Washington State Health Care Authority

Advisory Committee of Health Care Providers and Carriers

December 1, 2022

Washington State Health Care Authority

Agenda

TAB 1

Washington State Health Care Authority

Advisory Committee of the Health Care Providers and Carriers

December 1, 2022
2:00 p.m. – 4:00 p.m.
Zoom Meeting

AGENDA

Committee Members:					
☐	Mark Barnhart	☐	Stacy Kessel	☐	Megan McIntyre
☐	Bob Crittenden	☐	Ross Laursen	☐	Mika Sinanan
☐	Justin Evander	☐	Todd Lovshin	☐	Dorothy Teeter
☐	Paul Fishman	☐	Vicki Lowe	☐	Wes Waters
☐	Jodi Joyce	☐	Mike Marsh		
☐	Louise Kaplan	☐	Natalia Martinez-Kohler		

Committee Facilitator:
AnnaLisa Gellermann

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome and roll call	1	AnnaLisa Gellermann Health Care Authority
2:05 – 2:10 (5 min)	Approval of August meeting minutes	2	AnnaLisa Gellermann Health Care Authority
2:10 – 2:20 (10 min)	2023: Meetings and Milestones	3	AnnaLisa Gellermann Health Care Authority
2:20 – 2:40 (20 min)	Primary Care Committee Reccomendation: Definition	4	Jean Marie Dreyer, Sr. Policy Analyst Health Care Authority
2:40 – 3:10 (30 min)	Discussion and Feedback to the Board on Reccomendation		All
3:10 – 3:20 (10 min)	Public Comment		AnnaLisa Gellermann Health Care Authority
3:20 – 3:50 (30 min)	Primary Care: Introduction to Claims Based Measurement	5	Jean Marie Dreyer, Sr. Policy Analyst Health Care Authority
3:50 – 3:55 (5 min)	Adjourn		AnnaLisa Gellermann, Board Manager Health Care Authority

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

Washington State Health Care Authority

August meeting summary

TAB 2

Advisory Committee of Health Care Providers and Carriers meeting summary

August 3, 2022
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 board is available on the Health Care Cost Transparency Board webpage.

Members present

Bob Crittenden
Justin Evander
Jodi Joyce
Stacy Kessel
Ross Laursen
Todd Lovshin
Mike Marsh
Natalia Martinez-Kohler
Mika Sinanan
Dorothy Teeter
Wes Waters

Members absent

Paul Fishman
Louise Kaplan
Vicki Lowe
Megan McIntyre

Agenda items

Welcome, call to order, approval of June meeting summary

The June meeting summary was approved.

Topics for today

The topics included a review of the primary care statute, a presentation led by Dr. Judy Zerzan on primary care expenditures, and a discussion, also led by Dr. Zerzan, of next steps for primary care work, including the formation of the primary care committee.

Primary Care Statute and Primary Care

AnnaLisa presented an overview of SSB 5589, the statute establishing a state target for primary care expenditures. The presentation described the recommendations required of the Board to the legislature, and a legislative report. The recommendations for how to track primary care spending will be reviewed by Advisory Committees and

considered by the Board. There are several conditions in the legislation within which the 12 percent target must be achieved. There are many subsets under improving value for the health care system. The preliminary report on primary care expenditures is due in December with an annual report due every August. The breakdown by carrier, market, or payer fits with the cost benchmark reporting rubric. One of the required recommendations in the initial December report will include reporting barriers, which could include how to incentivize providers, or barriers to adoption of health information technology and how that drives costs. Dr. Judy Zerzan, Chief Medical Officer will serve as the subject matter expert for the primary care committee and will work in conjunction with the project team, along with some additional support from HCA's clinical quality care transformation (CQCT) team. The Board already approved the creation of the primary care committee and will approve members in September. The Committee of Providers and Carriers might need an additional meeting or two to engage in the stakeholdering and review process for the December primary care expenditures legislative report.

One committee member asked about the origin of the 12 percent target and its relationship to the Oregon statute and asked if there was more detail about how it was determined. AnnaLisa committed to contacting HCA's legislative team to find additional information behind the reasoning for the 12 percent target.

One member asked whether the 12 percent target for primary care spending would include spending on social determinants of health (SDOH) and whether the expected outcomes would consider the provider's ability to control the spending. AnnaLisa clarified that total health care expenditures would be the denominator for determining performance relative to the 12% target, and that primary care expenditures would include behavioral health spending and non-claims-based spending.

A new policy analyst will be hired to support the primary care work and primary care committee. The analyst will be onboarded in either mid-August or early September. Dr. Judy Zerzan will serve as the subject matter expert for the primary care committee and will work in conjunction with the project team, along with some additional support from HCA's clinical quality care transformation (CQCT) team. The Board has already approved the creation of the primary care committee and would approve members in September. The Committee of Providers and Carriers might need an additional meeting or two to engage in the stakeholdering and review process for the December primary care expenditures legislative report.

