wellness and Prevention	Colorectal Cancer Screening*	eCQM	X	X	X
Person-Centered Care	Person-Centered Primary Care Measure (PCPCM)	Survey	X	X	X
Behavioral Health	Screening for Depression with Follow Up Plan*	eCQM		X	X
	Depression Remission at 12 months	eCQM		X	X
Equity	Screening for Social Drivers of Health*+	TBD		X	X
Cost/ Utilization	Total Per Capita Cost (TPCC)	Claims		X	X
	Emergency Department Utilization (EDU)	Claims		X	X
	TPCC Continuous Improvement (CI) *(Non-Health Centers and Non-Indian Health Programs)*	Claims		X	X
	EDU CI *(Health Centers and IHPs only)*	Claims		X	X

+Screening for Social Drivers of Health (Quality ID#487) is a new, evolving measure focused on assessing the percent of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. The measure specifications are currently under development and CMS will work with participants to ensure they have the appropriate health IT infrastructure information to successfully report this measure.

Making Care Primary Timeline



Request for Application from providers:
https://innovation.cms.gov/media/document/mcp-rfa

Additional Information and Resources

CMS

Visit

https://innovation.cms.gov/innovation-models/making-care-primary

Help Desk

MCP@cms.hhs.gov

HCA

Visit

https://www.hca.wa.gov/about-hca/programs-and-initiatives/value-based-purchasing/multi-payer-primary-care-transformation-model

Help Desk

HCAPCTM@hca.wa.gov

Washington State Health Care Authority

Discussion

Appendices

Washington State Health Care Authority

Upfront Infrastructure Payment (UIP)

Start-up funding to support smaller organizations with fewer resources participate in and be successful in MCP through investments in infrastructure to support MCP's transformational goals as they take on the Model's care delivery and health IT capabilities. Optional payment only available to eligible Track 1 participants.

Eligibility: "Low-revenue" Track 1 participants and Track 1 applicants without an e-consult platform
("Low revenue" criteria will be specified in the Request for Applications)

Timing: Initial $72,500 distributed as a lump sum at the start of model; second payment of $72,500 distributed as a lump sum one year later

Amount: $145,000 per eligible Track 1 participant

MCP participants will submit a spend plan with anticipated spending prior to receiving the UIP, and report on how the UIP funds were spent

Reconciliation: Any unspent or misused UIPs must be repaid to CMS at the end of the participant's 30-month Track 1 participation period and can be recouped if the participant withdraws or CMS terminates its participation in the model prior to entering Track 3

Examples of Permitted Uses

- ***Increased staffing*** such as hiring nurse care managers to implement SDOH screening, behavioral health clinicians to integrate behavioral health treatment into primary care setting; or encouraging partnerships with healthcare systems and local CBOs to connect individuals with culturally and linguistically tailored, accessible health care services and supports
- ***SDOH strategies*** such as partnering with CBOs to address SDOH needs; providing patient caregiver supports; or implementing systems to provide and track patient referrals to community-based social services that assess and address social needs, as well as enable coordination and measurement of health and social care across communities where beneficiaries reside
- ***Health care clinician infrastructure*** such as investing in CEHRT system enhancements and upgrades; expanding HIT systems to include patient portals, telehealth systems for video visits, and/or e-consult technology; or developing infrastructure that would enhance sociodemographic data collection

Enhanced Services Payment (ESP)

Quarterly per-beneficiary-per-month (PBPM) payment that is adjusted to reflect the attributed population's risk level to provide proportionally more resources to organizations that serve high-needs patients, as they develop capabilities and provide enhanced services. Designed to support care management, patient navigation, connection to behavioral health, and other enhanced care coordination services, according to specific needs of patient population.

Eligibility: Participants in Tracks 1, 2, and 3

Timing: Prospective quarterly payment

Potential Amount: Track-based amount based on participant's MCP attributed population and adjusted for social and clinical risk factors, including CMS Hierarchical Condition (HCC), Low Income Subsidy (LIS), and Area Deprivation Index (ADI). *Estimated average* ESP PBPM amounts will be $15 in Track 1, $10 in Track 2, and $8 in Track 3.

See *Calculation Details* for more information on how CMS will determine ESP payment amounts.

