HEALTH CARE COST TRANSPARENCY BOARD'S

Advisory Committee on Primary Care Meeting

October 26, 2023

Washington State
Health Care Authority

Health Care Cost Transparency Board's
Advisory Committee on Primary Care
Meeting Materials Book

October 26, 2023
2 – 4 p.m.

(Hybrid attendance options)

Agenda and Presentations

P.O. Box 45502 • Olympia, Washington 98504-5502 • www.hca.wa.gov • hcahcctboard@hca.wa.gov

Tab 1

Washington State Health Care Authority

HEALTH CARE COST TRANSPARENCY BOARD'S
Advisory Committee on Primary Care
AGENDA

October 26, 2023
2:00 p.m. – 4:00 p.m.
Hybrid Meeting

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 September meeting summary	2	Stacey Whiteman, Committee Facilitator Washington State Health Care Authority
2:10-2:25 (15 min)	Public Comment	3	
2:25-3:10 (45 min)	Presentation: Approaches to Primary Care Investment in Rhode Island	4	Cory King, Acting Health Insurance Commissioner, Rhode Island
3:10-3:55 (45 min)	Presentation: Code-level definition data analysis, Making Care Primary (MCP) reminder • **Discussion and vote**	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

Washington State Health Care Authority

Health Care Cost Transparency Board's

Advisory Committee on Primary Care Meeting Summary

September 28, 2023

Hybrid meeting held electronically (Zoom) and in-person at the Health Care Authority (HCA)
2–4 p.m.

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

Members present

Dr. Judy Zerzan-Thul, Chair
Kristal Albrecht
Sharon Brown
Michele Causley
Tracy Corgiat
David DiGiuseppe
D.C. Dugdale
Sharon Eloranta
Chandra Hicks
Meg Jones
Lan Nguyen
Mandy Stahre
Jonathan Staloff
Sarah Stokes
Shawn West
Staici West
Ginny Weir
Maddy Wiley

Members absent

Tony Butruille
Gregory Marchand
Sheryl Morelli
Katina Rue
Linda Van Hoff

Call to order

Dr. Judy Zerzan-Thul, Committee Chair, called the meeting to order at 2:05 p.m.

Agenda items

Wecoming remarks

Chair Dr. Judy Zerzan-Thul welcomed committee members to the meeting.

Meeting summary review from the previous meeting

The committee members voted by consensus to adopt the August 2023 meeting summary.

Public comment

Jean Marie Dreyer, committee facilitator, called for comments from the public.

There were no public comments.

Making Care Primary Overview

Kahlie Dufresne, Special Assistant for Health Policy and Programs, Washington State Health Care Authority (HCA)

Kahlie's presentation focused on an overview of the Center for Medicaid and Medicare's (CMS's) new Making Care Primary (MCP) initiative. Kahlie briefed the committee on the initiative's goals, care teams, and flexible payment structure. HCA is interested in aligning with the Medicare model principles but does not yet have funding or legislative direction to require participation from its Public Employees Benefits Board (PEBB), School Employees Benefits Board (SEBB), or Medicaid populations. Kahlie reviewed organizations eligible to apply to MCP as well as the three primary participation track options. There are six payment types to support MCP participants, including: prospective primary care payment (PPCP), enhanced services payment (ESP), performance incentive payment (PIP), upfront infrastructure payment (UIP), MCP e-consult (MEC), and ambulatory co-management (ACM). MCP has 11 performance measures which were all selected to be actionable, clinically meaningful, and aligned with other CMS quality programs. Kahlie's presentation concluded with a review of the initiative's high-level timeline, noting a handful of significant program milestones.

Committee members' questions and comments in response to Kahlie's presenation can be found in the audio recording for the September 28, 2023 meeting **here**.

Presentation and Discussion of Primary Care Data Collection and Reporting

Shane Mofford, Consultant, Center for Evidence-based Policy

Shane reviewed the committee's primary charges from the Legislature including defining and measuring primary care, data reporting and collection of primary care expenditures, and policies to increase and sustain investments in primary care. Shane reviewed the committee's completed and in progress definitional asks and policy development charges.

Shane reviewed the current data collection processes used by HCA, including the all-payer data claims database (APCD) and HCA's aggregate data call. The existing data call process can be modified to incorporate the Board-approved primary care definition and solve for missing elements from the APCD, however, there are several challenges inherent in the data call. To solve for missing elements from the APCD and account for non-claims-based payments, HCA proposed a hybrid data collection and reporting solution where the APCD is used to collect claims-based payment information and the data call is used to collect and report on non-claims-based payments. By a majority of committee votes, the committee passed a motion to adopt HCA's hybrid data collection and reporting solution.