Mika relayed concerns about an apparent lack of focus on access to care. Increasing primary care spending could make the system smaller and better for people who receive care but still deliver insufficient care across the state.

Bob Crittenden noted problems with outcomes that are heavily overrepresented by low-income individuals, people with linguistic barriers, and undocumented persons. Further category breakdowns are needed to look at these populations, specifically looking beyond areas like Bellevue and Madrona to places like Yakima. Language and ethnicity should also be analyzed.

Jodi Joyce explained an acronym used to describe care delivery from the Institute for Healthcare Improvement (IHI), STEEP: safe timely, equitable, efficient, effective, and patient-centered. The committee should think about these six lenses when analyzing outcomes. Access should serve as a marker of quality rather than just supply and demand management.

Todd Lovshin brought up that the insurance section of Washington's state code has a primary care definition. Would the primary care committee make suggestions that might change the interpretation outlined by the state code? AnnaLisa responded that the Board could look at the legal definition within the insurance code, but that the primary committee's recommendation would mainly focus on a definition used for measurement purposes. The committee will focus less on what insurers would pay and more on how to measure and track the 12 percent target. If issuers want to look at the code to be in alignment with the definition used for measurement, they can. Todd clarified that the committee's definition doesn't have to align perfectly with the one provided in the insurance

code, but that the code should be taken into consideration. Multiple regulatory bodies use different definitions of primary care. AnnaLisa asked if Todd meant in state or elsewhere. Todd responded that the reference was to state agencies and organizations like the Exchange Board, the insurance commissioner in contracts, Cascade Care, and other products with rates for primary care. AnnaLisa clarified that the committee will attempt to define primary care in a way that will be as consistent as possible. The committee will evaluate the impact of different definitions in regulatory or contractual settings to determine how disparate they might be.

Public Comment

There was no public comment.

Primary Care Next Steps: Overview and Discussion

Dr. Judy Zerzan-Thul, HCA's Chief Medical Officer (CMO) gave a presentation on covering a background of primary spending, work from other states, and HCA-led work conducted through the Multi-Payer Primary Care Transformation Model (MPCTM). The presentation focused on challenges, existing efforts, and targets.

Judy began her presentation with an exhibit from 2003 from the Milbank Fund, which showed a positive association between the number of primary care providers and quality outcomes. The same data and article showed that primary care investments were associated with lower total costs. The evidence about the benefits of increasing investments in primary care has been around for 20 or 30 years, but overall spending remains low. Average primary care spending on a national level ranges from only 5 to 7 percent, with Washington falling within that range. Rhode Island and Oregon were early movers in adopting methods to measure primary care expenditures, and several states have passed laws or regulations related to primary care spending. Judy provided an overview of Rhode Island's primary care spending efforts. Rhode Island is the oldest adopter among states to track and increase primary care spending. Rhode Island's former insurance commissioner, Chris Kohler, spoke with this committee before. While primary care investment was likely a factor in bending Rhode Island's cost curve, their decision to cap hospital rate increases likely also contributed. Judy also described Oregon's primary care spending efforts, which began in 2015 with the establishment of the primary care payment reform collaborative.

Next, Judy discussed primary care spending more broadly. There is no universal definition of primary care spending. Tracking non-claims-based spending will be the trickiest to do for Washington. Judy provided an overview of who is involved with primary care (provider types), what constitutes primary care (services), and how primary care spending is measured. Oregon's goal resembles Washington's. The primary care committee will have the flexibility to engage with legislative sponsors to determine when the target must be reached. Judy described existing Washington primary care definitions including OFM, Bree, and RCW 74.09.010. Most states have both a narrow and a broad definition of primary care spending. Judy also gave an overview of existing Washington Primary Care expenditure reports, which included OFM and HCA carrier reporting (that started in 2020). Judy contrasted the results from the OFM report, which found spending rates of 4.4 percent based on a narrow definition and 5.6 based on a broader definition, with the HCA carrier self-reported range of 5 to 14 percent.

Mike Marsh brought up concerns around the need to account for private equity in healthcare provision. Private equity and technology disrupters have discovered healthcare as a business target. Most traditional providers are non-profits who serve people regardless of their ability to pay (Medicaid and Medicare being the primary examples of these types of populations). As the framework evolves, the healthcare ecosystem will undergo a significant shift with well-capitalized entrants who lacked the burden of caring for some populations.

Mika cautioned that Rhode Island's experience shows that causality between increased primary care spending and higher quality outcomes was inferred but that caps on hospital rates were a confounding factor. Judy responded that there is additional data in a national academies report that is available as well as more recent data from a plan

in California. Increasing primary care spending isn't' just for paying clinicians enough but also the team around them. Even in rural areas, most primary care is owned by rural hospitals, so taking note of consolidation and the changing market is important.

