North Carolina Primary Care Payment Reform Task Force

Meeting 2: PC Measurement & Benchmarking

January 31, 2024

Mary Jo Condon, MPPA, Principal Consultant, Project Director

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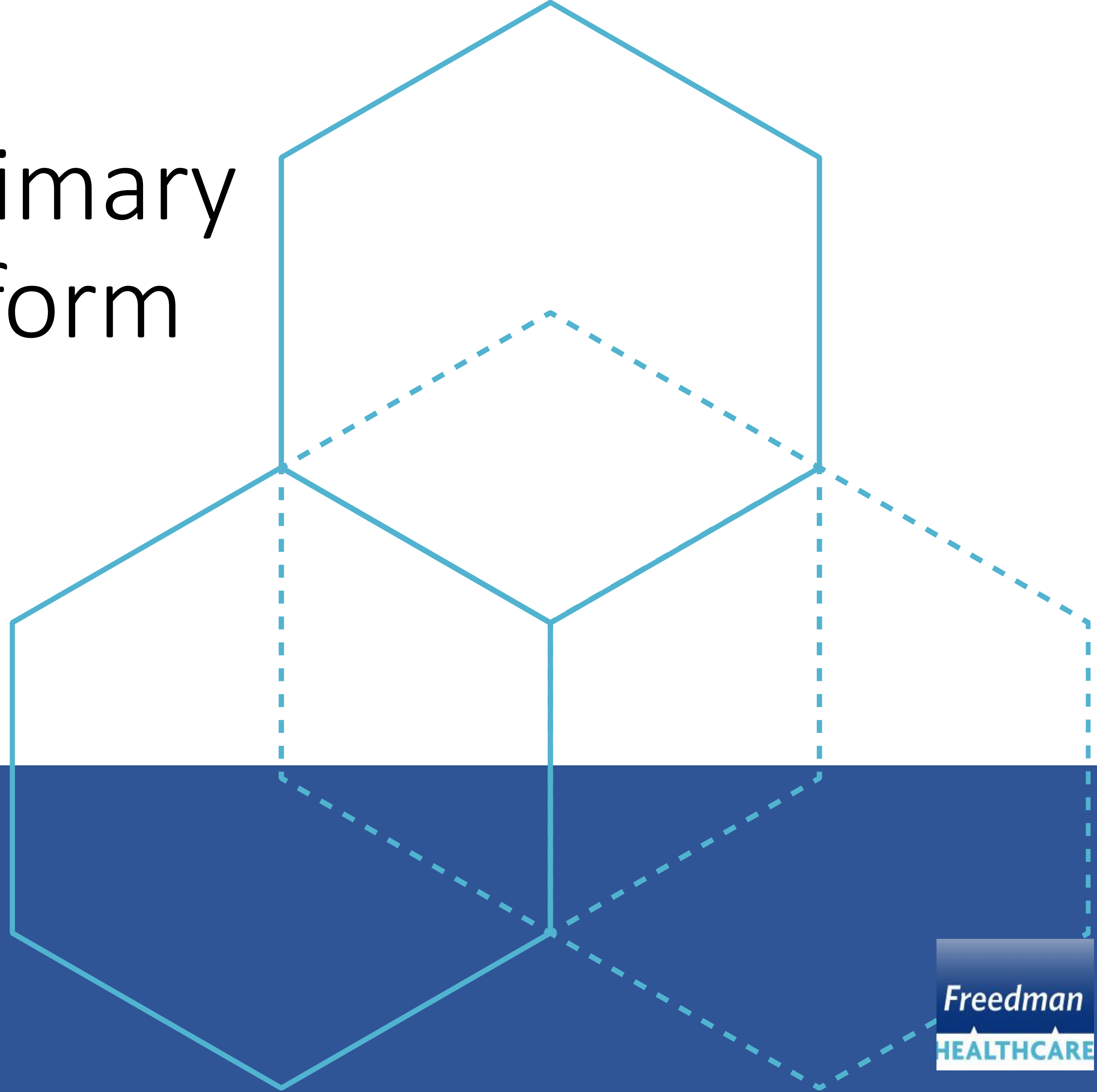

Etiquette for Easy Collaboration

- Mute your microphone when you are not speaking to avoid background noises
- Use of your camera is encouraged
- Raise your hand to make a comment, provide feedback, or offer an idea
- Use the chat box, reactions, and emojis to contribute to the conversation
- Be present and practice active listening, we want to hear your insights
- Be respectful of differences in understanding and perspective
- Hold the tension of both/and thinking, rather than either/or thinking

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Agenda

1.	Timeline and Legislative Charge	8:00 AM
2.	North Carolina's Vision for Primary Care	8:05 AM
3.	Primary Care Definition – Final Thoughts	8:15 AM
4.	Non-claims Based Payments	8:30 AM
5.	Primary Care Measurement & Targets	8:45 AM
6.	Next Steps	9:25 AM

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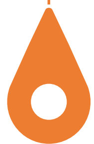
Timeline

February 2024

- ***Meeting 3: Measurement & Workforce***
  - Wednesday, 2/14 from 8:00 – 9:30 AM
- ***Meeting 4: Recommendations***
  - Wednesday, 2/28 from 8:00 – 9:30 AM
- ***Draft Report***

April 2024

- **Report Delivered by April 1st**



January 2024

- ***Meeting 1: National Overview & Definitions***
  - Friday, 1/19 from 2:00 – 3:00 PM
- ***Meeting 2: PC Measurement & Benchmarking***
  - Wednesday, 1/31 from 8:00 – 9:30 AM
- ***Data Review***
- ***Outline Report***

March 2024

- ***Finalize Report***

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Legislative Charge

Legislative Requirements
(Senate Bill 595)

The Task Force must submit a report to the Joint Legislative Oversight Committees on Health & Human Services and Medicaid.

The Report is to include ***findings and recommendations*** that are specific, concrete, and actionable steps that the State and General Assembly can act on.

- ✓ Provide a **national overview** of primary care measurement and investment
- ✓ Recommend a working **definition of primary care**
- ✓ Set the stage for ongoing primary care **measurement and investment**
- ✓ Recommend primary care **investment targets**
- ✓ Recommend a **data collection strategy**
- ✓ Recommend policies for **future legislative opportunities**
- ✓ Recommend next steps for evaluating primary care **workforce adequacy**

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Barbara Starfield's Pillars of Primary Care Practice

In 1992, Barbara Starfield identified 4 pillars of primary care practice which set the foundation for future elaborations of key primary care attributes.

1. First-Contact Accessible
2. Continuous
3. Comprehensive
4. Coordinated

Starfield B. Primary Care: Concept, Evaluation, and Policy. New York, NY: Oxford University Press; 1992.

