# Advisory Committee on Primary Care Meeting Summary

June 28, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

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

## Members present

Judy Zerzan-Thul
Kristal Albrecht
Michele Causley
Nancy Connolly
David DiGiuseppe
Sharon Eloranta
Lan H. Nguyen
Katina Rue
Mandy Stahre
Jonathan Staloff
Staici West
Ginny Weir
Maddy Wiley

## Members absent

Tony Butruille
Sharon Brown
Tracy Corgiat
DC Dugdale
Chandra Hicks
Meg Jones
Sheryl Morelli
Kevin Phelan
Eileen Ravella
Sarah Stokes
Linda Van Hoff
Shawn West
Gregory Marchand

# Call to order

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

# Agenda items

## Welcome, roll call, and agenda review

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

## Approval of May meeting summary

The committee voted to adopt the Meeting Summary from the May 2023 meeting with some modifications made to remove duplicate listings of attendees and absentees.

## Topics for Today

The main topics were a presentation on and discussion of committee charges to identify data collection barriers and propose solutions, code review finalization, and preparation for the next meeting.

## Public Comment

There were no public comments.

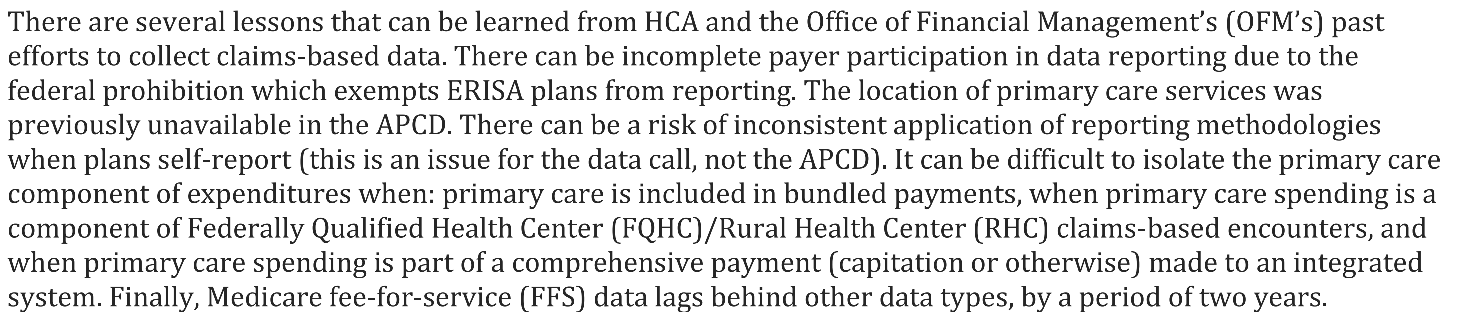
## Discussion: Committee charge to identify data collection barriers and propose solutions

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

Shane Mofford reviewed the goals of the meeting: Identifying gaps/challenges for primary care spending data collection, developing a baseline understanding of status quo data collection strategies, making recommendations for future policies to address gaps and challenges, voting on one outstanding code for the primary care definition, and preparing for policy discussion in upcoming meetings.

The legislative charge for primary care data collection included three directives: 1) reporting on annual barriers to access and use of primary care data and recommending ways to overcome barriers, 2) reporting on the annual progress needed for primary care expenditures to reach the 12 percent target of total health care spending, and 3) tracking accountability for annual primary care expenditure targets. Along with these directives, there were several instructions for how to report the data. The annual reports must include annual primary care expenditures for the most recent year for which data is available by insurance carrier, by market or payer, in total and as a percentage of total health care expenditures. Primary care expenditures must be broken down by relevant characteristics, such as whether expenditures were for physical or behavioral health, by type of provider, and by payment mechanism.

There are two primary methods of data collection from payers: data from the all-payer claims database (APCD) and HCA's aggregate data call. The APCD includes detailed data submitted by a subset of payers but does not include non-claims-based spending. This data can be queried by HCA. Federal regulations prohibit certain payers from reporting, including payers covered by the Employee Income Retirement Act (ERISA) plans. The HCA aggregate data call aggregates data submitted by all payers directly to HCA. The call includes some, but not all, ERISA plan data and includes a subset of non-claims-based expenditures. ERISA plan data is reported as commercial plan data rather than being carved out. HCA updates reporting specifications for the data call to meet current policy needs regularly, which allows for greater flexibility. Next year's updated primary care definition can be easily incorporated into the data call.



