Advisory Committee on Primary Care meeting

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Advisory Committee on Primary Care

June 28, 2023
2:00 p.m. – 4:00 p.m.
Hybrid 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 May meeting summary	2	Jean Marie Dreyer, Committee Manager Washington State Health Care Authority
2:10-2:25 (15 min)	Public Comment	3	
2:25-3:25 (60 min)	Discussion: Committee charge to identify data collection barriers and propose solutions	4	Shane Mofford and Amy Clary, Center for Evidence-based Policy (CEbP)
3:25-3:40 (15 min)	Code review finalization – additional code and next steps	4	Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
3:40-3:55 (15 min)	Preparation for next meeting – policy recommendation framework	4	Shane Mofford and Amy Clary, Center for Evidence-based Policy (CEbP)
3:55-4:00 (5 min)	Wrap-up and adjournment		Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority

Tab 2

Advisory Committee on Primary Care Meeting Summary

May 25, 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
Chandra Hicks
David DiGiuseppe
D.C. Dugdale
Jonathan Staloff
Katina Rue
Lan H. Nguyen
Linda Van Hoff
Madeline Wiley
Mandy Stahre
Meg Jones
Nancy Connolly
Sarah Stokes
Sharon Eloranta
Staici West
Tracy Corgiat

Members absent

Ginny Weir
Jonathan Staloff
Eileen Ravella
Kevin Phelan
Kristal Albrecht
Meg Jones
Michele Causley
Sharon Brown
Sheryl Morelli
Tony Butruille
Michele Causley
Shawn West
Sharon Eloranta

Greg 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

Jean Marie Dreyer, Health Care Authority (HCA)

Approval of April meeting summary

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

Topics for Today

The main topics were a presentation on defining non-claims-based primary care spending, a presentation on Oregon's payment arrangement file, and voting on remaining primary care service code sets.

Presentation: Defining Non-Claims Based Primary Care Spending

Michael Bailit, Bailit Health

Michael Bailit reviewed Bailit Health's methodology on non-claims-based spending. In 2017, Michael and his colleagues published a paper on claims-based spending. RAND performed a study on non-claims-based spending which Michael followed up on with another published analysis.

In 2020, Bailit Health, at Milbank's request, convened an advisory group of state officials, payers, and providers to inform a methodology for measuring non-claims-based payments. The group discussed key policy and design questions over the course of four virtual meetings. The findings were informed by conclusions from the 2020 RAND research report. Bailit also solicited feedback from payers in Colorado and Rhode Island.

The proposed methodology includes 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.

The first recommendation is a standard categorical framework. Bailit Health developed six primary categories with multiple subcategories for several reasons: potential insight into the composition of primary care payments within the state to inform policymaking, use for evaluating the impact of value-based purchasing (VBP) models, and potential use for validating information provided by a payer (e.g., if a payer reported nothing in a subcategory and it was unlikely that there would be nothing, could revisit with payer). The framework focuses on the purpose rather than the modality of the payment. The recovery category represents a negative payment.

The second recommendation is the application of a default percentage to each non-claims-based payment subcategory to determine the portion of primary care payments made to health systems or other multi-specialty provider organizations that include primary care. These payments include more than just primary care. As an example, there could be a total cost of care shared savings arrangement with a multi-specialty group with a payment after the end of the performance year. On the surface, it's unclear which percentage of this payment went to primary care clinicians and what portion went to specialty physicians. For mixed provider entities, it's more complicated. When spending data are collected, they should be categorized by how much is solely primary care, how much is no primary care, and how much is mixed. The assumption was that 100 percent of capitation payments were attributable to primary care. However, only six percent of global budget payments were considered attributable to primary care. It may be possible for some provider organizations to provide actual percentages rather than assigning a default, but the recommendation is to use default percentages.

The third recommendation is for states to include all non-claims-based spending for primary care and non-primary care in the total non-claims-based spending denominator, with some caveats. Pharmacy rebates should be included in the denominator, but long-term care and dental services should be excluded. This allows for comparable measurement of primary care spending across Medicare, Medicaid, and commercial populations.

The fourth recommendation is around reporting non-claims-based spending at four levels: state, market, insurer (by market) and large provider entity. This is the approach HCA currently uses for measuring cost growth benchmark performance. It is important to include the large provider entity level to gain insight into VBP adoption and provider influence over distribution of payments.

The fifth recommendation is for states to convene technical advisory groups to support implementation of non-claims-based payment data collection. These groups could assist with: implementation of the recommended approach, developing a process for collecting and validating data from payers, creating alignment between primary care spend efforts with existing statewide efforts, and facilitating documentation of the way a state categorizes payments to ensure consistency for comparison purposes (within the state and cross-state).

