Advisory Committee on Primary Care meeting

Washington State Health Care Authority

Washington State Health Care Authority

Advisory Committee on Primary Care
Meeting Materials

May 25, 2023
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting materials

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Advisory Committee on Primary Care

May 25, 2023
2:00 p.m. – 4:00 p.m.
Zoom Meeting

AGENDA

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

Time	Agenda Items	Tab	Lead
2:00-2:05 (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 April meeting summary	2	Jean Marie Dreyer, Committee Manager Washington State Health Care Authority
2:10-2:50 (40 min)	Presentation: Defining Non-Claims Based Primary Care Spending	3	Michael Bailit, Bailit Health
2:50-3:30 (40 min)	Presentation: Payment Arrangement File Measuring Non-Claims-Based Payments	5	Karen Hampton, Oregon Health Authority
3:30-3:45 (15 min)	Voting on remaining code-sets	7	Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
3:45-3:55 (10 min)	Public Comment		
3:55-4:00 (5 min)	Wrap-up and adjournment		Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority

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

Tab 2

Advisory Committee on Primary Care Meeting Summary

April 27, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

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

Members present

Judy Zerzan-Thul, Chair
Tony Butruille
Chandra Hicks
Ginny Weir
Katina Rue
Kristal Albrecht
Sheryl Morelli
Lan H. Nguyen
Linda Van Hoff
Mandy Stahre
Michele Causley
Nancy Connolly
Sharon Eloranta
Jonathan Staloff
Staici West
Shawn West
Madeline Wiley

Members absent

Tracy Corgiat
D.C. Dugdale
David DiGiuseppe
Gregory Marchand
Eileen Ravella
Kevin Phelan
Meg Jones
Sarah Stokes
Sharon Brown

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 March meeting summary

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

Topics for Today

The main topics were a presentation on and discussion of committee charges, a proposed amendment to the primary care definition, and discussion and voting on remaining code sets.

Public Comment

There were no public comments.

Presentation of Committee Charges

Jean Marie Dreyer, HCA

Jean Marie Dreyer reviewed the three categories of Legislative statute SB 5589: the primary care definition, data to support primary care, and policies to increase and sustain primary care. Throughout the meeting, each category was addressed and committee members had the opportunity to provide feedback through polling.

Proposed Amendment to Primary Care Definition

Jean Marie Dreyer, HCA

Jean Marie Dreyer presented a proposed amendment to the committee's approved definition of primary care received from a Washington State Hospital Association (WSHA) representative. Committee member Nancy Connolly suggested rewording the amendment to say, "to support patients in working towards their goals of physical, mental, and social health and wellbeing." This comes from the World Health Organization's definition of health. Committee member Linda Van Hoff suggested the language, "to promote overall health and wellness through illness prevention and minimizing disease burden via a continuous relationship over time." It's important to emphasize health promotion and preventive health. Committee member Lan Nguyen noted that the language, "create and maintain" places the ownership solely on providers whereas there could be language added "in partnership with" patients.

The amended definition read as:

> "Team-based care led by an accountable primary care clinician that serves as a person's source of primary contact with the larger healthcare system. Primary care includes a comprehensive array of equitable, evidence-informed services to support patients in working toward their goals of physical, mental, and social health and the general wellbeing of each person, through illness prevention, and minimizing disease burden, through a continuous relationship over time. This array of services is coordinated by the accountable primary care clinician but may exist in multiple care settings or be delivered in a variety of modes."

Dr. Zerzan-Thul proposed a motion to adopt the adapted definition. The motion passed unanimously.

Data to Support Primary Care

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

HCA and CEbP highlighted the National Academy of Sciences, Engineering and Medicine's (NASEM) research process to identify strategies at a national level for the Centers for Medicare and Medicaid (CMS). NASEM's five objectives for achieving high-quality primary care are: 1) Pay for primary care teams to care for people, not doctors to deliver services, 2) ensure that high-quality primary care is available to every individual and family in every community 3) train primary care teams where people live and work 4) design information technology that serves the patient, family, and interprofessional team, and 5) ensure that high-quality primary care is implemented in the U.S. These objectives largely align with this Committee's and Washington's goals to support primary care.

The data team from HCA reviewed NASEM's strategies and added context for Washington's current data strategies. NASEM's first data strategy recommendation is around meaningful exchange of data through: a centralized warehouse, an individual health data card, or distributed sources connected by a real-time functional health information exchange. HCA has four existing health exchange methods: a clinical data repository, the Washington All-Payer Claims Database, Washington's Health Information Exchange (HIE) operated by One Health Port, and Washington's Master Person Index (MPI). NASEM's second data strategy focuses on accountability and infrastructure for technology in place for electronic health records (EHRs). Washington currently has HCA's EHR-as-a-service initiative, and an Electronic Consent Management (ECM) initiative.

Shane Mofford polled the committee on existing data policies to recommend for measurement and support of primary care. The poll allowed members to list additional data policy suggestions. Dr. Zerzan-Thul emphasized that these suggested policies will be incorporated into the Cost Board's annual report to the Legislature. The highest support was expressed for HCA's EHR-as-a-service-initiative, followed by HCA's ECM initiative.

Committee member Chandra Hicks asked to what extent the Total Medical Expenditures (TME) and cost growth data are useful/applicable for these types of data policies. Shane Mofford replied that there is a suite of use cases to support the use of primary care data. Of the existing initiatives, some relate directly to primary care expenditures while others pertain to access to care. It's not just about increasing expenditures but increasing positive patient outcomes.

Committee member Maddy Wiley pointed out that adding an identification code could create privacy issues. Committee member Mandy Stahre noted an absence of expanding the workforce in the data suggestions. Shane Mofford clarified that the next section would reference workforce as part of other policy recommendations. Linda Van Hoff noted that investing in the EHR initiative will necessitate analyzing connectivity. Building a technical bridge is complicated and the group should think about who is responsible for building that infrastructure.

Policies to Increase and Support Primary Care

Gretchen Morley, CEbP

Gretchen Morley led a discussion of strategies to drive toward the 12 percent primary care expenditure target. There are four key dynamics that influence primary care expenditure statistics: direct investment, capacity growth, patient behavior (increased use of primary care services), and reduced expenditures on other services. Gretchen Morley reviewed the key actors, levers, and strategies involved in each of the four key dynamics.

Additionally, Gretchen Morley presented NASEM strategies that support primary care sustainability. NASEM recommends moving away from fee-for-service (FFS) models to alternative models with either full or partly capitated models. NASEM also recommends that states use their authority to facilitate multi-payer collaboration on primary care payment and fee schedules. Washington payers, purchasers, and providers continue to collaborate to develop a new framework to support primary care through payment models, provider supports, and aligned policies to reduce administrative burden, to develop consistent standards and expectations. NASEM also recommends diversifying the primary care workforce to expand the type of available providers through training and economic incentives. To impact patient behavior, NASEM recommends that all covered individuals declare a usual source of primary care annually.

Committee member Sheryl Morelli commented on how different it is to compare the adult and pediatric population for primary care spending.

Committee members ranked increasing primary care reimbursement as a top priority to support achievement of the primary care target. The second priority was increasing payer focus on reducing administrative burdens/costs for providers, followed by forgiveness for non-compete clause penalties.

Committee member Sharon Eloranta commented that she did not want to fill out the poll before tabulating the existing spending on primary care. There was no policy included in the poll requiring health carriers to designate a primary care provider (PCP) for each member to ensure proper attribution. Committee member Michele Causley noted that Oregon has a bill requiring health carriers to assign a PCP. This poses challenges because employers want open access.

Committee member Jonathan Staloff noted that in addition to increasing reimbursement for primary care services, it's important to bolster Medicaid reimbursement to support equity in primary care services, and Maddy Wiley agreed. It could also be useful to create financial incentives for receiving evidence-based preventive services. For training PCPs, there could be more support for teaching health center residencies in rural areas. Also, there are many non-compete clauses which incur significant financial penalties for providers that could be amended. Nancy Connolly expressed support for eliminating non-compete clauses.

