Advisory Committee on Primary Care Meeting Summary

March 30, 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
Ginny Weir
Gregory Marchand
Katina Rue
Kristal Albrecht
Lan H. Nguyen
Linda Van Hoff
Madeline Wiley
Mandy Stahre
Nancy Connolly
Sharon Eloranta
Staici West
Shawn West
Tony Butruille
Tracy Corgiat

Members absent

Jonathan Staloff
Eileen Ravella
Kevin Phelan
Meg Jones
Michele Causley
Sarah Stokes
Sharon Brown
Sheryl Morelli

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 February meeting summary

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

Topics for Today

The main topics were a presentation on progress to date and a review of discussion goals, as well as a code-level discussion of primary care services.

Public Comment

Katerina LaMarche, Washington State Hospital Association (WSHA), noted that members of the Advisory Committee of Health Care Providers and Carriers were unable to give additional feedback on the primary care definition because their most recent meeting was cancelled. The definition should include the *why* of primary care. Ensuring primary care and outpatient services are adequately supported is critical to maintaining a cost-effective system. It is imperative that the work of the committees and the board is structured so that members' expertise can be exercised before decisions are made.

Presentation of Progress-to-date and Review of Discussion Goals

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

Amy Clary provided a recap of the Advisory Committee on Primary Care's (the Committee's) work on the definition of primary care. Decisions were made at previous meetings related to the *who* and the *where* and discussion had begun at the February meeting to determine a code level set of primary care services. The goal of today's meeting is to finalize the code-level list of primary care services. The Committee also reviewed the general definition of primary care created by the Committee that was approved by the Board in February.

Amy Clary explained the ground rules for today's meeting: 1) the primary care definition needs to account for the intersection of the *who*, the *where*, and the *what*; 2) this is a "working" definition; 3) there will be no changes to existing statutory categories; 4) future data analysis may inform refinements of the final definition.

The Committee reviewed the list of facilities and providers approved at prior meetings. These may be revisited based on data analysis. For providers, the Committee chose to add Advanced Practice Registered Nurses (APRN), internal medicine pediatrics, and Physician Assistant (PA) to the narrow list. The Committee added psychiatric mental health APRNs and psychiatric mental health PAs to the broad category and removed homeopaths from either of the lists.

Dr. Judy Zerzan-Thul led a motion to approve the facilities and providers list. There will be another review of these lists after initial data analysis is performed.

Committee member Madeline Wiley cited a question from Linda Van Hoff about listing Advanced Registered Nurse Practitioners as APRNs. Legally, they are abbreviated as ARNPS. Dr. Zerzan-Thul responded that both could be included to sufficiently cover the different notations.

Committee member David DiGiuseppe asked whether the overlap between primary care providers and specialists had been addressed at previous meetings. Dr. Zerzan-Thul responded that it hadn't. There are some codes that include general practice that suggest surgical versus medical. The Committee planned to use medical rather than surgical for PAs. There is more nuance with APRN categories, and less for PAs. David DiGiuseppe pointed out that at some point, someone will have to code in the claims data to identify primary care, which is more complex than the discussion at this level. Dr. Zerzan-Thul noted that the Washington Health Alliance has a good provider list. The Committee may want to discuss something like that for tagging specific people as primary care on an annual basis.

Committee member Nancy Connolly asked how the Committee would handle a home care visit. A home isn't typically a facility, primary care can happen there. Additionally, how is the Committee considering the team-based component of the definition as it relates to these chosen categories of providers and facilities? Dr. Zerzan-Thul clarified that the Committee hasn't thought about how the team-based component will function with specific coding. For codes, home visits are included. Telehealth usually uses a facility to bill home visits. The visits might happen from home but are billed from an office at some point. Staff can investigate how home visits are billed for a future meeting.

Committee member Tracy Corgiat asked if the group had discussed pharmacists. Dr. Zerzan-Thul stated that the group hadn't discussed pharmacists. Tracy Corgiat asked if there would be an opportunity to do that. Dr. Zerzan-Thul said there could be. Other states haven't included pharmacists. The Committee needs to find the bulk of primary care, not identify every single service. If there's a place for future investment, this work will guide that. Tracy Corgiat cautioned against limiting inclusion of pharmacists in the future. Pending future data analysis allows for conditional approval today. The Committee can look at future data to see the level of inclusion with pharmacists. Committee member Shawn West moved to approve the current facilities and providers list, pending future data analysis. The motion was seconded and passed.