The final recommendation is that states define the population for which non-claims-based payment data will be collected. Bailit Health presented two options for collecting this data: by location of the resident and the provider, or by the situs of the insurance contract. There are advantages and disadvantages associated with each of these options. These data collection methods are not exclusive to non-claims-based but are also used for claims-based payments. The most critical issues are developing the categories for non-claims-based spending, then figuring out what payments go to organizations that include more than primary care clinicians.

Committee member Nancy Connolly asked how to account for team-based approaches to care provision. Is there a way to build in spending that isn't currently accounted for? That would be more of a payment model strategy measurement rather than a framework. Oregon has been working on a consensus multi-payer-based payment model which would address the teams-based activities.

Committee member Sheryl Morelli asked whether there would be a difference between pediatric versus adult populations. There are no differences for capturing spending in between these two groups. It might be interesting to see how the raw percentages differ or how the types of subcategories vary between pediatrics and adults.

Committee member Maddy Wiley asked what the payments for primary care provider salaries were. These are payments to account for a staff model employed physician where there were no claims paid. Nancy Connolly asked

whether there are systems where there are direct salaries for providers in capitated models. It's unclear whether states use this category.

Following Michael's presentation, the Center for Evidence-Based Policy (CEbP) polled committee members to gather feedback. The first question was about important takeaways. Some comments included: this is complicated and will never be perfect, the level of detail is good, there needs to be a system for capturing global payments (e.g., shared savings) that go to primary care when the payment goes to a larger multispecialty organization, variations make a streamlined approach difficult, and current payment measures and models are limited by what we do now, rather than the potential for what we might do.

The second CEbP poll asked what policies/strategies Washington should adopt that address the key takeaways. Some comments included: the measurement strategy could adopt the categories listed for non-claims-based measurement, need to measure the things that matter to patients, ensure that payments for claims-based measurement backs out current administrative component baked into claims payment rates if there is a non-claims-based component to a primary care incentive payment, see if there's any literature on how larger organizations divide global budgets or shared savings type payments and if there are any patterns in what proportions go to primary care.

Presentation: Payment Arrangement File Measuring Non-Claims-Based Payments

Karen Hampton, Oregon Health Authority

Karen Hampton presented Oregon's approach to measuring non-claims-based payments which covered who is required to submit, what is reported and how, resource planning and interactions, communication, data validation and processing, and compliance.

Identifying who is required to report relates directly to Michael Bailit's fourth recommendation about reporting methods. Oregon created the Payment Arrangement File (PAF) several years after claims reporting had been developed. Oregon would recommend staying general whenever possible. There are three statutes: who reports, what is reported, and the third is compliance. Use language such as "including, but not limited to." Oregon opted to receive data from carriers, coordinated care organizations, and third-party administrators (TPAs). Medicare Advantage (MA) and employee benefit board contractors must also report. Pharmacy benefit managers (PBMs) were excluded since prescription costs are exclusively fee-for-service (FFS). Some carriers report pharmacy contracts if the amounts relate to a provider or clinic contract on total expenditures for patients. Oregon receives data from dental carriers separately from medical claims to prevent dilution of primary care spending. Oregon doesn't collect data from long-term care organizations or large provider groups, but the cost growth group does.

Oregon adopted a standard categorical framework, the Health Care Payment Learning Action Network (HCP-LAN), with two modifications and a standard layout with instructions important for data management and validation. The PAF document includes look up tables, control tables, and an exemption process for an error threshold. Oregon also accepts an Excel version of the PAF. The data submitter can see what the data will look like to reviewers before submission.

Oregon recommends that instructions are clear for comparability and consistency on an annual basis. The All Payer All Claims (APAC) database reporting requires two different categorizations: primary care with a definition based on provider or clinic taxonomy and procedure diagnosis; and the payment methodology (e.g., one of the HCP-LAN categories). It's helpful to rely on percentages to determine the proportion of primary care payments.

There are two variations submitters can report FFS payment that interact with another contract that is non-FFS based as a 1(a) rather than 1, this is most often pharmacy costs. The second variation is that Oregon uses a 2(a)(i) and a 2(a)(ii). Correct reporting of LAN categories is essential because coordinated care organizations are required to meet a threshold of LAN spending on an annual basis.