Calculation Details

The decision tree below describes the steps CMS will use to determine ESP payment for each MCP patient:

Enrolled in Low-Income Subsidy?	
No	**Yes**
Amount varies based on patient's HCC and ADI-designated risk tier (see table below)	$25

CMS-HCC Clinical Risk Tier (Risk Score Percentile)	ADI Social Risk Tier (ADI Percentile)	Track 1	Track 2	Track 3
Tier 1 (< 25th)	NA±	$9	$4	$2
Tier 2 (25th – 49th)	NA±	$11	$5	$2.50
Tier 3 (50th – 74th)	NA±	$14	$7	$3.50
Tier 4 (≥75th)	Tier 1, Tier 2, or Tier 3 (< 75th)	$18	$8	$4
	Tier 4 (≥75th)	$25		

Notes: 1) MCP payments are for Medicare FFS beneficiaries attributed to the MCP and will be subject to geographic adjustments.
2) ± Listed as NA, or Not Applicable, because payment for patients in HCC tiers 1 to 3 is only based on LIS or HCC.

Prospective Primary Care Payment (PPCP)

Quarterly per-beneficiary-per-month (PBPM) payment that is calculated for each participant's patient population and is designed to support a gradual progression from fee-for-service (FFS) payment for primary care services* to a population-based payment structure. These payments are designed to allow practices to deliver enhanced, comprehensive services without the incentive to increase volume of patients or services to achieve a favorable financial outcome.

Eligibility: Participants in Tracks 2 and 3

Timing: Prospective quarterly payment

Potential Amount: For the first two PYs, the amount is based on each participant's historical billing data for its attributed Medicare beneficiaries over a two year period and will be updated annually; CMS will introduce a regional component to the payment methodology by PY3.

Reconciliation: Amount is partially reconciled against actual claims expenditures based on portion of primary care services sought by beneficiaries outside the participant organization. See *Calculation Details* for more information on how CMS will determine PPCP amounts.

Calculation Details

The type of payment for primary care services will vary based on an organization's MCP Track.

Payment Type for Primary Care Services	Track 1	Track 2	Track 3
Prospective Primary Care Payment (PPCP)	0%	50%	100%
Fee-for-Service (FFS)	100%	50%	0%

Data sources for billing calculation differs by organization type:

- **FQHCs:** PPCP based on services billed under the Medicare FQHC Prospective Payment System (PPS)
- **Non-FQHCs:** PPCP based on services billed under the Physician Fee Schedule (PFS)

**The primary care services included in or affected by the PPCP will be shared in the MCP Request for Applications (RFA) that will be released in August 2023.*

Performance Incentive Payment (PIP)

Upside-only performance incentive payment designed to reward MCP participants for improvements in patient outcomes and quality measures

Eligibility: Participants in Tracks 1, 2, and 3

Timing: Half of estimated PIP will be paid in the first quarter of each performance year and second half will be paid in the third quarter of the following performance year

Potential Amount: Track-based percentage adjustment to the sum of payments for primary care services (FFS and/or PPCP)

Risk: Upside only; paid up-front and reconciled based on performance

See *Calculation Details* for more information on how CMS will determine PIP.

Calculation Details

Track 1	Track 2	Track 3
Potential to receive upside-only PIP of up to **3%** sum of fee-for-service (FFS)	Potential to receive upside-only PIP of **up to 45%** sum of FFS and prospective primary care payments (PPCP)	Potential to receive upside-only PIP of **up to 60%** sum of prospective primary care payments (PPCP)

- MCP participants must report all required quality measures and achieve the national 30th percentile on TPCC to *qualify* for any PIP
- Quality measures will have varying degree of impact on the PIP calculation based on the participant's track*
- Full credit for a measure for exceeding upper benchmark (70th percentile in Tracks 1 and 2, 80th percentile in Track 3). Half credit for exceeding lower benchmark (50th percentile)
- Participants in Tracks 2 and 3 will have the opportunity to receive additional PIPs for continuous improvement (CI) in utilization/cost

**More information on how MCP's quality measures will impact the PIP calculation, refer to the MCP Request for Applications (RFA) that will be released in August 2023.*