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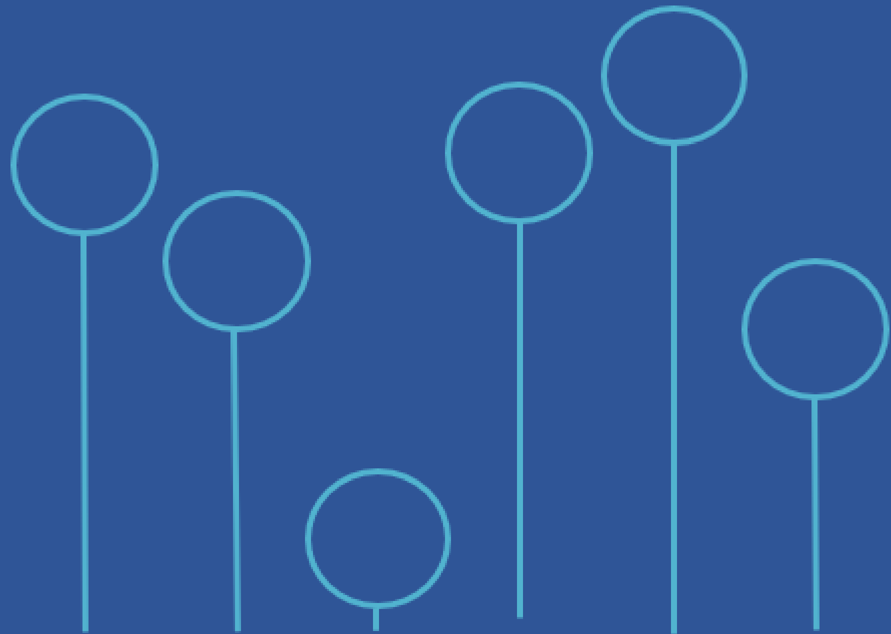
Key Decision Points



Defining Primary Care:

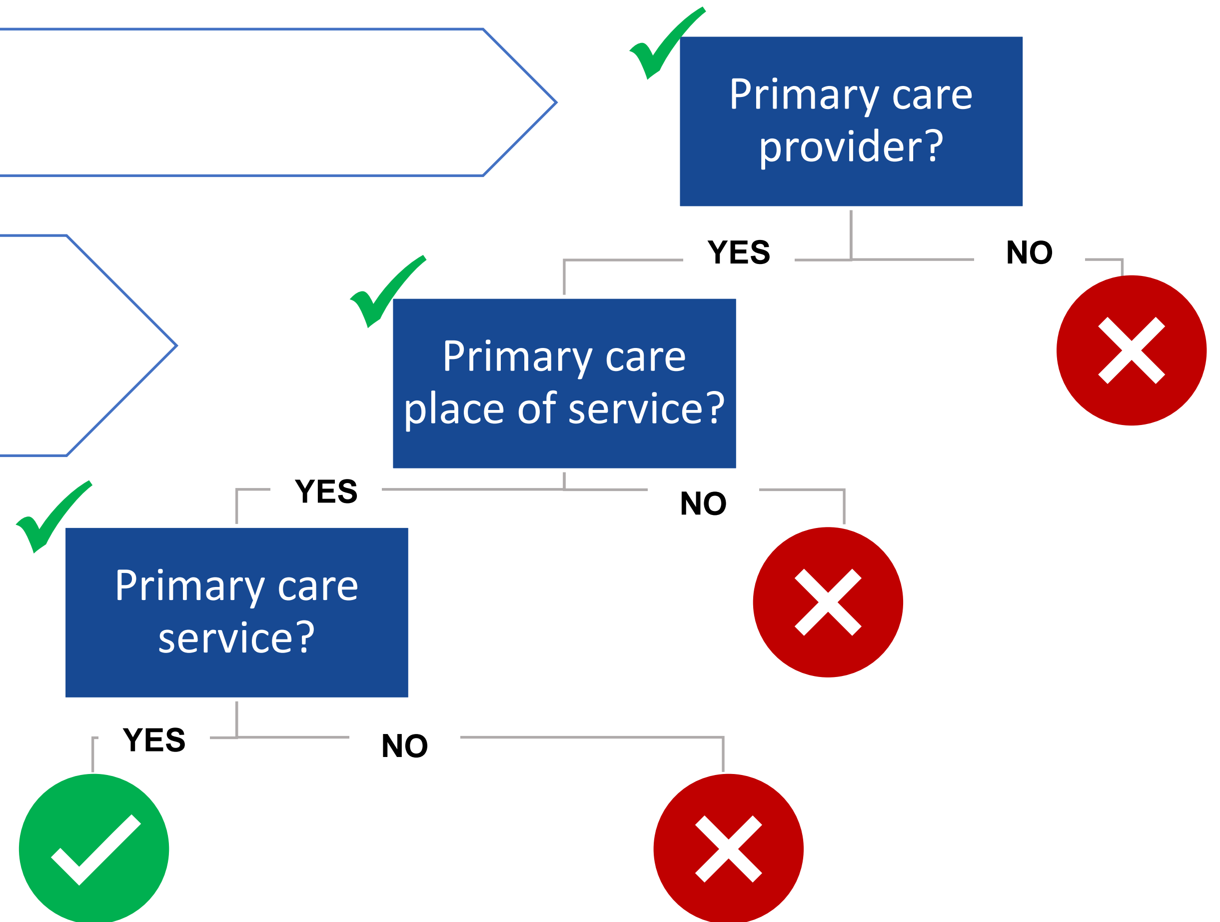
- Narrow or broad set of providers?
- Narrow or expanded set of services, or all?
  - Include or exclude behavioral health services and/or providers?
  - Include or exclude OB/GYN services and/or providers?
- Restrict places of service?
- Include non-claims spending?

Defining Primary Care

Provider taxonomy defined as primary care

Typically Included: Office, telehealth, home
Typically Excluded: Inpatient setting, emergency room
Often Debated: Urgent Care, retail clinic

Services defined as being a part of primary care, often using a list of HCPCS/CPT codes or as any service provided by a primary care provider.



