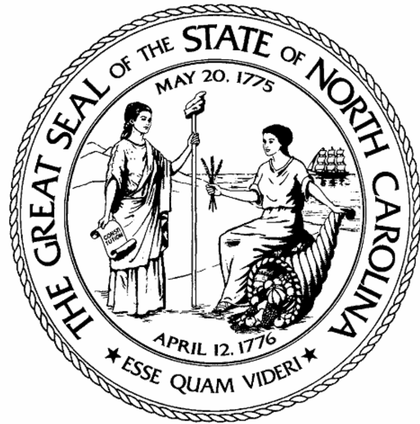
North Carolina Primary Care Payment Reform Task Force

Session Law 2023-134, Section 9E.28.(c)



Report to

Joint Legislative Oversight Committee on Health and Human Services

Joint Legislative Oversight Committee on Medicaid

by

North Carolina Primary Care Payment Reform Task Force

April 17, 2024

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EXECUTIVE SUMMARY

In a 2021 report, the National Academies of Sciences, Engineering, and Medicine defines high-quality primary care as "comprehensive person-centered, relationship-based care that considers the needs and preferences of individuals, families, and communities." Primary care is unique in that is designed for everyone to use throughout their lives—from healthy children to older adults managing multiple comorbidities and people with disabilities. Countries and health systems that provide high-quality primary care are associated with improved health outcomes and greater health equity.[1]

Recognizing the importance of primary care, the General Assembly of North Carolina (General Assembly) in Sections 9E.28.(c) of Session Law 2023-134 (see Appendix A) directed the Department of Health and Human Services, Division of Health Benefits ("NC Medicaid") to establish a Primary Care Payment Reform Task Force (Task Force) and to submit a report with the Task Force's findings and recommendations, no later than April 1, 2024, to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid. The Task Force was to define primary care relevant to NC Medicaid, the State Health Plan, commercial insurance, and Medicare Advantage plans. It was required to analyze primary care spending and adequacy of the primary care delivery system in North Carolina compared with other states, develop strategies for related data collection, and inform the creation of an investment target. Additionally, Task Force members were asked to consider the need for an ongoing Primary Care Payment Reform Task Force and perform other necessary studies for improving primary care delivery.

The Task Force met five times between January and March 2024 to develop the report recommendations. NC Medicaid contracted with Freedman HealthCare, LLC (FHC) to facilitate these meetings and ensure that the legislative charge was met. For each topic, FHC provided the Task Force with available information from North Carolina and an overview of other states' approaches.

Task Force Key Findings:

- Primary care plays an indispensable role within the healthcare delivery system, which is currently under-resourced and facing significant strain. According to a 2023 report by the Milbank Memorial Fund, these challenges include a "trifecta" of low reimbursement rates, administrative hurdles such as extensive charting and the need for preauthorization for medications, tests, and procedures, and diminished autonomy for physicians who are employed by larger healthcare organizations.[2]

[1] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.
[2] National Academy for State Health Policy. 2022. State Strategies to Support the Future of the Primary Care Physician and Nursing Workforce.

- There is a need for continued dialogue to identify solutions that adequately resource primary care services for rural and urban regions, as well as underserved communities.
- To enhance health outcomes and ensure sufficient access, it is important to increase investment in primary care, consider opportunities to evolve how primary care is paid, and address access, quality, and affordability. Such an approach acknowledges primary care's critical function within the larger health system and its contribution to the health and wellbeing of North Carolinians.
- North Carolina currently lacks the data to adequately evaluate primary care investment across payers. Primary care investment across payers is not currently collected, and there is no central repository or entity designated with the authority to report on primary care investment.
- One national source publishes some information on primary care investment in North Carolina. It found primary care investment in North Carolina was 5.7% of total medical expense, higher than the national average of 4.7% in 2021, according to publicly available data from the Milbank Memorial Fund and the Physicians Foundation Primary Care Scorecard.[3]
- National data does not reflect the Task Force's definition of primary care, nor does it provide information on a sufficiently timely basis to support monitoring.
- North Carolina will need to collect data on primary care investment across payers on an ongoing basis in a way that minimizes data submitter burden. NC Medicaid will oversee a baseline voluntary primary care investment data collection that will be added as an addendum to this report by summer 2024. This baseline data collection will include the primary care definition and technical specifications to serve as a foundation for future data collections.
- For North Carolina, approximately 92% of demand for primary care providers will be met in 2024.[4] The same data projects that by 2033 only 88% of demand for primary care will be met.

Task Force Recommendations:

- **Defining Primary Care**: The Task Force recommended a primary care definition that includes a broad set of services, delivered by a variety of providers to recognize the wide and deep capabilities of primary care and promote all providers working at the top of their license. It reflects a vision for team-based primary care in a variety of settings while excluding care delivered in inpatient settings, emergency rooms, urgent cares, retail clinics, and other settings which typically do not provide continuous, longitudinal care.
- **Setting a Primary Care Investment Target**: The Task Force recommended the General Assembly consider targeting an increase in primary care investment equal to one (1)

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[3] Jabbarpour, Y., Petterson, S., Jetty, A., & Byun, H. (2023). The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care. The Milbank Memorial Fund and The Physicians Foundation.
[4] National Center for Health Workforce Analysis. (2024). Workforce projections. Retrieved February 1, 2024, from https://data.hrsa.gov/topics/health-workforce/workforce-projections

percent of total healthcare spending per year. National data demonstrates increased investment in primary care is correlated with better performance on quality and patient experience measures, lower hospital and emergency department use, and lower total cost of care. [5,6] This recommendation from the Task Force would require legislative adoption from the General Assembly.