Judy presented an overview of Washington's MPCTM, and highlighted its goals to align all payers, increase access, and align quality measures and different payment methods. Judy described the basic components of the model and its associated workgroups: one is the multi-payer group and the other is a provider summit (clinicians, health systems, and patient representatives at the beginning, who later dropped off).

Bob commented that the MPCTM should consider issues of equity and how to reach out to the whole population. The model should account for how to measure community impact. Judy clarified that there is some equity as well as SDOH components integrated into the certification process, but that further discussions on equity will be needed. The plan is to get a structure in place for alignment and to add in equity as the model proceeds. Bob noted that other places around the country factor in equity with incentive payments to ensure outreach to non-English speaking populations or other hard to reach individuals.

Mike asked how HCA has partnered with or triangulated information from the Washington Healthcare Alliance. Judy responded that there has not been collaboration on a data front, however, the alliance has been engaged in the summit group for development. Ginny Weir from Bree was involved in the summit group. HCA has not compared data on primary care spending yet.

Mika commented on the quality measures included in the model. Judy agreed that the measures were chosen to maintain consistency across payers. The Performance Measures Coordinating Committee (PMCC) runs the common measure set and payers around the table committed to aligning the 12 measures with the measures in their contracts. HCA initiated work to change its measures and encountered some restrictions. Mika asked if the payers who agreed to the metrics included national companies like Cigna. Judy clarified that Cigna was not included but that every other payer is present, including Pacific Source.

Dorothy Teeter suggested that HCA should consider partnering with the Alliance and Bree. Judy acknowledged that patient experience isn't currently addressed in the MPCTM. The MPCTM stratifies measures by race, ethnicity, etc. Both the Bree Collaborative and the Washington Healthcare Alliance were on the primary care summit and are connected to the MPCTM.

Judy transitioned to next steps for the primary care committee and provided an overview of the recommendations required for the December legislative report: a definition of primary care, how to measure claims-based spending, how to measure non-claims-based spending, and a description of reporting requirements, barriers, and how to overcome them. Judy provided definitions of primary care from the MPCTM. Judy explained non-claims-based spending, which can include alternative payment models (APMs), collaborative care, community health workers (CHWs), and data management. Judy proposed that the primary care committee adopt the existing certification workgroup.

Ross Laursen asked whether there was a representative from Premera on the workgroup. The workgroup doesn't have a Premera rep but there is a Premera rep at the payer table. Judy already spoke with the certification workgroup members to inform them that they were being considered. Additional people will be added to the proposed member list. The Board will hold a discussion of nominations at their next meeting.

Jodi noted a lack of providers on the proposed member list. Judy clarified that the initial list presented today is intended to serve as a base and will not constitute a final list.

Ross pointed out that the proposed list doesn't include roles and titles and recommended expanding the list's details to include roles and responsibilities along with scope.

Adjournment

The meeting adjourned at 4:00 p.m.

Next meeting

Wednesday October 5, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Washington State Health Care Authority

2023: Meetings and Milestones

TAB 3

2023: Milestones and Meetings

AnnaLisa Gellermann
Board and Commissions Director
Health Care Authority

Washington State Health Care Authority

The Year Ahead: Major Milestones

- January — Considering 2022 Cost Driver Analysis
- May: — 2022 Benchmark Report and Primary Care Recommendations for 2023 report
- June: — 2023 Benchmark Data Call (data period tbd)
- Aug: — Legislative Report
- Nov — Cost Driver Analysis 2023

Matching Meetings to Milestones

Health Care Cost Transparency Board		
Date	Time	Topic
February 15	2:00pm - 4:00pm	1. Primary Care Recommendation: Definition & Claims Based 2. OnPoint Cost Driver Analysis: Discussion 3. Introduction to IHME Grant
April 19	2:00pm - 4:00pm	1. Approve 2023 Benchmark Submitters & Reported Entities 2. Finalize Recommendations Re: Cost-Driver Analysis (Leg Report) 3. Primary Care Recommendation: Non-Claims Based 4. Adjusted Hospital Cost Report
May 17*	2:00pm - 4:00pm	1. Board Presentation 2022 Benchmark Results 2. Last Possible date for Primary Care Recommendation Approval for Leg Report 3. Potential: Introduction to Cascade Select Presentation & Outline of Report (if applicable- 10,000 covered lives)

Matching Meetings to Milestones

June 21	**2:00pm-4:00pm**	**1. Board Discussion of 2022 Benchmark Recommendations** **2. Discussion of Data Barriers from Data Committee**
July 18*	2:00pm-4:00pm	1. Review and Approve August Leg. Report 2. Share draft of Cascade Care Report 3. Primary Care Recommendations
October 18	2:00pm - 4:00pm	1. Welcome New Members 2. Update on National Benchmark Work 3. Revisit the Benchmark Value
November 15	2:00pm - 4:00pm	1. OnPoint 2023 Cost-Driver Presentation 2. 1st IHME Cost-Driver Presentation 3. Discussion of Cost-Drivers

Committees: Time for Feedback

- Provide advance notice of topics to be considered so representatives can stakeholder with members.
- Provide opportunity for feedback *prior* to Board consideration, so it can be considered with the initial presentation to the Board.
- Provide ample time for feedback, and additional opportunities if possible.
- Consider inviting committee members to present feedback directly to Board.