Shane's presentation concluded with a reminder about the MCP provider application due date. Applications are being accepted from September 4 through November 30, 2023. This is the only time for providers to enroll in MCP. The application can be found **here**.

Committee members' questions and comments in response to Shane's presentation can be found in the audio recording for the September 28, 2023 meeting **here**.

Adjournment

Meeting adjourned at 3:12 p.m.

Next meeting

October 26, 2023
Meeting to be held on Zoom and in-person at HCA
2–4 p.m.

Tab 3

Washington State Health Care Authority

Public Comment

Tab 4

Approaches to Primary Care Investment in Rhode Island

October 26, 2023

Cory King

Acting Health Insurance Commissioner

RHODE ISLAND

About OHIC

- The Office of the Health Insurance Commissioner (OHIC) is Rhode Island's commercial health insurance policy reform and regulatory enforcement agency. OHIC seeks to improve health care access, affordability, and quality. The office does so as it:
  - Protects the interests of consumers,
  - Encourages fair treatment of health care providers,
  - Improves the health care system, and
  - Guards the solvency of commercial health insurers.

Rhode Island’s goals for health system transformation

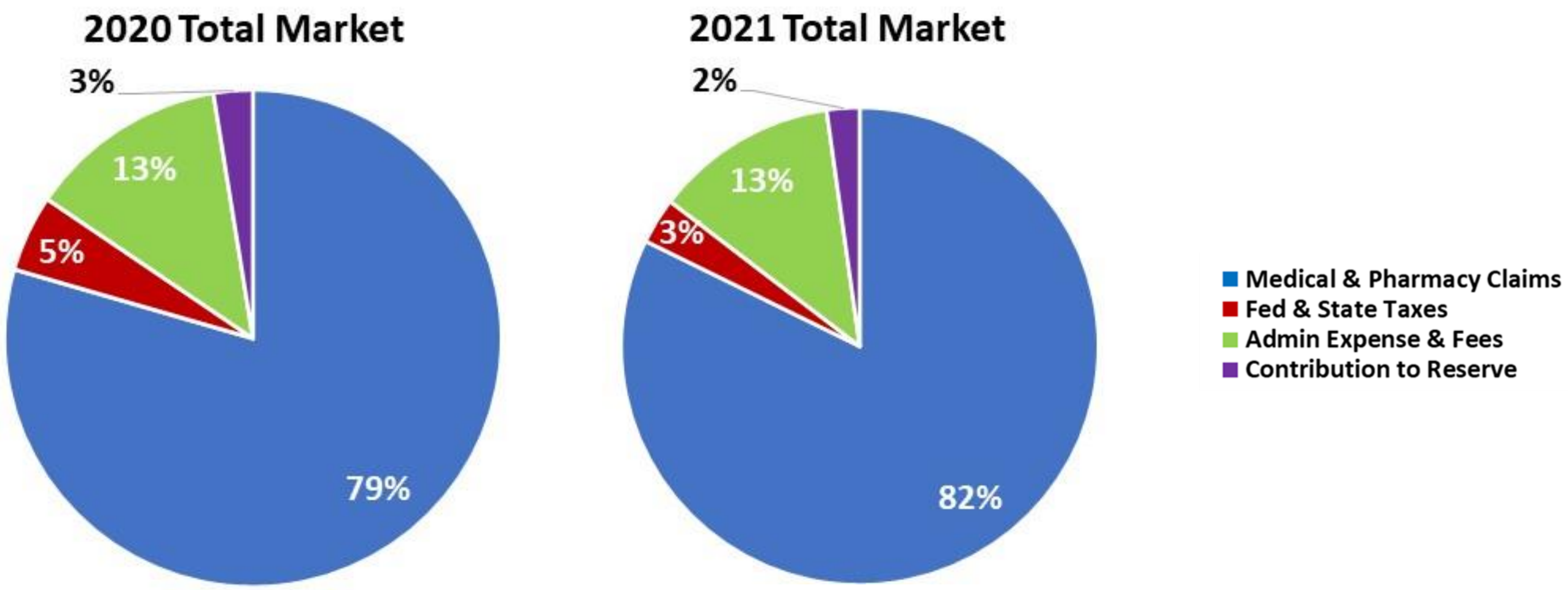
- Affordable and predicable cost growth.
- Technical innovation in care delivery to support population health management and quality excellence.
- Financially stable delivery systems that provide accessible and high-quality care.