- **Developing a Primary Payment Care Data Collection Strategy**:
    - By summer 2024, NC Medicaid plans to develop an Excel template to voluntarily collect information on primary care spending from public and private payers using the Task Force's definition and technical specifications developed by FHC. An analysis will be included as an addendum to the report. The addendum and any subsequent voluntary data collection based on this template may include a breakdown of primary care spending as a percentage of total medical expense. It also will list which health plans voluntarily contributed data.
    - Build on this approach over the next 12 to 18 months to annually assess progress toward the investment target with minimal data submitter burden.
    - Convene stakeholders and explore future data collection options that enhance the existing data ecosystem over the next three to five years. This may include incorporating NC Medicaid and other data into an integrated data system to enhance policy making.
    - Consider opportunities to access federal funding to minimize state resources necessary to develop this infrastructure.
- **Assessing Workforce Adequacy:** Continue to use available data to better understand primary care workforce adequacy in the state to inform policy decisions and consider opportunities to invest in improved data collection strategies. Current data solutions cannot fully address the legislation's mandates and the questions posed by the Task Force and would require continued discussion and investment.
- **Ongoing Work and Future Activities:**
    - Designate an entity with the authority to recommend policy changes and support implementation of Task Force recommendations.
    - Consider appropriations to support the designated entity's efforts to implement Task Force recommendations. For example, Task Force members expressed an interest in developing a primary care scorecard to monitor changes in access, quality, and affordability, as well as better understand the impact of new investments. This could include engagements with such entities as the NC Center on the Workforce for Health or the North Carolina Institute of Medicine (NCIOM).
    - Evolve the Task Force composition to reflect the charge of the group and continue to represent all impacted parties.

[5] California Health Care Foundation, April 2022. Investing in Primary Care: Why It Matters for Californians with Commercial Coverage.
[6] Patient-Centered Primary Care Collaborative. (2019, July). Investing in Primary Care: A State-Level Analysis. Robert Graham Center. Milbank Memorial Fund.

The work of the Task Force provides a solid foundation for North Carolina to make data-informed decisions to improve the state of primary care to meet the needs of all North Carolinians. These data are necessary to capture current primary care investment and measure progress towards a primary care investment target. Payer representatives strongly encouraged data collection to continue to occur on a voluntary basis. Other members agreed so long as the Task Force continued to meet and there was transparency regarding which payers participated in data collection efforts. Implementing the Task Force's recommendations will require resources to support ongoing data collection, additional convening to refine the definition of primary care, and analyses.

A. INTRODUCTION

Task Force Overview

SL 2023-134, Section 9E.28.(a) established the Task Force with a requirement that it be composed of members from a list of agencies, organizations, and communities impacted by and responsible for primary care in the state. Section 9E.28.(b) requires the Task Force to:

1. Define primary care for the Task Force's use, ensuring the definition is relevant to services and care under the NC Medicaid program, the State Health Plan, and commercial insurance.
2. Perform an actuarial analysis of current expenditures on primary care services across the NC Medicaid program and the commercial sector, including Medicare Advantage plans.
3. Assess the effectiveness of North Carolina's primary care delivery system, focusing on its impact on the availability of primary care providers in the state.
4. Study the primary care payment landscape in other states, especially those that have established a minimum spending requirement for primary care.
5. Develop strategies for data collection and measurement and inform the creation of a primary care investment target for the NC Medicaid program, the State Health Plan, and commercial insurance, along with methods to track progress towards this goal.
6. Consider the necessity of establishing a permanent Primary Care Payment Reform Task Force or a similar entity and determine the most appropriate state agency or body to manage its operations.
7. Undertake any additional studies, evaluations, or analyses deemed necessary by the Task Force.

The Task Force met five times from January 2024 through March 2024 to define primary care and develop recommendations before the April 1, 2024, deadline. Each meeting had a focus:

1. Defining Primary Care in North Carolina
2. Setting Investment Targets for Primary Care
3. Assessing Primary Care Workforce Adequacy and Developing a Data Collection Strategy
4. Reviewing Draft Recommendations
5. Finalizing Task Force Report and Recommendations (optional)

NC Medicaid contracted with consultants from Freedman HealthCare, LLC (FHC) to develop materials and facilitate Task Force meetings. Task Force meetings were open to the public and formal meeting minutes were posted following each meeting (See Appendix C). NC Medicaid also invited written public comments to the Task Force via e-mail or mail.

FHC presented Task Force members with key decision points to facilitate group discussions on each topic. Their discussions and recommendations are reflected in this report. Task Force discussions noted the recommendations represent an initial step towards addressing long-term needs. Implementing the Task Force’s recommendations will require authority for data collection and resources to support additional convening to refine the definition of primary care and analysis.

