Advisory Committee on Primary Care meeting minutes

September 28, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
11:30 a.m. – 1:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the board is available on the Health Care Cost Transparency Board webpage.

Members present

Judy Zerzan-Thul
Kristal Albrecht
Tony Butruille
Michele Causley
Nancy Connolly
Tracy Corgiat
David DiGiuseppe
DC Dugdale
Sharon Eloranta
Chandra Hicks
Meg Jones
Sheryl Morelli
Lan H. Nguyen
Eileen Ravella
Katina Rue
Mandy Stahre
Jonathan Staloff
Sarah Stokes
Linda Van Hoff
Shawn West
Staici West
Ginny Weir
Maddy Wiley

Members absent

Sharon Brown
Kevin Phelan

Agenda items

Welcome and call to order

Dr. Judy Zerzan-Thul, the committee chair, called the meeting to order and welcomed new committee members.

Topics for today

The topics were listed as committee member and staff introductions; introduction to the committee workplan; overview of primary care spending; presentation on Office of Financial Management (OFM) and Bree primary care definitions; and next steps.

Committee member and staff introductions

Jean Marie Dreyer, HCA

Jean Marie Dreyer reviewed the meeting agenda and facilitated committee member introductions.

Introduction to committee workplan

Dr. Judy Zerzan-Thul, HCA

Dr. Zerzan-Thul presented the history, structure, and purpose of the Advisory Committee on Primary Care (the primary care committee).

Senate Bill 5589 directs that the Health Care Cost Transparency Board (the board) will "measure and report on primary care expenditures and the progress toward increasing to 12 percent of total health care expenditures (THC)." The statute includes a set of recommendations for the board to make to the Legislature to define and measure primary care spending. The Legislature requires the board to include and address prior work, such as reports from the OFM and the Bree Collaborative, in its recommendations.

Dr. Zerzan-Thul described the function and purpose of the cost board and its connection to the primary care committee. The cost board creates and identifies trends in health care cost growth, establishes a health care cost growth benchmark/target, and measures total health care expenditures. The primary care committee will report to and advise the cost board on the Legislature's prescribed primary care recommendations and the committee's recommendations will also be reviewed by the cost board's two subcommittees: the Advisory Committee of Providers and Carriers and the Advisory Committee on Data Issues.

The primary care committee will provide four recommendations for adoption to the cost board: 1) a definition of primary care, 2) measurement methodologies to assess claims-based spending, 3) measurement methodologies to assess non-claims-based spending, and 4) how to overcome barriers to access and use of primary care data. Additional tasks that the primary care committee will focus on include tracking annual primary care spending, reporting annual progress on the 12 percent primary care spending target, recommending methods to achieve the 12 percent spending target, and recommending reimbursement practices and methods necessary to achieve and sustain primary care spending targets.

Dr. Zerzan-Thul reviewed the primary care committee's meeting cadence, member terms, format, and meeting material distribution process.

Lastly, Dr. Zerzan-Thul outlined the timeline and process for making recommendations to the board. The first two of the four initial recommendations, a definition of primary care and measuring claims-based spending, will be developed by the end of 2022, and included in the December report to the Legislature. The October 25 primary care committee meeting will conclude discussion of the first recommendation, a definition of primary care. At the November 21 meeting, the committee will discuss the second recommendation, claims-based measurement. The remaining two recommendations will be developed in 2023 and included in the board's August legislative report. Recommendations will be subject to a motion and vote by committee members.

