Advisory Committee on Primary Care

October 25, 2022

Agenda

TAB 1

Advisory Committee on Primary Care

October 25, 2022
1:00 – 2:30 p.m.
Zoom Meeting

AGENDA

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

Time	Agenda Items	Tab	Lead
1:00-1:10 (10 min)	Welcome, roll call, and agenda review	1	Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
1:10-1:15 (5 min)	Approval of September meeting minutes	2	Jean Marie Dreyer, Committee Facilitator Health Care Authority
1:15-1:20 (5 min)	Charter review	3	Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
1:20-1:50 (30 min)	Presentation on primary care work from other states	4	Larry McNeely, Policy Director Primary Care Collaborative
1:50-2:00 (10 min)	Public comment		Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
2:00-2:25 (25 min)	Discussion of Recommendation 1 – Defining Primary Care	5	Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
2:25-2:30 (5 min)	Wrap-up and adjournment		Jean Marie Dreyer, Committee Facilitator

Subject to Section 5 of the Laws of 2022, Chapter 115, also known as HB 1329, the Board has agreed this meeting will be held via Zoom without a physical location.

Approval of September meeting minutes

TAB 2

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.

Charter review

TAB 3

Advisory Committee on Primary Care: Charter

1. **Problem Statement:**
Washington State primary care expenditures remain low as a proportion of total health care expenditures when compared to other states and the national average. Some of the lower spending estimates may be due to the exclusion of non-claims-based spending. While Washington tracks claims-based spending, the state lacks a standard process for tracking non-claims-based spending.

2. **Background:**
In 2022, the Legislature passed Senate Bill 5589, a statute on primary care. In the statute, the Legislature directed the Health Care Cost Transparency Board to "measure and report on primary care expenditures and the progress toward increasing to 12% of total health care expenditures (THC)."

   A preliminary report to the Legislature from the Health Care Cost Transparency Board, which includes recommendations on how to define primary care, measurement considerations, and how to achieve the 12 percent target, is due December 1, 2022.

3. **Purpose:** To recommend a definition of primary care and primary care expenditures measurement methodology to the Health Care Cost Transparency Board to increase primary care expenditures to 12 percent of total health care expenditures in Washington State while keeping total costs below the 3.2 percent cost growth benchmark goal.

4. **Duties and Functions**
The Advisory Committee on Primary Care will advise the Health Care Cost Transparency Board and its subcommittees to adopt recommendations for:

   - A statewide definition of primary care
   - Measurement methodologies to assess claims and non-claims-based spending
   - How to overcome barriers to access and use of primary care data
   - How to report on the annual progress needed for primary care expenditures to reach 12 percent of total health care expenditures in a reasonable amount of time
   - How and by whom annual primary care expenditure targets are achieved
   - Methods to incentivize achievement of the 12 percent target
   - Specific practices and methods of reimbursement to achieve and sustain primary care expenditure targets

5. **Structure**
The committee will be chaired by Dr. Judy Zerzan with administrative support from other HCA staff. The committee will consist of primary care providers, organizations representing primary care providers, carriers, as well as representatives from the Office of Financial Management and the Bree Collaborative. Members will be appointed by the Health Care Cost Transparency Board.

6. **Meetings**
The committee will hold meetings beginning in September 2022 which will continue until the required recommendations are completed and submitted to the Board to run monthly through August 2023. Meetings are subject to the Open Public Meetings Act. All materials will be distributed electronically and made publicly available on the Board website, and meetings will be recorded and the video also posted.

7. **Discussion Guidelines**

   The Zoom chat function will be disabled during committee discussions of recommendations. Committee members will use the “Raise Hand” icon to encourage organized discussion. To allow for broad participation among a large group, individuals will keep their comments brief and limited in scope to the assigned discussion topic.

8. **Voting**

   Recommendations from the committee will be the subject of a motion and vote by committee members, and, if necessary, determined by majority.