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Working Definition of Primary Care

	Types of Providers	Places of Service	Types of Services

Nearly All Include	✓ ***Family Medicine***
	✓ ***Internal Medicine***
	✓ ***General Practice***
	✓ ***Geriatrics***
	✓ ***Pediatrics***
	✓ ***Federally Qualified Health Center***
	✓ ***Physician Assistant***
	    ✓ Medical
	✓ ***Nurse Practitioner***
	    ✓ Adult Health/Family/Pediatrics/ Primary Care
	✓ ***Primary Care & Rural Health Clinics***
		✓ Office
		✓ Telehealth
		✓ School
		✓ Home
		✓ Federally Qualified Health Center
		✓ Public Health
		✓ Rural Health Clinic
		✓ Worksite
		✓ **Street Medicine** ***(new code)***
		✗ ~~Walk-in Retail Health Clinic~~
		✗ ~~Urgent Care Facility~~
			✓ Office visit
			✓ Home visit
			✓ Preventive visits
			✓ Immunization administration
			✓ Transitional care & chronic care management
			✓ Health risk assessment
			✓ Advanced care planning

Most Include	✓ ***Adult Medicine*** ✓ ***Adolescent Medicine*** ✓ Behavioral health ✓ ***OB-GYN*** ****Bolded indicates currently defined as primary care within Medicaid***	✓ Homeless Shelter ✓ Indian Health Service ✓ Tribal Facility ✓ Correctional Facility ✓ Assisted Living Facility ✓ Group Home ✓ Mobile Unit	✓ Interprofessional consult (e-consult) ✓ Team conference w or w/o patient ✓ Prolonged preventive service ✓ Domiciliary or rest home care/ evaluation ✓ Hospital outpatient clinic visit

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Non-Claims Spend on Primary Care

1. What is the current state of non-claims payment arrangements in North Carolina's commercial and Medicaid markets?
2. What data would be needed to identify the percent of non-claims spend directed to primary care?
3. What approach is recommended regarding measurement of non-claims primary care spend?
    a. What data is available?
    b. Should non-claims spend measurement be incorporated into the next iteration of primary care measurement?

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Non-Claims Spend in North Carolina

North Carolina is a leader in the Southeast in terms of shifting the health care market away from fee-for-service towards more value-based payment arrangements. As North Carolina is still in the process of standing up some of these data collection processes, it may be best to incorporate non-claims primary care spend measurement in a future measurement cycle.

NC Medicaid	Commercial

• As a result of Medicaid Transformation, a large portion of Medicaid beneficiaries are enrolled with a managed care organization (MCO).
• Medicaid managed care plans have been encouraged to move their spend to alternative payment models (e.g., the base payments for the Advanced Medical Home program) which will increase the percent of primary care spend paid via non-claims.
• ***NC Medicaid is evolving existing data collection processes to capture non-claims data.***
	• Blue Cross NC has launched value-based payment programs, like Blue Premier, to support providers transition to high-value care.
	    • Offers non-claims arrangements that jointly hold the payer and provider accountable for meeting quality and cost measures.
	    • Some arrangements offer additional payments based on quality/cost and shared savings opportunities
	• ***To be determined whether commercial non-claims payments will be included in the initial data collection.***

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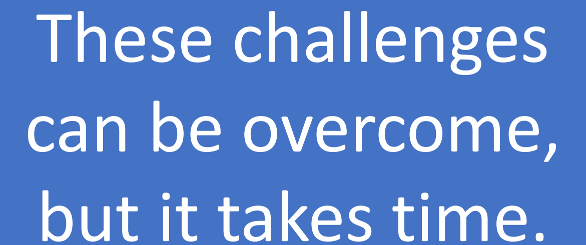
Blue Cross NC'S Industry-Leading Blue Premier Program Saves $197 Million in 2020 Health Costs, Expands Value-Based Care Across State, 2021.

Challenges of Non-claims Based Payments

- There is little standardization of categories and definitions of non-claims payments across plans and across states. They typically support specific programs at the plan level or at the state level and therefore can vary widely.
- There is minimal or no transparency into the portion of the non-claims payments dedicated to primary care. This is a particular challenge for risk-settlement payments paid to a large health system.
- It is difficult to verify whether data submissions are accurate or reflect the intention of the technical specifications.



These challenges can be overcome, but it takes time.

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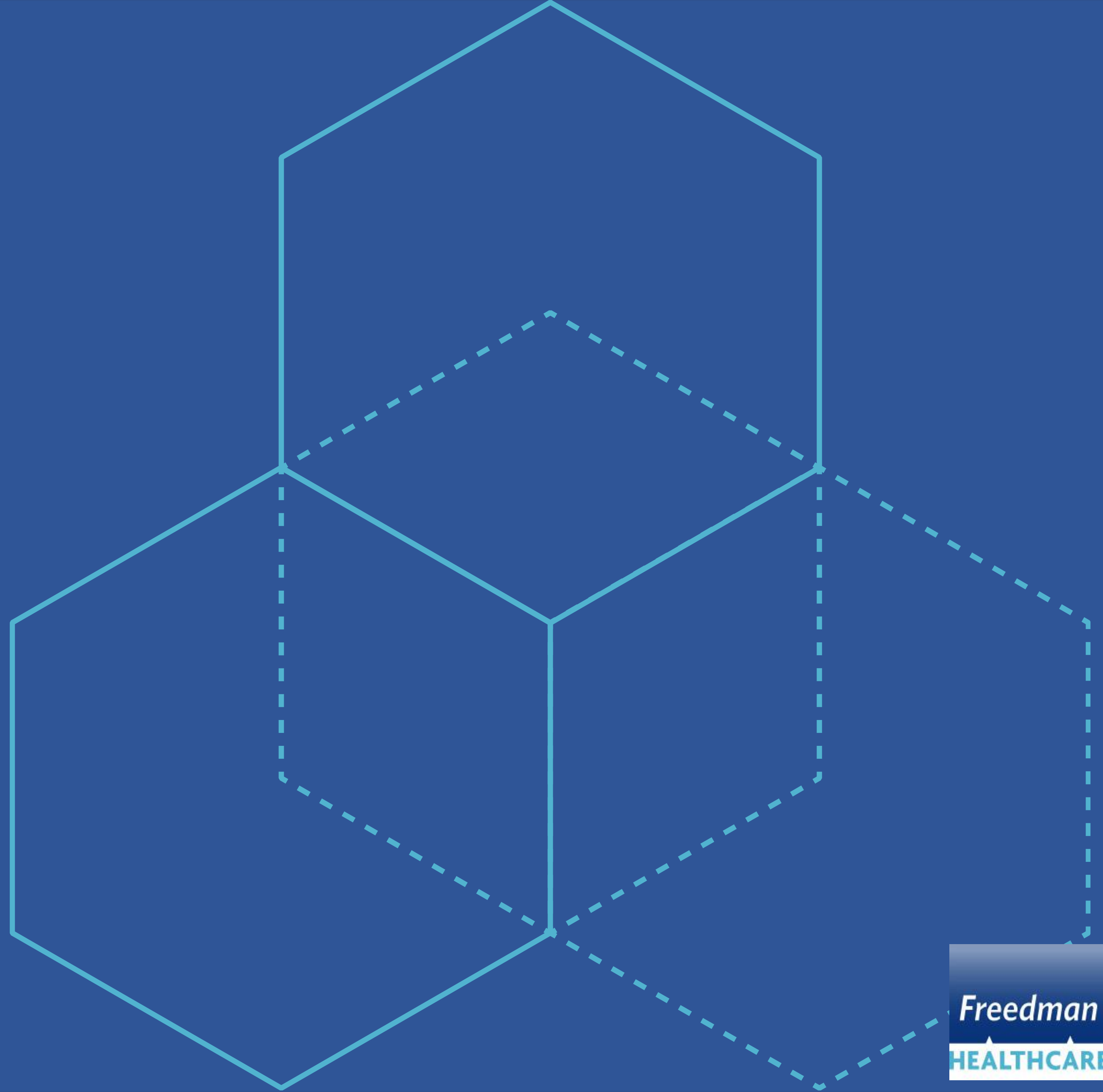
Primary Care Targets in North Carolina



Higher Investment in Primary Care Associated with Better Outcomes – Example 1

A 2019 study by the Patient-Centered Primary Care Collaborative and the Robert Graham Center found states with higher primary care investment had lower rates of hospitalizations and emergency department visits.