National Landscape

With the Task Force and this report, North Carolina joins a growing number of states evaluating how to strengthen their systems of primary care through stronger investment and improvements in care delivery and access.

Many of these state efforts are inspired by research that find higher investment in primary care is associated with improvements in quality and patient experience and reductions in hospitalization and emergency department visits.

- A 2022 study that included 80% of Californians with commercial HMO coverage found: "Greater investment in primary care among health plans was associated with better quality care and fewer hospital visits. Among the provider organizations, larger investments in primary care were associated with better quality, better patient experience, and fewer hospital and emergency room visits, as well as a lower total cost of care."[7]
- A 2019 study by the Patient-Centered Primary Care Collaborative and the Robert Graham Center, found states with higher primary care investment experience lower rates of hospitalization and emergency department visits though causation cannot be inferred this is a relationship replicated in the research literature.[8]

Research has also found that greater access to primary care is associated with better patient outcomes and longer life expectancy.

- A 2021 report from the National Academies of Sciences, Engineering, and Medicine highlights that primary care is the only healthcare component where an increased supply is associated with better population health and more equitable outcomes.[9]
- A 2021 study from researchers at Harvard Medical School found that in counties with fewer primary care providers per person, an increase in the number of primary care providers would be expected to substantially improve life expectancy.[10]

More than a dozen states have passed laws to measure and report the percentage of healthcare spending dedicated to primary care.[11] Five states - Colorado, Delaware, Oklahoma, Oregon, and Rhode Island - require a defined level of primary care investment for at least one payer type. Others including Connecticut, California, and Maryland, have developed voluntary targets or are in the process of doing so. Most states begin by creating a statewide definition of primary care for measurement and reporting purposes.

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[7] Patient-Centered Primary Care Collaborative. (2019, July). Investing in Primary Care: A State-Level Analysis. Robert Graham Center. Milbank Memorial Fund.
[8] California Health Care Foundation, April 2022. Investing in Primary Care: Why It Matters for Californians with Commercial Coverage.
[9] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press.
[10] Basu S, Phillips RS, Berkowitz SA, Landon BE, Bitton A, Phillips RL. Estimated Effect on Life Expectancy of Alleviating Primary Care Shortages in the United States. Ann Intern Med. 2021 Jul;174(7):920-926. doi: 10.7326/M20-7381. Epub 2021 Mar 23. PMID: 33750188.
[11] Primary Care Collaborative. (n.d.). State Primary Care Investment Initiatives. Retrieved February 21, 2024, from https://thepcc.org/primary-care-investment/legislation/map

B. DEFINING PRIMARY CARE IN NORTH CAROLINA

For the purposes of measurement, definitions of primary care are typically based on a code set that includes the providers, services, and care settings that will count as primary care. Some definitions also include certain non-claims payments. The Task Force discussions focused on four decision points to define primary care in North Carolina.

1. *Include a narrow or broad set of providers?*
   a. *Include or exclude behavioral health providers?*
   b. *Include or exclude OB-GYN providers?*
2. *Include a narrow or broad set of services, or all services?*
3. *Limit the places of service considered primary care?*
4. *Include non-claims primary care spending in the initial measurement?*

FHC presented Barbara Starfield's four pillars of primary care practice - first-contact accessibility, continuity, comprehensiveness, and coordination – as a potential vision for primary care and a construct for evaluating the Task Force's recommendations.[12] Task Force members agreed with this approach. Starfield was a pioneering American pediatrician and researcher. The four pillars Starfield established in 1992 set the foundation for future elaborations of key primary care attributes.[13] Starfield's research has shown how primary care improves population health and lowers healthcare expenditures, and galvanized research and policy on the importance of primary care.[14]

The Task Force adopted a primary care definition that aligns well with definitions from other states. The Task Force recommended including a broad set of services to recognize the wide and deep capabilities of primary care and promote all providers practicing at the top of their license. The Task Force definition includes a wide range of provider types to reflect a vision for team-based primary care. The Task Force definition excludes care delivered in inpatient settings, emergency rooms, urgent cares, and retail clinics and other settings which typically do not provide continuous, longitudinal care. The Task Force recommended including obstetrics and gynecology (OB-GYN) providers and a limited set of OB-GYN services. The Task Force also recommended including certain behavioral health providers and a set of behavioral health services often delivered in primary care settings. Table 1 includes a complete list of providers, places of service, and types of services recommended by the Task Force. Please note that for any spending to be considered primary care, the care must be performed by a primary care provider, in a primary care place of service, and be for a primary care service (See Appendix D). Members of the Task Force recognized that the definition of primary care may change over time.

FHC translated the categories of services into Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Codes, the provider types into taxonomy codes

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[12] Starfield B. Primary Care: Concept, Evaluation, and Policy. New York, NY: Oxford University Press; 1992.
[13] The 10 Building Blocks of High-Performing Primary Care. Thomas Bodenheimer, Amireh Ghorob, Rachel Willard-Grace, Kevin Grumbach. The Annals of Family Medicine Mar 2014, 12 (2) 166-171; DOI: 10.1370/afm.1616
[14] The Milbank Quarterly, June 2020. Detailing the Primary Care Imperative–Remembering Barbara Starfield.

and the care settings into place of service codes to support measurement (See Appendix B for a full list of included codes). For services and providers, FHC used the code set developed by the New England States Consortium Systems Organization (NESCSO), as it has emerged as a common starting point for several states' definitions, and then refined the list to reflect Task Force members' recommendations. NESCSO does not limit by place of service; as such, FHC added the appropriate CMS Place of Service (POS) codes to the final list.