Health insurance regulator tool kit: prior approval rate review

- One of OHIC's core functions is to review health insurance premiums for the individual market, small group market, and large group market.
- OHIC can approve as filed, modify, or reject rate filings. The rate filings must satisfy two standards set forth in law:
- The applicant shall be required to establish that the rates proposed to be charged or the rating formula to be used are consistent with the proper conduct of its business and with the interest of the public.

Health care expenditures drive premiums

82 cents of every premium dollar is paid to providers as medical or pharmacy claims



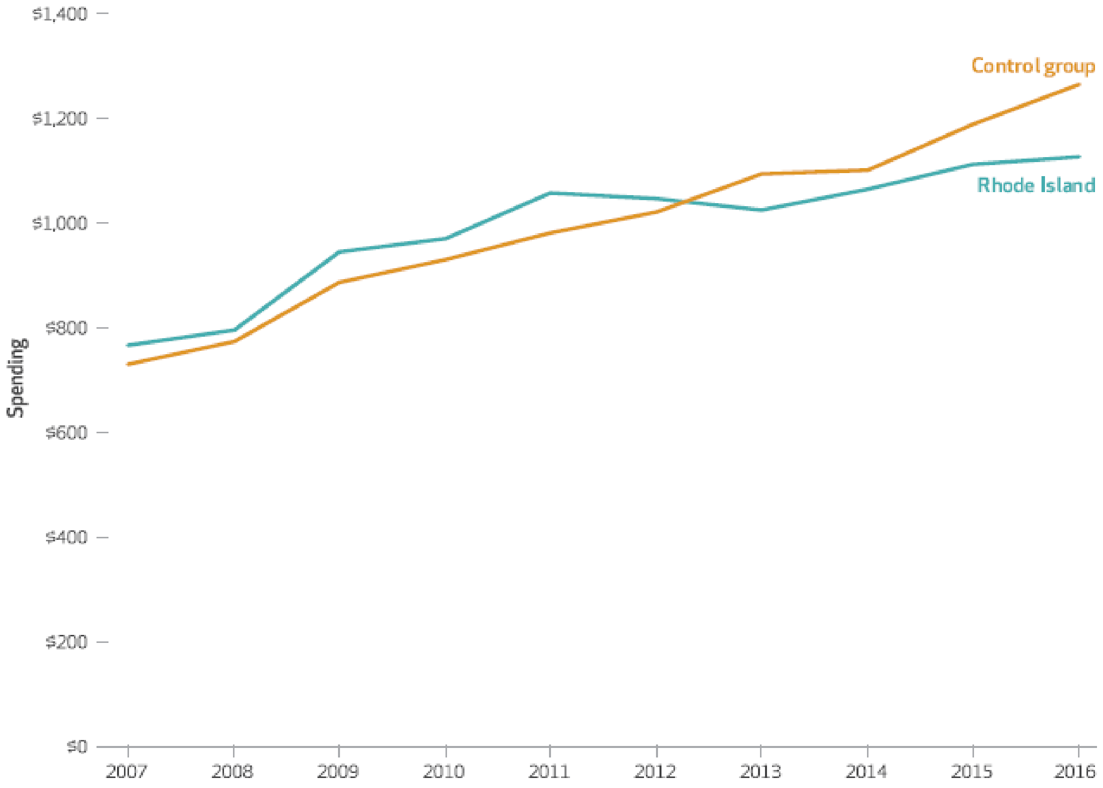
Rate review is necessary, but not sufficient

Actions are needed to address the systemic factors that drive of health care spending: market structure, prices, use of services, service mix, and population health.

State Action

- Transparency into the absolute level and growth rate of health care expenditures.
- Mandated investments in primary care.
- Price growth caps governing hospital inpatient and outpatient facility prices.
- Mandated value-based payment models that reward efficiency and the right care in the right setting.

Quarterly per enrollee fee-for-service spending in the Rhode Island and control-group cohorts, 2007–16



RHODE ISLAND

Why focus of primary care

- Primary care is essential to support population health, the efficient management of individuals with chronic conditions, and achieving reductions in avoidable acute care utilization.
- OHIC views a well-resourced system of primary care as essential to the production of affordable, high quality health care.

Formulation of the target

- In 2009 OHIC drew data from a convenience sample of "high performing health insurers," international benchmarks, and other insurer benchmarks to compare Rhode Island insurers primary care expenditures as a percentage of total expenditures.