Advisory Committee of Health Care Providers and Carriers

Advisory Committee of Health Care Providers and Carriers		
Date	**Time**	**Topic**
January 5	2:00pm-4:00pm	1. Review Primary care Recommendations 2. Review Cost-Driver Report and Provide Recommendations to the Board
March 7	2:00pm-4:00pm	1. First Look at Risk Adjusted Hospital Report 2. Primary Care Recommendations 3. Review of 2023 Benchmark Data Call Reported Entities
June 6 (combined)	2:00pm-4:00pm	1. Review of 2022 Results Feedback to Board
September 7	2:00pm-4:00pm	1. TBD
December 5	2:00pm-4:00pm	1. Review of 2023 Cost-Driver Analyses (OnPoint and IHME)

Advisory Committee on Data Issues

Data Advisory Committee		
Date	**Time**	**Topic**
February 7	2:00pm-4:00pm	1. IHME Introduction 2. Discussion of 2023 Draft Technical Manual 3. Review Hospital Cost Adjustment Criteria 4. Data Barrier Topic
April 4	2:00pm-4:00pm	1. Primary Care Review: Data Barriers and Access 2. Stakeholder Design of 2023 Cost-Driver Analysis 3. Continue Data Barrier Discussion
June 6 (combined)	2:00pm-4:00pm	1. Review of 2022 Results Feedback to Board 2. Statewide Attribution Method 3. Data Barrier: Discussion Continued 4. Primary Care Review
October 3	2:00pm-4:00pm	1. Look at Primary Care Measurement 2. Look at Technical Design of 2024 Benchmark 3. Cost-Driver Design

Advisory Committee on Primary Care

Primary Care Advisory Committee		
Date	**Time**	**Topic**
January 31	2:00pm-4:00pm	1. Claims-Based Measurement Recommendation
February 23	2:00pm-4:00pm	1. Non-Claims-Based Measurement Discussion
March 30	2:00pm-4:00pm	1. Non-Claims-Based Measurement Recommendation
April 27	2:00pm-4:00pm	1. Barriers to Use and Access of Primary Care Data 2. How to Overcome Barriers
May 25	2:00pm-4:00pm	1. Barriers to Use and Access of Primary Care Data 2. How to Overcome Barriers
June 28	2:00pm-4:00pm	1. Recommendation: How to Overcome Barriers
July 25	2:00pm-4:00pm	1. TBD
August 31	2:00pm-4:00pm	1. TBD
September 28	2:00pm-4:00pm	1. TBD
October 26	2:00pm-4:00pm	1. TBD

Washington State Health Care Authority

Primary Care Committee Reccomendation: Definition

TAB 4

Advisory Committee on Primary Care: Recommending a Statewide Definition of Primary Care

Jean Marie Dreyer

Senior Health Policy Analyst, HCA

Washington State Health Care Authority

Washington's statutory and regulatory primary care definitions

- RCW 74.09.010
  - "General practice physician, family practitioner, internist, pediatrician, osteopathic physician, naturopath, physician assistant, osteopathic physician assistant, and advanced registered nurse practitioner"
- Insurance Code 48.150.010
  - "Primary care" means "routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of health, and detection and management of disease or injury."

Washington's primary care definition evolution: OFM to Bree

- OFM definition – based on 1996 National Academy of Medicine (formerly the Institute of Medicine) definition
  - "The provision of ***integrated***, ***accessible*** health care services by clinicians who are ***accountable*** for addressing a large majority of personal health care needs including physical, mental, emotional, and social concerns, developing a ***sustained*** partnership with patients, and practicing in the context of family and community"
  - **Narrow**: Representing providers who traditionally perform roles contained within strict definitions of primary care.
  - **Broad**: Representing providers who perform roles not traditionally contained within a strict definition of primary care (e.g., OBs).
- Bree definition
  - "***Team-based*** care led by an ***accountable*** provider that serves as a person's source of ***first contact*** with the larger healthcare system and coordinator of services that the person receives. Primary care includes a ***comprehensive*** array of ***appropriate***, evidence-informed services to foster a ***continuous*** relationship over time. This array of services is ***coordinated*** by the accountable primary care provider but may exist in multiple care settings or be delivered in a variety of modes."

