Advisory Committee on Primary Care meeting minutes

October 25, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
1:00 p.m. – 2:30 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
Sharon Brown
Michele Causley
Nancy Connolly
Tracy Corgiat
David DiGiuseppe
Sharon Eloranta
Chandra Hicks
Meg Jones
Sheryl Morelli
Lan H. Nguyen
Kevin Phelan
Katina Rue
Mandy Stahre
Jonathan Staloff
Linda Van Hoff
Shawn West
Staici West
Ginny Weir
Maddy Wiley

Members absent

Tony Butruille
DC Dugdale
Gregory Marchand
Eileen Ravella
Sarah Stokes

Agenda items

Welcome, roll call, and agenda review

Dr. Judy Zerzan-Thul, the committee chair, called the meeting to order at 1: p.m.

Topics for today

The topics were listed as charter review; presentation on primary care work from other states; and discussion of recommendation 1 – defining primary care.

Approval of September meeting minutes

The committee approved the September meeting minutes.

Charter review

Dr. Judy Zerzan-Thul, HCA

Dr. Judy Zerzan-Thul reviewed the committee charter. There were no questions or comments.

Presentation on primary care work from other states

Larry McNeely, Policy Director, Primary Care Collaborative

The committee heard a presentation on other states' efforts to increase investments in primary care, including an overview of the Primary Care Collaborative (PCC), an introduction to the primary care investment landscape, a deep dive into California and Virginia's primary care investment efforts, and examples of how to measure primary care spending.

The PCC is a not-for-profit multistakeholder organization with over 67 members which advocates for policy changes with public and private policymakers through the dissemination of evidence-based data on primary care.

Larry turned to an introduction to the primary care spending landscape across the U.S. In 2018, Oregon and Rhode Island were the main state leaders dedicated to reporting primary care spending. By 2022, at least 18 states have committed to reporting on primary care spending. Six states have committed via legislation to achieving targets in primary care spending without growing total cost of care: Rhode Island, Oregon, Colorado, Connecticut, Delaware, and Washington.

Larry detailed California and Virginia's recent primary care investment efforts. In California, the California Quality Collaborative (CQC) developed shared standards and attributes around Advanced Primary Care (APC). California has obtained multi-payer commitments to strengthen primary care across six organizations: Aetna, Aledade, Blue Shield of California, Health Net, Oscar, and United Healthcare. California recently passed legislation to establish a statewide Office of Health Care Affordability (OHCA) which will be focused on transparency and goal setting for: a statewide cost growth target, growing alternative payment models (APM), strengthening primary care, providing workforce support, monitoring quality of care, and monitoring care consolidation and market power.

Sharon Eloranta asked who is penalized in California as part of the accountability process: Providers? Payers? It is unclear who is penalized but they have rate review processes.

Virginia's Task Force on Primary Care was established in July 2020 by the Virginia Center for Health Innovation to address urgent primary care needs and to consider new models of allocation and accountability by emphasizing higher quality, lower costs, and greater equity across populations. Like California, the Virginia Task Force used similar criteria to define primary care services, i.e., accessible, integrated, equitable, convenient, and affordable. The Task Force consists of health plans, primary care clinicians and public and private employers.

Sharon asked whether if to participate, a practice needs to accept multiple types of insurance, and it was clarified that a review of the Memorandum of Understanding (MOU) would yield more information and that a link to the MOU would be shared.

Nancy Connolly asked if committee members could have access to the specific metrics associated with Virginia's patient-centered primary care measure and what matters index. Larry offered to obtain and send the original

slides for review. Lisa Watkins also included a link to an article on the index https://www.annfammed.org/content/17/3/221.

Finally, Larry reviewed three examples of how to measure primary care spending. The first example, from the PCC's 2020 evidence report on primary care spending, used both broad and narrow definitions of primary care spending, not including non-claims-based spending. There was an overall decline in primary care spending between 2017 and 2019. Primary care services included services delivered in office (not inpatient), evaluation and management visits, preventive visits, care transition/coordination services, screening, and counseling. The second example of primary care spending came from the New England States' All-Payer Report on Primary Care Payments produced by the New England States Consortium Systems Organization (NESCSO). The report included data on primary care payments from 7.2 million commercial, Medicare Advantage, Medicare Fee-for-Service (FFS), and Medicaid members. Payments were combined as a percentage of total medical payments using both narrow and broad definitions of services. The range of primary care payments fell between 5.5 and 8.2 percent, within range of other published studies on primary care payments. Information on non-claims-based payments was collected directly from payers. The third example of primary care spending, from Oregon's 2020 primary care taxonomy, recognized primary care providers included physicians from a variety of specialties, physicians' assistants, naturopathic medicine providers, nurses, primary care clinics, Federally Qualified Health Centers (FQHCs), and rural health clinics. Primary care services included office or home visits, routine medical and child health exams, preventive medicine evaluation, routine obstetric care excluding delivery, and other preventive medicine.

