NC Primary Care Payment Reform Task Force | Meeting 4 Minutes

Date: February 28, 2024
Time: 8:00 AM
Location: Virtual via Microsoft Teams
Attendees (41) - Task Force Members:

1	**Bobby Croom** - NC Department of Insurance	**5**	**Dr. Larry Wu** – Blue Cross Blue Shield NC (NC Association of Health Plans - commercial nominee)
2	**Dr. Genie Komives** – WellCare of NC (NC Association of Health Plans Medicaid prepaid health plan nominee)	**6**	**Dr. Mark McNeil** - NC Academy of Family Physicians
3	**Hugh Tilson** - NC Area Health Education Centers Program	**7**	**Michelle Schmerge** - NC Nurses Association
4	**Jay Ludlam** - NC Medicaid		

Other Attendees/Guests:

8	**Allison Stewart -** AmeriHealth Caritas	**24**	**Dr. Janelle White –** NC Medicaid
9	**Anna Wadhwani -** NC Medicaid	**25**	**Jordan Roberts -** Blue Cross NC
10	**Becki Gray -** Blue Cross NC	**26**	**Julia Lerche –** NC Medicaid
11	**Ben Kellman**	**27**	**Kerry Willis -** State Health Plan
12	**Ben Twilley –** Cigna	**28**	**Kristen Dubay -** NC Medicaid
13	**Dr. Betsey Tilson -** Division of Public Health	**29**	**Lisa Shock -** United
14	**Brittany Watson -** NC Medicaid	**30**	**Maggie Sauer -** Office of Rural Health
15	**Chris Paterson -** Carolina Complete Health	**31**	**Max Yates**
16	**Christie Burris -** NC Health Connex	**32**	**Michael Ogden –** Healthy Blue
17	**D. Frick**	**33**	**Niya Nelson -** NC Medicaid/Accenture
18	**Diego Martinez -** Amerihealth Caritas	**34**	**Pamela Perry –** Carolina Complete Health
19	**Eamonn McAteer –** Blue Cross NC	**35**	**Peter Daniel -** NC Association of Health Plans
20	**Elizabeth Hudgins -** NC Pediatric Society	**36**	**Samar Muzaffar -** United
21	**Elizabeth Kasper -** NC Medicaid	**37**	**Shawn Parker -** NC Academy of Family Physicians staff
22	**Emma Kate Burns -** NC Medical Society	**38**	**Dr. William Lawrence –** Carolina Complete Health
23	**Greg Griggs -** NC Academy of Family Physicians staff		

Facilitators:

39	**Gary Swan –** Freedman Healthcare
40	**Julia Sledzik –** Freedman Healthcare
41	**Mary Jo Condon –** Freedman Healthcare

Meeting Minutes:

Agenda

1. Definition of Primary Care
2. Primary Care Investment Targets
3. Data Collection Strategy & Ongoing Activities
4. Measuring the Primary Care Workforce
5. Wrap Up

1. Timeline of Report and Legislative Charge

- Report Updates
  - Draft Report
    - Delivered to Taks Force: March 1st, 2024
  - Optional Task Force Meeting – Report Review
    - Date: March 6th, 2024
    - Time: 8:00 – 9:00 AM
  - Deliver Task Force Written Feedback on Draft
    - Deadline: 5:00 PM, March 8th, 2024
  - Health Plan Voluntary Data Collection: March & April 2024
- Legislative Charge
  1. Provide a national overview of primary care measurement and investment
  2. Recommend a working definition of primary care
  3. Set the stage for ongoing primary care measurement and investment
  4. Recommend primary care investment targets
  5. Recommend a data collection strategy
  6. Recommend policies for future legislative opportunities
  7. Recommend next steps for evaluating primary care workforce adequacy

