Advisory Committee on Primary Care Meeting Summary

November 21, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
9:30 a.m. – 11:00 a.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
Ginny Weir
Gregory Marchand
Jonathan Staloff
Kevin Phelan
Kristal Albrecht
Linda Van Hoff
Madeline Wiley
Mandy Stahre
Meg Jones
Michele Causley
Nancy Connolly
Sarah Stokes
Sharon Brown
Sharon Eloranta
Shawn West
Tony Butruille
Tracy Corgiat

Members absent

Lan H. Nguyen
Katina Rue
Sheryl Morelli
Staici West

Call to order

Jean Marie Dreyer, Committee Manager, called the meeting to order.

Agenda items

Welcome, roll call, and agenda review

Jean Marie provided an overview of the agenda.

Approval of October meeting summary

The committee members present voted to adopt the Meeting Summary from the October 2022 meeting.

Topics for Today

The topics were listed as discussion of drafted primary care definition and presentation on claims-based measurement.

Primary Care Definition Discussion

Dr. Judy Zerzan-Thul, Health Care Authority

Judy Zerzan-Thul presented an updated version of the committee's recommended definition of primary care which included feedback emailed by committee members. The definition is intended to serve as a high-level, aspirational conception of Washington's definition of primary care. The definition is not necessarily connected to existing RCWs and does not contain taxonomy codes. As primary care spending is operationalized, codes will be further discussed and examined.

D.C. Dugdale agreed that the definition works from an aspirational perspective, but noted that from an operational perspective, there are many minefields.

Sharon Eloranta posited that the word "accountable" implies measurement. Judy Zerzan-Thul clarified that "accountable" refers to quality measurement, and possibly cost, but primarily refers to someone taking care of an individual patient and to accountability for the patient's health. The Learning Action Network (LAN) has a good discussion at the national level about accountable care, with perspectives from clinician and systems levels. The updated definition is an amalgam of the National Academy of Sciences of Engineering and Medicine (NASEM) and the Bree Collaborative's definitions.

Tracy Corgiat shared an experience from a recent event about patient access with two takeaways. First, the traditional conception of one person quarterbacking care with an accountable care clinician is changing. There are scheduling limits right now with seeing one provider. The second takeaway was about health maintenance. Judy Zerzan-Thul noted that primary care would be a team-based sport moving forward.

Nancy Connolly expressed a preference for a doctor to serve as a team leader, rather than an osteopath or naturopath. Judy Zerzan-Thul clarified that this committee's definition would not limit team-based leadership to doctors. Advanced nurses can perform this role, too. Nancy Connolly agreed that a team could include a nurse but would be surprised to have a team without a physician. Judy Zerzan-Thul responded that there are teams led by Advanced Registered Nurse Practitioners (ARNPs) without doctors and this committee would not exclude them. Tracy Corgiat noted that team-based leadership differs in different places. There are many places trying to recruit doctors in rural areas that don't have them.

Sharon Eloranta asked what is meant by provider, noting that a practice, rather than a person, could be held accountable for metrics. Judy Zerzan-Thul clarified that defining a provider is a separate issue handled by Medicaid.

Jonathan Staloff asked about the difference between what the definition says, versus what it aspires to be.

David DiGiuseppe noted that the definition appears to be complementary with the multi-payer primary care transformation (PCTM) work. Judy Zerzan-Thul noted that the work on the PCTM is separate from, but complementary with, the primary care measurement work of this committee. It is okay for the definitions used in the two workstreams to differ.

Tony Butruille suggested switching out the word "first" for "primary." Ginny Weir suggested that "primary" might be more realistic than first.
Chandra Hicks asked whether care that didn't meet the criteria of this definition would be considered primary care. Judy Zerzan-Thul responded that to be considered primary care, the criteria in this definition must be met.
Chandra Hicks asked whether a provider must meet this definition to get paid. Judy Zerzan-Thul clarified that a general practitioner operating without a team wouldn't be excluded. The definition is moving towards a more equitable vision and is a general framework towards which to move.
Chandra Hicks asked if the committee should create a separate working definition that is purely aspirational. Judy Zerzan-Thul affirmed that the current definition is sufficient. The committee's next task will involve selecting how to code providers and services.
Tracy Corgiat asserted that the committee should be clear that this isn't a legislative definition.
Nancy Connolly explained that there are times when a patient is seen for urgent care at one clinic but is empaneled at another – this would mean that even though the provider is a primary care provider, the care provided isn't primary because it isn't continuous. Judy Zerzan-Thul clarified that the who, what, and where all have to intersect for the definition to apply. Urgent care might not be a qualified place.
Nancy Connolly made a motion to the accept the definition. D.C. Dugdale seconded. The entire committee approved the definition.