Sharon Eloranta asked how facility fees will be calculated to avoid rewarding locations that are already up charging.

Code Review Finalization

Dr. Judy Zerzan-Thul, HCA

Dr. Zerzan-Thul led voting on the remaining primary care service code sets. Dr. Zerzan-Thul made a motion to include the full set of codes for domiciliary, rest home, or custodial care services. The motion passed unanimously.

Next, Dr. Zerzan-Thul made a motion to include the full set of codes for prolonged services. Michele Causley commented that many of these codes were deleted in 2023 and replaced by a new code, 99417. This set would be relevant for reviewing past data, but the new code would need to be included. The motion passed unanimously.

Dr. Zerzan-Thul moved to exclude all codes in lab testing and supplies (Part 1). The motion passed unanimously.

Dr. Zerzan-Thul moved to exclude all codes in lab testing and supplies (Part 2). The motion passed unanimously.

Next, Nancy Connolly moved to include all codes in temporary codes (Part 1). Linda Van Hoff asked if it was important to exclude the EKG code. Sharon Eloranta proposed excluding the EKG code. Maddy Wiley also agreed with removing it. Committee member Kristal Albrecht proposed an amendment to include all codes except the EKG code. The motion passed unanimously.

The next category was temporary codes (Part 2). "Ppps" is a code to designate an annual wellness visit. Michele Causley noted that wellness codes are more informational and not based on reimbursement. Linda Van Hoff cautioned against excluding codes that were informational. Kristal Albrecht also expressed hesitancy to remove the ppps code but supported removing EKG. Kristal Albrecht made a motion to include all but the EKG codes. The motion passed unanimously.

Dr. Zerzan-Thul moved to include and exclude temporary codes (Part 3). The motion passed unanimously.

For supervision, Dr. Zerzan-Thul made a motion to include all codes except those relating to nursing facilities. Nancy Connolly advised that hospice is generally characterized as primary care. Maddy Wiley and Tony Butruille agreed. Jonathan Staloff noted that the *what* and the *who* of hospice is primary care, but the *where* is changeable depending on the setting. Maddy Wiley suggested that the billing codes would differ for inpatient. There should be a site of service that can be excluded from the professional claim. Jonathan Staloff moved to include and exclude as noted on the slide while also excluding anything that's inpatient. The motion passed unanimously.

Dr. Zerzan-Thul made a motion to exclude all codes in cardiac and pulmonary testing/procedures. The motion passed unanimously.

Dr. Zerzan-Thul made a motion to exclude all codes in dermatology. Sharon Eloranta asked whether this would affect increases in reimbursement and added that many of these codes could happen in a primary care setting. Dr. Zerzan-Thul noted that because these codes are revenue generating it might artificially increase the 12 percent. Maddy Wiley agreed that this set of codes isn't core primary care. The motion passed unanimously.

The next category was newborn care services. Only 25 percent of other state definitions include these codes. Dr. Zerzan-Thul made a motion to exclude the codes in this category. Maddy Wiley said the 99461 code is not used as a first newborn visit code. The motion passed unanimously.

The next category was obstetrics. Some states include a percentage of these codes, like Oregon. Dr. Zerzan-Thul proposed excluding all codes in this set. There were insufficient votes, so this category will be voted on at the next meeting.

Adjournment

The meeting adjourned at 4:00 p.m.

Next meeting

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

Tab 3

Washington State Health Care Authority

Defining Non-claims-based Primary Care Spend

Presentation to the Advisory Committee on Primary Care

May 25, 2023

bailit health

Agenda

- Project Purpose and Methodology
- Proposed Methodology for Measuring Non-Claims-Based Spending
- Questions

Purpose and Methodology

Origins

The Milbank Memorial Fund believes that standardized measurement of primary care spending will support ***increased attention to financial support for primary care***.

Quantifying investment in primary care requires measuring **claims-based** and **non-claims-based payments.**

- Existing data sources can be leveraged to measure claims-based primary care spending, yielding a consistent data collection process across states.
- There is significant variation, however, in how states are measuring non-claims-based spending.

Goal

Milbank aimed to develop a standardized methodology for collecting and analyzing non-claims-based primary care spending.

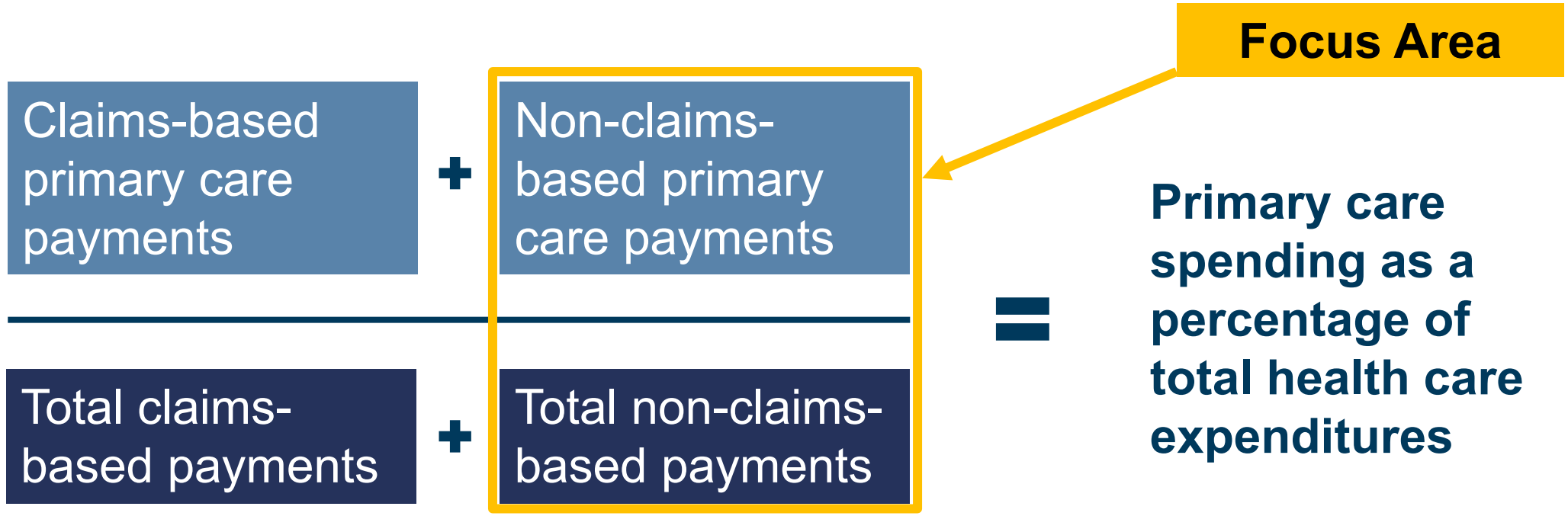

Figure adapted from the Oregon Health Authority

Methodology

- Bailit Health, at the request of Milbank, convened an advisory group of state officials, payers, and providers in 2020 to inform the methodology.
- The advisory group discussed key policy and design questions over the course of four virtual meetings.
  - The design questions were informed by the findings from Carmen, Reid, and Damberg a 2020 RAND research report.
- Bailit Health solicited additional feedback from payers in Colorado and Rhode Island to confirm that the proposed approach was sound and feasible.

Publication

https://www.milbank.org/publications/measuring-non-claims-based-primary-care-spending/

Proposed Methodology for Measuring Non-Claims-Based Spending

Six Recommendations for Measuring Non-Claims-Based Spending

1. States should adopt a **standard categorical framework** and collect non-claims-based payments by subcategory.
2. States should apply a **default percentage** to each subcategory to determine the primary care portion of non-claims-based payments.
3. States should include **all non-claims-based spending, except long-term care and dental services**, for primary care and non-primary care in the **denominator**.
4. States should **collect and report** data at the **state**, **market**, **insurer** (by market) and **large provider entity** levels.
5. States should convene **technical advisory groups** to support implementation of this approach.
6. States should **define the population** for which data will be collected.

Defining and Collecting Non-Claims-Based Payments

1

> Recommendation: States should adopt a standard categorical framework and collect non-claims-based payments by subcategory.