How We Stack Up: Benchmark Data

	Primary Care Spend as a percentage of total medical spending
High Performing Health Insurers in US	▪ Geisinger Health Plan: 8.25% ▪ Intermountain (health plan): 7.6%
Other International Systems	▪ National Health Service, England: 26-28%[13]
Other Benchmarks	▪ Massachusetts HMOs[14]: 7.1% ▪ Group Health Cooperative, Seattle WA[15]: 14%[16] ▪ BCBS Tennessee reported 7% in 2002[17] ▪ Tufts Health Plan (Massachusetts HMO only): 8.3% ▪ Neighborhood Health Plan RI: 10.8%

Formulation of the target, contd.

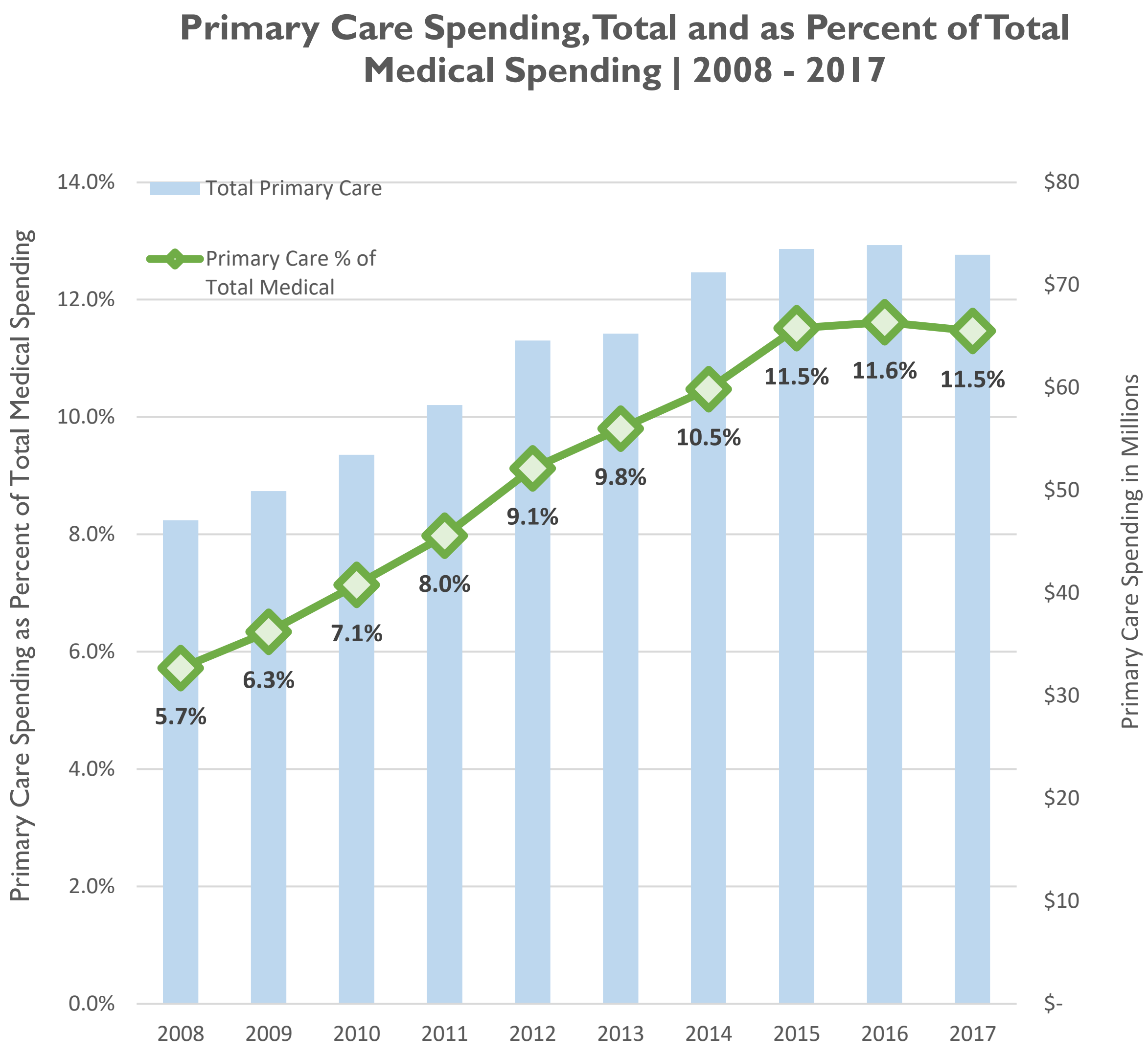
- Beginning in 2010, OHIC directed commercial insurers to increase the percentage of total medical spending dedicated to primary care by 1 percentage point per year over a five-year period compared to baseline.
- The baseline was 2008.
- The target is based on fully insured experience (individual, small group, large group).
- Expenditures are based on payments to Rhode Island providers, regardless of the residence of the member.