Principle expansion: OFM and Bree

OFM	Bree
Accountable	Accountable
Integrated	Comprehensive
Sustained	Continuous
Accessible	First contact
	Team-based/Coordinated
	Appropriate

Washington State and national definitions

- Bree definition:
  - ***Team-based*** care led by an ***accountable*** provider that serves as a person's source of ***first contact*** with the larger healthcare system and coordinator of services that the person receives. Primary care includes a ***comprehensive*** array of ***appropriate***, evidence-informed services to foster a ***continuous*** relationship over time. This array of services is ***coordinated*** by the accountable primary care provider but may exist in multiple care settings or be delivered in a variety of modes."
- NASEM definition:
  - "High-quality primary care is the provision of ***whole-person***, ***integrated***, ***accessible***, and ***equitable*** health care by ***interprofessional*** teams that are ***accountable*** for addressing the majority of an individual's health and wellness needs across settings and through ***sustained*** relationships with patients, families, and communities."

Principle expansion: Bree and NASEM

Bree	NASEM
Accountable	Accountable
Comprehensive	Whole-person/Integrated
Continuous	Sustained
First contact	Accessible
Team-based/Coordinated	Interprofessional
	Equitable
Appropriate	

Proposed definition

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

Definition feedback from primary care committee members

- Consider substituting the word “primary” in place of “first”.
- Might be able to remove “and coordinator of services that the person receives” in the first sentence.
- WSMA is working to not use the term provider for MD/DOs.

Updated definition

"**Team-based** care led by an **accountable** health professional 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 foster a **continuous** relationship over time. This array of services is **coordinated** by the accountable primary care professional but may exist in multiple care settings or be delivered in a variety of modes."

Questions for consideration

- How will the proposed definition inform the measurement process for claims-based payments?
- How will this new definition work with or supersede existing definitions of primary care?
- How will activities like care coordination be accounted for with this definition, as well as other non-claims-based payments?

Public comment

Washington State Health Care Authority

Washington State Health Care Authority

Primary Care: Introduction to claims-based measurement

TAB 5

Introduction to Claims-Based Measurement

Jean Marie Dreyer

Senior Health Policy Analyst, HCA

Washington State Health Care Authority

Claims-based measurement: two levels of analysis

- Type of clinician providing service (taxonomy)
- Services provided

Office of Financial Management 2019 Primary Care Expenditures Report

- Used WA-APCD claims to measure primary care expenditures
- Separate definitions used for PCPs and primary care services
- Narrow and broad definitions used for both providers and services

Office of Financial Management 2019 Primary Care Expenditures Report: continued

- For 2018, primary care expenditures were:
  - 4.4% ($838M) based on narrow definition and;
  - 5.6% (about $1B) based on broad definition
- Providers identified using taxonomy codes
- Services identified using CPT/HCPC codes

OFM primary care provider definition: narrow

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

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

OFM primary care provider definition: broad

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

Caveats for OFM claims-based data

- Narrow and broad categories modeled on other national efforts to measure primary care spending
- Utilized claims data
  - Focused on billing
  - Didn't capture EMR information
- Services provided by NPs and PAs had to be imputed