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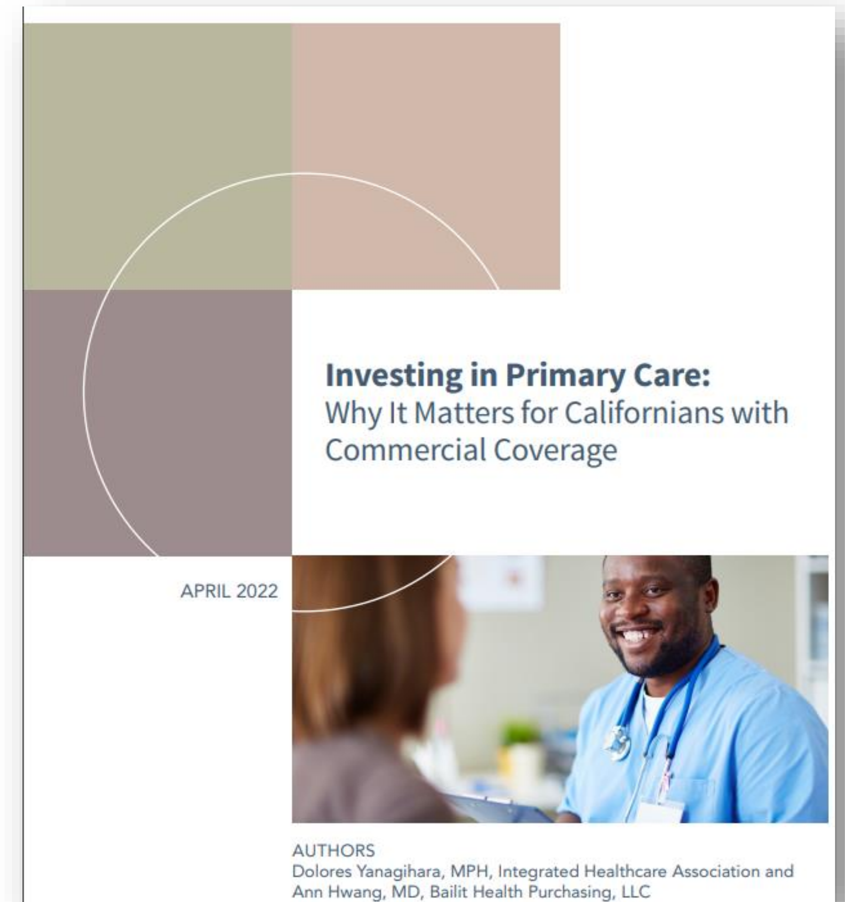
Higher Investment in Primary Care Associated with Better Outcomes – Example 2

A study by the Integrated Healthcare Association (IHA) and commissioned by the California Health Care Foundation (CHCF) found increased primary care investment results in better outcomes.

A study of 80% of Californians with commercial HMO coverage found higher spending on primary care was associated with….

- Better performance on quality and patient experience measures
- Lower hospital and emergency department use
- Lower total cost of care



California Health Care Foundation. Investing in Primary Care: Why It Matters for Californians with Commercial Coverage. April 2022.

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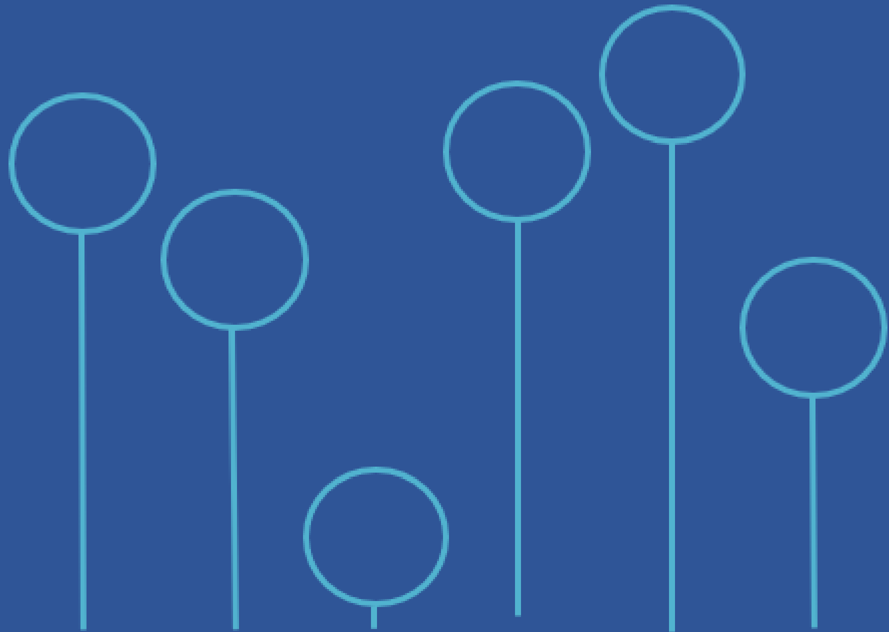
Key Decision Points