Presentation on primary care work from other states

TAB 4

Primary Care in Other States

Presentation to Washington Health Care Authority
Larry McNeely
Director of Policy
October 25, 2022

OVERVIEW

- **Intro to PCC**
- **Primary Care Investment Landscape**
- **California and Virginia:** Deep Dive Focus on Two Recent Efforts
- **Getting Granular:** How to Measure PC Investment, Examples

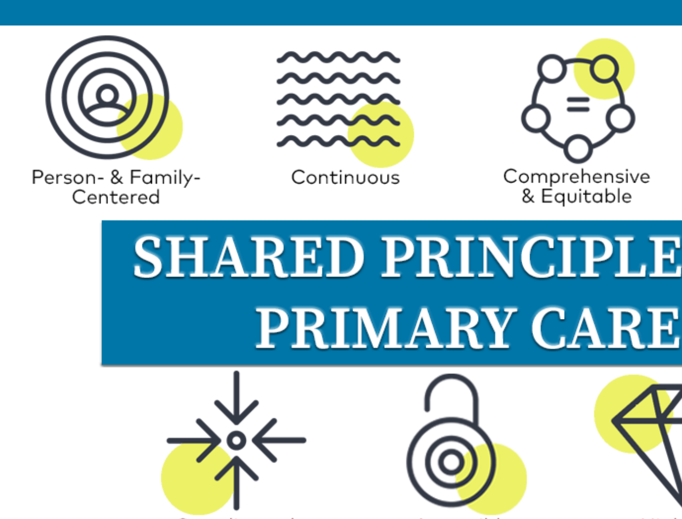
About the PCC

WHO WE ARE

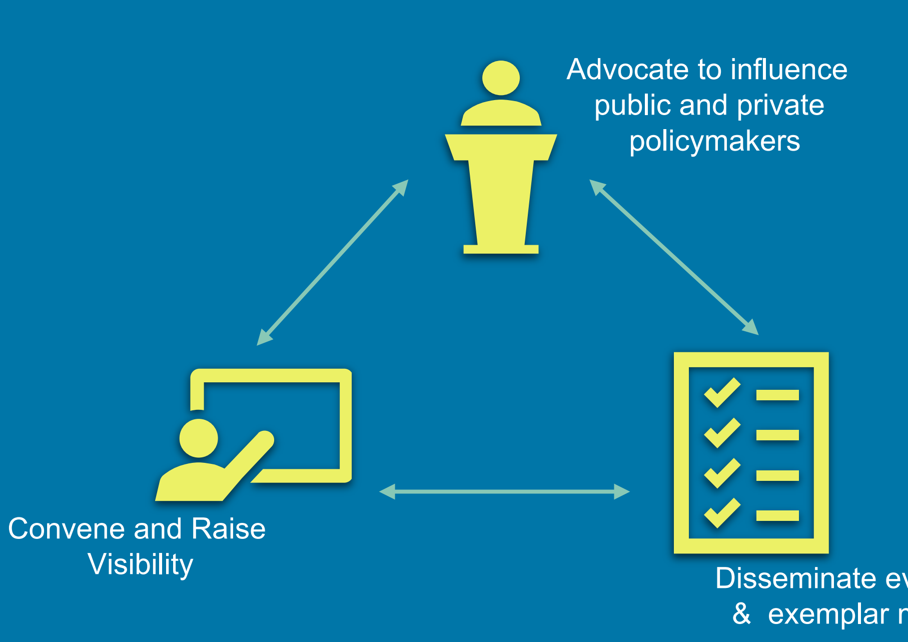
- Not -for -profit, multistakeholder organization with 67 members

OUR MISSION

- The Primary Care Collaborative advances comprehensive primary care to improve health and health care for patients and their families by convening and uniting stakeholders around research, care delivery and payment models, and policies.



PCC Levers to Achieve Mission and Vision



67+ Members

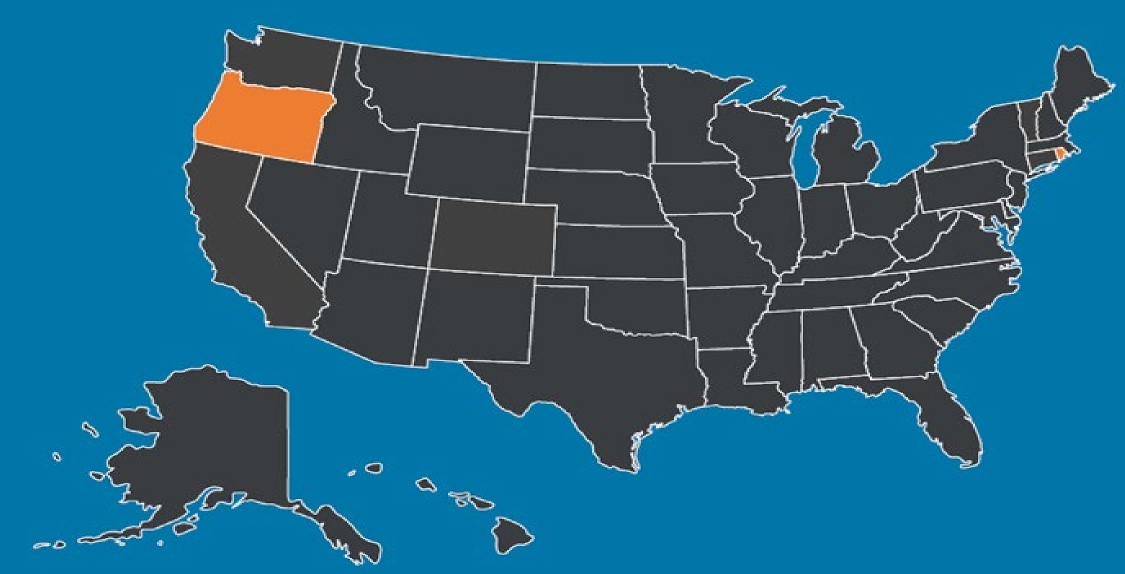
From AARP to URAC and 65 organizations in between