Oregon recommends that as non-claims-based reporting is incorporated, it is important to consider how it interacts with the timing with the program's and the data submitter's other obligations. For communication, Oregon notes that less frequent activity requires more frequent, deliberate communication. It is important to establish a standard contact process with compliance officers that copies business and IT leads. Oregon uses a Technical Advisory Group (TAG). This group is helpful to ask questions and make suggestions before a problem occurs. Communication requires internal coordination and external exchange. For primary care, OHA uses seven different definitions of primary care. The PAF is the official reporting mechanism for three different programs.

Contracts are generally not written in LAN categories. Therefore, it is important to apply data quality checks at each step of the validation process. Validating summary data is different than claims-level data but is still worthwhile to find reporting errors. Oregon uses historical comparisons to provide early notice of significant differences. Claims files and payment arrangement files are not expected to match but should be compared.

Compliance is generally about resource competition, not unwillingness to comply. It is important to plan for compliance needs and their impact on resources for other activities and use compliance to avoid issues (such as insufficient staffing for reports). Data is used for policy decisions. Oregon recommends considering publications of data as informal compliance/data quality opportunities. Be prepared to decide whether to publish with errors or leave information out of a report. Commercial carriers with more than a certain threshold of costs and premiums get reported.

Committee member D.C. Dugdale asked how many organizations submit data. For the PAF, there are approximately 50 medical and dental insurers, as well as TPAs.

CEbP polled committee members on Karen's presentation. The key takeaway was: There are many steps to this work that must be planned and executed carefully, and it is likely to take more than one year to feel confident about the data.

Voting on Remaining Code Sets

Dr. Judy Zerzan-Thul, HCA

Dr. Zerzan-Thul led voting on the remaining code sets.

For obstetrics, committee members voted at the last meeting to support the exclusions listed in the presentation, but some votes were counted after the cutoff. Dr. Zerzan-Thul moved to accept the recommendations for obstetrics. The motion was seconded and passed unanimously.

Otology services had four codes, all of which were recommended for exclusion. Dr. Zerzan-Thul moved to approve the exclusions. The motion was seconded and passed unanimously.

The other (part 1) category contained mostly codes to exclude, along with four inclusions. D.C. Dugdale asked about the dermatology codes listed as excluded. Shane Mofford mentioned that HCA would use Medicaid data to

extract a sample to answer that kind of question, i.e., codes where it might be recommended as primary care but are predominantly specialty codes. Dr. Zerzan-Thul moved to adopt the listed recommendations. The motion was seconded and approved unanimously.

The other (part 2) category, like part 1, contained predominantly codes to exclude, with some inclusions. D.C. Dugdale commented that the 96110 and 96127 are common codes that should be included and Sheryl Morelli agreed. Dr. Zerzan-Thul moved to accept the listed recommendations but to include 96110 and 96127 on the included list. The motion was seconded and approved unanimously.

Public Comment
There were no public comments.

Adjournment
The meeting adjourned at 4:00 p.m.

Next meeting
June 28, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Tab 4

Washington State Health Care Authority

HCCTB Advisory Committee on Primary Care Meeting

June 28, 2023

2:00-4:00 PM

Washington State Health Care Authority

Meeting Goals

- Identify gaps/challenges for primary care expenditure data collection
- Develop baseline understanding of status quo data collection strategies
- Make recommendations for future policy to address gaps and challenges
- Vote on one outstanding code for primary care definition
- Prepare for policy discussions in upcoming meetings (if time)

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

Relevant Statutory Requirements

SB 5589 (2022) Section 1 (3) (a)–(c)

"To the extent possible, the reports must:

(a) 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 expenditure;

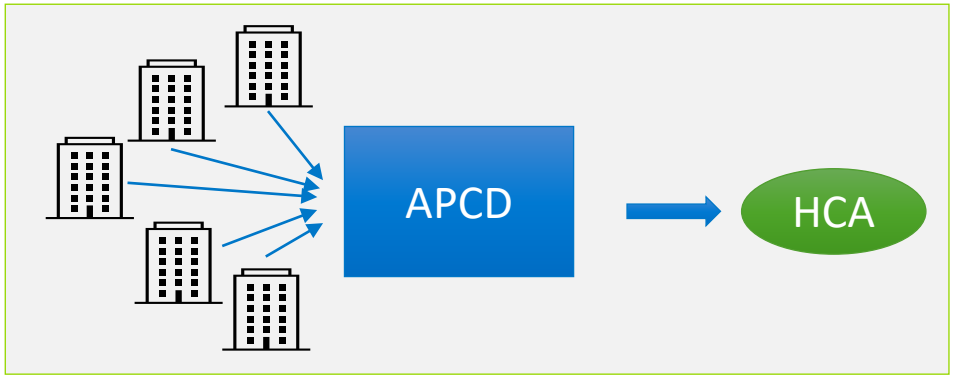
(b) Break down annual primary care expenditures by relevant characteristics such as whether expenditures were for physical or behavioral health, by type of provider and by payment mechanism; and

(c) If necessary, identify any barriers to the reporting requirements and propose recommendations for how to overcome them."