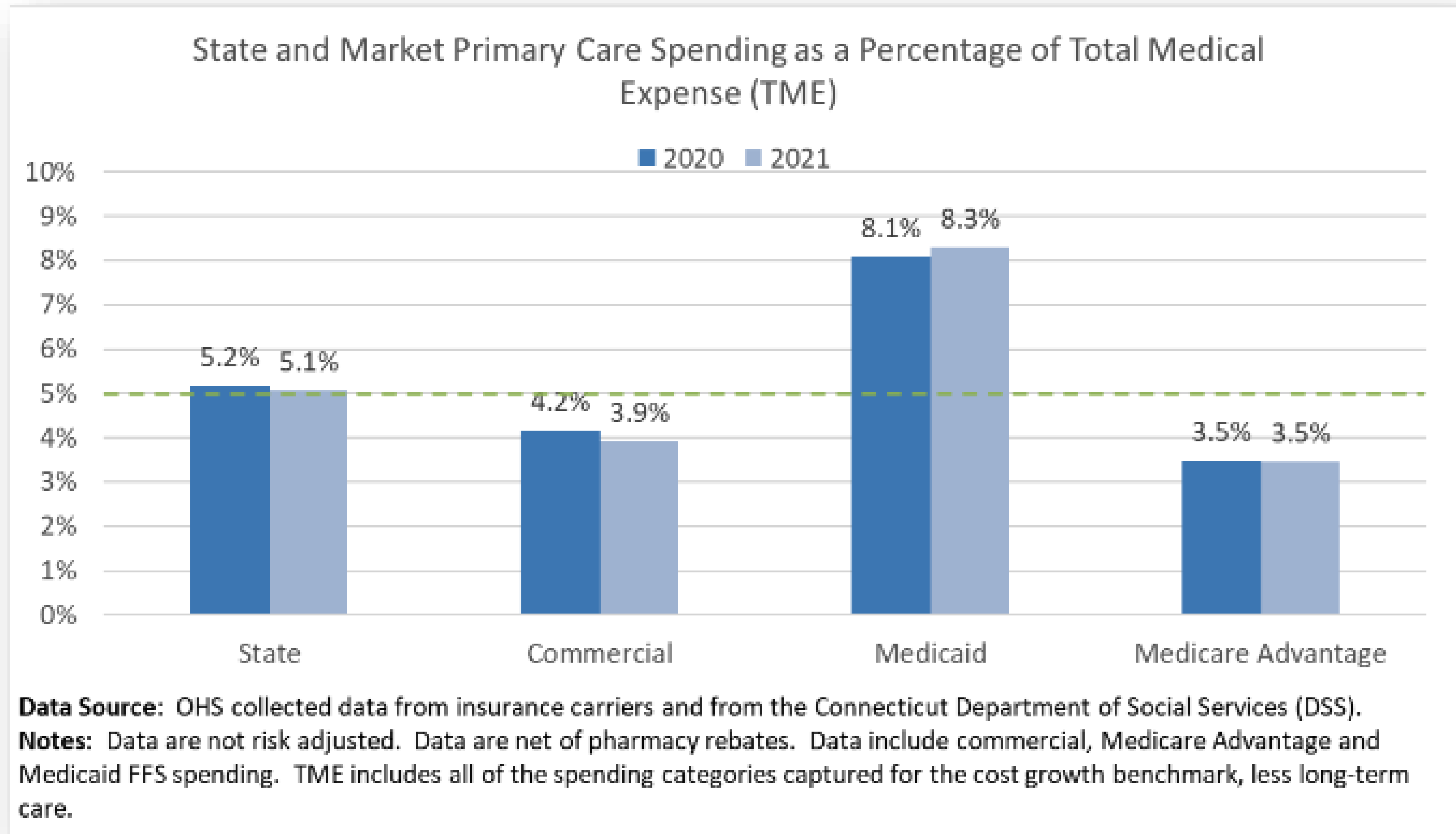
Setting a Target for Primary Care Investment:

- Setting a single target for all payers, or multiple targets by payer type?
- Establish a single target for all ages or establish separate age groups?
- Set the target as a percentage of spending, or as a defined amount?
- Set an absolute, relative, or stairstep target?

> - Are we defining primary care for measuring or investing?
>
> *We need to do both.*

Example of Single Benchmark Versus Benchmarks for Each Payer Type

- All current state benchmarks are a single benchmark across all payer types
- Some states, such as Connecticut, report results by payer type
- Depending on a state's goals, variation across payer types may call for different benchmarks



Healthcare Cost Growth Benchmark And Primary Care Spending Target Initiatives. 2020 and 2021. Connecticut Office of Health Strategy.

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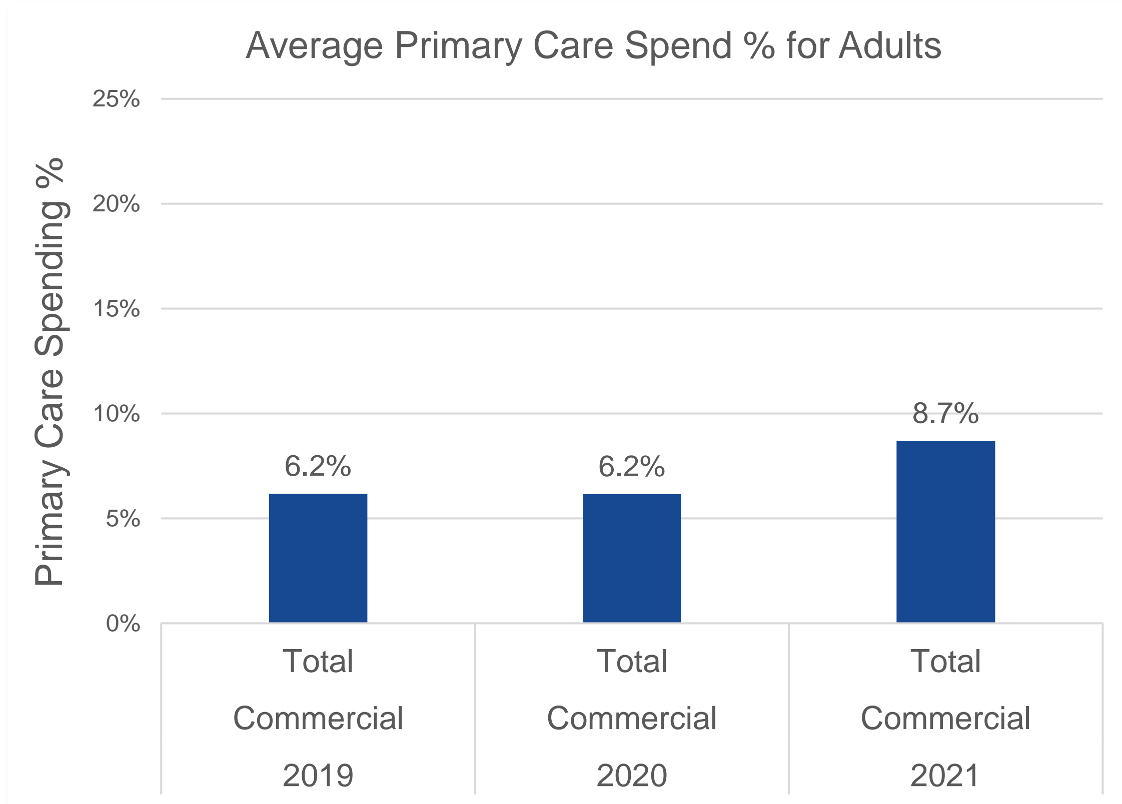
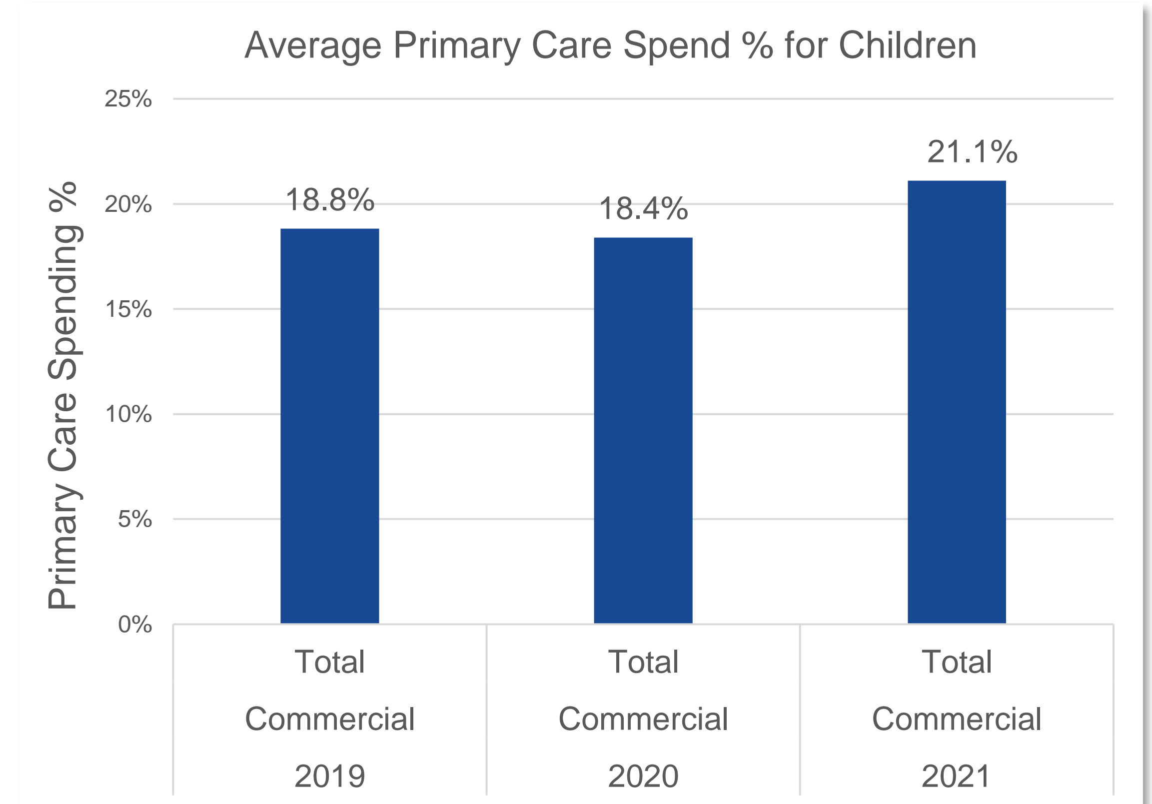
Example of Commercial Primary Care Spending for Adults & Children