Table 1. Summary of Task Force Definition of Primary Care

Types of Providers	Places of Service	Types of Services

• 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
• Adult Medicine
• Adolescent Medicine
• Behavioral health
• OB-GYN
	• Office
	• Telehealth
	• School
	• Home
	• Federally Qualified Health Center
	• Public Health
	• Rural Health Clinic
	• Worksite
	• Street Medicine
	• Homeless Shelter
	• Indian Health Service
	• Tribal Facility
	• Correctional Facility
	• Assisted Living Facility
	• Group Home
	• Mobile Unit
		• Office visit
		• Home visit
		• Preventive visits
		• Immunization administration
		• Transitional care & chronic care management
		• Health risk assessment
		• Advanced care planning
		• Interprofessional consult (e-consult)
		• Team conference w/ or w/o patient
		• Prolonged preventive service
		• Domiciliary or rest home care/ evaluation
		• Hospital outpatient clinic visit

The Task Force also considered the role of non-claims payments in measuring primary care spending. Non-claims payments are financial transactions that are made through alternative or value-based payment arrangements, such as population-based payments, quality incentives, care transformation fees, and risk-sharing arrangements. While important, accurately capturing and understanding the percentage of healthcare spending allocated to primary care through non-claims payments is challenging. In North Carolina, Task Force members said non-claims payments currently comprise a small but growing portion of primary care spending. Examples include NC Medicaid Advanced Medical Home per-member per-month payments and care management payments made to providers. Considering the complexity, and lack of existing data, the Task Force acknowledged the importance of this data and recommended including non-claims payments as part of future data collection strategies.

C. SETTING INVESTMENT TARGETS FOR PRIMARY CARE

With Task Force agreement on the value primary care delivers, and based on the definition of primary care, the Task Force discussed how the state might structure a primary care investment target for North Carolina. The discussion was guided by examples from other states and national data on primary care spending in North Carolina. The state currently lacks the data to evaluate primary care investment across all payers. The national data provides a starting point. However, it does not reflect the Task Force's definition of primary care, nor does it provide information on a sufficiently timely basis to support monitoring progress toward the target. The Task Force discussions focused on four decision points to setting a target for primary care investment.

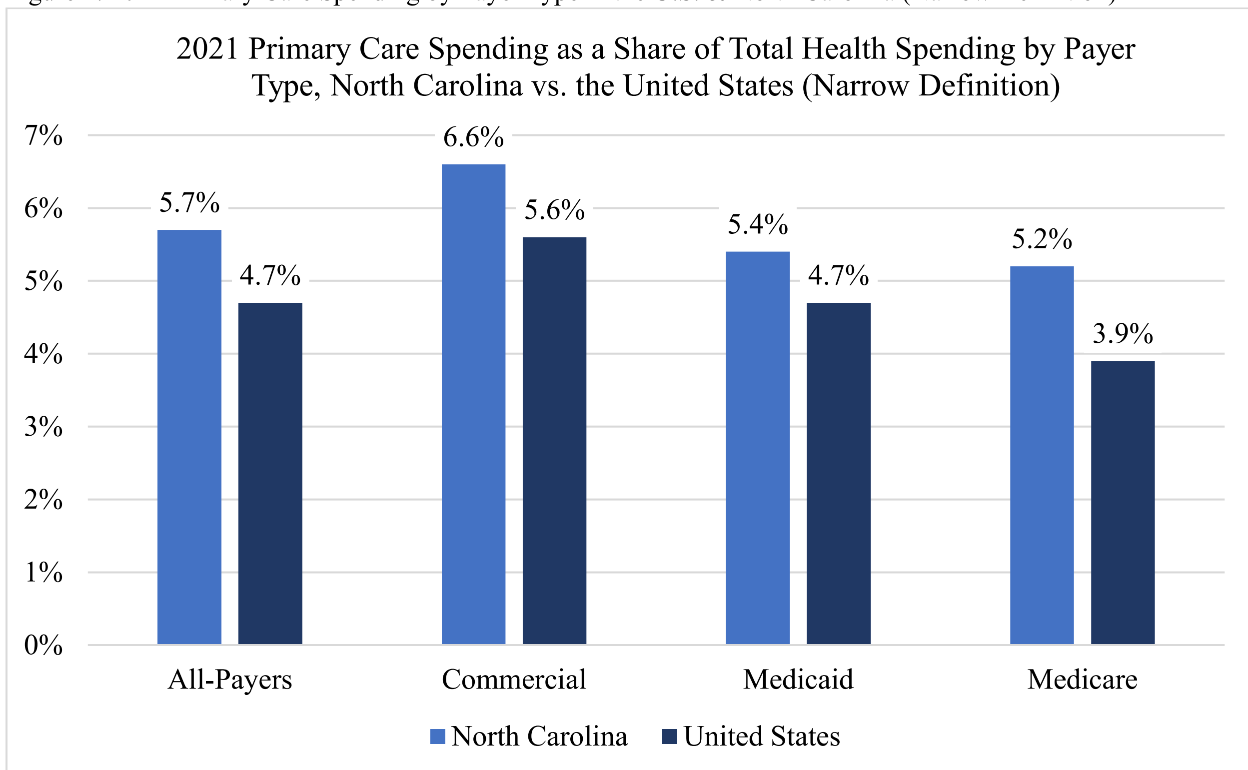
1. *Set a single target for all payers, or multiple targets by payer type?*
2. *Set a single target for all ages or set separate targets by age group?*
3. *Set the target as a percent of spending, or as a defined amount?*
4. *Set an absolute, relative, or stairstep target?*