Chandra Hicks asked about the decline in primary care spending and whether spending has gone down, or that it's a smaller share? Larry clarified it's a smaller share. Chandra asked if there is a risk measuring primary care as a percent of total spending. It was clarified that this increases primary care's vulnerability but that other industrialized nations are investing more in primary care than the U.S. Lisa added that measuring primary care as a portion of total spending is the standard convention. Larry mentioned PCC's an annual evidence report comes out on November 16 and will show that a substantial number of patients aren't reporting a usual source of care.

Sharon asked what areas went up or stood out if primary care is a percent of total spend. PCC's analysis was with regard to primary care spend as a percentage of the total, not focused on the drivers, and looked at a commercially insured population. Sharon noted that low reporting of a usual source of care could indicate a decline in specialists.

Michele Causley asked about excluding pharmacy in the denominator. Pharmacy should be excluded due to the volatility and the costs. Judy asked Larry and Lisa to comment on the pharmacy portion. Meg Jones asked if PCC's analysis included pharmacy spending as part of total spending. Lisa noted that pharmacy was not included and offered to do more research to see what states have or haven't done. The 2020 PCC report did not include pharmacy data but there was some form of imputed spend included.

Nancy asked about how the committee would capture claims versus non-claims-based spending. The committee will develop a recommendation for non-claims-based spending. Lisa referred Nancy to Michael Bailit's report on non-claims-based spending noting that there is no standard methodology though there are examples from other states. Oregon calculated a substantial portion of primary care spending from non-claims-based payments.

Sheryll Morelli asked how measurement would be different for the pediatric population. Pediatric is a very different population with the services provided but there are ways to measure it in a way that is consistent with primary care measurement overall. Kids are medically healthy, but not in areas outside of health care spending, e.g., childcare, schools, juvenile justice. There are huge resource discrepancies for kids. Larry clarified that it depends how the definition is constructed, and that the committee may want to ensure that collaborative care claims flow into primary care spend. A few states have looked at how primary care spending and behavioral health interact. California's crosswalk of claims shows some of the choices that can be made.

Jonathan Staloff asked whether any of the methodologies considered how to count telemedicine services from providers who have a brick-and-mortar site, and whether to count services from providers that only offer telemedicine services (e.g. teledoc). Teledoc can possibly be included in a narrow definition by specialty and by provider and services.

Michele asked about looking at cost by line of business. The NESCO report evaluated claims from a line of business perspective. Michele asked whether to use a standard cost. Lisa suggested getting in touch with the OnPoint consultants who helped conduct the NESCO analysis.
The PCC is partnering with Milbank to develop a web tool that allows for analysis of states' current primary care legislation and legal precedent for measuring primary care.
Kristal Albrecht asked which of the available studies captured a larger, or the largest group and if the PCC website have this. Larry pulled up the PCC website to show to the group examples of other states' published reports.
David DiGiuseppe mentioned the HCCTB data request which outlined primary care based on taxonomy and CPT codes. How did that definition come to be? Is it temporary for data reporting? HCA has been measuring claims and non-claims-based spending (not made public) using the 2018 Office of Financial Management (OFM) template. This committee is focused on a legislatively directed, broader stakeholder approach. The decision is whether to keep the OFM definition and whether to tweak it. OFM didn't report non-claims-based, HCA created measurement for that on their own. Judy asked Larry how often states revisit their definition? Larry said he didn't know but could investigate it.

Public comment

Justin Montoya, Pacific Source Health Plans, noted that the questions being asked were prudent and important. The moving denominator is an issue. Aiming for 12 percent is difficult, especially when pharmacy is increasing dramatically. The group should continue to evaluate the denominator and recognize that as that increases, whether pharmacy or specialty care, that will be an ongoing challenge. Getting to the definition of primary care is particularly challenging when different states have different approaches. Oregon included behavioral health.

Discussion of recommendation 1 – defining primary care

Dr. Judy Zerzan-Thul, Committee Chair, HCA
Judy reviewed and compared core principles from multiple definitions of primary care, including Washington's statutory (RCW 74.09.010) and regulatory (Insurance Code 48.150.010) definitions; OFM's 2019 definition; the Bree Collaborative definition from 2021, and National Academy of Science, Engineering, and Medicine's (NASEM's) definition. Judy would like the group to compare the Bree and NASEM definitions to come up with a final definition which will be discussed and decided at future meetings.

Adjournment

Meeting adjourned at 2:25 p.m.

Next meeting

Monday November 21, 2022
Meeting to be held on Zoom
9:30 a.m. – 11:00 a.m.