Our definition will impact how we decide to approach target setting. Primary care spending among children can be 2 to 3 times the spending of adults as a proportion of medical expense.





Integrated Healthcare Association. California Commercial Primary Care Spending Results. 2019-2021

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How Other States Address Key Decisions

Decision Point	CT	DE	RI	OR	CO
Single or Multiple Payer Targets	Single	Single	Single	Single	Single
Target for All Ages or Separate Age Groups	All Ages	All Ages	All Ages	All Ages	All Ages
Percentage of Spend or Defined Amount	10% by 2025	11.5% by 2025	10.9%	12%	N/A
Absolute or Relative Improvement?	Absolute (Stairstep) 5% →5.3%→6.9%→ 8.5%→10%	Absolute (Stairstep) +1.5% per year	Absolute Previously Relative +1% per year	Absolute	Relative +1% per year

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Recommending an Approach for Target Setting Based on Other State Approaches

Many states begin by setting a relative 1% increase in investment per year improvement target for all-payer types and all ages.

Key Decisions for Setting a Target for Primary Care:

- Setting a single target for all payers, or multiple targets by payer type?
  - **Single target for all payers**
- Set an absolute, relative, or stairstep target?
  - **Stairstep approach – relative increase with an absolute target**
- Set the target as a percentage of spending, or as a defined amount?
  - **Percentage of spending**
- Establish a single target for all ages or establish separate age groups?
  - **Single target for all ages**

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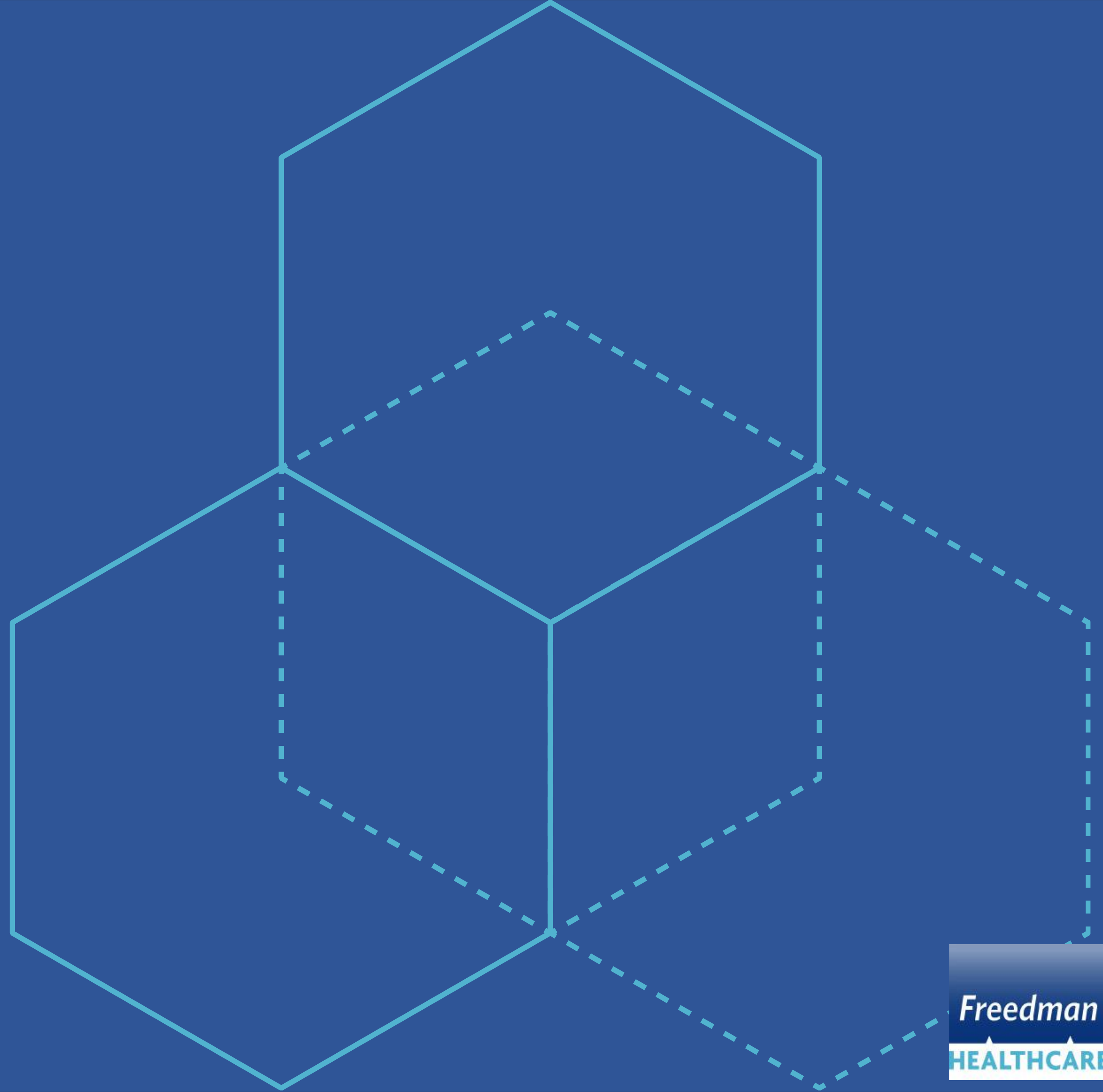
Next Steps