Category	Subcategory(ies)
1. Prospective Capitated, Case Rate, or Episode-based Payments	• Capitation payments • Global budget payments • Prospective case rate payments • Prospective episode-based payments
2. Primary Care Performance Incentive Payments	• Risk-based payments (shared savings distributions; shared risk recoupments) • Retrospective / prospective incentive payments (P4P; P4R)
3. Payments for Primary Care Provider Salaries	• Provider salary payments
4. Payments to Support Population Health and Practice Infrastructure	• Care management / care coordination / population health • Data analytics • EHR/HIT infrastructure payments • Medication reconciliation • PCMH recognition payments • Primary care and behavioral health integration
5. Recovery	• Recoveries
6. Other Payments	• Other

Attributing Non-Claims Spending to Primary Care

2

- Recommendation: States should apply a default percentage to each non-claims-based payment subcategory to determine the primary care portion of non-claims-based payments to health systems or other multi-specialty provider organizations that include primary care.
  - Attributing primary care spending for primary care-only entities is straightforward.
  - For entities without primary care clinicians, it is also straightforward because there would be no primary care-related spending in reported non-claims-based spending.
  - Payments made to health care systems / multi-specialty provider groups / accountable care organizations, and independent physician associations are more complicated.

Sample Template for Defaulting Primary Care Spending Percentages

Table 1: Payments to Primary Care-Only Organizations

#	Non-claims-based Payment Categories and Subcategories	Percentage Attributed to Primary Care	Primary Care Non-claims-based Spending	Non-primary Care Non-claims-based Spending	Total Non-claims-based Spending
1.	**Prospective Capitated, Case Rate or Episode-based Payments**	N/A	$0.00	N/A	$0.00
a.	Capitation payments	N/A		N/A	$0.00
b.	Global budget payments	N/A		N/A	$0.00
c.	Prospective case rate payments	N/A		N/A	$0.00
d.	Prospective episode-based payments	N/A		N/A	$0.00
	Total Payments	N/A	$0.00	N/A	$0.00

Table 2: Payments to Health Systems or Multi-Specialty Provider Organizations that Include Primary Care

#	Non-claims-based Payment Categories and Subcategories	Percentage Attributed to Primary Care *Illustrative Only*	Primary Care Non-claims-based Spending	Non-primary Care Non-claims-based Spending	Total Non-claims-based Spending
1.	**Prospective Capitated, Case Rate or Episode-based Payments**		$0.00	$0.00	$0.00
a.	Capitation payments	100%	$0.00	$0.00	
b.	Global budget payments	6%	$0.00	$0.00	
c.	Prospective case rate payments	100%	$0.00	$0.00	
d.	Prospective episode-based payments	100%	$0.00	$0.00	
	Total Payments		$0.00	$0.00	$0.00

Table 3: Payments to Organizations that Do Not Include Primary Care Clinicians

	Non-claims-based Payment Categories and Subcategories	Percentage Attributed to Primary Care	Primary Care Non-claims-based Spending	Non-primary Care Non-claims-based Spending	Total Non-claims-based Spending
	Total Non-claims-based Payments	N/A	N/A	$0.00	

This framework **does not** include payments that fund public or multi-provider infrastructure. (For example, Rhode Island includes payer investment in a statewide health information exchange in its definition of primary care spend.) States can modify this modify this framework to include additional rows to capture these payment types.

Table 4: Summary of Total Payments

Total Primary Care Non-claims-based Spending	Total Non-primary Care Non-claims-based Spending	Total Non-claims-based Spending
$0.00	**$0.00**	**$0.00**

Standardizing the Denominator: Inclusions / Exclusions

3

> Recommendation: States should include all non-claims-based spending for primary care and non-primary care in the total non-claims-based spending denominator, with the following notes:

- Inclusion: Pharmacy rebates
  - Pharmacy rebates are a substantial non-claims-based offset to pharmacy spending. Including rebates in the denominator will yield a more precise assessment of non-claims-based spend.
- Exclusions: Long-term care and dental services
  - Long-term care and dental services are typically only covered by Medicaid. Excluding these categories supports comparison of spend across Medicaid, Medicare and commercial populations.

Establishing Levels for Collection and Reporting

4

> Recommendation: States should collect and report data at the state, market, insurer (by market) and large provider entity levels.

Level	Rationale for Collection / Reporting
State	• Offers a snapshot of the level of investment payers and providers in the state are making toward primary care
Market	• Recognizes differences in spending pattern by population given differences in demographics and payment policy
Insurer, by Market	• Insurers have varying degrees of control over spending levels and can therefore influence % of spend to primary care
Large Provider Entity	• Promotes transparency and can support identification of variation in adoption of value-based contracting. • Also, large provider entities, especially those employing clinicians and those assuming risk, have some measure of influence over the distribution of payments among providers.

Convening Technical Advisory Groups

5

> Recommendation: States should convene technical advisory groups to support implementation of this approach.

- Technical advisory groups can assist states with:
  - implementing the recommended approach (e.g., including examples of state-specific programs that would fall in each spending category);
  - developing a process for collecting and validating data from payers;
  - creating alignment between primary care spend efforts with existing statewide efforts (e.g., cost growth target programs), and
  - facilitating documentation of the way a state is categorizing payments to ensure consistency for comparison purposes (within the state and cross-state).

Defining the Population for Which Data Are Collected

> Recommendation: States should define the population for which data will be collected.

Options	Advantages	Disadvantages
1. Location of the Resident and the Provider	• Applied with existing primary care spend target programs/studies (e.g., CT, DE, OR, RI and NESCSO) and cost growth benchmark programs • APCDs are organized to capture spending for state residents • May yield a more stable year-over-year population that is less sensitive to fluctuations associated with corporations shifting office locations	• States do not regulate insurance contracts written in other states (even if they cover state residents) • May be challenging for payers to identify how to allocate non-FFS payments to only residents of a state if the contract covers care for non-state residents
2. Situs of the Insurance Contract	• States regulate insurance contracts in their state.	• If contracts cover different populations, it may be inappropriate to combine data for aggregate statistics or for calculating the share of spending through APMs. • Does not align with existing state primary care spend target and cost growth benchmark programs.

Questions?

Michael Bailit

Bailit Health

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Appendix

Operational Definitions and Concepts

- Non-claims-based: Payments that are made for something other than a fee-for-service claim. Non-claims-based payments can be based on historical claims data, but they are not paid on a fee-for-service claims basis.
- Primary care services: All medical services delivered by family medicine, general internal medicine, general pediatrics, and general practice physicians and their non-physician practice colleagues, as well as by geriatric and adolescent medicine physicians and their non-physician practice colleagues.
- Primary care spending: Payments to organizations that deliver primary care services or that contract with payers on behalf of providers of primary care services. This may include organizations that deliver services beyond primary care.

Tab 4

Washington State Health Care Authority

Presentation 1 - What were the most important takeaways from your perspective?

Nobody has responded yet.

Hang tight! Responses are coming in.

Presentation 1 - What policies/strategies should Washington adopt that address the key takeaways?

Nobody has responded yet.

Hang tight! Responses are coming in.

Tab 5

Washington State Health Care Authority

Payment Arrangement File
Measuring non-claims based payments

Oregon All Payer All Claims for
Washington State Health Care Authority
May 25, 2023

APAC
ALL PAYER • ALL CLAIMS

Oregon Health Authority

Organization for today

- Identifying who is required to submit
- What is reported and how
  - Using non-data as data
- Resource planning and interactions
- Communication
- Data validation and processing
- Compliance
  - Direct compliance
  - Indirect through publication of data

APAC
ALL PAYER • ALL CLAIMS

Oregon Health Authority

IDENTIFYING WHO IS REQUIRED TO REPORT

Identifying who is required to report
Same group as claims or variation?

Recommendation – if writing law, go with broad purpose for flexibility in meeting future needs

- Oregon law specifies mandatory reporters, but not file content; this allows APAC to determine best use of resources
  - Oregon Revised Statute (ORS) 442.372 defines 'reporting entity' but does not tie reporter to specific data requirements
  - ORS 442.373 identifies
    - Purposes for which data is collected
    - Standards applied (X12, CMS, NCDPP)
    - Coding system that reflects all health care utilization and costs
  - ORS 442.373 has useful phrases such as 'including but not limited to' and 'determined by the authority to be necessary to carry out the purposes of this section'

Who – same group or variation?