Accounting for primary care expenditures

- Insurers receive credit for the following expenditures:
  - FFS claims billed by primary care providers on a paid basis count.
  - Non-FFS expenditures, such as care management PMPMs, P4P bonuses, shared savings distributions, integrated behavioral health.
  - Non-medical related expenditures on the administration of the Care Transformation Collaborative of Rhode Island and the Health Information Exchange.
  - Other expenditures approved by the Commissioner.

Primary care spending

- Between 2010 and 2014 primary care expenditures increased in total and as a percent of total medical expenditures.
- In 2015, OHIC elected to hold expenditures at 10.7% of total medical spending, which was the market average at the time of rulemaking.



RHODE ISLAND

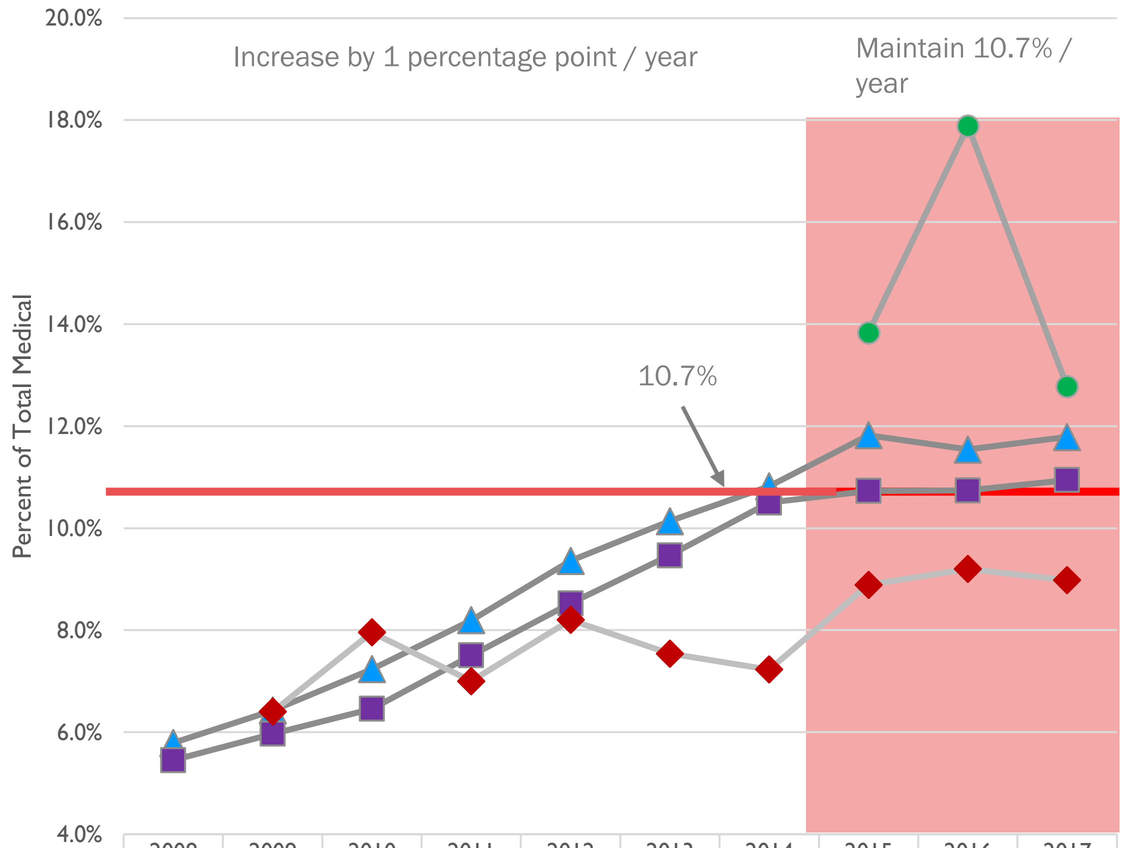
Monitoring and enforcement

- OHIC collects data from insurers on a semi-annual basis.
- The data allows OHIC to track insurer expenditures relative to the target and understand how insurers are spending money on primary care.
- In the past some insurers have failed to achieve a necessary volume of expenditures to meet the target.
- OHIC works with the insurer to agree upon the amount necessary to close the gap and will agree upon the mechanism to make the expenditure.