Upcoming Activities

Task Force asks

- Review materials for meeting 3

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- Draft report
  - Update based on Task Force meetings
- Data analysis and collection
  - Release data collection request
  - Host review and technical assistance sessions

Task Force Meeting Dates and Times

Meeting	Date	Time
✓ 1	Friday, 1/19	2:00 – 3:30 PM
2	Wednesday, 1/31	8:00 – 9:30 AM
3	Wednesday, 2/14	8:00 – 9:30 AM
4	Wednesday, 2/28	8:00 – 9:30 AM

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Meeting 3: PC Measurement & Benchmarking

Working agenda -

- Recap Meeting 2 - Close Outstanding Items
- Workforce overview and definitions
- Workforce data
- Preview of Meeting 4

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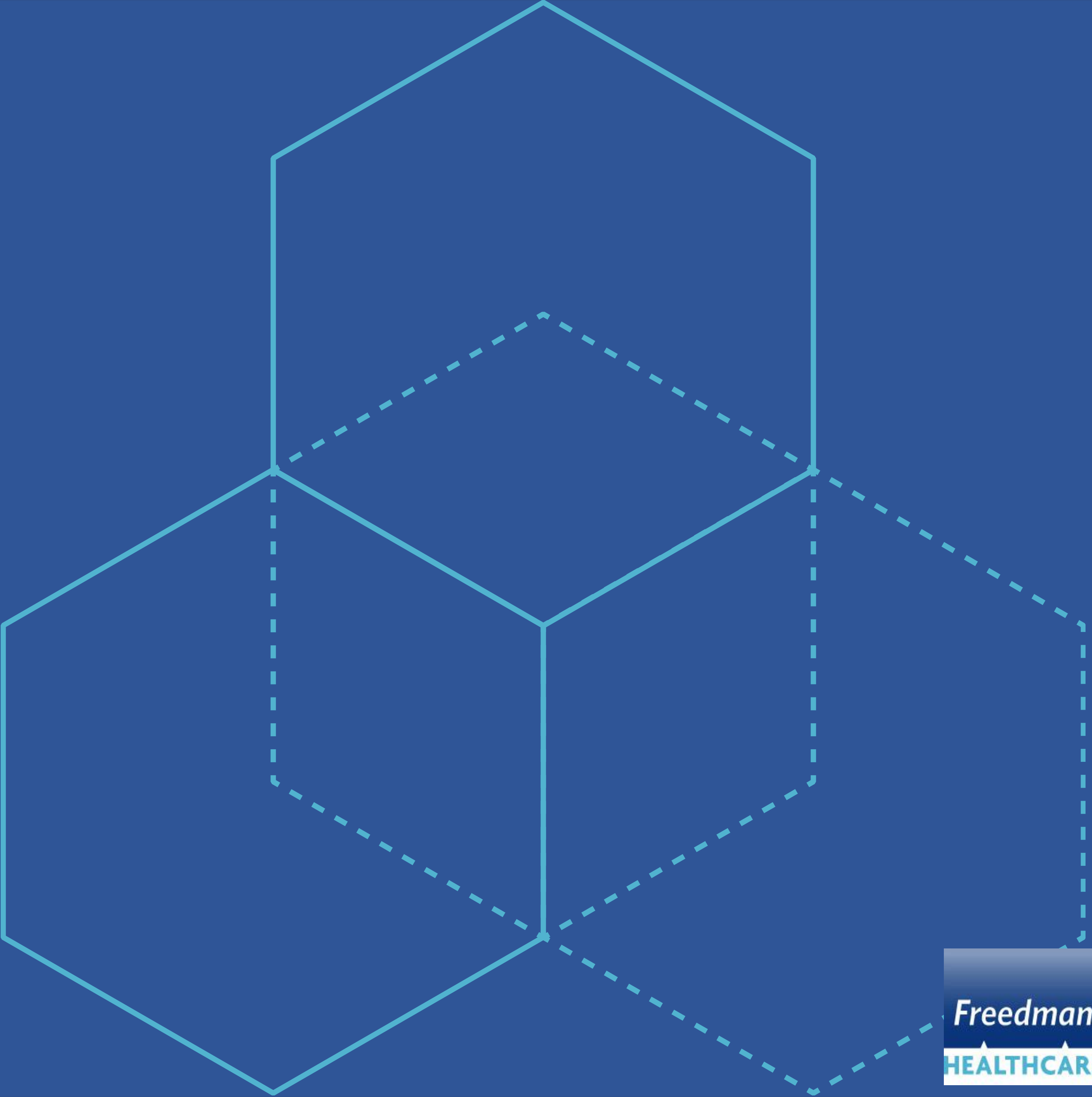
Appendix