Recommendation – Consider data needed and sources of usable data in crafting the data reporters

- Oregon chose variation
  - Pharmacy benefit managers excluded from reporting payment arrangement files as currently all activity is per service/prescription
  - Coordinated care organizations, Oregon's Medicaid contractors, report payment arrangement files but do not directly report claims
    - OHA assumed responsibility for submitting claims under contracts
- Insurers, including those providing Medicare Part A, B or D, third party administrators, and health care service contractors file both claims and payment arrangement file directly

WHAT IS REPORTED AND HOW

Determining file layout (what is collected)

Recommendation – If possible, involve potential reporters before finalizing content and process through a use case review

- Data required determined from what is available or what is needed?
  - Selection criteria for what is reported – contract situs
    - Inclusion criteria for payment arrangement different than claims
  - Location of information within the organization
    - Oregon requirements for the payment arrangement file pushed reporters to new areas of their business
    - IT hadn't connected with Contracts/Procurement when reporting claims but doing so is essential for payment arrangement files
  - Oregon did a use case review with mandatory reporters' technical representatives two years after started collecting

Determining file layout (how collected)

Recommendation – Establish standard file layouts, error (data quality) thresholds and field details (for example, decimals implied or explicit)

- Standard files are easier to validate and administer
  - Standard field contents, formatting, etc. (content, length, character or numeric, decimal yes or no)
  - File naming convention included at the end of each file type
  - Use a control file (separate or header row) as first validation of data completeness and quality
- Oregon established a file layout for traditional .txt and controlled template excel file (scraped by vendor)

Payment Arrangement Files

All mandatory reporters except Pharmacy Benefit Managers must report payment arrangements on an annual basis. Payment arrangement files must include data for group contracts sitused in Oregon and data for individual contracts where the subscriber resides in Oregon. OAR 409-025-0125

Appendix 1: Payment Arrangement File

Note: PBM's that offer stand-alone prescription drug plans are not required to file this report, nor do they have to file a Form APAC-1 (waiver or exception of reporting requirements).

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
PRAPM003	Contract ID	Text	30 Min. length 2	Yes	Internal ID of the entity receiving the payment or bearing the risk. Contract ID can be proprietary (i.e. specific to the payer reporting the data) but should be consistent throughout all reporting so that all payments/risk attributed to the same Contract ID can be summed up to capture the total payments/risk attributable to that contract entity by the payer. If PRAPM103 = A, then leave this field blank If PRAPM103 = V, then leave this field blankl	1.0%
PRAPM018	Billing Provider or Organization NPI	Text	10	Yes	NPI for the billing provider or organization which received the payment from the mandatory reporter If PRAPM103 = 2Ai, then report the PCPCH Practice ID in this field	1.0%

Excel version of the Payment Arrangement File

Basic information starting on left

Contract ID	Provider NPI	Provider Tax ID	Last Name	First Name	Entity Type	Line of Business	Payment Model	Perf. Period Start	Perf. Period End	Member Months

Additional fields to the right

Submitted Amounts				Prorated Amounts				
Total PC Claims Payments	Total PC Non-Claims Payments	Total Claims Payments	Total Non-Claims Payments	Member Months	Total PC Claims Payments	Total PC Non-Claims Payments	Total Claims Payments	Total Non-Claims Payments

Second worksheet gives an option to check results before submitting

Line of Business	Payment Model	# of Unique Provider	# of member months	Total PC Claim Payments	Total PC Non Claim Payments	Total Claim Payments	Total Non Claim Payments	PC Claims PMPM	PC Non Claims PMPM	Claims PMPM	Non Claims PMPM

APAC ALL PAYER • ALL CLAIMS

Oregon Health Authority

Using non-data as data

Using non-data as data

Recommendation – Instructions are critical for comparability and consistency year to year

- Contract level payment information does not originate as data
  - After several years, still no mention of writing a provider group contract by LAN category
  - Someone is using their best judgment to slot into the correct box

Two examples from Oregon

- Primary care determination is critical for Oregon's needs and unclear
  - Definition of primary care includes provider type/taxonomy and either ICD or CPT because that is required in law for primary care spending report
  - Detailed in FAQ document; moving this year to lookup table in file layout
- Payment methodology determination
  - Oregon uses modified HCP-LAN categories to accommodate our needs
  - The data reporter determines the category and assigns amount paid

Oregon primary care determination

Lookup Table PRAPM107: Total Primary Care Claims Payments

Primary care claims payments are payments made to a primary care provider (condition 1) for a primary care service (condition 2). Payments must be to a primary care provider for a primary care service.

Primary Care Provider Taxonomy Table (condition 1):

Taxonomy code	Description
261QF0400X	Federally Qualified Health Center
261QP2300X	Primary care clinic
261QR1300X	Rural Health Center
207Q00000X	Physician, family medicine

Primary Care Service Table (condition 2 – CPT or ICD)

CPT Codes	Description
59400	Routine obstetric care including vaginal delivery (global code) *60% of payment
59510	Routine obstetric care including cesarean delivery (global code) *60% of payment
59610	Routine obstetric care including VBAC delivery (global code) *60% of payment

ICD-10 Code	Description
G0507	Care management services for behavioral health conditions
G0513-G0514	Prolonged preventive service
Z00	Encounter for general exam without complaint
Z000	Encounter for general adult medical examination

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HCP-LAN categories for alternate payment methodology

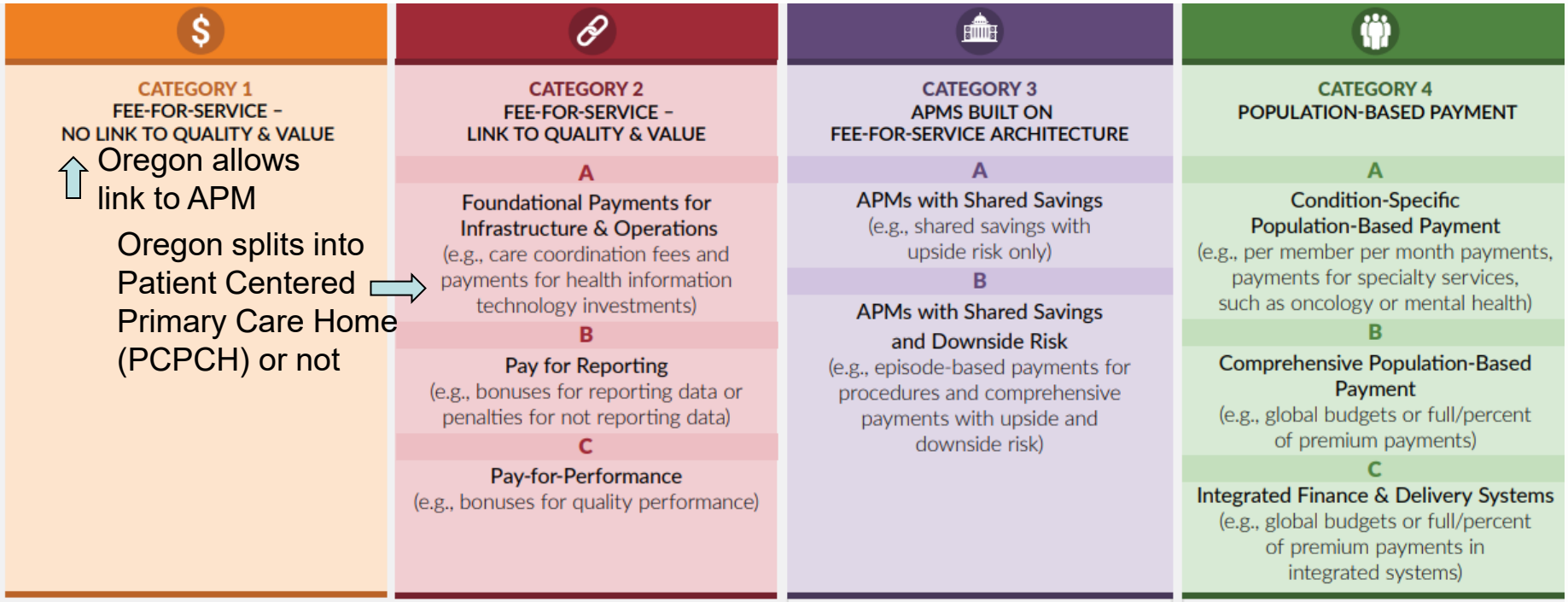

Figure 1: The Updated APM Framework

http://hcp-lan.org/workproducts/apm-factsheet.pdf

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RESOURCE PLANNING

Resource planning

Recommendation – As non-claims reporting is incorporated, consider how it interacts in timing with the program's and the data submitters' other obligations