Consistent with all other existing state primary care investment targets, the Task Force recommended the General Assembly adopt a relative increase of a single (1) percent of total healthcare spending target for all payer types and age groups. As data collection strategies are implemented and primary care spending is measured, the Task Force recommended tracking spend across several dimensions (i.e., age groups and payer types) to inform future discussions. The Task Force recommended setting the target as a relative improvement target to recognize the differences between payers and age groups. This is consistent with several other states' initial primary care investment targets including Colorado, Maryland, and Rhode Island.

Along with implementation of the data collection strategy, the General Assembly would need to enact legislation to adopt the Task Force's recommended primary care investment target for the State.

According to 2021 publicly available data from the Milbank Memorial Fund and the Physicians Foundation Primary Care Scorecard (Scorecard), primary care investment as a percent of total medical expense in North Carolina (5.7%) is higher than the national average (4.7%). Estimates reflect the Scorecard's "narrow" definition, which is most like the Task Force's recommended definition. The Scorecard reported primary care spending was consistently higher than the national rate over the previous five years.

Figure 1. 2021 Primary Care Spending by Payer Type in the U.S. & North Carolina (Narrow Definition)



Task Force members said the state may want to revisit considering 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.

D. DEVELOPING A PRIMARY CARE DATA COLLECTION STRATEGY & FUNDING CONSIDERATIONS

Task Force members discussed strategies for monitoring investments in infrastructure aimed at supporting primary care providers and reducing their workload. This includes initiatives to support the uniform collection of data such as the centralized collection of clinical and claims information for performance measurement and reporting. This is in part to reduce the existing administrative burden experience of primary care providers. In states that track and report primary care spending, data is typically collected through aggregation of financial information via Excel templates or reporting from all-payer claims databases (APCD) or both.

Nine (9) states that routinely measure and publicly report primary care investment have an APCD.[15] However, several of these states utilize a supplemental template to measure primary care spending in aggregate by payer. States typically take this approach because their APCDs lack information on spending by self-insured residents and/or lack information on non-claims

[15] Colorado, Connecticut, Delaware, Maine, Maryland, Massachusetts, Minnesota, Oregon, Vermont, Washington; Condon, M. J., Koonce, E., Sinha, V., Rourke, E., Adams-McBride, M., Green, L., & Freedman, J. (2022). Investing in Primary Care: Lessons from State-Based Efforts. The California Health Care Foundation. Retrieved from https://www.chcf.org/wp-content/uploads/2022/03/InvestingPCLessonsStateBasedEfforts.pdf

payments. States often use their APCDs to better understand granular trends such as which types of services and care settings experienced the greatest increased investment or how investments vary by intrastate geography. These data can also be leveraged to inform workforce supply and distribution across rural and urban areas.

North Carolina does not have an APCD and currently lacks the infrastructure to routinely evaluate primary care investment. The Task Force recommended a data collection strategy that focused on immediate needs and minimized data submitter burden. NC Medicaid will oversee a baseline voluntary primary care investment data collection that will be added as an addendum to this report by summer 2024. This baseline data collection will include the recommended primary care definition and technical specifications to serve as a foundation for future data collections. The analysis will measure primary care spending as defined by the Task Force, including specific criteria such as primary care taxonomy, place of service, and service codes. Data collection categories will include aggregate spending for: Inpatient Hospital, Outpatient Hospital, Professional (subdivided into Primary Care and Non-Primary Care), Other Medical, Total Medical Spend, and Prescription Drug. States typically do not employ an actuary for these analyses. The Task Force recommends dispensing with this step as it is not essential to understanding healthcare spending on primary care. Actuarial analyses would require additional resources and may also require more detailed data from the plans. This initial data collection template can be utilized and refined in the future, as needed, with input from the Task Force to annually assess progress toward the investment target with minimal data submitter burden.

Noting that states measuring primary care investment typically operate an APCD, the Task Force recommended the General Assembly call for a separate convening of stakeholders to explore future data collection options that enhance the state's health information exchange, NC HealthConnex, and existing data ecosystem over the next three to five years. Several states have accessed federal funding to reduce their reliance on state resources to develop this infrastructure.