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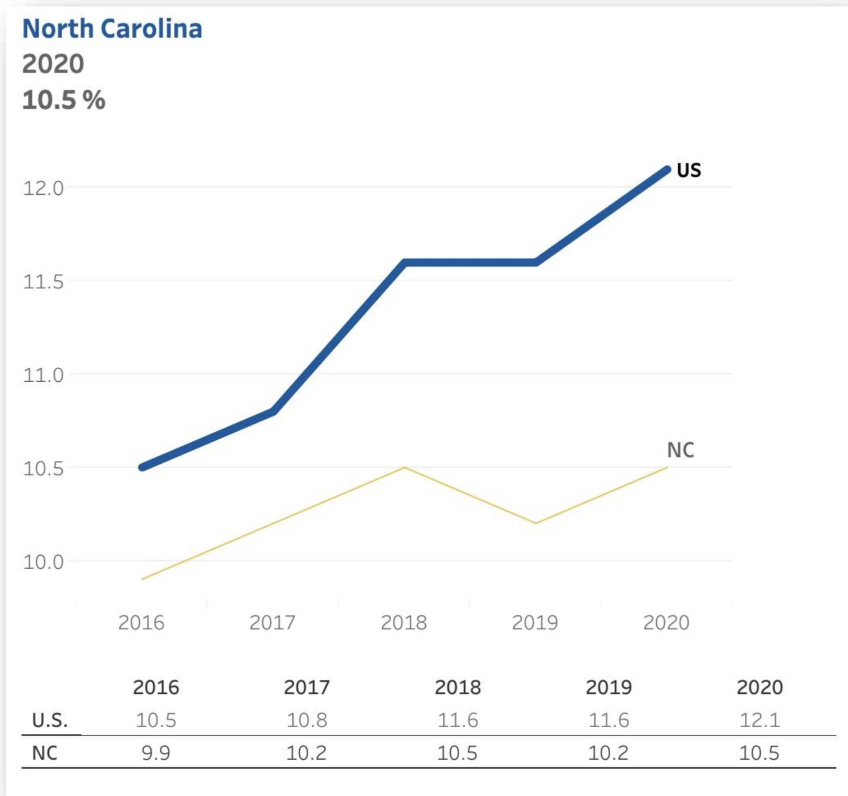
Milbank Memorial Fund: Primary Care Spend for North Carolina

Broad Definition Primary Care Spend in North Carolina vs. the US, 2016-2020



	2016	2017	2018	2019	2020
U.S.	10.5	10.8	11.6	11.6	12.1
NC	9.9	10.2	10.5	10.2	10.5

Jabbarpour Y., Petterson S., Jetty A., Byun H.The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care, The Milbank Memorial Fund and The Physicians Foundation. February 22, 2023.

North Carolina All-payers Percent Primary Care Spend 2015-2020

	Narrow	Broad
2016	5.9%	9.9%
2017	6.1%	10.2%
2018	6.0%	10.5%
2019	5.8%	10.2%
2020	**5.8%**	**10.5%**

Narrow Definition: Outpatient and office-based expenditures to primary care physicians (PCPs), defined as family physicians, general pediatricians, general internal medicine physicians, general practitioners, and geriatricians.

Broad Definition: Narrow Definition + Spending for office-based care from nurse practitioners (NPs), physician assistants (PAs), behavioral health clinicians, and obstetricians/gynecologists.

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Set A Single Target or a Set Of Targets By Payer-Type?

A key consideration is whether to provide a single target for all payer types (e.g., commercial, Medicaid) to work toward or whether to have different targets for each payer type.

Approach	Considerations and Trade Offs
Single Target	• Easier to communicate • May not recognize differences across populations
Target for Each Payer Type	• Recognizes differences in populations and covered services across payer types • May be confusing to stakeholders • May raise questions regarding the methodology and fairness of different targets

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Absolute Target, Relative Improvement, or Stairstep?

Another consideration is whether to set a target that reflects a desired, absolute level of primary care investment, to require improvements from a baseline, or to combine the incentives of both methods.

Approach	Considerations and Trade Offs
Absolute	• Sets a vision for the future • Helps approximate the budget needed for new primary care capabilities • Can include intermediate targets ("stairstep") • Rarely met as quickly as hoped • Less guidance on how to operationalize (e.g. how much should spending increase each year?) • What is the "right" level of primary care investment?
Relative	• Acknowledges that care delivery transformation takes time and requires incremental steps • More predictable increases in revenue • Less inspirational
Stairstep	• Allows all to succeed at a reasonable pace and defines an eventual ceiling

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Set Goal Based on Percent Total Medical Expense or Per Member Per Month Spend? Both?

Most states set goals for primary care investment and define the goal as a percent of total medical expense. Behind the scenes, it’s helpful to understand what the percentage translates to as a per member, per month amount.

Approach	Considerations and Trade Offs
Percent Total Medical Expense	• Consistent with other state and national approaches • Tries to communicate that increased spending on primary care should reallocate rather than increase total spending • Does not recognize differences in total cost of care across states
Per Member Per Month	• Easier to reflect the cost of achieving primary care delivery goals, sustainably and efficiently • More consistent with how payers typically measure health care costs • May not resonate with stakeholder audiences unfamiliar with per member, per month calculations

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Percent of Spending or Defined Amount?

The fourth consideration is the metric for presenting the targets: as a percentage or total expenditures, or as a per member, per month amount?

Approach	Considerations and Trade Offs
Percent of Spending	• Consistent with other state and national approaches • Signals that increased spending on primary care should reallocate not increase spending • Does not recognize the differences in total cost of care across states: primary care might be adequately funded at a lower percentage in higher cost states
Defined Amount	• Easier to reflect the cost of achieving primary care delivery goals, sustainably and efficiently • More consistent with how payers typically measure health care costs • No denominator issues in measurement and comparisons • Increases may reflect general spending trends, not shifting emphasis to primary care • May not resonate with stakeholder audiences unfamiliar with per member, per month or similar calculations

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Single Target, or Separate Targets for Children and Adults?

Children tend to receive more primary care and less other care than adults. Measuring primary care investment by age group will show wide variation. A consideration for setting targets is whether to set different targets for children and adults or to blend them.

Approach	Considerations and Trade Offs
Single All Ages Target: There is a single target for all ages	• Easier to communicate • Consistent with other states' practices • Masks significant differences between primary care spending for children and adults
Age Group Targets: There are separate targets for children and adults (and possibly older adults)	• Stakeholders might choose to focus attention on the importance, to long-term individual well-being and to population health, of investing in advanced primary care models for children • Optimal primary care spend looks different for children and adults

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A Common State Approach

Decision Point	Nationally Aligned Option	Considerations
Single or Multiple Payer Targets	Single	• Focusing on a single targets is easier to communicate, though it may overlook differences across populations • Using multiple targets raise questions about the methods used and the fairness of varying targets
Target for All Ages or Separate Age Groups	All Ages	• Setting a uniform target for all age groups is easier to communicate, but masks significant differences between primary care spending on children and adults • Establishing separate targets for different age groups acknowledges unique primary care spending patterns for children and adults
Percentage of Spend or Defined Amount	% (10-12% by 2030)	• A percentage approach signals increased spending on primary care should be a reallocation not increase spending • Defining a specific monetary amount simplifies primary care objectives, but it may not adequately represent needs for primary care
Absolute or Relative Improvement?	Absolute (Stairstep) (+1-1.5% Increase per year)	• Setting an absolute target establishes a clear vision for the future and helps in budget estimation for new primary care capabilities • A relative target ensures a more predictable revenue increase, however it may be less inspirational • An alternative option is to set an absolute target with incremental annual investment goals

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