- Claims files due four times a year, rolling twelve months, new file layout start January 31 for previous calendar year's data
- Payment arrangement file once a calendar year (twelve months) nine months after close for more complete data
- Rulemaking

Type	Discussion/process	Effective data	In use
Claims	June – September	December 1	January 31
PAF	January – May	August 1	September 30

  - File layouts incorporated in rules by reference
    - Requires rulemaking to change layouts
    - Certainty for mandatory reporters (timing of changes)
    - Easier to require compliance for program

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COMMUNICATION

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Communication needs

Recommendation – less frequent activity needs more frequent deliberate communication

- Effective communication is more difficult when communication is infrequent
  - In 2022, started requiring contact information from mandatory reporters
    Compliance officer Business lead IT lead
  - Coordinated care organizations only submit the payment arrangement file directly (once a year); claims are reported through OHA
  - Establishing standard contact process with Compliance officers, copying business leads and IT leads
- Everything covered in a Technical Advisory Group (TAG) meeting
  - Oregon TAG has chosen to be advisory and does not make group recommendations
  - Changes in file layouts or rules open for discussion at least twice before language moved to intended-final product

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Technical Advisory Group

- APAC was not designed with a technical advisory group.
- In 2013, at Governor Kitzhaber's request, the Oregon Health Policy Board recommended use of APAC to enhance transparency and accountability.
  - A technical advisory group was recommended to assist in identifying additional data sources, redundant data collection, etc.
- APAC's TAG has the flexibility to choose it's role since not defined in statute. For the past several years, they have selected advising as individual organizations rather than making group recommendations.
  - TAG has been a very useful, interactive group advising APAC on issues early in rules processes
    - Direct value – advise program early on proposed data collection, method changes, when clarifying communication is needed; sounding board on both sides
    - Indirect value – attendees have easier/earlier communication on individual needs; meetings provide a reason to reach out to non-attendees more frequently
    - Attendees have the inside lane – information first, easier contact; but everyone is welcome to attend

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Communication complications

Recommendation – plan resourcing and internal connections for an effective program

- Seven definitions of primary care at OHA
- Several groups at OHA talk about value based payments
  - Part of contract with coordinated care organizations
  - Value based payment compact; voluntary industry group staffed by OHA
- Payment arrangement file is official reporting for *three programs*
  - APAC; primary care spending report (required by law) due February 1
  - Coordinated care organizations primary care spending required by contract
  - Department of Consumer and Business Services, Division of Financial Regulation prominent carriers report required by law

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DATA VALIDATION AND PROCESSING

Data validation – Processing

Recommendation – apply data quality checks at each step

- Data does not naturally occur in .txt, .csv, pipe delimited, etc.
  - APAC has a 'traditional' file
  - Added accepting an excel file – requiring our template – that aids checks prior to data submission
- Despite (because?) summary nature at the source, there are frequent corrections
- 'Level 1' validations that occur at file submission
  - 57 validation rules for the payment arrangement file
    - One field has four rules applied
    - Nine rules enforce blanks in future development area
  - 37 validation rules for the payment arrangement control file
- Batch processing is cost-effective but can delay having a usable file if all reporters passing before analytic file is created

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Instructions to validations - example

Version 2022.1.0

Data Element	Name	Type	Max. length	Required?	Description/valid values	Error Threshold
PRAPM106	Member Months	Numeric	7	Situational	Total number of members in reported stratification that participate in the reported payment arrangement, expressed in months of membership Membership should align with what is reported in annual NAIC/SERFF filings and should only be reported for those members for whom the mandatory reporter is the primary payer. No decimal places; round to nearest integer. Example: 12345 Report this field only when PRAPM103 = 2Ai, 4A, 4B, 4C or 4N.	2.0%
PRAPM107	Total Primary	Numeric	14	Yes	Sum of all associated primary care claims payments	1.0%

ID	Element	Name	Description	Issue Type	Threshold
824	PRAPM106	Populated Member Months	When PRAPM103 is 2Ai, 4A, 4B, 4C or 4N, a valid entry means that the field is not blank.	Exemption	98%
812	PRAPM106	Valid Member Months	When not blank, a valid entry means the value is in integer format.	Exemption	100%

Data validation – Techniques

Recommendation – Validating summary data is different than claim-level but still worthwhile to find reporting errors

- Field level
  - Validation of the field content format and populated if required
  - Data quality threshold set for each field, including situational
- Row level for consistency between fields
  - if a population-based payment type, member months not blank
  - amount attributed to primary care cannot be greater than total amount
- Historical comparisons being introduced later this year; early notice of significant differences (ten percent)
- Because this is summary data, Oregon has not yet found a full replacement for eyes-on review

File interaction – informal data validation

Recommendation – do not expect a close match but expect the same ballpark

Claims files report

- Data for residents
- Procedures, amount paid (sometimes zero) and claim status (which could be encounter)
- Member months in enrollment file and
- Since January, payment type (capitation, fee for service, other) at the claim line level

Payment Arrangement files report

- Data based on contract situs
- Total amount paid during year
- Number of member months covered in payment
- Break out of primary care (or not primary care)
  - No other services detailed

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COMPLIANCE

Compliance

Recommendation 1 – plan for compliance needs and the impact on resources for other activities

Recommendation 2 – use compliance to avoid issues (such as insufficient staffing for reports)

- ORS 442.993 Civil penalties for failure to report health care data
  - APAC data 442.373 or rules
  - Cost growth data 442.386 or rules
- Oregon Administrative Rule 409-025-0150
  - One rule for both claims and payment arrangement
  - Written notification and ability to cure within 30 days (standard Oregon process for civil penalties)
    - 30 days to cure can cause significant delay and impact processing of quarterly files
    - Written notice is an expectation from office days – certified mail requires at least two and possibly three employees

Indirect compliance/data quality improvement through publication of the data

How do we use the data?

Recommendation – Consider publications/use of the data as informal compliance/data quality opportunities

- Primary care spending report

Primary Care Spending in Oregon

Senate Bill 231 (Oregon Law 2015) required the Oregon Health Authority and the Department of Consumer and Business Services to report on the percentage of medical spending allocated to primary care carriers, PEBB, OEBB and Coordinated Care Organizations (CCOs).

- 2022 Primary Care Spending in Oregon, Report to the Legislature
  - Executive Summary
  - Methodology and glossary
  - February 1, 2022 memo to the Legislature

  - 2023 report on 2021 data to be released soon
- Oregon's Health Care Payment Arrangements report
  - Supports interest in Oregon's Value-Based Payment Compact and general information on progress in sustainable healthcare cost

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- # Oregon's Health Care Payment Arrangements - 2021

Welcome | 12 Payment Categories | **CCOs' Payment Arrangements** | Other Carriers' Payment Arrangements | More Information

How did Oregon's Coordinated Care Organizations pay for health care in 2021?

Medical, behavioral, and dental payments are included in this analysis as dental is a covered benefit for Medicaid. In 2021, 53 percent of all CCO member expenses were made through payment category 2C or higher. Fourteen out of the 16 CCOs met their contractual requirement that no less than 35 percent of payments are in VBP category 2C or higher.