The Task Force identified the need for appropriations to support the continued development of a definition of primary care, the implementation and refinement of investment targets, the development of data collection and reporting mechanisms. Though figures were not discussed during Task Force meetings, as requested by Task Force members, FHC provided initial estimates of funding required to support Task Force recommendations (Table 2).

Table 2. Estimated funding of Task Force ongoing activity

Potential Funding Option	Description	Development Timeline	Estimated Expense Range
1. Primary Care Task Force Convening	• Continued Convening of the Task Force to further refine and execute recommendations	• 3-6 months to convene	$50,000 to $100,000
2. Primary Care Spend Data Collection (template)	• Flat file (Excel format or otherwise) data collection from public and private payers	• 3-4 months to refine • 2-4 months implementation period	$25,000 to $50,000
3. Primary Care Scorecard Development (utilizing public data)	• Quality performance scorecard identifying primary care quality and access and primary care investment outcomes across public and private payers	• 3-6 months to develop • 2-4 months implementation period	$50,000 to $100,000
4. Integrated Data Solutions (state agency data sources)	• Integration of state agency data sources into an integrated data solution • Alignment with NC Health Information Exchange Authority data solution	• 1-2 years design • 1-2 years implementation	$1.5 m to $3.5m
5. Integrated Data Solutions (non-state agency data sources)	• Integrated data solution building on item 4, includes the addition of non-state agency data sources	• 1-2 years to add additional data	$500,000 to $1m to add non-state agency data source

*Expense ranges estimate total financing required. These estimates do not include adjustments for federal funding or other resources.

E. ASSESSING PRIMARY CARE WORKFORCE ADEQUACY IN NORTH CAROLINA

Like other states and the nation as a whole, North Carolina faces a primary care workforce shortage. On average, primary care physicians earn 30% less than their counterparts in other medical specialties, contributing to one of the highest rates of physician burnout in the field. Four major trends – all heightened and complicated by the COVID-19 pandemic – are strongly

influencing the practice and expansion of primary care teams in the U.S., according to the 2021 NASEM report:[16]

1. A widening income gap between primary care and medical subspecialties
2. Pressure to increase efficiencies rather than effectiveness of primary care
3. General under-resourcing of primary care teams
4. Inconsistent scope of practices due to differences in state licensure laws, specifically for nurse practitioners and physician assistants.

Moreover, primary care providers face significant reporting and administrative challenges. According to a 2023 report by the Milbank Memorial Fund, these challenges include a "trifecta" of low reimbursement rates, administrative hurdles such as extensive charting and the need for preauthorization for medications, tests, and procedures, and diminished autonomy for physicians who are employed by larger healthcare organizations.[17]

Task Force discussions focused on three topics related to primary care workforce adequacy.

1. *What is the current state of the primary care workforce in North Carolina?*
2. *What efforts to address primary care workforce adequacy are occurring?*
3. *What are current and future approaches to measuring primary care workforce adequacy?*

For North Carolina, approximately 92% of demand for primary care providers will be met in 2024, according to the National Center for Health Workforce Analysis, a division of Health Resources and Services Administration (HRSA) (see Table 3). This data includes physician assistants, pediatricians, internal medicine, and family medicine professionals within its definition of primary care. "Adequacy" represents the difference between the estimated supply and demand. The same data projects that by 2033 only 88% of demand for primary care physician assistants, pediatricians, internal medicine, and family medicine will be met in the state. The estimates for North Carolina are higher than the national adequacy rate for 2024 (80%) and 2033 (78%). However, the projected decrease in adequacy for North Carolina (4.4%) from 2024 to 2033 is greater than the projected decrease for the U.S. (2.5%). These estimates consider factors such as variations in the U.S. population size, demographics, and geographic distribution, the entry of new providers and the exit of existing ones across various occupations, and variations in access to care.

[16] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press.
[17] 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.

Table 3. Physician Assistants, Pediatrician, Internal Medicine, Family Medicine Supply and Demand in North Carolina[18]

Year	Supply	Demand	Difference	Adequacy
2024	10,180	11,040	-860	92%
2033	11,070	12,640	-1,570	88%

The Task Force reviewed several efforts to address healthcare workforce adequacy in North Carolina including the North Carolina Center on the Workforce for Health (Center).[19] With many partners statewide, the Center aims to better align the supply and demand of healthcare workers by convening stakeholders, gathering relevant data, and providing technical assistance. Of all the ongoing efforts to address healthcare workforce in North Carolina, none specifically focus on addressing primary care workforce adequacy.

The Task Force recommended the following approach to 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.[20]
- 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, accessibility, geographic distribution, and equity.

As noted, additional data collection and funding may be required to execute these recommendations.

F. ONGOING WORK AND FUTURE ACTIVITIES

The Task Force's recommendations are an important step towards strengthening primary care in North Carolina. The recommendations put forth by the Task Force align with ongoing work in North Carolina to support health system transformation through value-based care initiatives and serve as a foundation to support care delivery investments in quality and health outcomes. These recommendations require authorizing legislation that:

1. Supports continued convening of a Task Force to advance and refine primary care recommendations,
2. Designates an entity to collect and report on primary care spending, and
3. Evaluates and legislatively adopts a statewide investment target.