Public Comment

No public comment.

Presentation on Claims-Based Measurement

Dr. Josh Liao and Dr. Ashok Reddy, University of Washington School of Medicine
Dr. Josh Liao and Dr. Ashok Reddy gave a presentation on their work operationalizing a claims-based definition of primary care for Washington State based on Medicaid claims. The presentation detailed the origins of the definition of claims-based primary care, provided an outline of the data used in their study, explained their process for refining provider, service, and facility codes, and gave a summary of the study's findings and caveats.
The study found 49 potential billing providers to service provider combinations.
Out of a sample of over 300,000 Medicaid beneficiaries, over the age of 18, who were residents of Washington, in managed care, and enrolled for over 11 months in 2019 and 2020, the study found: one-third of adult beneficiaries in the sample did not receive any outpatient medical services; there were twice as many primary care versus non-primary care outpatient medical services; most primary care outpatient medical services (almost 70 percent) were provided through locations or sites associated with Federally Qualified Health Centers and multispecialty groups; and, in 2019 and 2020, over 5,000 clinicians provided primary care outpatient medical services to beneficiaries in the study's sample.
There is a need for and a challenge to operationalize a claims-based definition of primary care for use in policy and practice change. A stepwise approach that builds on prior work can help address misclassification. The approach used in this study can be expanded in future work to include, validate, and apply procedures to different claims datasets.
D.C. Dugdale asked whether common wellness visits were included. Josh Liao clarified that wellness visits were not included.
Nancy Connolly asked about efforts to address value-based purchasing (VBP) in the study. Josh Liao clarified that VBP was beyond the scope of the study.
David DiGiuseppe asked how to account for services that aren't primary care but are offered at a designated primary care clinic. Josh Liao noted that a claims-based definition would never capture the essence of primary care. There is primary care happening at non-primary care locations.

Krystal Albrecht asked whether there were codes missing from the study. Josh Liao noted that in future work, there will be more visit types added. Other variables like place of service create data accuracy issues.
Ashok Reddy said additional taxonomies would be helpful.
Nancy Connolly asked how to approach and capture the patient-provider team relationship element of primary care, noting that if there isn't an intent for a relationship, it isn't primary care. Josh Liao noted a lack of an answer to Nancy's question. In the absence of reaching a new definition, the alternative isn't nothing. There are attribution challenges – there can be a relationship with a team, or a medical group. Existing definitions don't account for nuance.
Tracy Corgiat asked whether there are people consuming care that isn't considered primary care and how to better parse out service lines.
Nancy Connolly added that there are people who choose a "doc in a box" with episodic care. There should be a system where patients are empaneled with same-day access.
Josh Liao noted that the study's methodology isn't just for scaling, it's also for inputting data into the system.
Judy Zerzan-Thul added that other states created narrow and broad categories of primary care definitions to address the uncertainty of the type of relationships between providers and patients.
David DiGiuseppe posited that there could be an individual assigned to a Managed Care Organization (MCO) where the patient doesn't know they've been assigned and isn't necessarily seeking out care. There is intent for a relationship, but no current need. This could be an example of non-claims-based care.
Josh Liao noted that claims-based payments are for tracking, trending, and measuring. David DiGiuseppe and Nancy Connolly's comments highlight that if the system changes based on a patient's election to receive care, the existing claims methodology would live within that new system. There are ways outside of claims to gauge relationships.
Jonathan Staloff noted that a large chunk of care might be telemedicine. There should be some discussion about whether in-person is required.
Tony Butruille noted that in prior work on taxonomy codes with the Office of Financial Management (OFM), there was a desire to find site codes where primary care is performed and to allow more non-claims-based payments to funnel through those site codes, e.g., telemedicine, pharmacist, health coach, nutritionist. How difficult would it be to use the aspiration to work backwards from site codes to pay them via per member per month (PMPM)?
Ashok Reddy noted that ambulatory care could be added. The OFM report was narrowly focused on certain clinics.
Josh Liao caveated that billing location doesn't always equal treatment location. There will need to be a new code or a new system eventually. Currently, Fee-for-service (FFS) provides a system for tracking.
Nancy Connolly noted that there are many services FFS doesn't pay for. To promote team-based care delivery, it needs to be paid appropriately.
Josh Liao concluded that what gets paid for and how it is paid will necessitate a new system of payment and delivery. There needs to be a reimagination of the current system to pay for a team.

Adjournment
The meeting adjourned at 11:00 a.m.

Next meeting
February 15, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.