Advisory Committee on Primary Care Meeting Summary

April 27, 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
Tony Butruille
Chandra Hicks
Ginny Weir
Katina Rue
Kristal Albrecht
Sheryl Morelli
Lan H. Nguyen
Linda Van Hoff
Mandy Stahre
Michele Causley
Nancy Connolly
Sharon Eloranta
Jonathan Staloff
Staici West
Shawn West
Madeline Wiley

Members absent

Tracy Corgiat
D.C. Dugdale
David DiGiuseppe
Gregory Marchand
Eileen Ravella
Kevin Phelan
Meg Jones
Sarah Stokes
Sharon Brown

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 March meeting summary

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

Topics for Today

The main topics were a presentation on and discussion of committee charges, a proposed amendment to the primary care definition, and discussion and voting on remaining code sets.

Public Comment

There were no public comments.

Presentation of Committee Charges

Jean Marie Dreyer, HCA

Jean Marie Dreyer reviewed the three categories of Legislative statute SB 5589: the primary care definition, data to support primary care, and policies to increase and sustain primary care. Throughout the meeting, each category was addressed and committee members had the opportunity to provide feedback through polling.

Proposed Amendment to Primary Care Definition

Jean Marie Dreyer, HCA

Jean Marie Dreyer presented a proposed amendment to the committee's approved definition of primary care received from a Washington State Hospital Association (WSHA) representative. Committee member Nancy Connolly suggested rewording the amendment to say, "to support patients in working towards their goals of physical, mental, and social health and wellbeing." This comes from the World Health Organization's definition of health. Committee member Linda Van Hoff suggested the language, "to promote overall health and wellness through illness prevention and minimizing disease burden via a continuous relationship over time." It's important to emphasize health promotion and preventive health. Committee member Lan Nguyen noted that the language, "create and maintain" places the ownership solely on providers whereas there could be language added "in partnership with" patients.

The amended definition read as:

> "Team-based care led by an accountable primary care clinician that serves as a person's source of primary contact with the larger healthcare system. Primary care includes a comprehensive array of equitable, evidence-informed services to support patients in working toward their goals of physical, mental, and social health and the general wellbeing of each person, through illness prevention, and minimizing disease burden, through a continuous relationship over time. This array of services is coordinated by the accountable primary care clinician but may exist in multiple care settings or be delivered in a variety of modes."

Dr. Zerzan-Thul proposed a motion to adopt the adapted definition. The motion passed unanimously.

Data to Support Primary Care

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

HCA and CEbP highlighted the National Academy of Sciences, Engineering and Medicine's (NASEM) research process to identify strategies at a national level for the Centers for Medicare and Medicaid (CMS). NASEM's five objectives for achieving high-quality primary care are: 1) Pay for primary care teams to care for people, not doctors to deliver services, 2) ensure that high-quality primary care is available to every individual and family in every community 3) train primary care teams where people live and work 4) design information technology that serves the patient, family, and interprofessional team, and 5) ensure that high-quality primary care is implemented in the U.S. These objectives largely align with this Committee's and Washington's goals to support primary care.

The data team from HCA reviewed NASEM's strategies and added context for Washington's current data strategies. NASEM's first data strategy recommendation is around meaningful exchange of data through: a centralized warehouse, an individual health data card, or distributed sources connected by a real-time functional health information exchange. HCA has four existing health exchange methods: a clinical data repository, the Washington All-Payer Claims Database, Washington's Health Information Exchange (HIE) operated by One Health Port, and Washington's Master Person Index (MPI). NASEM's second data strategy focuses on accountability and infrastructure for technology in place for electronic health records (EHRs). Washington currently has HCA's EHR-as-a-service initiative, and an Electronic Consent Management (ECM) initiative.

Shane Mofford polled the committee on existing data policies to recommend for measurement and support of primary care. The poll allowed members to list additional data policy suggestions. Dr. Zerzan-Thul emphasized that these suggested policies will be incorporated into the Cost Board's annual report to the Legislature. The highest support was expressed for HCA's EHR-as-a-service-initiative, followed by HCA's ECM initiative.

Committee member Chandra Hicks asked to what extent the Total Medical Expenditures (TME) and cost growth data are useful/applicable for these types of data policies. Shane Mofford replied that there is a suite of use cases to support the use of primary care data. Of the existing initiatives, some relate directly to primary care expenditures while others pertain to access to care. It's not just about increasing expenditures but increasing positive patient outcomes.

Committee member Maddy Wiley pointed out that adding an identification code could create privacy issues. Committee member Mandy Stahre noted an absence of expanding the workforce in the data suggestions. Shane Mofford clarified that the next section would reference workforce as part of other policy recommendations. Linda Van Hoff noted that investing in the EHR initiative will necessitate analyzing connectivity. Building a technical bridge is complicated and the group should think about who is responsible for building that infrastructure.

Policies to Increase and Support Primary Care

Gretchen Morley, CEbP

Gretchen Morley led a discussion of strategies to drive toward the 12 percent primary care expenditure target. There are four key dynamics that influence primary care expenditure statistics: direct investment, capacity growth, patient behavior (increased use of primary care services), and reduced expenditures on other services. Gretchen Morley reviewed the key actors, levers, and strategies involved in each of the four key dynamics.