[18] National Center for Health Workforce Analysis. (2024). Workforce projections. Retrieved February 1, 2024, from https://data.hrsa.gov/topics/health-workforce/workforce-projections
[19] North Carolina Institute of Medicine. NC Center on the Workforce for Health.
[20] Sheps Center. (n.d.). Health Professions Data System. University of North Carolina. Retrieved February 21, 2024, from https://www.shepscenter.unc.edu/data/health-professions-data-system/

Implementing these recommendations will require resources to fund annual measurement of primary care investment and reporting on progress toward achieving the target. The voluntary data collection that will serve as an addendum to this report will provide a baseline for future measurement. However, creating a more complete view across payers may require the General Assembly to legislate health plans and other payers to submit and share data. Task Force members recommend continuing 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, and to continue advancing primary care work in North Carolina. For example, Task Force members expressed an interest in developing a primary care scorecard to monitor changes in access, quality, and affordability, as well as better understand the impact of new investments.

These recommendations require evolving current data resources and collection of necessary data elements. Additionally, future Task Force discussion topics may require different expertise than is currently represented at the Task Force. The Task Force composition, initially established by legislation, should evolve to reflect the charge of the group, while continuing to include important stakeholders such as representatives from the primary care provider community and governmental and private payers.

Potential entities to continue this work may include NC DHHS, or other state entities, providing those entities may delegate appropriate work and funding to respective organizations such as NCIOM or the Cecil G. Sheps Center at the University of North Carolina.

Task Force members also recommended the General Assembly convene stakeholders to explore future data collection options that continue to build on the state's existing data ecosystem over the next three to five years.

Several states have accessed federal funding to minimize state resources necessary to develop this infrastructure. Funding can include support for stakeholder convening – including future Primary Care Task Force sessions – strategy development, administrative planning, and developing the data systems.

Throughout the Task Force process, members and other primary care stakeholders in the state emphasized the importance of this work and expressed a desire to improve primary care for North Carolinians. The recommendations in this report set a crucial foundation for North Carolina to continue working to build a primary care system that better supports primary care physicians and individuals' health outcomes.

APPENDIX A: GENERAL ASSEMBLY OF NORTH CAROLINA, SESSION LAW 2023-134, , SECTION 9E.28.(a – d)

PRIMARY CARE PAYMENT REFORM TASK FORCE

SECTION 9E.28.(a) There is established the North Carolina Primary Care Payment Reform Task Force (Task Force) within the Department of Health and Human Services, Division of Health Benefits, for budgetary purposes only. The Task Force shall be composed of the following members:

(1) The Deputy Secretary for NC Medicaid, or the Deputy Secretary's designee.

(2) The Commissioner of the Department of Insurance, or the Commissioner's designee.

(3) The Executive Administrator of the North Carolina State Health Plan for Teachers and State Employees (State Health Plan), or the Executive Administrator's designee.

(4) The Director of the North Carolina Area Health Education Centers Program, or the Director's designee.

(5) The Director of the North Carolina Health Information Exchange Authority, or the Director's designee.

(6) A physician representative of the North Carolina primary care community, as selected by the North Carolina Academy of Family Physicians.

(7) An advanced practice registered nurse representative of the North Carolina primary care community, as selected by the North Carolina Nurses Association.

(8) A representative of the North Carolina commercial health insurance community, as selected by the North Carolina Association of Health Plans.

(9) A representative of a prepaid health plan that is under a capitated contract with the Department for the delivery of Medicaid services, as selected by the North Carolina Association of Health Plans.

(10) A representative of community health centers, as selected by the North Carolina Community Health Center Association.

All members of the Task Force are voting members. Any vacancies that occur for any membership positions that are not held as a function of office shall be filled by the selecting body upon vacancy. The Deputy Secretary for NC Medicaid, or the Deputy Secretary's designee, shall serve as the chair of the Task Force.

SECTION 9E.28.(b) The Task Force established under subsection (a) of this section shall have the following duties:

(1) Establish a definition of primary care to be utilized by the Task Force. This term should be applicable to services and care provided under the NC Medicaid program, the State Health Plan, and commercial insurance.

(2) Conduct an actuarial evaluation of the current healthcare spend on primary care services, both as it relates to the NC Medicaid program and the commercial market, including Medicare Advantage plans.

(3) Determine the adequacy of the primary care delivery system in North Carolina, including the impact this system has on the supply of the primary care providers in this State.

(4) Study the primary care payment landscape in other states, specifically considering states that have implemented a minimum primary care spend.
(5) Identify data collection and measurement systems to inform creation of a primary care investment target for the NC Medicaid program, the State Health Plan, and commercial insurance. This includes a method by which to measure improvements made toward that target.
(6) Evaluate the need for a permanent Primary Care Payment Reform Task Force, or other similar entity, including which State agency or body is best suited to oversee the work of that group.
(7) Perform any other studies, evaluations, or determinations the Task Force considers necessary.

SECTION 9E.28.(c) No later than April 1, 2024, the Task Force shall submit a report with its findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid. These findings and recommendations shall include specific, concrete, and actionable steps to be undertaken by the State and upon which the General Assembly could act.

SECTION 9E.28.(d) This section shall expire on May 1, 2024.