Discussion of Primary Care Services

Shane Mofford, CEbP

Shane Mofford reviewed a comparison between the Office of Financial Management's (OFM's) primary care services included in their 2019 report versus those services included in the Bree Collaborative's 2020 report. Care coordination and urgent care were included in Bree, but not in OFM. For today's meeting, codes have been put into discrete categories. If a service doesn't get included by this Committee for measurement, providers will still be reimbursed. Both the Primary Care Transformation Model (PCTM) and this Committee's statutory work aim to increase primary care spending while decreasing total health care spending. Today's discussion will focus on the *what* of primary care services. The intersection of all three – *who, where,* and *what* – will determine what's included for the 12 percent target.

For today's discussion: 1) The group doesn't need to capture every possible code that might be rendered; 2) the focus is ensuring the final code set includes services predominantly provided by primary care; 3) future analyses can identify services for future consideration that are frequently provided to be approved by the committee.

Each category of code sets will undergo a recommendation approval process. Each cluster will have a formal motion, followed by discussion. Motions pass by simple majority. If there's a no, then there's an amendment process.

The first category the Committee reviewed was preventive medicine services (Part 1). All codes in this set had 100 percent prevalence across other definitions and were recommended by HCA leadership for inclusion. A motion was made to vote on the category. The motion passed with 17 yeas, and no nays. The second category was preventive medicine services (Part 2). A motion was made to adhere to the recommendation to include all the codes in this set. The motion passed with 16 yeas and no nays. The third category was immunizations. The recommendation for the set was to include all codes.

Committee member Sharon Eloranta asked what other states who didn't include the codes were thinking, as the prevalence in other definitions was less than 100 percent across other states. Dr. Zerzan-Thul wasn't sure but explained that HCA clinical staff started with those codes that had broad agreement among states. Some immunizations happen in pharmacies. Shane Mofford added that this current level of analysis isn't looking at location or provider type. Dr. Zerzan-Thul noted that Washington is the only state that includes a location for analytical purposes. The Committee may want to revisit this code set based on future data analysis.

Madeline Wiley asked how the Committee knows it isn't leaving something out in a category. Dr. Zerzan-Thul clarified that these are the most common codes that have been used in anyone's definition. The Committee shouldn't do an exhaustive search. Shawn West pointed out that the Committee is capturing most codes. There will always be additions and subtractions.

A member of the public stated that if a vaccine is state-supplied, providers aren't billing using the immunization codes from this set, they're billing and adding an "SL" code to determine that it's an administrative charge. Dr. Zerzan-Thul said it will show up in the data analysis if providers don't bill for immunizations. The Committee can evaluate existing billing practices. Tracy Corgiat explained that most pediatric vaccines are state supplied and should be captured. Dr. Zerzan-Thul clarified that providers should be billing using the immunization administration codes in this set because they get paid more that way. This is why the Committee isn't including individual vaccines but the administration of vaccines. Katina Rue noted that there is also a SL state code for administration. The Committee should check to see if it needs the SL or can capture without. Dr. Zerzan-Thul responded that the current codes should capture all subvariants, but staff can double check. A motion was made to approve the immunization code set. There was no further discussion. The motion passed with 15 yeas, and no nays.

The next code set was special services, procedures, and reports (Part 1). Only Colorado included the first few, but HCA recommends inclusion of all codes in the set. Committee member Kristal Albrecht cautioned that office emergency care could add up quickly and reiterated that the codes should reflect true primary care. The Committee can vote to exclude a single code while keeping the remaining codes when voting on the set.

Tracy Corgiat asked if there is an option for further consideration to gain more context on lower percentages that were not as prevalent across other definitions. Committee member Tony Butruille noted that Washington's process is different from other states because Washington uses both the *who* and the *where*. The Committee should be more inclusive based on the three intersections the Committee has chosen. Dr. Zerzan-Thul expressed hesitation around making Washington's codes more like other states versus adopting a more state specific method of measurement. Washington's inclusion of facilities may narrow the definition. Kristal Albrecht voiced support for aligning with other states since the Committee had chosen to be fairly liberal with which facilities to include.