Overview of Primary Care Spending

Dr. Judy Zerzan-Thul, HCA

Dr. Zerzan-Thul presented an overview of primary care spending, which included the importance of the 12 percent primary care spending target and associated challenges, and prior state and national work on primary care spending that the committee must consider when developing its recommendations.
Dr. Zerzan-Thul emphasized the importance of Washington's 12 percent primary care spending target in the context of larger efforts to invest in and increase primary care spending. The resources needed to increase primary care investments have not kept pace with rising expectations of primary care delivery, which has led to issues like a sharp reduction in the workforce, reduced access to care, and inequitable care. In 2000, the Milbank fund reported the association between an increased numbers of primary care practitioners, higher quality outcomes, and lower total costs. According to the Centers for Medicare and Medicaid (CMS) primary care spending remains low, at only 5 to 7 percent for commercial carriers, when compared to other medical spending like hospital care, prescription drug costs, and other healthcare services.
State leaders in primary care spending measurement efforts include Rhode Island and Oregon. She noted that most states are in the same place as Washington and stated that the most important piece of measuring spending progress is to use a consistent definition of primary care.
Dr. Zerzan-Thul showed some older baseline data on primary care spending from Vermont, Rhode Island, Connecticut, and Massachusetts and noted that the two states with the highest spending levels were Rhode Island at 11.5 percent and Vermont at 9.7 percent. Though these states were geographically close, they still had wide variation in spending levels.
Dr. Zerzan-Thul outlined the challenges of the 12 percent spending target and explained that current spending levels in Washington range from 4.4 to 5.6 percent of total health care expenditures. However, the 4 to 5 percent range is only claims-based, and doesn't include non-claims-based spending, such as incentive payments. The exclusion of non-claims-based payments may contribute to Washington's lower spending percentages.
There are several existing definitions of primary care that were developed in Washington, including the statutory definition, OFM's 2019 narrow and broad definitions, and the Bree Collaborative's 2020 definition. The OFM report contained data from the All-Payer Claims Database (APCD) and showed state spending percentages of 4.4 percent based on a narrow definition of primary care and 5.6 percent based on a broad definition.
Dr. Zerzan-Thul described HCA's process for tracking primary care spending levels and explained that spending increased slightly in 2019 and dropped in 2020. HCA has contract requirements to track primary care spending for Managed Care Organizations (MCOs), the Public Employees Benefits Board (PEBB), the School Employees Benefits Board (SEBB) and Cascade Select. HCA has a template for self-reporting, which hasn't been audited because analysis of reporting barriers is ongoing. Self-reported percentages from HCA carriers ranged from 5 to 14 percent.
Dr. Zerzan-Thul concluded with a review of key elements necessary for defining and measuring primary care spending. These elements included the who, providers; the what, services; the where, location of service delivery, e.g., clinic, urgent care, hospital; and the how, methods for measuring both claims and non-claims-based spending.

Presentation on OFM and Bree primary care definitions

OFM Presentation

Mandy Stahre, OFM

Mandy Stahre began with a high-level overview of OFM's process for reporting on primary care expenditures. OFM spent several months developing a basis for defining primary care and gave special consideration to Barbara Starfield's work. The stakeholder group knew from the beginning that that they would use only claims-based spending data, which shaped their conversations.
OFM used separate definitions for providers and primary care services similar to how other reports have captured primary care expenditures. OFM also used narrow and broad definitions. The OFM stakeholder group identified providers using taxonomy codes and services using CPT and HCPC codes. There were some issues with taxonomy

because of FQHCs, and issues with including nurse practitioners (NP) and physician assistants (PA) because of the difficulty in determining who was in primary care settings.
Mandy discussed OFM's narrow definition of primary care and noted that the primary difference between OFM's narrow and broad definitions of primary care was the inclusion of OBGYNs. Some states include OBs and midwives in their definition of primary care, while other states don't include these groups, so OFM used both narrow and broad definitions. For billing purposes, a location may be more of a billing center than where a service actually took place and it was hard to determine if PAs and NPs were practicing in a primary care setting. The OFM stakeholder group used an adjustment factor, around 40 percent, to include PAs and NPs in total health care expenditures.
OFM modeled their definition on other, existing efforts to provide a better comparison between states. The most significant piece missing from the OFM report is anything in an electronic medical record (EMR) that the APCD wasn't built for, e.g. services where billing is low or wasn't otherwise captured. Claims aren't the perfect data source, but all databases have limitations. Without a central electronic medical records database to pull and supplement claims, better coverage would be difficult. OFM reported results broken down by insurance carrier.
David DiGiuseppe asked what definition was used for the 12 percent target and how this committee's chosen definition might affect the target. Dr. Zerzan-Thul explained that the definition was based on Oregon's and noted that they did not set an achievement deadline. It was clarified that the committee's initial discussions will inform future tweaks to any chosen definition. Oregon included non-claims-based spending and Washington's figures look smaller because OFM only analyzed claims-based spending.
Ginny Weir asked if the committee would talk about other states' approaches to primary care spending. It was noted that the committee will discuss other states' approaches to primary care at the next meeting.
Molly Nolette asked if urgent care clinics that bill as primary care clinics were parsed out. It was clarified that OFM based spending figures off providers and service types.
Sharon Eloranta asked if it was possible to artificially inflate spending and asserted that this should not be something the committee engages in. Sharon Eloranta suggested that to accurately measure spending before and after settling on a definition, the committee should recommend keeping the methodology the same. Dr. Zerzan-Thul assured that the committee would discuss these and other issues in future meetings.