Spending by insurer

- Insurers in the Rhode Island market vary in total enrollment/market share.
- BCBSRI and UnitedHealthcare are the two largest insurers.
- Tufts Health Plan and NHPRI were later market entrants.

Primary Care Spending as Percent of Total Medical Spending by Insurer | 2008 - 2017



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
BCBSRI	5.8%	6.4%	7.2%	8.2%	9.4%	10.1%	10.8%	11.8%	11.5%	11.8%
UHC	5.5%	6.0%	6.5%	7.5%	8.5%	9.5%	10.5%	10.7%	10.7%	10.9%
Tufts		6.4%	8.0%	7.0%	8.2%	7.5%	7.2%	8.9%	9.2%	9.0%
NHP								13.8%	17.9%	12.8%

Emphasizing non-claims-based expenditures

- OHIC emphasized non-claims-based expenditures as a key mechanism for insurers to achieve their targets.
- OHIC convened an all-payer patient medical home (PCMH) initiative.
- Some insurers created incentives, such as enriched fee schedules, for practices that achieved accreditation as PCMHs.
- In recent years OHIC has emphasized alternative payment models (APMs) such as primary care capitation.

Lesson learned

- How you measure primary care and total medical expenditures has a significant impact on the percentage measure.
- States should develop detailed measure specifications.
- Understanding how non-claims expenditures are paid and distributed within provider organizations is important.
- State should consider PMPM targets in addition to targets based on the percentage of total medical spending.
- OHIC is in the process of changing its measure specifications.

Shifting definitions

Category	Old Definition	New Definition
Payers required to report	Commercial payers only	Commercial payers for fully-insured lives only
Type of spending	Paid amounts	Allowed amounts
Secondary payer payments	Included	Excluded
Member residence	All members, regardless of location	Rhode Island residents only
Provider residence	RI health care providers and organizations only	All providers, regardless of location
Definition of primary care	General description of primary care spending and several categories of PCP types and professional credentials	Claims-level definition of primary care spending; taxonomy codes to define a PCP; primary care site of care definition
Definition of TME	Includes spending for prescription drugs, behavioral health, laboratory and imaging services	Includes spending for prescription drugs, behavioral health, laboratory and imaging services Excludes spending for dental, vision and long-term care

Thank you

RHODE ISLAND

Tab 5

Washington State Health Care Authority

HCCTB Advisory Committee on Primary Care

October 26, 2023

CENTER FOR EVIDENCE-BASED POLICY

Topics

1. Finalize Code-level Primary Care Definition (**Member Voting**)

2. Making Care Primary Reminder

Code-level Definition Data Analysis (Committee Members will be Voting)

CENTER FOR EVIDENCE-BASED POLICY

Poll: Warm up with instructions

In which region of the state do you live?

(Multiple choice)

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

What Counts as Primary Care?

WHO

Is the **provider** considered a primary care provider?

WHAT

Is the **service** considered a primary care service?

WHERE

Is the **facility** considered a primary care facility?