2. Definition of Primary Care

- Task Force Recommendation- Definition of Primary Care
  - A broader definition with some restrictions on place of service to try to capture spend for primary care that aligns with Starfield's four pillars - first-contact accessible, continuous, comprehensive, and coordinated.
  - Provider taxonomy defined as primary care: family medicine, internal medicine, pediatrics, general practice, nurse practitioners, physician assistants, geriatrics, and gynecologists.
  - Traditional office visits in clinics and other settings that are someone's home or workplace. Excludes hospital inpatient sites, emergency departments, urgent care centers, and retail clinics.
  - Core primary care services including family medicine, internal medicine, pediatrics, and general practice and some mental health and OB-GYN services.
- Task Force Recommendation- Primary Care Definition Details
  - Exclude care delivered in inpatient settings, emergency rooms, urgent cares, and retail clinics and other settings which typically do not provide continuous, longitudinal care
  - Include obstetrics and gynecology (OB-GYN) providers and a limited set of OB-GYN services

  - Include behavioral health providers and a set of behavioral health services delivered in primary care settings
  - Capture non-claims payments as part of future data collection strategies
  - Task Force Code Set Written Comments
    - Please send comments via email on suggested updates to Gary Swan (gswan@freedmanhealthcare.com) by 5:00 PM on March 1, 2024
- Summary of Task Force Discussion & Feedback
  - Discussion on challenges related to the CMS Place of Service code for "Office".
    - Some concern that the code will include some non-primary care office (e.g., specialty care office) and interest in how other states address the challenge.
    - This challenge plagues all state definitions- none of the approaches used are perfect nor widely used. The most widely used is the taxonomy.
    - States that require health plans maintain lists of who can take on primary care provider attribution, may restrict to this list. This approach runs the risk of undercounting.
    - An emerging method from the University of Washington uses a combination of rendering and billing provider taxonomy.
    - California is considering requiring primary care providers be licensed as a primary care provider by their Department of Managed Health Care.
    - For North Carolina, it may be valuable to revisit as methods and evidence emerge and determine if they should be incorporated.
  - Do other states codify their definition (i.e., code set) in statute?
    - No, states do not codify their definitions given that billing coding guidance is frequently evolving. Most often state regulations give an entity the authority to create the definition and then reference the code set. Regulations also include how the code set/definition will be maintained. This approach to regulation works well because it identifies who will do updates and how often and maintains flexibility for evolving practices.
    - Task Force agreed that establishing a code set via statute would not be practical or appropriate for North Carolina.
  - How does this definition and approach incentivize creative payment solutions to increase investment in primary care?
    - Given that non-claims primary care payments will not be included in this initial step, there is limited power to incentivize investment in primary care. The definitions power tends to lie more in being one of many drivers towards increasing investment in primary care.
    - Given the primary care investment target will be voluntary and not a requirement, there is limited opportunity to hold payers accountable for not working towards the target.
  - The Task Force expressed a desire to change the status quo of primary care for the better.

3. <u>Primary Care Investment Target</u>

- Task Force Recommendation- Primary Care Investment Target

    - Increase primary care investment 1 percent of total healthcare spending per year i.e. moving primary care spending from an estimated 5.8% of total healthcare spending today to an estimated 6.8% of total healthcare spending in 2025
- Task Force Recommendation- Primary Care Measurement and Investment
    - Track primary care investment by health plan and market category, i.e. Medicaid, commercial, Medicare Advantage
    - Track primary care investment by age group
    - Revisit an absolute target such as 10% to 12% of total medical spending after gaining a better understanding of current investment by payer type using the Task Force's definition
- Summary of Task Force Discussions & Feedback
    - Where did the data finding that North Carolina invested 5.8% of total spend in primary care in 2020?
        - The Health of US Primary Care: 2024 Scorecard Data Dashboard | Milbank Memorial Fund
    - One Task Force member expressed concern that a relative 1% increase in primary care would be a significant absolute increase.
        - Task Force discussed that the 1% relative increase recommendation is based on evidence from other states that it is both achievable and limits unintended increases in inflation.
        - For example, one Task Force member noted that Rhode Island increased around 5.5% to 10% in a 3–5-year period and while still lowering spend. For every extra $1 in primary care in Rhode Island, there was about a $6 reduction in overall spend, and quality measures improved.
    - One Task Force member expressed concern that the investment target would only increase spending without addressing access and accountability.
        - Task Force discussed an accompanying future recommendation to develop primary care scorecards.
        - The Task Force also reinforced that the target is completely voluntary and that no requirements are being implemented at this time.
        - One Task Force member also noted that that there is lots of data from other states that go back many years that shows increased investment in primary care improves quality.