96% of PCC members renewed in 2021

pcc
primary care collaborative

AARP · Accreditation Association for Ambulatory Health Care, Inc. · Alzheimer's Association · America's Agenda · American Academy of Child & Adolescent Psychiatry · American Academy of Family Physicians · American Academy of Pediatrics · American Academy of Physician Associates · American Association of Nurse Practitioners · American Board of Family Medicine Foundation · American Board of [illegible] Foundation · American Cancer Society · American College of Clinical [illegible] · American College of Lifestyle Medicine · American College of Osteopathic Family Physicians · American College of Osteopathic Internists · American College of Physicians · American Psychiatric Association Foundation · American Psychological Association · [illegible] Array Behavioral Care · Ascension Medical Group · Black Women's Health Imperative · Blue Cross Blue Shield of Michigan · CareFirst, BlueCross BlueShield · Catalyst Health Network · Community Care of North Carolina · CVS Health · Families USA · Harvard Medical School Center for Primary Care · [illegible] · Humana · IBM · Included Health · Innovaccer · Institute for Patient- and Family-Centered Care · Johns Hopkins Community Physicians, Inc. · Johnson & Johnson · Mathematica Policy Research · MedNetOne [illegible] Health America · Merck · Morehouse School of Medicine - National Center for Primary Care · [illegible] Healthcare Purchaser Coalitions · National Association of ACOs · National Coalition on Health Care · National Interprofessional Initiative on Oral Health · National PACE Association · National Partnership for Women & Families · National Rural Health Association · NCQA · Oak Street Health · One Medical · PCC Pediatric EHR Solutions · Pediatric Innovation Center · Penn Center for Community Health Workers · Primary Care Development Corporation · Purchaser Business Group on Health · Society of General Internal Medicine · Society of Teachers of Family Medicine · St. Louis Area Business Health Coalition · Takeda Pharmaceuticals · UPMC Health Plan · URAC

Primary Care Spend Reporting in 2018



Primary Care Spend Reporting in 2022

It takes a Village:

States Committed to PC Spend Reporting in 2022

State Leaders Reorienting Toward Primary Care

- As of June 2022, 18 states with more possible. (CO, CT, DE, MA, MD, ME, NE, NH, NM, OR, RI, UT, VT, WA; Medicaid only: NJ, WV, OK, CA, HI)
- In 2022 alone, legislation enacted or passed in Connecticut, California, Maryland, Nebraska, New York, Oklahoma (Utah, and Washington
- 6 states have set targets for primary care spending in legislation without growing total cost of care
  - Rhode Island: 10.6% by 2014
  - Oregon: 12% by 2023
  - Colorado: +1% in 2022 and 2023
  - Connecticut: 10% by 2025
  - Delaware: 11.5% by 2025
  - Washington: 12%, date TBD

California Quality Care Collaborative Advanced Primary Care (APC): Shared Standards

- Advanced Primary Care: High quality, high-value primary care centered around the patient
- Purchaser Business Group on Health (PBGH) and California Quality Collaborative (CQC) defined a shared standard of APC
  - ➢ Developed through a multi-stakeholder process that included input from purchasers, health plans, providers and patients
- Shared standard of attributes and measures:
  - ➢ Enables purchasers and patients to recognize and identify practices providing APC and to pay for it differently
  - ➢ Provides clear guidance to providers on how to deliver APC
  - ➢ Identifies technical assistance and support required to scale APC