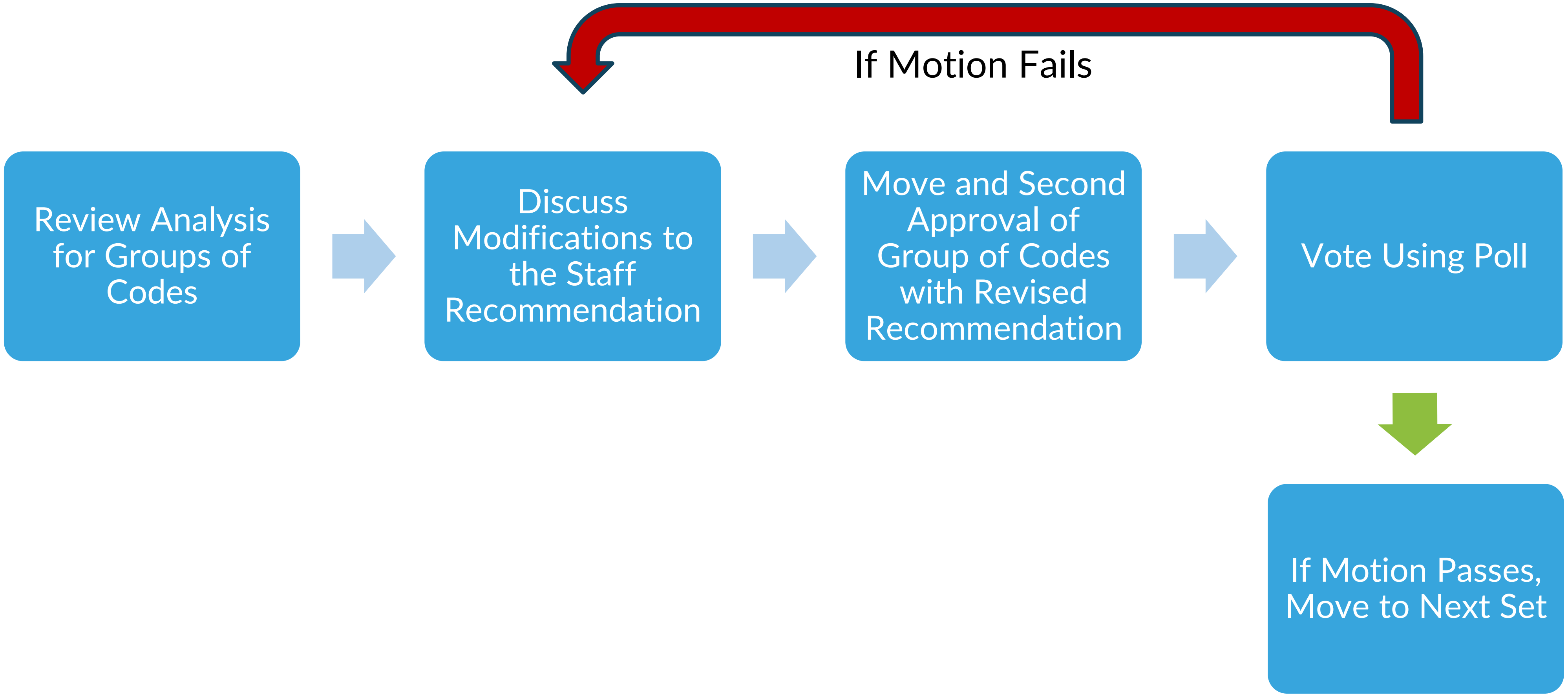
Yes + Yes + Yes =

Primary care that counts toward the 12% target

Primary Care Definition – Data Analysis

- The Committee voted on the initial code set, but requested data to help inform the definition
- HCA conducted analysis using the All-Payer Claims Database (APCD) to answer the following questions:
  - Which codes included in the Committee definition of primary care have significant utilization by provider/location types that are not included in the primary care definition?
  - Which codes were excluded from the Committee definition that have significant utilization by provider/location types that are included in the primary care definition?
  - Does location significantly change the results?

Primary Care Definition Refinement Process



Analysis Results - Location

Conclusion: Using location criteria excludes 9.49% of expenditures when using the narrow definition and 7.50% of expenditures when using the broad definition.

Narrow Definition

Meets Location Definition	Expenditures	Percent
No location provided	$210M	4.38%
No	$206M	4.29%
Yes	$4,385M	91.33%
Total	$4,801M	100.00%

Broad Definition

Meets Location Definition	Expenditures	Percent
No location provided	$129M	2.45%
No	$238M	4.53%
Yes	$4,896M	93.02%
Total	$5,263M	100.00%

Analysis Results - Codes

The data analysis highlighted four major categories of services that warrant review and one outlier code:

- Contraceptive Codes
- Domiciliary or Rest Home Care codes
- Nursing Facility/Hospice Supervision codes
- Interprofessional Electronic Health Assessment codes
- Assessment and Care Planning for Patient w/ Cognitive Impairment code

Contraceptives

Code	Description	Previous Vote	Total Spend (3 years in APCD)	Percent Meeting Narrow Definition	Prevalence in Other State Definitions	Recommendation
11976	Remove Contraceptive Capsule	Include	$0.30 M	42%	8%	Include
11981	Insert Drug Implant Device	Include	$11.70 M	41%	33%	Include
11982	Remove Drug Implant Device	Include	$6.00 M	43%	33%	Include
11983	Remove W/ Insert Drug Implant	Include	$4.65 M	46%	33%	Include
57170	Fitting Of Diaphragm/Cap	Include	$0.03 M	18%	33%	Include
58300	Insert Intrauterine Device	Include	$ 32.60 M	30%	33%	Include
J1050	Injection Medroxyprogesterone Acetate 1 Mg	Include	$10.70 M	66%	0%	Include