	FFS & Other Payments – No Link to Quality			FFS – Link to Quality				Shared Savings and/or Risk		Population-Based Capitation		
	FFS – No Link to Quality (1)	Risk-Based Payments No Link to Quality (3N)	Capitated Payments No Link to Quality (4N)	FFS – Link to APM Payments (1A)	Pay for Infrastructure Including PCPCH (2A)	Pay for Reporting (2B)	Pay for Performance (2C)	Shared Savings (3A)	Shared Savings and Risk (3B)	Condition-Specific Population-Based Payment (4A)	Comp. Population-Based Payment (4B)	Integrated Finance & Delivery System (4C)
Statewide CCOs	31%	1%	1%	4%	3%		13%	4%	12%	10%	1%	13%
Advanced Health, LLC	31%	4%	11%				3%		4%	48%		
AllCare CCO	63%	1%	1%		1%		34%					
Cascade health Alliance, LLC	31%						1%		49%	19%		
Columbia Pacific CCO, LLC	38%			7%	1%		33%		1%	5%		
Eastern Oregon CCO, LLC	1%	7%					14%	66%		13%	1%	
Health Share of Oregon	26%		1%	5%	3%		9%			2%		35%
InterCommunity Health Network, Inc.	44%			10%	2%		29%			8%		6%
Jackson Care Connect	39%			7%	2%		17%		16%	4%		
PacificSource - Central Oregon CCO	29%				1%		5%		27%	35%		
PacificSource - Columbia Gorge CCO	41%			2%	3%		9%		34%	11%		
PacificSource - Lane CCO	37%			3%	2%				50%	9%		
PacificSource - Marion and Polk CCO	31%			1%	3%		4%		41%	12%	8%	
Trillium CCO - Southwest	49%			2%	3%		10%	7%	5%	12%		
Trillium CCO - Tri County	42%						24%	6%	1%	13%		
Umpqua Health Alliance	34%	5%	3%			3%	31%		12%	13%		
Yamhill Community Care	35%				12%		27%	1%		24%		

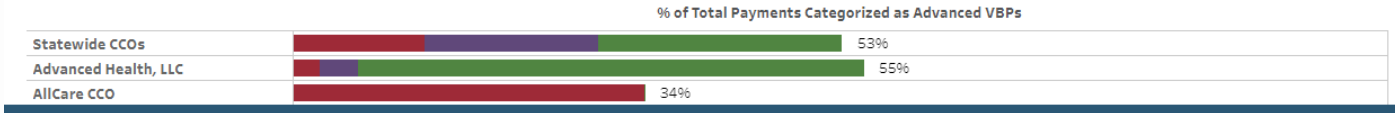
* The percent of payments for Medicaid CCOs in the payment categories may not sum to one hundred percent due to differences between PAF data and audited financial data. For additional detail, please see the methodology section on "More Information" tab.

For each CCO, what is the percentage of payments that are VBPs?

VBPs include the following HCP-LAN categories: pay for performance (2C), shared savings (3A), shared savings and risk (3B), and population-based capitation with link to quality (4A, 4B, 4C). Use the drop-down list below to select VBP categories you are interested in.

Use the drop-down list to select VBP categories you are interested in.

Payment Category 2C or Higher



Commercial carriers are also published

Welcome | 12 Payment Categories | CCOs' Payment Arrangements | **Other Carriers' Payment Arrangements** | More Information

How did Oregon's health insurance carriers pay for health care in 2021?

Other health insurance carriers are broken into three markets: Medicare Advantage, PEBB/OEBB, and commercial (excluding PEBB/OEBB). In 2021, Medicare Advantage payers had the highest share of payments (65 percent) in VBPs. Both commercial and PEBB/OEBB payers had 44 percent of dollars in VBP category 2C or higher. Note that dental payments in these three markets are not included in this analysis.

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Use the buttons below to see payment arrangements at market level and at carrier level.

Market Level | **Carrier Level**

Select a market to view the proportion of dollars in payment arrangements among Oregon's health insurance carriers:

Commercial (excluding PEBB/OEBB)

	FFS & Other Payments – No Link to Quality			FFS – Link to Quality				Shared Savings and/or Risk		Population-Based Capitation		
	FFS – No Link to Quality (1)	Risk-Based Payments No Link to Quality (3N)	Capitated Payments No Link to Quality (4N)	FFS – Link to APM Payments (1A)	Pay for Infrastructure Including PCPCH (2A)	Pay for Reporting (2B)	Pay for Performance (2C)	Shared Savings (3A)	Shared Savings and Risk (3B)	Condition-Specific Population-Based Payment (4A)	Comp. Population-Based Payment (4B)	Integrated Finance & Delivery System (4C)
Aetna	50%				2%			48%				
Cigna	96%				4%							
Health Net Health Plan of Oregon	47%			52%					1%			
Kaiser Permanente	16%											84%
Moda Health Plan, Inc.	47%	16%		34%			1%			2%		
PacificSource Health Plans	89%							3%	7%			
Providence Health Plan	42%			1%	7%		50%					
Regence Blue Cross Blue Shield of Oregon	57%						26%	4%	13%			
Samaritan Health Plans, Inc.	72%			26%			1%					
UnitedHealthcare	99%						1%					
UnitedHealthcare of Oregon	97%		3%									

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RECOMMENDATIONS

Recommendations – who and what

- If writing law, follow broad purpose for flexibility in meeting future needs; you don't want to go back to the legislature for policy shifts
- Consider data needed and sources of usable data in crafting the data reporters
- If possible, have a use case review before finalizing content and process
  - Work through use cases, reserving changes as more use cases are known, with potential reporters for best method of reporting
  - Example of input, when multiple payment methods in one contract, 'long' with different rows using contract identifier to link a contract or 'wide' with field to report each type of payment methodology for a contract in single row
- Establish standard file layouts, error (data quality) thresholds and field details (for example, decimals implied or explicit)

Recommendations - communication

- Instructions are critical for comparability and consistency year to year and between reporters
- Less frequent activity needs more frequent deliberate communication
  - Active transparency - announce data use and implications to reporters to show why they should care and avoid blindsiding
- Plan resourcing and internal connections for an effective program
- Access to mandatory reporters
  - Require contacts for
    - those who control resources (compliance officers)
    - those who interpret instructions and requirements (business lead)
    - Those who produce the files (IT lead)
  - Keep compliance officers aware of requirements for files and data quality so they support use of resources that allow business leads and IT to do a good job

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Recommendations – data validation and process

- Apply data quality checks at each step
  - As complete as practical
    - Internal to field (correct length and format)
    - Internal to file (pieces not greater than the whole)
    - Historical (10% increase or decrease requires confirmation
- Validating summary data is different than claim-level but still worthwhile to find reporting errors
  - There is no replacement for ‘eyes on’ review
- Do not expect a close match with other data received but expect the same ballpark
  - Assuming encounter data is reported
  - Oregon just added claims type of payment and we are considering adding capitation payment to Enrollment file at member level

Recommendations - compliance

- Plan for compliance needs and the impact on resources for other activities
- Use compliance to avoid issues
  - Enforcement process timely to data processing and use
  - Civil penalties can move resources via compliance officers when partnerships cannot
  - Gradual ramp-up but quickly enough to develop strong data (within three years); ongoing poor quality as ‘all that’s available’ limits long term
- Indirect compliance - Consider publications/use of the data as informal compliance opportunities

Links

- APAC Data Submitter page including file layouts
- Primary Care Spending Reports
- 2021 Health Care Payment Arrangements
- APAC Payment Arrangement File Workgroup
- Oregon Revised Statutes
  - ORS 442.372 (who)
  - ORS 442.373 (authority to collect)
  - ORS 442.993 (civil penalties)
- Oregon Administrative Rules
  - Definitions 409-025-0100
  - General Reporting 409-025-0110
  - Payment Arrangement Reporting 409-025-0125
  - Data Submission Requirements 409-025-0130
  - Compliance and Enforcement 409-025-0150

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Questions?

- apac.admin@odhsoha.Oregon.gov

- Karen Hampton
  APAC Program Manager
  Karen.R.Hampton@oha.Oregon.gov

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Tab 6

Washington State Health Care Authority

Presentation 2 - What were the most important takeaways from your perspective?