Bree Presentation

Ginny Weir, Bree Collaborative
The Bree Collaborative is a public private group that was created by the Legislature in 2011 to look at areas of healthcare that are high cost, have poor outcomes, or patient safety issues and have no existing mechanism to address them. The collaborative consists of members from diverse backgrounds and represents people with lived experience, health plans, and purchasers. HCA serves as the Collaborative's main channel for implementing policies to include in purchasing contracts.
The collaborative began to focus on defining primary care in 2020. Bree's approach was more philosophical than OFM and based on principles rather than actual claims. Similar to OFM, Bree based their definition on Barbara Starfield's definition, as well as the definition used by the Institute of Medicine (IOM) and other studies.
The Bree definition emphasizes several important elements that are very difficult to measure: team-based, accountable, first contact, comprehensive, continuous, and coordinated.
Bree's list of primary care services includes care coordination, integrated behavioral health, disease prevention and screening, chronic condition management, medication management, health promotion, and person-centered care that considers physical, emotional and social needs. Screening social determinants of health would provide an opportunity to expand the impact and scope of primary care.
Ginny and Mandy presented comparisons between OFM and Bree definitions of primary care providers. Main differences are that Bree's excluded homeopaths and included care coordinators. Most of the categories were common across both the OFM broad definition and Bree's definition.

Dr. Zerzan-Thul noted that these comparisons are somewhat blurred together but some of these categories will be covered in greater detail during the claims discussion.
Next, Ginny and Mandy compared OFM and Bree's inclusion of primary care services and noted the strong similarities between the two, but that OFM and Bree took very different approaches to analyzing primary care. It was emphasized that the purpose of the claim is for billing purposes, not data analysis, meaning there will be some interpretative choices.

Public Comment

Molly Nolette noted that data collection will be affected in the future as we move towards value-based care, which is why it's important to collect claims and non-claims-based.
Claims identify place of service, for example whether someone is at a hospital, office visit, etc., or to know whether it's an FQHC, RHC, etc. Physicians also have a taxonomy of specialties and NPs and PAs only have a small portion of the code because they might be in a surgical unit. Eileen Ravella clarified that a PA's license is tied to a place that can't change.
Tony Butruille, who served on OFM noted that the challenge this committee faces is to marry the aspirational elements of the Bree definition with the practical elements of how to boost spending to the 12 percent target.

Next Steps

Dr. Judy Zerzan-Thul, HCA
Committee staff will send out additional information in advance of the next meeting that will come from NASEM, Milbank, and others states for committee members to review.
The goal for the next meeting is to adopt the Bree's six principles of primary care and to use these in a flexible approach along with OFM's narrow and broad definitions. Dr. Zerzan-Thul noted a preference for the committee to use the NASEM definition of primary care.
Ginny asked if it would be possible to reference definitions outside of other countries. Dr. Zerzan-Thul agreed this could be a good idea. Michele Causley noted that 12 percent has been a commonly used target in European models but cautioned that their target included dentists.
D.C. Dugdale asked why neurologists were included since they may be an outlier for primary care providers. Mandy explained that they were included in the taxonomy codes with psychiatry. Providers were included in broad definition but had to be connected to services for claims to be counted. D.C. Dugdale noted that neurologists perform many services that could end up in primary care service types. Dr. Zerzan-Thul noted there has been additional work done that could be considered for additional refinements.
Lan Nguyen asked about including member perspectives when developing a definition. Dr. Zerzan-Thul noted that there were plenty of carriers and clinicians and noted the consumer perspective on the committee. Nancy Connolly replied that there's not sufficient time to discuss more. Jean Marie noted that there will be more time for discussion of these topics at the next meeting.

Adjournment

Meeting adjourned at 12:52 p.m.

Next meeting

Tuesday October 25, 2022
Meeting to be held on Zoom
1:00 p.m. – 2:30 p.m.