Tracy Corgiat recommended erring on the side of greater inclusion. Dr. Zerzan-Thul noted that some facilities are broader, such as on-site hospital clinics and multi-specialty. David DiGiuseppe stated a preference not to be overly expansive for what services to include and asked for further clarification on the voting process. Shane Mofford explained that if the group votes no on a category, then it should make amendments to the list for what to include or exclude, and re-vote. The Committee could add a question to the data analysis around prevalence. What is the alignment with other states? Tracy Corgiat asked whether someone could voice an amendment or had to wait until it's a no. Shane Mofford responded that if there is not currently a movement to approve, a member could propose a change to the recommendation before the formal vote. Tracy Corgiat made a motion to only include the codes at 100 percent in the special services, procedures, and reports (Part 1) set. The motion was seconded. There were 12 yeas and 3 nays.

The next code set was special services, procedures, and reports (Part 2). Committee member Staici West asked whether all of the office visits in this set would be captured working in multi-specialty clinics. OFM used a formula of 60 percent of PA services and asked Mandy Stahre if OFM limited their calculations to general or surgical. Committee member Mandy Stahre responded that there were three categories. Madeline Wiley stated that surgical wasn't included. Mandy Stahre further explained that the 60 percent was based on literature reviews. Shane Mofford noted that checking the percentage of PA office visits would be a good follow-up item. David DiGiuseppe noted that there are specialty and taxonomy codes that can be used to address some of these issues. Dr. Zerzan-Thul responded that taxonomy codes will be used for physicians. These codes are narrower but still reasonable for APRNs, with 10 to 15 codes. For PAs, there are only three codes. A motion was made to include all codes in the Part 2 special services set. The motion passed with 14 yeas, and 1 nay.

The next code set category was special evaluation and management services. All codes except remote monitoring were recommended for inclusion. Tracy Corgiat asked about the difference between remote psychological monitoring and other codes in the set. Committee member Ginny Weir noted that disability exams also didn't show a high prevalence across other definitions but had been recommended for inclusion. These could also be excluded for consistency. Sharon Eloranta added that remote initial and programming are primary care. Tracy Corgiat recommended changing the remote monitoring codes to be included.

David DiGiuseppe asked about the percentages and dollars associated with low prevalence codes. If the Committee reaches 20 percent because it included low prevalence codes, that's a different situation. Tracy Corgiat added that the Committee is currently only taking one data point to include or exclude and suggested maybe there should be more. The Committee should include all codes and then report back by groupings on the impact of inclusion.

Shane Mofford clarified that if single data points on prevalence aren't significant to the group, the Committee could accept the current recommendation and do further refinement when the analysis comes back. The Committee could use the current recommendation process and could add codes later as dictated by further analysis. Or the Committee could include everything now and refine the list to be potentially narrower in the future. Dr. Zerzan-Thul suggested that having a smaller code set might be more helpful in the future to assess the target. The Legislature could use this as a place to target primary care reimbursement. It may not be worth it to have low volume codes because the Committee should focus on the main parts of primary care. Kristal Albrecht suggested looking only at codes with 75 to 100 percent prevalence to get through the sets more quickly.

Tracy Corgiat asked whether voting to include a code enables the data analysis or whether the analysis is already underway. There is not currently enough information for selection. If the Legislature is making decisions on payments based on this, the group needs better ground for choosing. The data analysis depends on Dr. Zerzan-Thul's preference. Dr. Zerzan-Thul clarified that there are very few data analysis resources and no analysis is

happening right now. The plan is to pull the data once, analyze it, and make necessary refinements. The data will come from cost board solicited health plan data. Ideally, a final code set would be included in July reporting for carriers, but there may not be enough time for that to happen this year. There needs to be a stable point of measurement for future comparison.

Tony Butruille expressed a strong desire to lean towards more inclusivity. There is an intersection between primary care and specialty. It would be bad to disincentivize primary care from doing more complicated procedures (injections, excisions, etc.) because then more services/procedures will be sent to specialty. Dr. Zerzan-Thul responded that people do varied things with different roles. There isn't a code if a family physician, internal medicine physician, or pediatrician works in the Emergency Room. Locations don't necessarily place a provider in a primary care clinic. A motion was made to approve all codes in the special evaluation and management services set – changing two excluded codes to include. This motion was approved with 12 yeas, and 3 nays.