Source: Presentation on Multi-Stakeholder Progress in California by Castiglione and Peterson, August 3, 2022

California Advanced Primary Care: Attributes

- Attribute domains:
  - Access to care
  - Continuity
  - Care coordination
  - Population-based
  - Comprehensive
  - Patient-centered
  - Team-based

- Attributes define advanced primary care:
  - From the patient perspective and how the patient experiences care
  - Agnostic to the method, or the 'how', each attribute was achieved

- A patient's description of primary care that embodies a patient-centered approach addressing both access and continuity of care

Source: Presentation on Multi-Stakeholder Progress in California by Castiglione and Peterson, August 3, 2022

Attributes of Advanced Primary Care

How Employer-Identified Practice Attributes Align with the Shared Principles of Primary Care

This table crosswalks employer-identified attributes of advanced primary care (APC) with the Shared Principles of Primary Care. It is a first step on the path to achieving APC. Measures, including those reported by and about patients, that assess the extent to which a practice has achieved advanced primary care are forthcoming. We will continue to engage with all the stakeholders in primary care and expect that these attributes will evolve over time.

Employer-Identified Attributes of Advanced Primary Care*	Shared Principles of Primary Care						
	Person & Family-Centered	**Continuous**	**Comprehensive & Equitable**	**Team-based & Collaborative**	**Coordinated & Integrated**	**Accessible**	**High Value**
	The patient statements below offer examples of what patients want from primary care. They were developed by PBGH through a multi-stakeholder process.						
	"I can get care and information from my primary care team when I need it and in the way that best meets my needs"	*"My primary care team knows me and keeps me well."*	*"My primary care team knows and supports the whole me—not just my body."*	*"My primary care team can meet most of my healthcare needs."*	*"When I do need a specialist, [my primary care team] helps me find the right one and communicates with them about me. "*	*"I can get care and information from my primary care team when I need it and in the way that best meets my needs"*	*"When I need planned surgery or emergency care, [my primary care team] knows what happened and support me in becoming well again."*
Enhanced access for patients							
Patients can access care in a way that meets their needs and preferences without financial barriers to access, including via: same-day and walk-in appointments; virtual care; a secure patient portal to view their medical records, receive labs and communicate with their care team; access to a care team member after hours.	✓	✓	○	○	○	✓	○
Optimize time with patients							
Patients are active participants in their care through: shared decision-making; input on their care plan and treatment goals; opportunities to share their preferences, including serious illness conversations, advanced directives, and end-of-life care; and addressing barriers due to their social determinants of health.	✓	○	✓	○	○	○	○
Realigned payment methods							
Practices are paid in a way that that enables and promotes quality, access, efficiency, team-based patient-centric care and population health management. Primary care payments are tied to patient experience and outcomes, and not volume or face-to-face visits.	✓	✓	✓	✓	✓	✓	✓

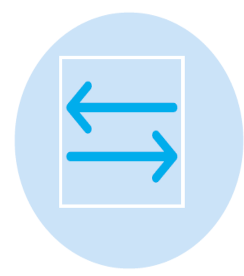
Multi-payer Commitments to Strengthen Primary Care in California

- Six organizations that pay for primary care (health plans and provider groups) signed an MOU, committing to a shared set of goals to strengthen APC in CA between 2022 and 2025:
  - Aetna
  - Aledade
  - Blue Shield of California
  - Health Net
  - Oscar
  - United Healthcare

- CQC and the Integrated Healthcare Association (IHA) have been convening large payers since January to align on this effort

Source: Presentation on Multi-Stakeholder Progress in California by Castiglione and Peterson, August 3, 2022

California's Advanced Primary Care MOU



Transparency: Commit to reporting of primary care investment, growth of hybrid payment models that support delivery of APC, and performance on the APC measure set.

Primary Care Payment: Adopt the hybrid payment model that supports APC. Ensure patients have access to a continuous relationship with a primary care provider and team.

Investment: Increase overall investment in primary care, as demonstrated by the commitment to a collaborative process to set primary care investment quantitative target goals, without increasing total cost of care.