Primary Care Collaborative 2020 evidence report on primary care spending

FINDINGS:
U.S. PC Investment Low *and* Declining

PC Spending Declined Among Commercially Insured 2017–2019

PCC finds decline similar to other recent analyses

Definition	2017	2019
Narrow	4.88%	4.67%
Broad	7.8%	7.69%

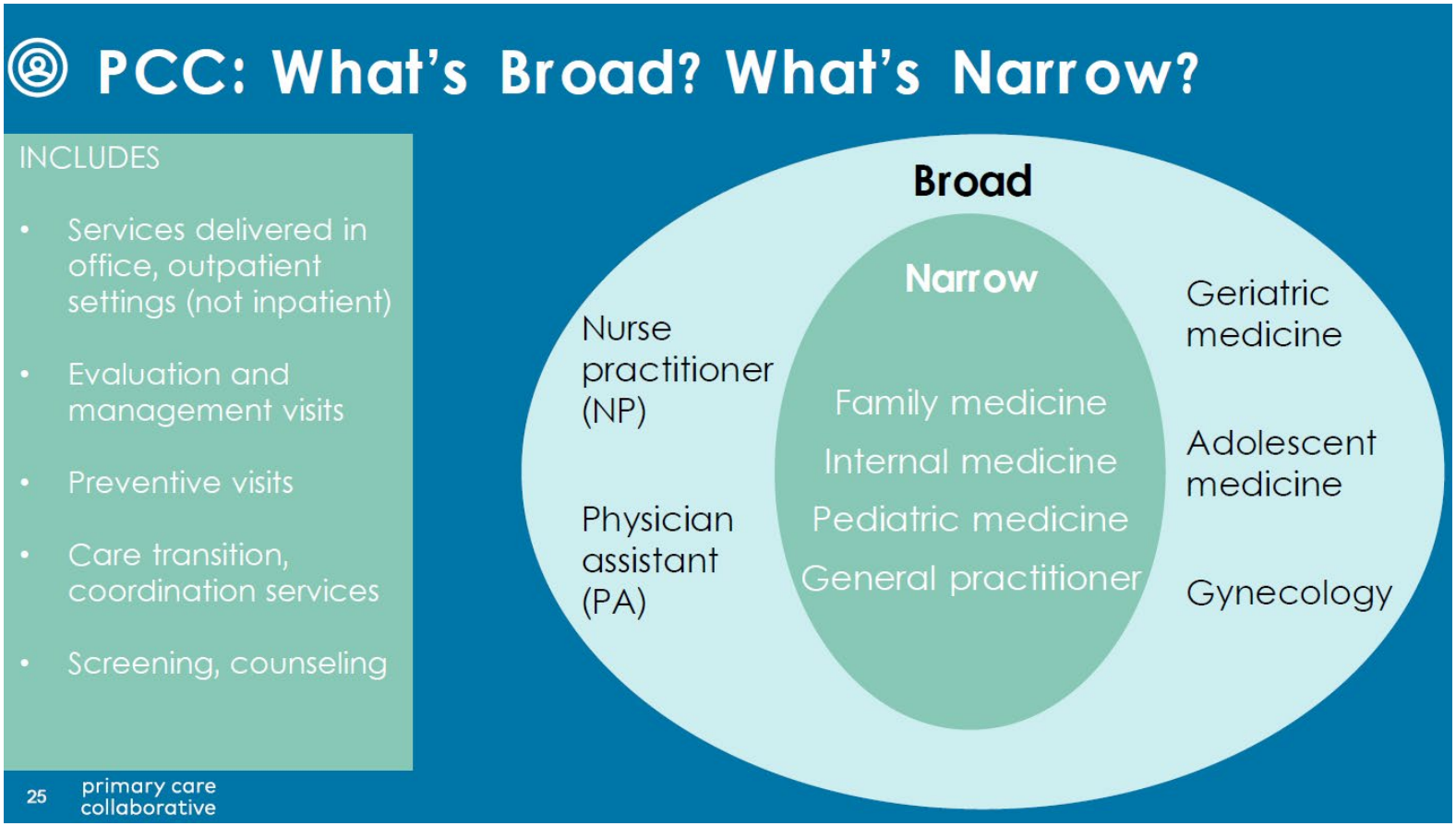
JAMA Internal Medicine 2020 All Payer Decline 2002–2016

- 6.5% to 5.4% decline, narrow definition

JAMA 2019 Commercially Insured Decline 2013–2017

- 4.6% to 4.35% decline, narrow definition
- 8.97% to 8.04% decline, broad definition

Primary Care Collaborative: broad and narrow categories for claims-based spending



New England States All-Payer Report: overview

- Primary care payments related to 7.2 million commercial, Medicare Advantage, Medicare FFS, and Medicaid members
- Combined primary care payments as a percentage of total medical payments:
  - 5.5 percent using a narrow definition of services
  - 8.2 percent using a broad definition of services
- Payments varied by payer and state

New England States All-Payer Report: overview continued

- OB/GYN providers and services included, but reported separately
- Naturopaths and behavioral health providers not included
- Information on non-claims payments collected directly from payers
  - Few states, if any, have standards for collection of non-claims-based payment data

New England States All-Payer Report: narrow and broad categories

Table 2. Providers & Service Definitions Included in This Study

#	Definition	Description
1	Defined PCPs, Selected Services	• Selected claims payments for general practice, family medicine, pediatrics, internal medicine, nurse practitioner, physician assistant * • Excludes OB/GYN services • Definition #1 is narrower and service based
2	Defined PCPs, All Services	• All claims payments for general practice, family medicine, pediatrics, internal medicine, nurse practitioner, physician assistant * • Excludes OB/GYN services • Definition #2 is a broader measure that does not restrict on service codes
3	OB/GYNs, Selected OB/GYN Services	• All OB/GYN services payments for OB/GYN practitioners • Excludes all services provided by PCPs • Payments reported in Definition #3 can be added to definitions #1 or #2 as desired
4	Defined PCPs, Selected OB/GYN Services	• Selected OB/GYN services payments for general practice, family medicine, pediatrics, internal medicine, nurse practitioner, physician assistant * • Excludes all primary-care services and services provided by OB/GYNs • Payments reported in Definition #4 can be added to definitions #1 or #2 as desired

* Primary care also included taxonomy codes for Federally Qualified Health Centers, Rural Health Centers, clinics, Critical Access Hospitals, and rural hospitals. For these taxonomy codes, restrictions were always applied using revenue and procedure codes.