How Does Data Collection From Payers Work Today?

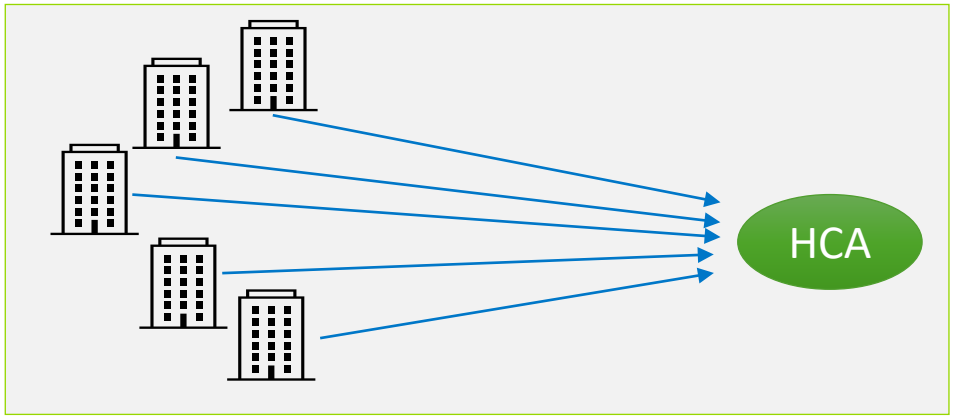
All Payer Claims Database

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



HCA Aggregate Data Call

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



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Claims-Based: Lessons Learned From Other Efforts

- Incomplete payer participation in data reporting due to federal prohibition on requiring ERISA plans to report
- Location type in APCD data previously unavailable
- Risk of inconsistent application of reporting methodology when plans self-report (not an APCD issue)
- Difficulty isolating primary care component of expenditure when included in bundled payments
- Difficulty isolating primary care component of expenditure when included in FQHC/RHC encounter
- Difficulty isolating primary care payment when comprehensive payment (capitation or otherwise) made to an integrated system
- Medicare FFS lagged significantly (2 years)

Non-Claims-Based: Lessons Learned From Other Efforts

- Isolating primary care expenditures in non-claims payment of services that are part of a broader scope of services
- Need a standard categorical framework for non-claims-based payments by subcategory
- Risk of inconsistent application of reporting methodology when plans self-report data

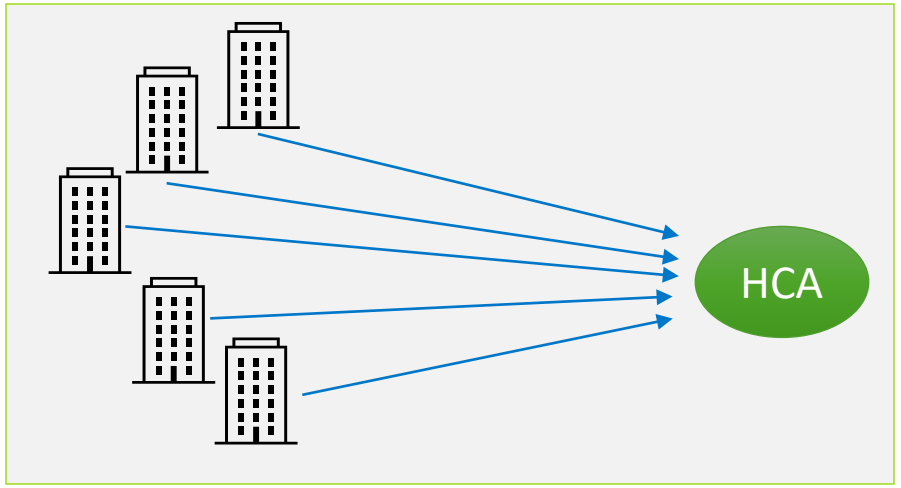
Gap Analysis

- Gaps and challenges generally fall into two high-level categories:
  - Data collection mechanism: How is the data collected and what are the implications for consistency, completeness, and accountability?
  - Standardized reporting framework: What data is reported and how is it organized?