Practice Transformation Continue collaborative dialogue toward: 1) supporting integration of behavioral health services 2) expanding data collection, exchange and stratification based on race, ethnicity and language (REaL) data 3) delivering targeted technical assistance

Source: Presentation on Multi-Stakeholder Progress in California by Castiglione and Peterson, August 3, 2022

California's New Statewide Office of Health Care Affordability

- California passed legislation to create a new office for transparency and goal setting to:
  - Set a cost target: Overall statewide cost growth target
    - Specific targets by sector
    - Based on economic indicators
    - First target set in 2024 for 2025
  - Grow alternative payment models: Statewide goal for APM adoption
  - Strengthen primary care: Measure and promote a sustained investment in PC and integration with BH
    - Measure % spent
    - Set spending benchmarks
  - Provide workforce support: Monitor and address workforce stability
  - Monitor quality to ensure there are no unintended consequences
  - Monitor care consolidation and market power

- Accountability through:
  - Technical assistance
  - Testimony
  - Corrective action plans
  - Financial penalties

Source: Presentation on Multi-Stakeholder Progress in California by Castiglione and Peterson, August 3, 2022

Virginia Task Force on Primary Care

- Launched July 2020, staffed by Virginia Center for Health Innovation
- Call to action to address urgent needs of primary care and consider new models of allocation and accountability
- Emphasis on ensuring primary care maintains its proven effects
  - Higher quality care
  - Lower costs
  - Greater equity across populations
- Funding support from Arnold Ventures and the Commonwealth of Virginia

- Source: Presentation on Virginia Task Force on Primary Care, Boortz, August 3, 2022

Virginia Task Force Definitions of Success

- VA clinicians and payers partner in seeking better health and lower cost care
- Primary care services are:
  - Accessible
  - Integrated
  - Equitable
  - Convenient
  - Affordable
- Virginia promotes a positive PC practice experience, to retain and grow of PC
- Payment is predictable and tied to meaningful performance measurement
- PC is less susceptible to changes in the economy
- Positive PC innovations adopted during the pandemic are maintained and advanced

Source: Presentation on Virginia Task Force on Primary Care, Boortz, August 3, 2022

Virginia Task Force Composition

Health Plan...

Primary Care Clinicians

Employers, State Gov't,...

Source: Presentation on Virginia Task Force on Primary Care, Boortz, August 3, 2022

Virginia Task Force Key Accomplishment: Data for Decision-Making

- Developed PC spend and total cost of care (TCOC) methodologies and produced baseline reports
- Partnered with VCU to expand the 2022 Virginia Primary Care Practice Survey to include practice interviews focused on anticipated impacts of Medicaid payment reform
- Prepared a primer on other states' Medicaid primary care payment reforms
- Gathered and reviewed data on the composition of Virginia's primary care workforce, with a focus on ownership arrangements and their impacts on incentive-based contracts

Source: Presentation on Virginia Task Force on Primary Care, Boortz, August 3, 2022

Virginia Task Force Key Accomplishment: Consensus Building

- Captured the ideal state of PC from each stakeholder perspective:
  - Clinician
  - Health plan
  - Employer
  - Patient
- Reached consensus around seven essential performance measurement categories
- Developed a plan for piloting:
  - Patient-Centered Primary Care Measure
  - What Matters Index
- Developed a concept model for enhancing PC infrastructure supports

Source: Presentation on Virginia Task Force on Primary Care, Boortz, August 3, 2022

Virginia Task Force Key Accomplishment: Legislative Advocacy

- Secured funding in the Virginia biennium budget for FY 2023 and 2024
  - Purchase of a bidirectional immunization data sharing tool (ImmuTrak) – $350K
  - Task Force continuation – $1.325M
  - Increased payment for Medicaid primary care services – $81.91M

Source: Presentation on Virginia Task Force on Primary Care, Boortz, August 3, 2022

Virginia Task Force 2023 Workplan

- Expand PC spend and TCOC reports to include trend analysis and an assessment of COVID-19 impact
- Develop a plan to disseminate actionable practice-level TCOC reports to PC clinicians
- Pilot a Virginia Primary Care Scorecard
- Pilot the Patient-Centered PC Measure and the What Matters Index and evaluate potential for national implementation
- Encourage and document health plan Core Quality Measures Collaborative measure adoption

Source: Presentation on Virginia Task Force on Primary Care, Boortz, August 3, 2022