There are several lessons that can be learned from HCA and the Office of Financial Management's (OFM's) past efforts to collect claims-based data. There can be incomplete payer participation in data reporting due to the federal prohibition which exempts ERISA plans from reporting. The location of primary care services was previously unavailable in the APCD. There can be a risk of inconsistent application of reporting methodologies when plans self-report (this is an issue for the data call, not the APCD). It can be difficult to isolate the primary care component of expenditures when: primary care is included in bundled payments, when primary care spending is a component of Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) claims-based encounters, and when primary care spending is part of a comprehensive payment (capitation or otherwise) made to an integrated system. Finally, Medicare fee-for-service (FFS) data lags behind other data types, by a period of two years.

The presentations at the previous primary care committee meeting outlined several data collection barriers for non-claims-based spending. It is hard to isolate primary care spending in a non-claims payment of services that are part of a broader scope of services. To properly account for non-based-claims payments, there must be a standard categorical framework applied to the payments by subcategory. There is a risk of inconsistent application of reporting methodologies when plans self-report data (this is also a barrier for traditional claims-based data). Some of these barriers apply to the APCD as a data source, some apply to HCA's data call, and some don't apply to Washington's current data infrastructure.

Committee member David DiGiuseppe suggested accounting for how the definition varies by percent threshold across states. There may be policy considerations to account for based on the different definitions which can be applied as data is collected. Shane Mofford noted that the aggregated data call solves for many of the challenges posed. The committee will be choosing principles/criteria for data collection and one of those principles could be to maintain the integrity and consistency of the data by applying processes consistently over time to the extent possible.

A gap analysis revealed two high-level categories of data collection issues: the mechanism of data collection and a standardized reporting framework. Questions related to the mechanism of data collection include: how is the data collected and what are the implications for consistency, completeness, and accountability? Questions related to the data reporting framework include: what data is reported and how is it organized?

The committee has made progress on the data collection mechanism by developing a Washington specific definition that can be updated into the current data call process. HCA already collects some information on non-claims-based expenditures. There are, however, some persistent challenges. The committee needs to think about whether the challenges are tolerable or must be changed and improved upon. Some of the challenges include: multiple entities calculate primary care spending based on state-provided specifications, there is an opportunity for inconsistent application of the specifications; self-reported aggregate data reduces accountability and transparency (e.g., to the extent that there is a mechanism to hold payers accountable for a spending target, when there's room for interpretation, there isn't a proper validation mechanism); the collection process is administratively burdensome and partially duplicative with APCD reporting by plans. These challenges show what the current processes are and potential weaknesses.

Some states have updated the data collection of their APCD to collect non-claims-based expenditures and other data elements used to calculate primary care spending. There are several considerations: Some payers that optionally report aggregate data may not opt to report detailed data, it would take significant time (could take many years) and resources for the APCD to become a single solution for payer expenditure reporting, changing methodologies (from data call to APCD if it became available in the future) would result in changes in benchmark and expenditure reporting that could be disruptive. It may be worth exploring if the APCD is the best long-term

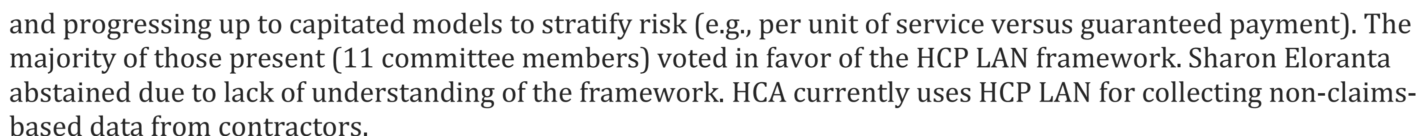
solution for the state. The decision to change the APCD will largely depend on the state's long-term vision as well as if other use cases are supported by the investment of resources required for comprehensive expenditure reporting.