Oregon 2020 primary care spending: provider taxonomy

- Physicians specializing in:
  - Child and adolescent psychiatry
  - Family medicine
  - General medicine
  - General psychiatry
  - Geriatric medicine
  - Obstetrics and gynecology
  - Pediatrics or preventive medicine
- Physicians' assistants
- Naturopathic medicine providers

Oregon 2020 primary care spending: provider taxonomy continued

- Nurses
  - Nurse practitioners
  - Nurse non-practitioners
  - Certified clinical nurse specialists

- Includes:
  - Primary care clinics
  - Federally qualified health centers (FQHCs)
  - Rural health clinics (RHCs)

Oregon 2020 primary care spending: primary care services

- Office or home visits
- General medical exams
- Routine medical and child health exams

Oregon 2020 primary care spending: primary care services continued

- Preventive medicine evaluation or counseling
- Administration and interpretation of health risk assessments
- Routine obstetric care excluding delivery (60 percent of payment amount reported on claims included to represent non-delivery services)

University of Washington Value and Systems Science Lab: analysis of Medicaid claims

- Data source was Washington Medicaid claims from 2019 and 2020
- Data types:
  - Demographic data
  - Outpatient/inpatient claims data
  - Provider data
- Beneficiary sample:
  - 328,315 Medicaid beneficiaries
  - Adults 18+
  - Managed care
  - WA residents
  - Enrolled for 11+ months in both 2019 and 2020

University of Washington Value and Systems Science Lab: primary care providers

- Started with provider taxonomy codes for clinicians, groups, and facilities used in 2019 OFM Primary Care Expenditures Report
- Adapted eligible taxonomy codes for certain clinician and facility types
- Generated all potential combinations of billing and servicing provider taxonomies and then conducted quality checks for empty or inaccurate codes

University of Washington Value and Systems Science Lab: primary care providers continued

- Three provider types:
  - Clinicians
  - Groups
  - Facilities
- Two outpatient service types
  - Primary care
  - Non-primary care
- Potential for missing values in either taxonomy position

University of Washington Value and Systems Science Lab: primary care providers

Taxonomy Code	Description
261Q00000X	Ambulatory Health Care Facilities - Clinic/Center
261QC1500X	Ambulatory Health Care Facilities - Clinic/Center - Community Health
261QM1300X	Ambulatory Health Care Facilities - Clinic/Center - Multi-Specialty
282NC0060X	Hospitals - General Acute Care Hospital - Critical Access
363L00000X	Nurse Practitioner
363LA2100X	Nurse Practitioner, Acute Care
363LA2200X	Nurse Practitioner, Adult Health
363LC1500X	Nurse Practitioner, Community Health
~~363LC0200X~~	~~Nurse Practitioner, Critical Care Medicine~~
363LF0000X	Nurse Practitioner, Family
363LG0600X	Nurse Practitioner, Gerontology
~~363LN0000X~~	~~Nurse Practitioner, Neonatal~~
~~363LN0005X~~	~~Nurse Practitioner, Neonatal, Critical Care~~
~~363LX0001X~~	~~Nurse Practitioner, Obstetrics & Gynecology~~
363LX0106X	Nurse Practitioner, Occupational Health
363LP0200X	Nurse Practitioner, Pediatrics
~~363LP0222X~~	~~Nurse Practitioner, Pediatrics, Critical Care~~
~~363LP1700X~~	~~Nurse Practitioner, Perinatal~~
363LP2300X	Nurse Practitioner, Primary Care
363LP0808X	Nurse Practitioner, Psychiatric/Mental Health
~~363LS0200X~~	~~Nurse Practitioner, School~~
363LW0102X	Nurse Practitioner, Women's Health
363A00000X	Physician Assistant
363AM0700X	Physician Assistant, Medical
~~363AS0400X~~	~~Physician Assistant, Surgical~~

Taxonomy Code	Description
207Q00000X	Family Medicine
207QA0000X	Family Medicine, Adolescent Medicine
207QA0505X	Family Medicine, Adult Medicine
207QG0300X	Family Medicine, Geriatric Medicine
261QF0400X	Federally Qualified Health Center
208D00000X	General Practice
207R00000X	Internal Medicine
207RG0300X	Internal Medicine, Geriatric Medicine
175F00000X	Naturopath
208000000X	Pediatrics
183500000X	Pharmacy Service Providers - Pharmacist
2080A0000X	Pediatrics, Adolescent Medicine
2083P0500X	Preventive Medicine, Preventive Medicine/Occupational Environmental Medicine
261QP2300X	Primary care clinic
261QR1300X	Rural health clinic
390200000X	Student, Health Care - Student in an Organized Health Care Education/Training Program

University of Washington Value and Systems Science Lab: primary care providers

Taxonomy Code	Description
261QF0400X	Federally Qualified Health Center
261QM1300X	Multi-Specialty Clinic/Center
261QR1300X	Rural Health Clinic
261QP2300X	Primary Care Clinic
261Q00000X	Ambulatory Health Clinic/Center
261QC1500X	Community Health Clinic/Center
282NC0060X	Critical Access Hospital

Three facility types (261QF0400X, 261QR1300X, 261QP2300X) were included in the 2019 Office of Financial Management Primary Care Expenditures Report. To this list, the highlighted facilities were added based on conversations with HCA leadership about facilities that may be providing primary care outpatient services. Lists may undergo additional refinement.