4. <u>Data Collection Strategy & Ongoing Activities</u>

- Task Force Recommendation- Data Collection Strategy
    - Next 0-6 months
        - Currently developing an Excel template for voluntarily collection on primary care spending using the Task Force's definition and the final code set defining primary care.
        - Refine the template as needed with input from the Task Force to annually assess progress toward the investment target with minimal data submitter burden
    - Recommendations for the Future

        - Convene stakeholders to explore future data collection options that enhance the state's health information exchange and existing data ecosystem over the next three to five years
        - Explore access to federal funding to minimize state resources necessary to develop this infrastructure
        - Include NC Medicaid and other data in an integrated data system to enhance policy making and decisions
- Task Force Recommendation - Future Legislative Opportunities
    - Continue to convene a Task Force as needed to ensure the definition of primary care is updated to reflect changing best practices in primary care delivery and coding
        - Update the composition to reflect the charge of the group
    - Fund annual measurement of primary care investment and reporting on progress toward achieving the target
        - Provide authority to collect the necessary data from health plans
    - Develop a primary care scorecard to monitor changes in access, quality, and affordability, as well as better understand the impact of new investments
        - Explore federal funding to support development

- Summary of Task Force Discussions & Feedback
    - Some Task Force members expressed that they believed the recommended data collection approach to be very aspirational based on limited available data and a reluctance to mandate data collection.
    - Discussion on how it will be important to allow sufficient time for the health plans to build the report based on the lists of codes provided.
    - Some Task Force members expressed discomfort with the use of the "authority" in the recommendations because it could be misconstrued as mandate.
        - Other task Force members disagreed, noting that some authority is needed to set guidelines for a collaborative effort. These members understood the anxiety around d mandates and requirements but felt it does not reflect logistical realities. They shared that, to drive this forward, authority is needed to collect data. Given that right now providers are shouldering the cost of data collection, they urged payers to think broadly about meeting providers other halfway.
    - Discussion on importance of identifying an entity to be responsible for data collection.
    - How does the output of the NC Center on the Workforce for Health impact the perspective of this group in the immediate and long term?
    - Discussion on whether "permission" might be a better fit for this recommendation.
    - Discussion on the evidence that increasing investment in primary care has widespread positive impacts on population and individual health.
        - One member noted recent data shows in longitudinal care that there is an 18% increase in longevity if you have a primary care doctor.

5. <u>Measuring the Primary Care Workforce</u>

- Task Force Recommendation - Future Legislative Opportunities
    - Track primary care workforce adequacy in North Carolina:
        - Use existing available data from state data sets and other resources like the Health Professions Data System to meet near-term reporting needs

        - Focus new analyses on understanding variation across provider types, ages, and geographies
        - Incorporate data on the economic contributions of physicians within communities
        - Assess workforce adequacy through the lens of health outcomes and accessibility
- Summary of Task Force Discussions & Feedback:
    - Recognized that existing data system only measures supply, not demand, so there is no current way to measure adequacy, and that working with other partners to determine a solution for measuring demand is necessary.
    - Recommendation to develop adequacy measures leveraging existing available data from state data sets like ... and supporting the development of new needed data sets.

6. <u>Wrap Up</u>

- Upcoming Activities
    - Task Force asks
        - Review code set and report
        - Optional report review meeting
- Freedman Healthcare
    - Update report based on Task Force meetings
    - Submit report
    - Data analysis and collection
        - Release data collection request
        - Host review and technical assistance sessions