Defining Primary Care Spend

Two Components of Potentially Measurable PC Spend

- Claims-based
- Non-claims-based

Within Claims-based Spend, Two Levels of Analysis

- Type of clinician providing service (Taxonomy)
- Services provided

Ex. 1: PCC's 2020 Evidence Report

Primary Care Spending:
High Stakes, Low Investment

Authors:
Ann Kempski , PCC Advisor
Ann Greiner, President and CEO

thePCC.org

FINDINGS: U.S. PC Investment Low *and* Declining

PC Spending Declined Among Commercially Insured 2017–2019

PCC finds decline similar to other recent analyses

Definition	2017	2019
Narrow	**4.88%**	**4.67%**
Broad	**7.8%**	**7.69%**

JAMA Internal Medicine 2020 All Payer Decline 2002–2016

- 6.5% to 5.4% decline, narrow definition

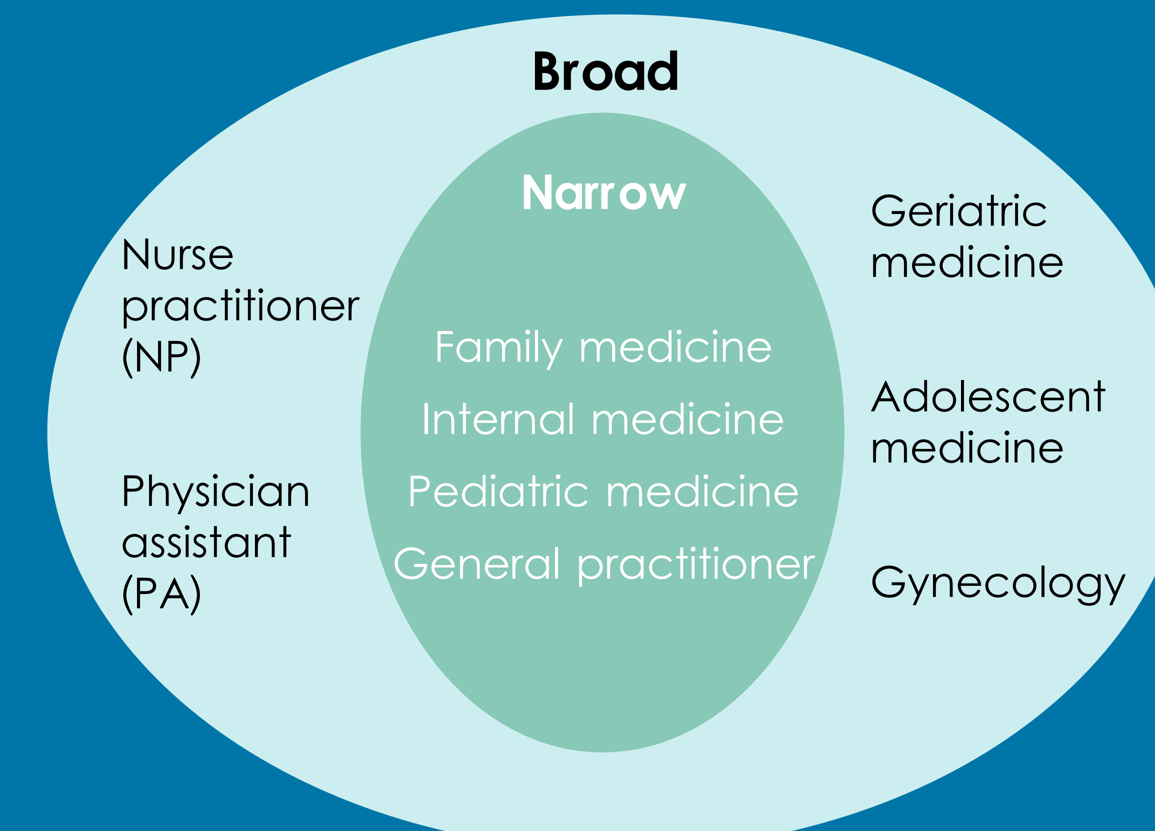
JAMA 2019 Commercially Insured Decline 2013–2017

- 4.6% to 4.35% decline, narrow definition
- 8.97% to 8.04% decline, broad definition

PCC: What's Broad? What's Narrow?