Nobody has responded yet.

Hang tight! Responses are coming in.

Presentation 2 - What were the most important takeaways from your perspective?

Nobody has responded yet.

Hang tight! Responses are coming in.

Tab 7

Washington State Health Care Authority

Code Review Finalization

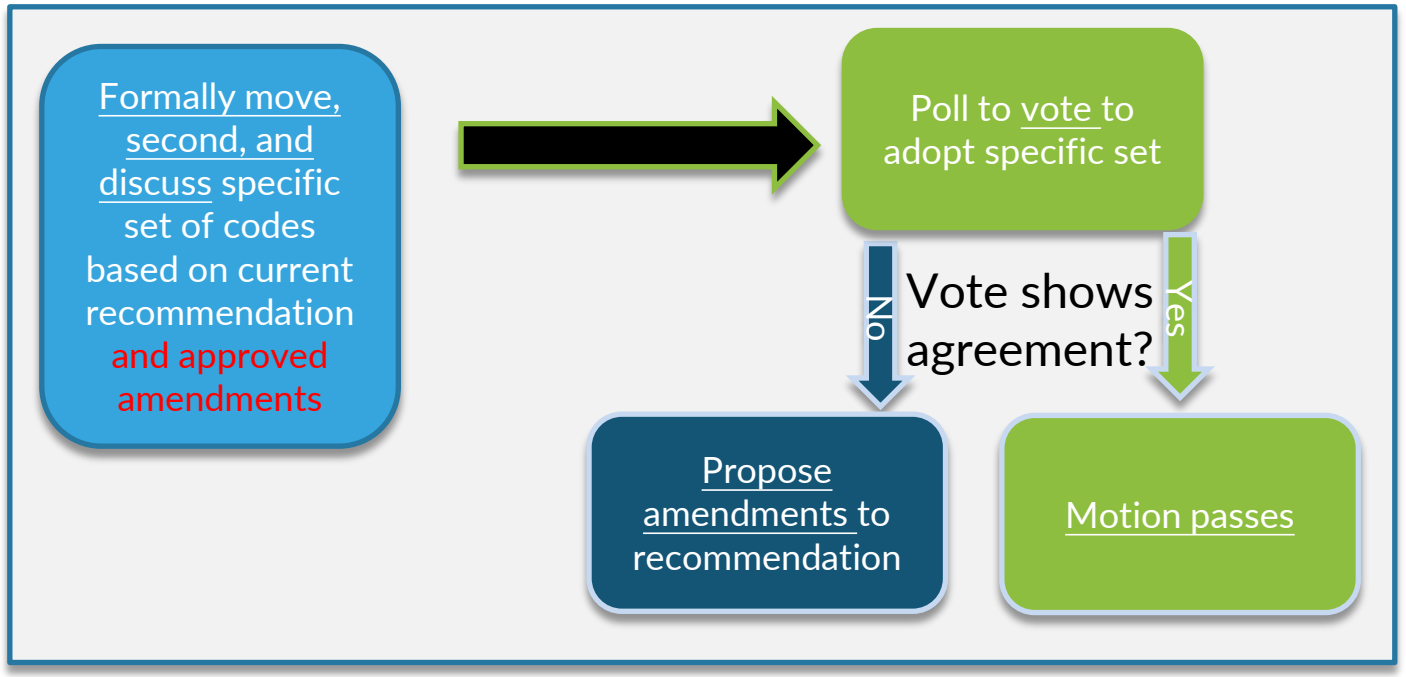
HCCTB Advisory Committee on Primary Care Charges

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

- Data Focused to support primary care
  - Report on barriers to access and use of primary care data and how to overcome them
  - Report annual progress needed for primary care expenditures to reach 12 percent of total health care expenditures
  - Track accountability for annual primary care expenditure targets

- Policies to Increase and Sustain Primary Care
  - Recommend methods to incentivize achievement of the 12 percent target
  - Recommend specific practices and methods of reimbursement to achieve and sustain primary care expenditure targets

