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
Sheryll Morelli
Staici West
Tracy Corgiat

Members absent

Ginny Weir
Eileen Ravella
Kevin Phelan
Kristal Albrecht
Meg Jones
Michele Causley
Sharon Brown
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.