Poll: Contraceptive Codes

- Approve
- Do not approve
- Abstain

Domiciliary or Rest Home Care

Code	Description	Previous Vote	Total Spend (3 years in APCD)	Percent Meeting Narrow Definition	Prevalence in Other State Definitions	Recommendation
99324	Domiciliary Or Rest Home Custodial Care 20 Min	Include	$0.19 M	0%	42%	Exclude
99325	Domiciliary Or Rest Home Custodial Care 30 Min	Include	$0.43 M	1%	42%	Exclude
99326	Domiciliary Or Rest Home Custodial Care 45 Min	Include	$0.93 M	3%	42%	Exclude
99327	Domiciliary Or Rest Home Custodial Care 60 Min	Include	$1.74 M	6%	42%	Exclude
99328	Domiciliary Or Rest Home Custodial Care 75 Min	Include	$0.65 M	3%	42%	Exclude
99334	Domiciliary Or Rest Home Evaluation 15 Min	Include	$1.20 M	1%	50%	Exclude
99335	Domiciliary Or Rest Home Evaluation 25 Min	Include	$4.50 M	3%	42%	Exclude
99336	Domiciliary Or Rest Home Evaluation 40 Min	Include	$21.21 M	5%	50%	Exclude
99337	Domiciliary Or Rest Home Evaluation 60 Min	Include	$3.79 M	6%	50%	Exclude

Poll: Domiciliary or Rest Home

- Approve
- Do not approve
- Abstain

Nursing Facility/Hospice Supervision

Code	Description	Previous Vote	Total Spend (3 years in APCD)	Percent Meeting Narrow Definition	Prevalence in Other State Definitions	Recommendation
99374	Home/Nursing Facility Visits 15-29 Min	Include	$0.00 M	48%	25%	Exclude
99375	Home/Nursing Facility Visits 30 Min	Include	$0.03 M	82%	25%	Exclude
99377	Supervision Hospice Patient/Month 15-29 Min	Include	$0.00 M	0%	25%	Exclude
99378	Supervision Hospice Patient/Month 30 Minutes/>	Include	$0.00 M	50%	25%	Exclude
99309	Sbsq Nursing Facil Care/Day New Problem 25 Min	Exclude	$38.23 M	74%	25%	Include
99310	Sbsq Nurs Facil Care/Day Unstabl/New Prob 35 Min	Exclude	$28.52 M	74%	25%	Include
99308	Sbsq Nursing Facil Care/Day Minor Complj 15 Min	Exclude	$14.40 M	60%	25%	Include
99306	Initial Nursing Facility Care/Day 45 Min	Exclude	$12.78 M	78%	25%	Include
99305	Initial Nursing Facility Care/Day 35 Min	Exclude	$4.35 M	64%	25%	Include
99316	Nursing Facility Discharge Management 30 Min>	Exclude	$3.85 M	69%	25%	Include
99315	Nursing Facility Discharge Management 30 Min<	Exclude	$0.82 M	61%	25%	Include

Poll: Nursing Facility/Hospice Supervision

- Approve
- Do not approve
- Abstain

Interprofessional Electronic Health Assessment

Code	Description	Previous Vote	Total Spend (3 years in APCD)	Percent Meeting Narrow Definition	Prevalence in Other State Definitions	Recommendation
99446	Interprofessional Electronic Health Assessment 5-10 Min	Include	$0.02 M	17%	42%	Exclude
99447	Interprofessional Electronic Health Assessment 11-20 Min	Include	$0.05 M	35%	42%	Exclude
99448	Interprofessional Electronic Health Assessment 21-30 Min	Include	$0.04 M	16%	42%	Exclude
99449	Interprofessional Electronic Health Assessment 31 Min <	Include	$1.22 M	15%	42%	Exclude

Poll: Interprofessional Electronic Health Assessment

- Approve
- Do not approve
- Abstain

Assmt. & Care Planning Pt w/ Cognitive Impairment

Code	Description	Previous Vote	Total Spend (3 years in APCD)	Percent Meeting Narrow Definition	Prevalence in Other State Definitions	Recommendation
99483	Assmt & Care Planning Pt W/Cognitive Impairment	Include	$1.22 M	40%	42%	Include

Poll: Assessment and Care Planning Pt w/ Cognitive Impairment

- Approve
- Do not approve
- Abstain

Making Care Primary Reminder

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!