Additionally, Gretchen Morley presented NASEM strategies that support primary care sustainability. NASEM recommends moving away from fee-for-service (FFS) models to alternative models with either full or partly capitated models. NASEM also recommends that states use their authority to facilitate multi-payer collaboration on

primary care payment and fee schedules. Washington payers, purchasers, and providers continue to collaborate to develop a new framework to support primary care through payment models, provider supports, and aligned policies to reduce administrative burden, to develop consistent standards and expectations. NASEM also recommends diversifying the primary care workforce to expand the type of available providers through training and economic incentives. To impact patient behavior, NASEM recommends that all covered individuals declare a usual source of primary care annually.

Committee member Sheryl Morelli commented on how different it is to compare the adult and pediatric population for primary care spending.

Committee members ranked increasing primary care reimbursement as a top priority to support achievement of the primary care target. The second priority was increasing payer focus on reducing administrative burdens/costs for providers, followed by forgiveness for non-compete clause penalties.

Committee member Sharon Eloranta commented that she did not want to fill out the poll before tabulating the existing spending on primary care. There was no policy included in the poll requiring health carriers to designate a primary care provider (PCP) for each member to ensure proper attribution. Committee member Michele Causley noted that Oregon has a bill requiring health carriers to assign a PCP. This poses challenges because employers want open access.

Committee member Jonathan Staloff noted that in addition to increasing reimbursement for primary care services, it's important to bolster Medicaid reimbursement to support equity in primary care services, and Maddy Wiley agreed. It could also be useful to create financial incentives for receiving evidence-based preventive services. For training PCPs, there could be more support for teaching health center residencies in rural areas. Also, there are many non-compete clauses which incur significant financial penalties for providers that could be amended. Nancy Connolly expressed support for eliminating non-compete clauses.

Sharon Eloranta asked how facility fees will be calculated to avoid rewarding locations that are already up charging.

Code Review Finalization

Dr. Judy Zerzan-Thul, HCA

Dr. Zerzan-Thul led voting on the remaining primary care service code sets. Dr. Zerzan-Thul made a motion to include the full set of codes for domiciliary, rest home, or custodial care services. The motion passed unanimously.

Next, Dr. Zerzan-Thul made a motion to include the full set of codes for prolonged services. Michele Causley commented that many of these codes were deleted in 2023 and replaced by a new code, 99417. This set would be relevant for reviewing past data, but the new code would need to be included. The motion passed unanimously.

Dr. Zerzan-Thul moved to exclude all codes in lab testing and supplies (Part 1). The motion passed unanimously.

Dr. Zerzan-Thul moved to exclude all codes in lab testing and supplies (Part 2). The motion passed unanimously. Next, Nancy Connolly moved to include all codes in temporary codes (Part 1). Linda Van Hoff asked if it was important to exclude the EKG code. Sharon Eloranta proposed excluding the EKG code. Maddy Wiley also agreed with removing it. Committee member Kristal Albrecht proposed an amendment to include all codes except the EKG code. The motion passed unanimously.

The next category was temporary codes (Part 2). "Ppps" is a code to designate an annual wellness visit. Michele Causley noted that wellness codes are more informational and not based on reimbursement. Linda Van Hoff cautioned against excluding codes that were informational. Kristal Albrecht also expressed hesitancy to remove the ppps code but supported removing EKG. Kristal Albrecht made a motion to include all but the EKG codes. The motion passed unanimously.

Dr. Zerzan-Thul moved to include and exclude temporary codes (Part 3). The motion passed unanimously.

For supervision, Dr. Zerzan-Thul made a motion to include all codes except those relating to nursing facilities. Nancy Connolly advised that hospice is generally characterized as primary care. Maddy Wiley and Tony Butruille agreed. Jonathan Staloff noted that the *what* and the *who* of hospice is primary care, but the *where* is changeable depending on the setting. Maddy Wiley suggested that the billing codes would differ for inpatient. There should be a site of service that can be excluded from the professional claim. Jonathan Staloff moved to include and exclude as noted on the slide while also excluding anything that's inpatient. The motion passed unanimously.

Dr. Zerzan-Thul made a motion to exclude all codes in cardiac and pulmonary testing/procedures. The motion passed unanimously.

Dr. Zerzan-Thul made a motion to exclude all codes in dermatology. Sharon Eloranta asked whether this would affect increases in reimbursement and added that many of these codes could happen in a primary care setting. Dr. Zerzan-Thul noted that because these codes are revenue generating it might artificially increase the 12 percent. Maddy Wiley agreed that this set of codes isn't core primary care. The motion passed unanimously.

The next category was newborn care services. Only 25 percent of other state definitions include these codes. Dr. Zerzan-Thul made a motion to exclude the codes in this category. Maddy Wiley said the 99461 code is not used as a first newborn visit code. The motion passed unanimously.

The next category was obstetrics. Some states include a percentage of these codes, like Oregon. Dr. Zerzan-Thul proposed excluding all codes in this set. There were insufficient votes, so this category will be voted on at the next meeting.

Adjournment

The meeting adjourned at 4:00 p.m.

Next meeting

May 25, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.