Data Collection Mechanism

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

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



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Primary Care Data Collection Mechanism (2)

- Some states have updated the data collection of their APCD to collect non-claims-based expenditures and other data elements relevant to primary care expenditure calculation. While this could help with some of Data Call challenges, there are several key considerations:
  - Some payers that optionally report aggregate data may not opt to report detailed data.
  - It would take significant time 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 as a solution) would result in changes in benchmarks and expenditure reporting that could be disruptive.
  - Despite these challenges, it may be worth exploring if the APCD is the best long-term solution for the state. The answer will largely depend on the state's long-term vision for the APCD and if other use cases are supported by the investment of resources required for comprehensive expenditure reporting.

POLL and Discussion - Data Collection

- Based on understanding of challenges and current infrastructure, what principles do members recommend the state adhere to when implementing data reporting processes to calculate primary care expenditures?

Standardized Reporting Format

- Statute requires stratification of payments by type of payment.
- Reporting by type of payment is also an accountability mechanism as it allows for tracking on progress on offering sustainable/accountable payment models to providers.
- Additionally, the state will need to develop allocation methodologies to estimate the portion of bundled/capitated/non-claims reimbursement that should be classified as primary care expenditures.

Poll and Discussion – LAN to Guide Strategy

- I support using an HCP LAN-based categorization strategy. Yes/No

Poll and Discussion – Reporting Principles

- As the state refines the reporting framework, what principles should the state adhere to?

Code Review Finalization

Washington State Health Care Authority

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Outstanding Code Review Follow-up

- A Committee member identified that an IUD removal code was not in the list members voted on.
- The Committee approved including IUD placement codes.
- Do members approve adding 58301: Removal of IUD to the primary care definition code set?

Finalizing the Code Set - Next Steps

- We anticipating having utilization analysis on the codes the Committee voted on in an upcoming meeting
- Plan to highlight codes that fall into one of the following categories:
  - *Included/Low Utilization:* The Committee voted to include, but utilization is very low or the utilization by primary care providers is a small percent of the overall utilization of the code.
  - *Excluded/High Utilization:* Committee voted to exclude, but utilization is very high or the utilization by primary care providers is a large percent of the overall utilization of the code.
- Are there other specific cases you would want to review?
- Plan to review provider location to see how much it impacts the combination of who, what, and where and if the field is reliably populated.

Policies to Achieve the Primary Care Expenditure Target

Washington State Health Care Authority

HCCTB Advisory Committee on Primary Care Charges

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Policies to Increase & Sustain Primary Care – 12% in Context

- Four key domains that influence the primary care expenditure statistics:
  - Direct investment
  - Capacity Growth
  - Patient Behavior
  - Reduced Expenditure on Other Services

•Reduce utilization of other services due to improved primary care access

• Increase patients' use of primary care services

Washington State Health Care Authority

General Strategies to Increase & Sustain Primary Care

The general strategies below, ordered by preference, had at least some support from committee members.

1) Direct Investment - Increase primary care reimbursement.
2) Capacity Growth - Payer focus on reducing administrative burden/costs for providers.
3) Forgiveness for non-compete clause penalties incurred by primary care clinicians who leave a position to work elsewhere in Washington State.
4) Patient Engagement - encourage employers to support/incentivize/encourage patients in selecting a PCP.
5) Capacity Growth - State funded expansion of loan forgiveness opportunity.
6) Capacity Growth - Work with education system to bolster pipeline of healthcare professionals.
7) Increasing Medicaid reimbursement for primary care services.
8) Capacity Growth – Multi-payer collaboration to develop and implement payment models that offer greater financial flexibility and incentives while growing access and improving quality.
9) Provide options for practice teams to have a fully capitated system.
10) Increase FFS for remote patient monitoring services, chronic care management.
11) Increase FFS reimbursement for care team members such as clinical pharmacists, care coordinators / Community Health Workers, registered nurses, etc.

Data Strategies to increase and sustain primary care

The data-related strategies below, ordered by preference, had at least some support from committee members.

1) Invest in and support HCA's EHR-as-a-Service initiative which will provide access to certified EHR for BH, small, and rural providers
2) Invest in and support HCA's Electronic Consent Management (ECM) initiative to support exchange of health information.
3) Maximize utility of One Health Portal through investment and other policy initiatives
4) Maximize comprehensiveness/utility of APCD by encouraging self-funded plans to contribute data
5) Support Master Patient Index by promoting use of a uniform identifier
6) Expand reach of Clinical Data Repository through investment and other policy initiatives

Organizing framework for policy recommendations

Upcoming work on policy recommendations:

- List refinement
- Greater level of detail
- High-level strategies for each recommendation
- Discuss accountability and incentives for the different actors to execute the policy recommendations

Wrap-up and Adjournment

Washington State Health Care Authority

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

Washington State Health Care Authority