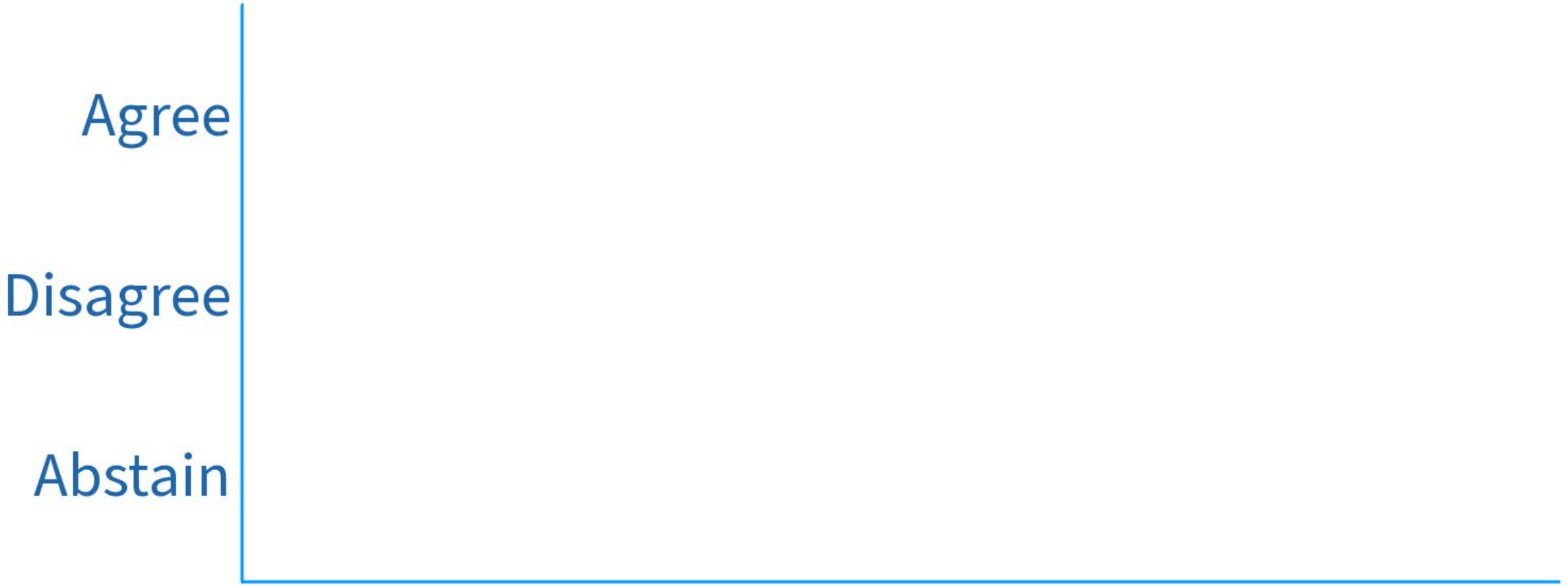
Recommendation approval process



Obstetrics

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

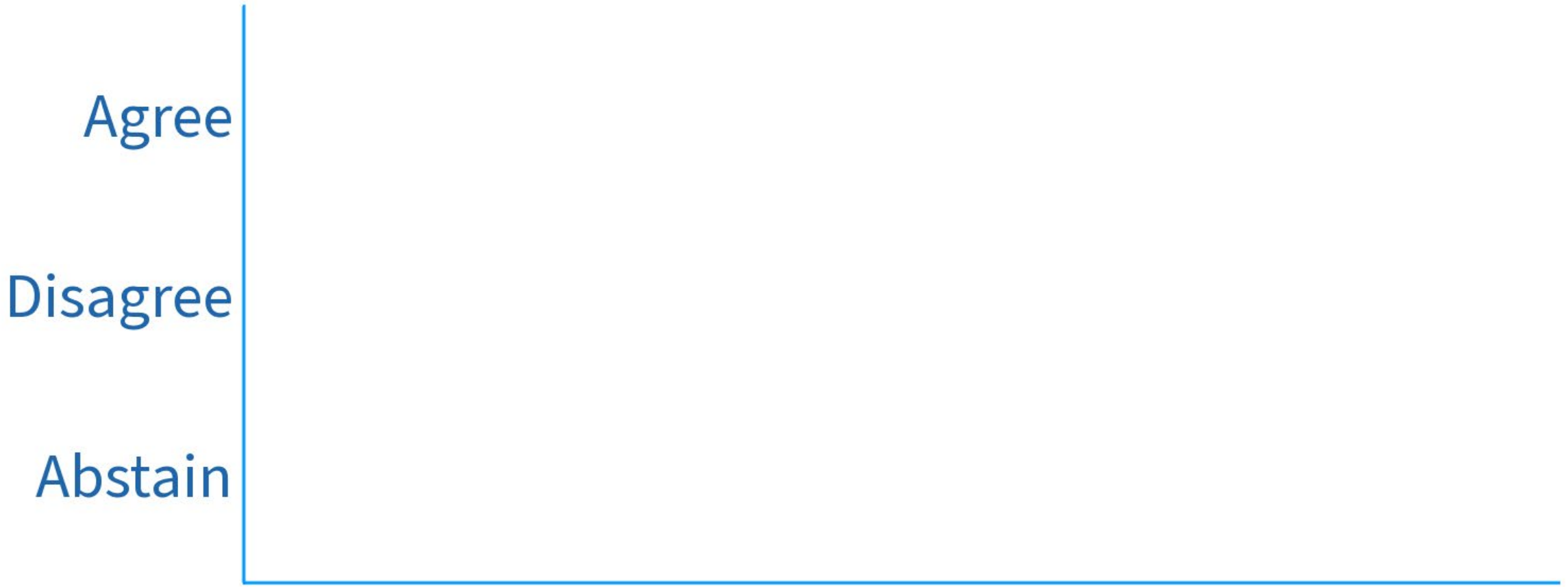
Obstetrics: I support the current recommendations for inclusion/exclusion of codes in this set



Otology Services

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

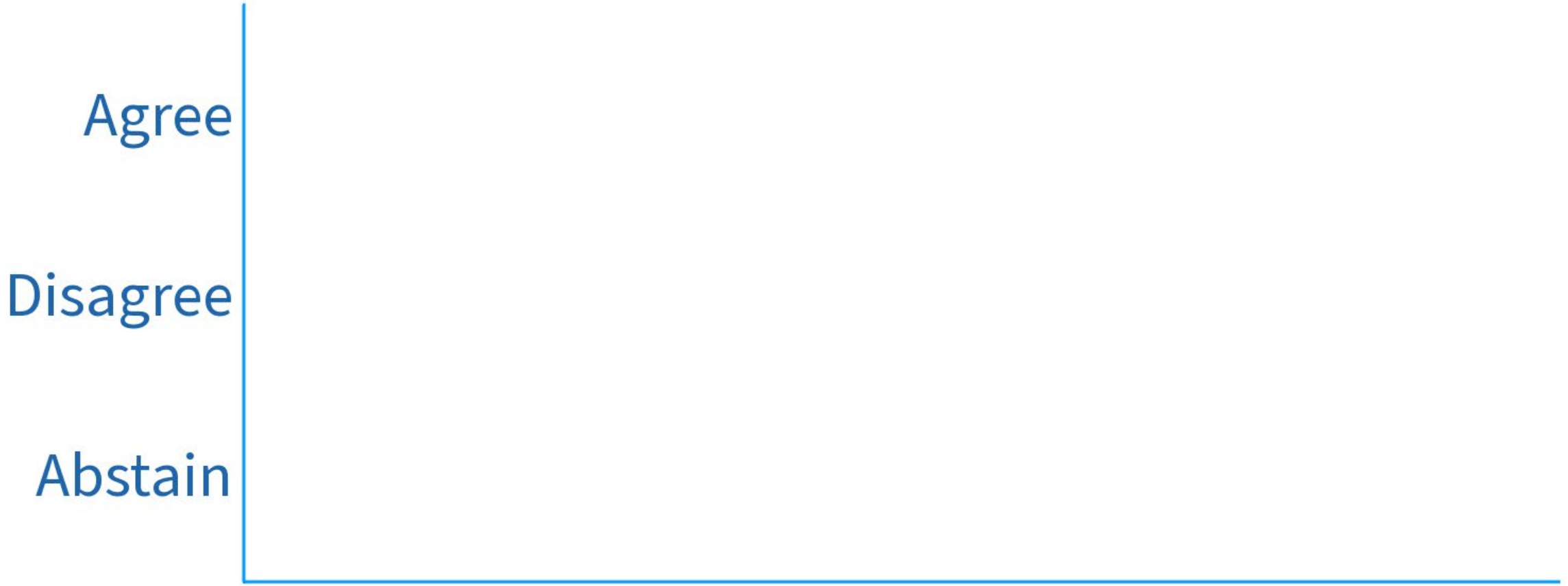
Otology Services: I support the current recommendations for inclusion/exclusion of codes in this set



Other (Part 1)

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

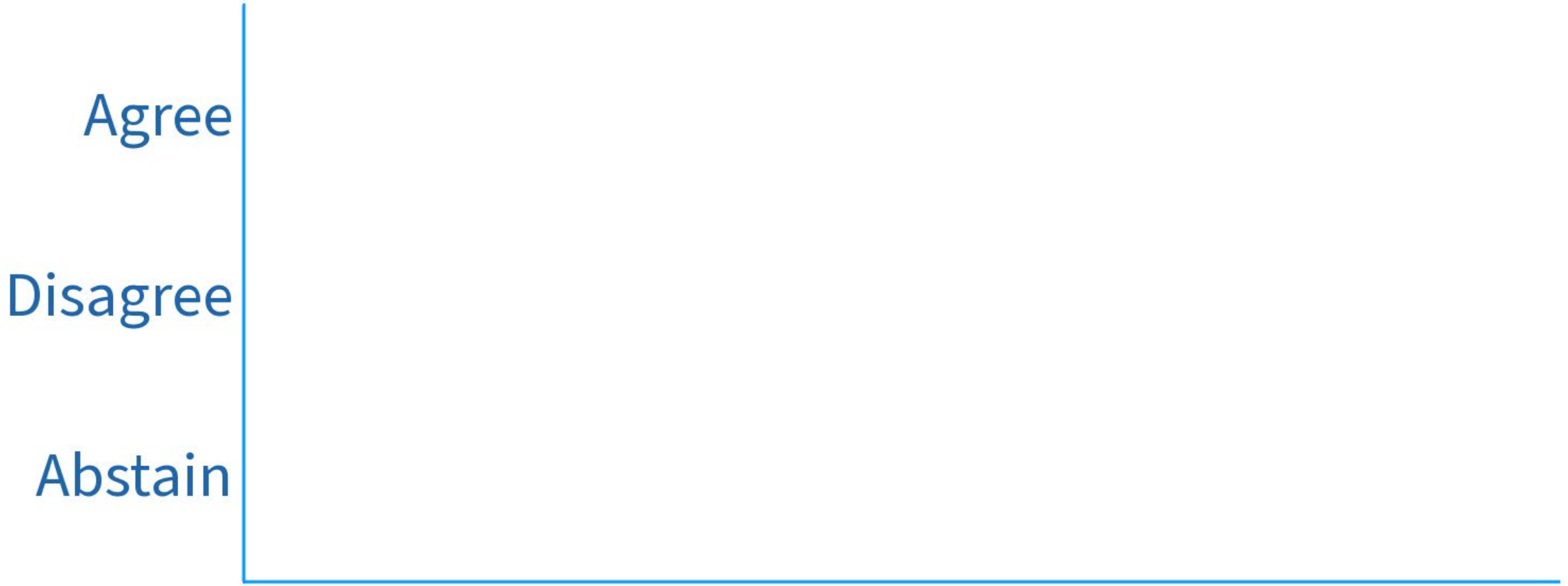
Other (Part 1): I support the current recommendations for inclusion/exclusion of codes in this set



Other (Part 2)

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

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



Public comment

Washington State Health Care Authority

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

Washington State Health Care Authority