Tab 5

Washington State Health Care Authority

HCCTB Advisory Committee on Primary Care Charges

Washington State Health Care Authority

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

Definition Development

Completed

- ✓ Draft and initial approval of primary care provider list
- ✓ Draft and initial approval of primary care setting list
- ✓ Draft and initial approval of primary care services list
- ✓ Review experience of current WA processes and other states for lessons learned on data collection and categorization frameworks
- ✓ Develop principles for HCA to develop recommendations on methodology for claims/non-claims-based spending

To-do

- Review data analysis to refine initially approved lists
- Select either broad or narrow definition for official measurement
- Vote on high-level data collection strategy

Policy Development

Completed

- ✓ Develop framework for understanding policy levers to achieve 12% target
- ✓ Identify initial policies of interest within framework
- ✓ Review three primary policy levers (executive order, legislation, insurance regulation) for primary 12% expenditure target policy

In Progress

- Review other state policies and experiences for achieving 12% target
- Review Washington, federal, and other state reimbursement models that could support progress towards the 12% target

To-do

- Gather additional learnings from other states that have implemented a primary care expenditure target policy
- Develop recommendation for specific primary policy that includes:
  - Timelines for expected progress
  - Implementation mechanisms to incentivize achievement
- Develop recommendation for secondary policies to support achievement of target based on learnings from other states

Data Collection Strategy

Washington State Health Care Authority

HCCTB Advisory Committee on Primary Care Charges

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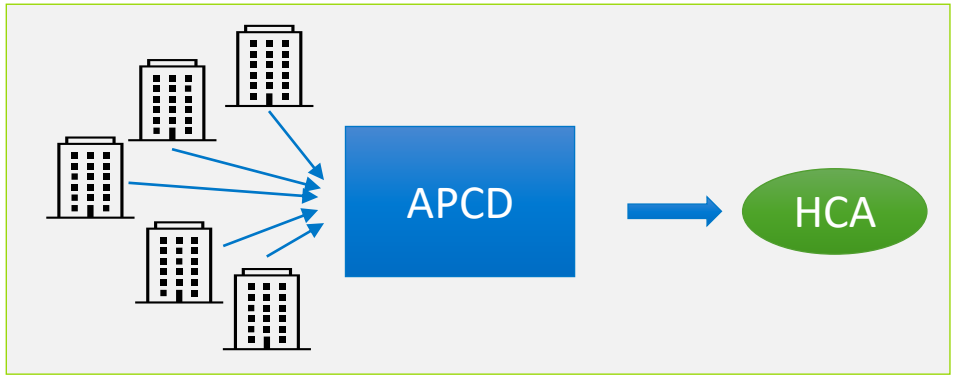
How Does Data Collection From Payers Work Today?

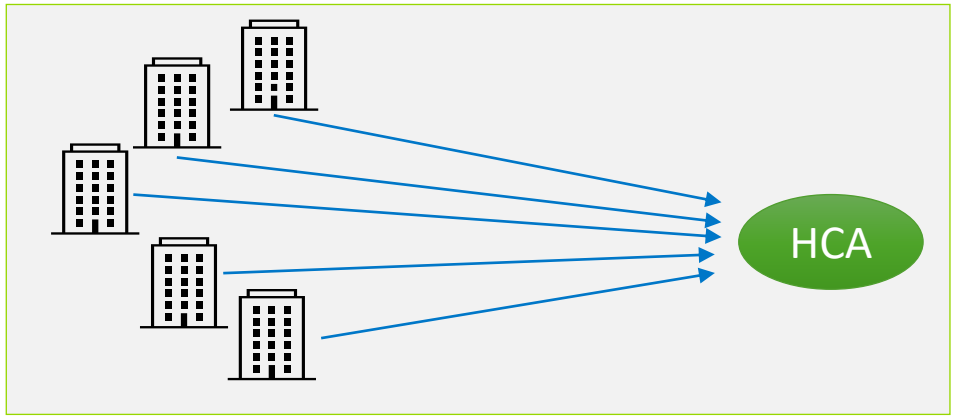
All Payer Claims Database

- **Detailed data** submitted by **subset of payers** to APCD
- APCD detailed data can be queried by HCA
- **Does not** include ERISA plans
- **Does not** include non-claims-based expenditures



HCA Aggregate Data Call

- **Aggregate data** submitted by all payers directly to HCA
- **Includes** ERISA plans' data
- **Includes** non-claims-based expenditures
- HCA updates reporting specifications to meet current policy needs regularly.