University of Washington Value and Systems Science Lab: primary care providers

Billing Taxonomy	Servicing Taxonomy
PC Clinician	PC Clinician
PC Clinician	Non-PC Clinician
(empty)	PC Clinician
Non-PC Clinician	Non-PC Clinician
Multi-Specialty Group	PC Clinician
Multi-Specialty Group	(empty)
Single Specialty Group	PC Clinician
Single Specialty Group	Non-PC Clinician
PC Facility	PC Clinician
PC Facility	Non-PC Clinician
Non-PC Facility	PC Clinician
(empty)	(empty)
…	…

A sample of the 49 potential billing and servicing provider taxonomy code combinations

University of Washington Value and Systems Science Lab: Outpatient medical services

Billing and Servicing Provider Combinations	# of Claims	% of Claims	PC vs Non-PC
PC Facility & PC Individual	419,997	31.7%	PC
Multi-Specialty & PC-Individual	315,796	23.8%	PC
Multi-Specialty & Not-PC Individual	202,362	15.3%	Non-PC
Non-PC Facility & PC Individual	77,351	5.8%	Non-PC
Single Specialty & PC Individual	76,019	5.7%	PC
PC Facility & Non-PC Individual	64,650	4.9%	Non-PC
Single Specialty & Non-PC Individual	55,483	4.2%	Non-PC
Not-PC Facility & Non-PC Individual	44,256	3.3%	Non-PC
PC Individual & PC Individual	5,475	0.4%	PC
Non-PC Individual & Non-PC Individual	4,436	0.3%	Non-PC
Total	**1,265,825**	**95.4%**	

Notes: PC=primary care. Data from 2019 (data from 2020 not shown but show similar combinations with >95% of claims accounted for)

University of Washington Value and Systems Science Lab: Outpatient service utilization by group and organizational facilities – 2019 and 2020

2019	% of Primary Care Outpatient Services**
Multi Specialty Group (N=236)	34.1%
Single Specialty Group (N=278)	17.8%
Primary Care Facilities (N=441)	
Federally Qualified Health Center sites (N=171)	28.1%
Multi Specialty Clinic/Center (N=24)	9.4%
Rural Health Clinic (N=107)	6.0%
Primary Care Clinic (N=48)	1.7%
Other* (n=91)	1.5%

2020	% of Primary Care Outpatient Services**
Multi Specialty Group (N=204)	36.6%
Single Specialty Group (N=238)	16.2%
Primary Care Facilities (N=441)	
Federally Qualified Health Center sites (N=169)	27.0%
Multi Specialty Clinic/Center (N=27)	6.9%
Rural Health Clinic (N=101)	8.9%
Primary Care Clinic (N=42)	1.9%
Other* (n=72)	1.3%

Notes:
*includes Ambulatory Health Clinic/Center, Community Health Clinic/Center, and Critical Access Hospital.
** Percentages add to about 99% due to exclusion of PC clinicians

University of Washington Value and Systems Science Lab: summary

- Used billing details versus servicing providers to address accuracy of primary care definitions
- Additional steps may be needed to incorporate primary care HCPCS/procedure codes into claims-based definitions
- One-third of adult beneficiaries in the sample didn't receive any outpatient medical services

University of Washington Value and Systems Science Lab: summary continued

- Twice as many primary care vs non-primary care outpatient medical services
- Most primary care outpatient medical services were provided through locations or sites associated with FQHCs and multispecialty groups
- In 2019 and 2020, >500 clinicians provided primary care outpatient medical services to adult beneficiaries in the sample

Next steps for Advisory Committee on Primary Care

- Preliminary definition of primary care to be submitted to the cost board for review on December 14
  - Will include feedback from Advisory Committee of Providers and Carriers

- 2023 meetings:
  - January and February: Discussion and development of methodology to assess claims-based spending
  - March: Presentation from Oregon subject matter experts on non-claims-based measurement
  - April: Presentation from Michael Bailit on non-claims-based measurement
  - May: Finalize claims-based recommendations to include in HCCTB's annual legislative report in August

Committee feedback: questions for consideration

- How should the Advisory Committee on Primary Care account for primary care services provided at non-primary care designated locations?
- Claims-based measurement is different from payment model design. How should HCA's work on the Multi-Payer Primary Care Transformation Model (MPPCTM) inform the Advisory Committee on Primary Care's primary care spending measurement efforts?
- How would the Advisory Committee of Providers and Carriers recommend accounting for less straightforward primary care providers and services? Which providers and services must be included and which are discretionary?

Thank you for attending the Advisory Committee of Providers and Carriers Meeting!

Washington State Health Care Authority