The next code set for consideration was care plan oversight services. The recommendation for this set was to include all codes. Shane asked the group whether they wanted to continue with the current recommendation approval process considering today's conversations about prevalence. David DiGiuseppe asked if services could be bucketed into narrow and broad like the providers were. Dr. Zerzan-Thul said this might be possible. Jean Marie Dreyer noted that only Washington used narrow and broad categories to assess primary care services.

Nancy Connolly brought up the issue of teams-based delivery again. Dr. Zerzan-Thul reiterated that there's no way of knowing via coding whether a provider is part of a team. The Committee could account for the team-based aspect when assessing non-claims-based payments. Jean Marie Dreyer added that this could be a qualitative analysis the group does later after running initial numbers. Dr. Zerzan-Thul added that Oregon has a certification for primary care with self-attestation. Shane Mofford suggested that the teams-based aspect could be evaluated as part of a secondary level of analysis after the initial analysis is completed. The first level analysis looks to see if a provider, place, or service counts as primary care. The second analysis would investigate how a service is delivered. Nancy Connolly reminded the group that if a team member is doing something in a primary care team setting, then any provider in that setting should be included. Dr. Zerzan-Thul clarified that there wasn't broad agreement on that. The Committee will run the risk of diluting certain services if everyone gets included. Dr. Zerzan-Thul made a motion to approve the current set of care plan oversight services. The motion was seconded. There was no further discussion. The motion passed with 14 yeas, and no nays.

The next category for consideration was consultation services. All codes in this set were recommended for inclusion and the prevalence was 83 percent. A motion to approve the set was proposed, seconded, and passed with 14 yeas, and no nays.

The next code set was home health services, which Dr. Zerzan-Thul noted should be titled home visits. All codes in the set were recommended for inclusion and had a prevalence of 92 percent across other definitions. A motion to approve the set was made, seconded, and passed with 14 yeas, and no nays.

The next code set was complex chronic care coordination services. All codes were recommended for inclusion and all but one had a prevalence above 50 percent. A motion to approve the set was made, seconded, and passed with 14 yeas, and no nays.

The next code set was non-face-to-face physician and non-physician services. A motion to approve the set was made, seconded, and passed with 14 yeas, and no nays.

The next code set was nursing facility services. All codes in the set had 25 percent prevalence and were recommended for exclusion. A motion to approve the excluded codes was made and seconded.

Nancy Connolly asked about a primary care physician who has checked their patient into a Skilled Nursing Facility (SNF). Dr. Zerzan-Thul explained that can happen through billing but wouldn't count in this measurement process. Tracy Corgiat expressed concern if this category were used for billing. Dr. Zerzan-Thul explained that none of these codes will be excluded from regular business. Nancy Connolly worried that excluding these codes could discourage a primary care doctor from following their patient. Dr. Zerzan-Thul clarified that the choice to exclude these codes won't discourage care coordination and physicians who follow their patients will still get paid. Rarer services aren't worth including because they're such a small percentage and won't affect the outcome one way or another. If in 10 years this practice changes and more doctors follow patients into nursing facilities, this group can update the process. A motion was made to exclude the code set from measurement. The motion was seconded and passed with 13 to yeas and one nay.

The next code set was domiciliary, rest home, or custodial care services. All codes were recommended for inclusion. Tony Butruille asked if the set refers to assisted living more than nursing homes. Dr. Zerzan-Thul was not sure. Tony Butruille added that assisted living is supposed to be mobile enough for office visits. Nursing facilities are in-house with their own providers. Jean Marie Dreyer will do more research on this topic. The group decided to refrain from voting on the domiciliary set until a later time.

The final code set was osteopathic manipulative treatment. There was a low prevalence in other definitions, but all codes were recommended for inclusion. A motion was made to approve the included osteopathic codes. The motion was seconded and passed with 9 yeas, and 2 nays.

At the next meeting, the Committee will finish reviewing the code sets. Senate Bill 5589 also requires the Committee to discuss barriers to access, how and by whom it should be determined whether the primary care target is being met, methods to achieve the desired levels of primary care, and methods of reimbursement to achieve sustained levels. Staff will send the legislative language for members to review. There is a report due in the early summer. In May, the group will hear presentations on non-claims-based spending.

Adjournment

The meeting adjourned at 4:00 p.m.

Next meeting

March 30, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.