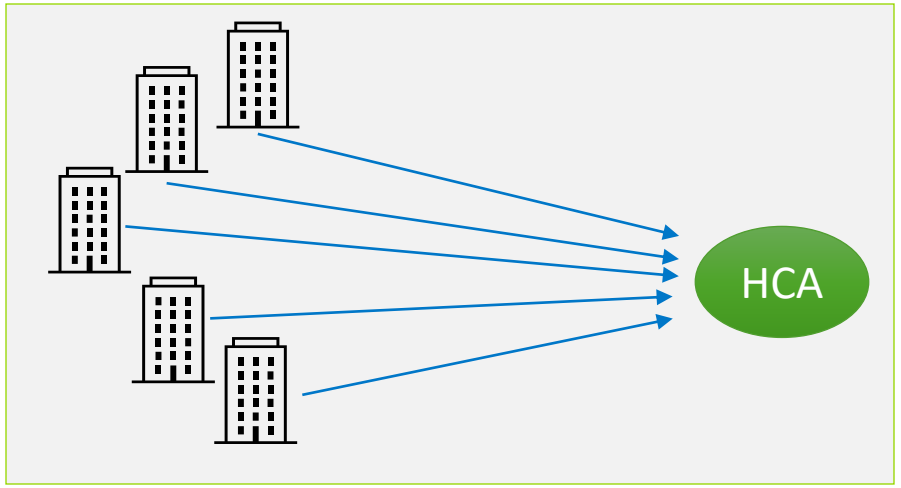


Washington State Health Care Authority

Data Collection Mechanism

Existing aggregate data call that can be modified to incorporate the Board-approved primary care definition and to solve for missing data elements in the APCD. However, there are several persistent challenges:

- Multiple entities calculate PC expenditures based on state-provided specifications = opportunity for inconsistent application of the specifications.
- Self-reported aggregate data reduces accountability and transparency
- The process is administratively burdensome and partially duplicative with APCD reporting by plans.



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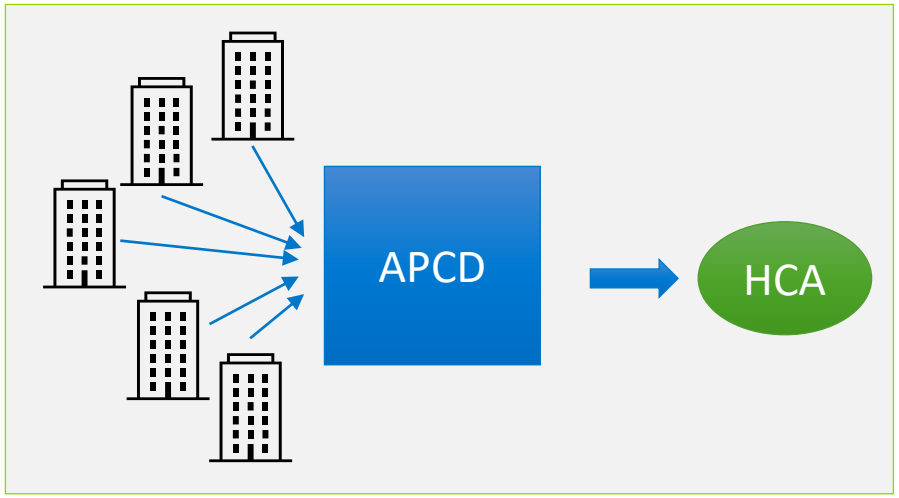
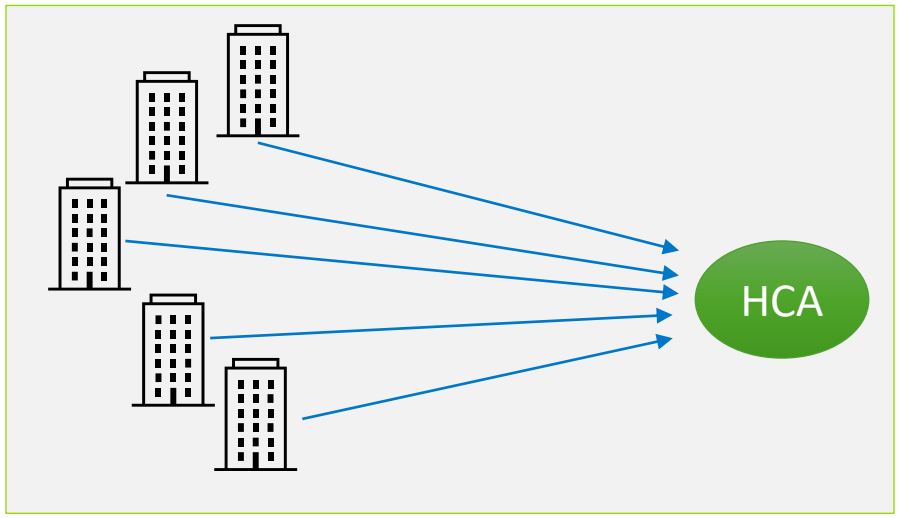
HCA Proposal – A Hybrid Solution