INCLUDES

- Services delivered in office, outpatient settings (not inpatient)
- Evaluation and management visits
- Preventive visits
- Care transition, coordination services
- Screening, counseling



Ex. 2: New England States All-payer Report

"The New England States' All-Payer Report on Primary Care Payments"

(Process, Methods, Results, and Recommendations)

PCC Investment Workgroup -- February 9, 2021

Richard Slusky, Slusky Consulting, LLC
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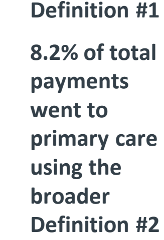
NESCSO Report -- Results and Findings

- The report includes primary care payments related to 7.2 million Commercial, Medicare Advantage, Medicare Fee-for-Service, and Medicaid members
- The all-payer combined primary care payments as a percentage of total medical payments was:
  - 5.5% using the narrower definition of services
  - 8.2% using the broader definition of services
  - These results fell within the range of other published studies on the percentage of primary care payments
- Payments varied by payer and by state
- OB/GYN providers and services were included, but reported separately
- Naturopaths and behavioral health providers were not included in this study.
- Information on non-claims payments was collected directly from payers
  - Few states, if any, have standards regarding the collection of non-claims payment information.

Figure 1: Primary Care Percentage of Total Medical Expenditures by Payer Type, 2018 *

*Massachusetts data for 2018 were not available. Commercial results for Massachusetts were for 2017, and Medicaid results were for 2016. Massachusetts did not report Medicare FFS or Medicare Advantage data. Connecticut's Medicaid APCD data was not sufficiently complete for inclusion in the analysis.



- 5.5% of total payments went to primary care using Definition #1
- 8.2% of total payments went to primary care using the broader Definition #2

	% Definition #1 (Defined PCPs, Selected Services)				% Definition #2 (Defined PCPs, All Services)			
	Medicare FFS	Medicare Advantage	Commercial	Medicaid	Medicare FFS	Medicare Advantage	Commercial	Medicaid
All-State Average	3.4%	5.5%	6.1%	8.0%	5.4%	8.4%	9.3%	10.4%
Lowest Value	2.8%	4.7%	4.9%	5.4%	4.5%	7.1%	7.4%	8.3%
Highest Value	4.2%	6.1%	8.0%	10.1%	6.4%	10.7%	11.0%	12.4%

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NESCSO: What's Broad? What's Narrow

Table 2. Providers & Service Definitions Included in This Study

#	Definition	Description
1	Defined PCPs, Selected Services	• Selected claims payments for general practice, family medicine, pediatrics, internal medicine, nurse practitioner, physician assistant * • Excludes OB/GYN services • Definition #1 is narrower and service based
2	Defined PCPs, All Services	• All claims payments for general practice, family medicine, pediatrics, internal medicine, nurse practitioner, physician assistant * • Excludes OB/GYN services • Definition #2 is a broader measure that does not restrict on service codes
3	OB/GYNs, Selected OB/GYN Services	• All OB/GYN services payments for OB/GYN practitioners • Excludes all services provided by PCPs • Payments reported in Definition #3 can be added to definitions #1 or #2 as desired
4	Defined PCPs, Selected OB/GYN Services	• Selected OB/GYN services payments for general practice, family medicine, pediatrics, internal medicine, nurse practitioner, physician assistant * • Excludes all primary-care services and services provided by OB/GYNs • Payments reported in Definition #4 can be added to definitions #1 or #2 as desired

* Primary care also included taxonomy codes for Federally Qualified Health Centers, Rural Health Centers, clinics, Critical Access Hospitals, and rural hospitals. For these taxonomy codes, restrictions were always applied using revenue and procedure codes.

Ex. 3: Oregon 2020 PC Spend

Oregon’s Primary Care Taxonomy

Physicians specializing in

- Child and adolescent Psychiatry
- Family medicine
- General medicine
- General psychiatry
- Geriatric medicine
- Obstetrics and gynecology
- Pediatrics or preventive medicine

Physicians’ assistants

Naturopathic medicine providers

Nurses

- Nurse practitioners
- Nurse non-practitioners
- Certified clinical nurse specialists

INCLUDES:

- Primary Care Clinics
- FQHCs
- Rural Health clinics

Oregon's Included Primary Care Services

- Office or home visits
- General medical exams
- Routine medical and child health exams
- Preventive medicine evaluation or counseling
- Administration and interpretation of health risk assessments •
- Routine obstetric care excluding delivery (60 percent of payment amount reported on claims is included to represent non -delivery services), and
- Other preventive medicine .

Learn More: Additional Resources

Primary Care Collaborative's State Investment Web Page

- https://www.pcpcc.org/primary-care-investment

Other PCC Publications

- Consensus Recommendations on Primary Care Investment
- Lessons from Multi-stakeholder Advisory Groups

Milbank Memorial Fund: Measuring Non Claims-Based Primary Care Spending

California Health Care Foundation: Primary Care CPT Crosswalk (ZIP file)

References

Baillieu R, Kidd M, Phillips R, Roland M, Mueller M, Morgan D, Landon B, DeVoe J, Martinez-Bianchi V, Wang H, Etz R, Koller C, Sachdev N, Jackson H, Jabbarpour Y, Bazemore A. The Primary Care Spend Model: a systems approach to measuring investment in primary care. BMJ Glob Health, July 2019.