Committee members were polled to provide principles they would recommend the state adhere to when implementing data reporting processes to calculate primary care expenditures. Policy recommendations don't have to be constrained by what's available today. There could be recommendations for additional resources from the Legislature in the future. Some of the principles selected were completeness, ease of collection, consistency, transparency, ability to apply reasonability checks on data, ability of HCA to analyze APCD data, and pragmatism.

David DiGiuseppe asked for clarification of state resources for analytic capabilities. There are some resources allocated to the cost board, but they are limited. A preliminary analysis will provide more information on what the codes look like before they are fully finalized. There is a tradeoff between interpreting the APCD for detailed access versus relying on data suppliers running a primary care algorithm to submit a total dollar amount. The aggregate data call captures more plans' data which can't be captured fully by the ACPD. If there are 20 entities applying a standard to a calculation, that standard may be inconsistently applied. It's difficult to estimate the magnitude of some of the reporting issues (e.g., variation). David DiGiuseppe asked whether claims could be limited to APCD processing where non-claims-based would be supplied by the data call. Shane Mofford pointed out there would still be some data loss from the APCD process for claims-based data. Dr. Zerzan-Thul noted it would be hard to divide claims and non-claims-based information from different sources, rendering the process incomplete to an uncertain degree. David DiGiuseppe asked whether completeness as a principle would rule out using the APCD. Shane Mofford noted that completeness is only a problem if there is significant variation in reporting, which is hard to know at this time. One principle could focus on maximizing the stability of the primary care definition over time so that there is a single data solution in the future to reduce instability in reported statistics. Committee member Michele Causley asked for further clarification between the two data sources. It's unknown how differently payers might interpret measurement methodologies. Committee member Mandy Stahre pointed out that it's easier for one person to apply methodologies across available data rather than multiple entities handing off results. It's easier to put parameters on the data when there's only one data processor. Committee member Sharon Eloranta explained that the Washington Health Alliance notes when data comes in from a certain payer and there's an expected ballpark for how many claims will be received. Committee member Nancy Connolly asked whether there are models that rely more on providers than payers to submit claims. This doesn't exist for claims-based expenditures currently due to administrative burden. Dr. Zerzan-Thul noted that payers only pay a portion of provider submitted claims. It would be difficult to distinguish the different amounts received by providers from different payers depending upon payment arrangements. Nancy Connolly noted that payments to providers get diluted when transmitted to payers. Shane Mofford noted that a disconnect between services rendered and final payment connects to the principle of data completeness. Committee member Katina Rue also endorsed looking more closely at data from a provider perspective to account for services that might be underpaid. Shane Mofford suggested that the committee could look at this more closely when the committee discusses policy principles, e.g., how to pay more for primary care and consider alternative payment methodologies.

The second high-level category in the data collection gap analysis was the use of a standardized reporting format. The current legislative statute requires stratification of payments by payment type. Reporting by payment type is also an accountability mechanism that allows for tracking progress on offering sustainable/accountable payment models to providers. The state will need to develop allocation methodologies to estimate the portion of bundled/capitated/non-claims-based reimbursements that should be classified as primary care expenditures.

Committee members were polled on their support for using a Health Care Payment Learning Action Network (HCP-LAN) based categorization strategy. This framework, used nationally, has four major categories starting from FFS



and progressing up to capitated models to stratify risk (e.g., per unit of service versus guaranteed payment). The majority of those present (11 committee members) voted in favor of the HCP LAN framework. Sharon Eloranta abstained due to lack of understanding of the framework. HCA currently uses HCP LAN for collecting non-claims-based data from contractors.

Committee members were polled on what principles the state should adhere to when refining the data reporting framework. Responses will be taken back to HCA staff to consider and vet for further refinement. Committee member Jon Staloff asked for clarification on what was meant by the reporting framework. Shane Mofford clarified that the data call has a specific way to gather information from payers. Whatever principles the committee chooses may be used to update the current collection process, e.g., risk stratification categories, notation of primary care payment types, etc. David DiGiuseppe asked if the reporting came from carriers to HCA or from HCA to the Legislature. Shane Mofford clarified that this is how payers report to HCA. David DiGiuseppe asked whether there would be detailed criteria for payers to use when reporting. Some of the principles selected included: transparency, alignment with industry standards, when possible, the ability to track data over time, including demographic information (as able) to track primary care investment with an equity lens, and ease of access.