Claims-based Expenditures



- Standardization of reporting and interpretation
- Increased process transparency
- Leverage existing infrastructure

Non Claims-based Expenditures



- Solution for APCD data gaps
- Customizable for reporting under value-based purchasing or other categorical frameworks

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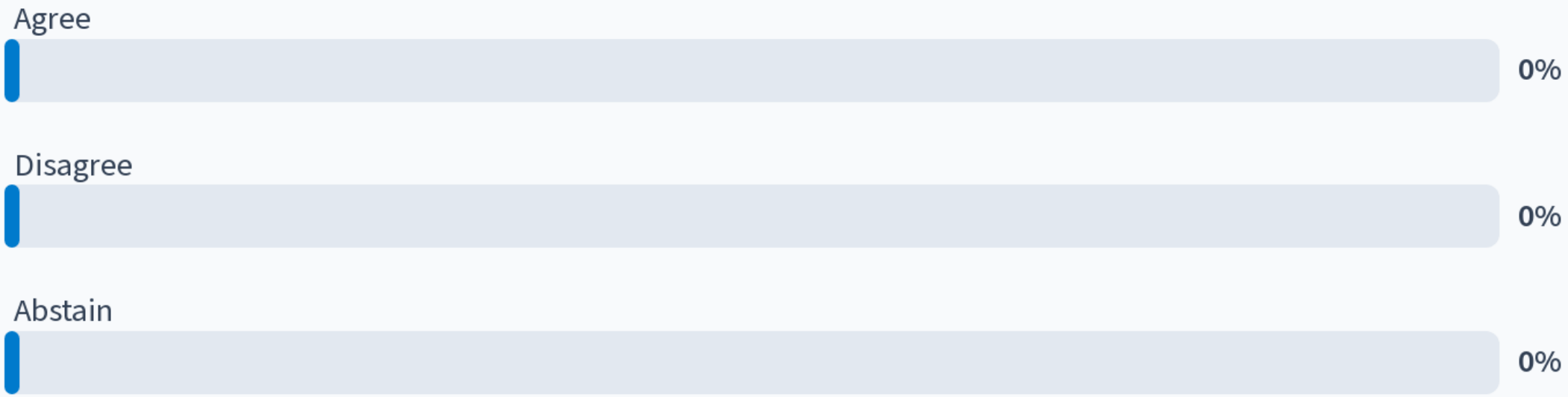
I support the HCA proposed hybrid solution for data collection.



Definition

Washington State Health Care Authority

Definition Development

- Data analysis is nearly complete
- We will begin discussing the results in the October meeting

Making Care Primary Reminder

Washington State Health Care Authority

MCP Provider Application

- On August 14th, CMS issued the provider application for Making Care Primary
- Applications are being accepted from September 4, 2023 through November 30, 2023
- This will be the only time for providers to enroll in Making Care Primary.

The application can be found here:
https://innovation.cms.gov/media/document/mcp-rfa

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

Washington State Health Care Authority