Bailit, M. Friedberg, M, Houy, M, Standardizing the Measurement of Commercial Health Plan Primary Care Spending, Milbank Memorial Fund, July 25, 2017.

Jabbarpour, Y, et al. Investing in Primary Care: A State-Level Analysis. Primary Care Collaborative, 2019.

Reiff, J, Brennan, N, Fuglesten Beiniek, J. Primary Care Spending in the Commercially Insured Population. JAMA Network, December 10, 2019.

Martin, S, Phillips, R, Petterson, S, Levin, Z, Bazemore, A. Primary Care Spending in the US, 2002-2016. May 18, 2020. JAMA Intern Med.

NESCSO, The New England States' All-Payer Report on Primary Care Spend, Dec. 2020.

State of Oregon, 2022 Primary Care Spending in the State of Oregon, Report to the Legislature, Feb. 2022.

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Public comment

Discussion of reccomendation 1 – defining primary care

TAB 5

Discussion: Necessary Principles of a Primary Care Definition

Dr. Judy Zerzan-Thul

CMO, HCA

Desired Outcomes

- Select core principles for Washington’s primary care definition. To do this, we will:
  - Review and compare principles from multiple standards
- We will use the definition to guide claims and non-claims-based measurement discussion
- We will not draft our definition today
  - Committee staff will draft a definition based on today’s conversation for a final review

Washington’s Statutory and Regulatory Primary Care Definitions

- RCW 74.09.010
  - “General practice physician, family practitioner, internist, pediatrician, osteopathic physician, naturopath, physician assistant, osteopathic physician assistant, and advanced registered nurse practitioner”
- Insurance Code 48.150.010
  - “Primary care” means “routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of health, and detection and management of disease or injury.”

Washington's Primary Care Definition Evolution: OFM to Bree

- OFM definition – based on 1996 National Academy of Medicine (formerly the Institute of Medicine) definition
  - "The provision of ***integrated***, ***accessible*** health care services by clinicians who are ***accountable*** for addressing a large majority of personal health care needs including physical, mental, emotional, and social concerns, developing a ***sustained*** partnership with patients, and practicing in the context of family and community"
  - **Narrow**: Representing providers who traditionally perform roles contained within strict definitions of primary care.
  - **Broad**: Representing providers who perform roles not traditionally contained within a strict definition of primary care (e.g., OBs).
- Bree definition
  - "***Team-based*** care led by an ***accountable*** provider that serves as a person's source of ***first contact*** with the larger healthcare system and coordinator of services that the person receives. Primary care includes a ***comprehensive*** array of ***appropriate***, evidence-informed services to foster a ***continuous*** relationship over time. This array of services is ***coordinated*** by the accountable primary care provider but may exist in multiple care settings or be delivered in a variety of modes."

Principle Expansion: OFM and Bree

OFM	Bree
Accountable	Accountable
Integrated	Comprehensive
Sustained	Continuous
Accessible	First contact
	Team-based/Coordinated
	Appropriate

Washington State and National Definitions

- Bree definition:
  - ***Team -based*** care led by an ***accountable*** provider that serves as a person's source of ***first contact*** with the larger healthcare system and coordinator of services that the person receives. Primary care includes a ***comprehensive*** array of ***appropriate***, evidence-informed services to foster a ***continuous*** relationship over time. This array of services is ***coordinated*** by the accountable primary care provider but may exist in multiple care settings or be delivered in a variety of modes."
- NASEM definition:
  - "High-quality primary care is the provision of ***whole-person***, ***integrated***, ***accessible***, and ***equitable*** health care by ***interprofessional*** teams that are ***accountable*** for addressing the majority of an individual's health and wellness needs across settings and through ***sustained*** relationships with patients, families, and communities."

Principle Expansion: Bree and NASEM

Bree	NASEM
Accountable	Accountable
Comprehensive	Whole-person/Integrated
Continuous	Sustained
First contact	Accessible
Team-based/Coordinated	Interprofessional
	Equitable
Appropriate	

Next Steps

- Committee staff will:
  - Compile today's comments and;
  - Distribute final recommendation for primary care definition via email