## Code review finalization

Dr. Judy Zerzan-Thul, HCA

The committee previously approved intrauterine device (IUD) placement codes. Dr. Zerzan-Thul called for a motion to approve adding code 58301(removal of IUDs). The motion was seconded and passed with a majority of votes.

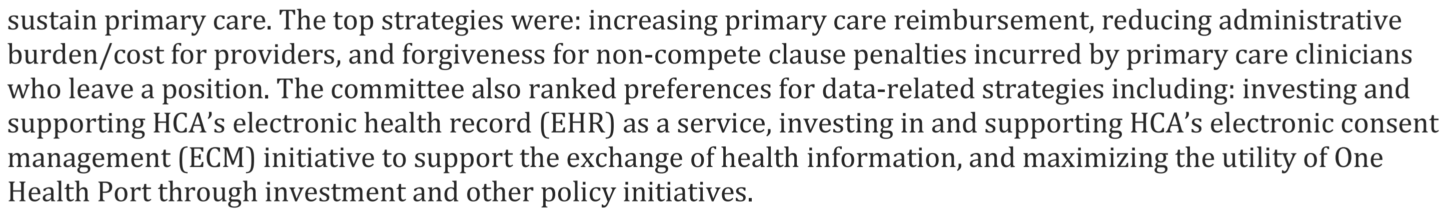
HCA is currently performing a utilization analysis of codes selected and voted on by the committee. These codes have been stratified by location and utilization. Highlighted codes will fall into two categories: codes that were included but had low utilization, and codes that were excluded by the committee, but utilization is very high or the utilization by primary care providers is a large percent of the overall utilization of the codes. The committee will also review the provider location to see how much it impacts the combination of who, what, and where and if the field is reliably populated.

David DiGiuseppe suggested differentiating between the different percentage thresholds used by Washington and other states when analyzing the data. Nancy Connolly asked whether location is purely physical or accounts for team-based delivery of services. Dr. Zerzan-Thul clarified that it won't be possible to identify a team-based component, so location is limited to physical address. Sharon Eloranta noted that location makes a great deal of difference. One of the issues with price transparency is that the biller of services will bill from the address inside an office building instead of the place of service code. This is a big issue with the current trend towards the consolidation of health systems. This is a data collection barrier. Sharon Eloranta will check with the Alliance to follow up on this issue to see what reasonability checks currently exist. Jonathan Staloff asked whether the combined methods of who, what, and where came from the University of Washington (UW) lab. The combined method does come from UW and there will be more details provided on the methodology when the analysis results come back to the group for review.

## Preparation for next meeting – policy recommendation framework

Shane Mofford, CEbP

Shane Mofford reviewed the legislative charge to achieve the 12 percent primary care spending target and the four domains that influence primary care spending: direct investment, capacity growth, patient action, and reduced expenditure on other services. The committee initially came up with a list of 11 general strategies to increase and



sustain primary care. The top strategies were: increasing primary care reimbursement, reducing administrative burden/cost for providers, and forgiveness for non-compete clause penalties incurred by primary care clinicians who leave a position. The committee also ranked preferences for data-related strategies including: investing and supporting HCA's electronic health record (EHR) as a service, investing in and supporting HCA's electronic consent management (ECM) initiative to support the exchange of health information, and maximizing the utility of One Health Port through investment and other policy initiatives.

At the next meeting, the committee will revisit the lists of policies and will: refine the lists, provide a greater level of detail on individual policies, discuss high-level strategies for each recommendation, and discuss accountability and incentives for the different actors to execute the policy recommendations. Committee member Maddy Wiley asked what other states and regions have done to implement primary care policies. There will be additional context provided around other states' policies and how they align with the policies this committee is interested in. Jon Staloff asked that any materials related to the making care primary initiative be included for review before the next committee meeting.

### Adjournment

The meeting adjourned at 4:00 p.m.

## Next meeting

July 25, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.