APPENDIX B: PRIMARY CARE DEFINITION & CODE SET

This code set is the recommendation put forth by the Task Force. It encompasses a list of National Uniform Claim Committee (NUCC) provider taxonomies, Healthcare Common Procedure Coding System. (HCPCS) and Current Procedural Terminology (CPT) codes,[21] and Centers for Medicare & Medicaid Services (CMS) Place of Service (POS) codes.[22]

Table 4: HCPCS/CPT Codes

Code	Description
10060	Drainage Of Skin Abscess Simple
10061	Drainage Of Skin Abscess Complicated
10080	Drainage Of Pilonidal Cyst Simple
10120	Remove Foreign Body Simple
10121	Remove Foreign Body Complicated
10160	Puncture Drainage Of Lesion
11000	Debride Infected Skin
11055	Trim Skin Lesion Single
11056	Trim Skin Lesions 2 To 4
11200	Removal Of Skin Tags <W/15
11201	Remove Skin Tags Add-On

[21] The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes are standardized coding systems used in the United States for reporting medical procedures and services for billing and efficiency.
[22] The Centers for Medicare & Medicaid Services (CMS) Place of Service code is a two-digit code placed on health care professional claims to indicate the setting in which a service was provided.

Code	Description
11300	Shave Skin Lesion 05 Cm/<
11301	Shave Skin Lesion 06-10 Cm
11302	Shave Skin Lesion 11-20 Cm
11303	Shave Skin Lesion >20 Cm
11305	Shave Skin Lesion 05 Cm/<
11306	Shave Skin Lesion 06-10 Cm
11307	Shave Skin Lesion 11-20 Cm
11310	Shave Skin Lesion 05 Cm/<
11311	Shave Skin Lesion 06-10 Cm
11400	Exc Tr-Ext B9+Marg 05 Cm<
11401	Exc Tr-Ext B9+Marg 06-1 Cm
11402	Exc Tr-Ext B9+Marg 11-2 Cm
11403	Exc Tr-Ext B9+Marg 21-3 Cm
11420	Exc H-F-Nk-Sp B9+Marg 05/< Cm
11421	Exc H-F-Nk-Sp B9+Marg 06-1 Cm
11422	Exc H-F-Nk-Sp B9+Marg 11-2 Cm
11423	Exc H-F-Nk-Sp B9+Marg 21-3 Cm
11720	Debride Nail 1-5
11730	Removal Of Nail Plate Simple
11750	Removal Of Nail Bed Partial/Complete
11765	Excision Of Nail Fold Toe
11900	Inject Skin Lesions </W 7
11981	Insert Drug Implant Device
11982	Remove Drug Implant Device
11983	Remove W/ Insert Drug Implant
19000	Drainage Of Breast Lesion
20520	Removal Of Foreign Body Simple
20550	Inj Tendon Sheath/Ligament
20551	Inj Tendon Origin/Insertion
20552	Inj Trigger Point 1/2 Muscl
20553	Inject Trigger Points 3/>
20600	Drain/Inj Joint/Bursa W/O Us Small
20605	Drain/Inj Joint/Bursa W/O Us Intermediate
20610	Drain/Inj Joint/Bursa W/O Us Major
20612	Drain/Inj Ganglion Cyst
36415	Routine Venipuncture
57170	Fitting Of Diaphragm/Cap
58300	Insert Intrauterine Device
58301	Remove Intrauterine Device
59400	Obstetrical Care

Code	Description
59425	Antepartum Care Only 4-6 Visits
59426	Antepartum Care Only 7< Visits
59430	Postpartum Care Only
59510	Routine Ob Care
59610	Routine Obstetric Care After Prevs C-Section
59618	Routine Ob Care Post Vaginal Delivery After Prev C-Section
69200	Clear Outer Ear Canal W/Out Anesthesia
69209	Remove Impacted Ear Wax Irrigation
69210	Remove Impacted Ear Wax Instruments
90460	Immunization Admin 1St/Only Component 18 Years<
90461	Immunization Admin Each Addl Component 18 Years<
90471	Immunization Admin 1 Vaccine Single/Combo
90472	Immunization Admin Each Add-On Single/Combo
90473	Immunization Admin Oral/Nasal Single/Combo
90474	Immunization Admin Oral/Nasal Addl Single/Combo
96127	Brief Emotional/Behav Assmt
96156	Health Behavior Assessment Or Re-Assessment
96158	Health Behavior Intervention, Individual Face-To-Face 30 Min
96159	Health Behavior Intervention, Individual Face-To-Face 15 Min
96160	Pt-Focused Hlth Risk Assmt
96161	Caregiver Health Risk Assmt
98966	Hc Pro Phone Call 5-10 Min
98967	Non-Physician Telephone Services 11-20 Min
98968	Non-Physician Telephone Services 21-30 Min
98969	Online Service By Hc Pro
99000	Specimen Handling Office-Lab
99050	Medical Services After Hrs
99056	Med Service Out Of Office
99078	Phys/QHP Education Materials for Pts In Group Setting
99173	Visual Acuity Screen
99188	App Topical Fluoride Varnish
99201	Office/ outpatient visit new
99202	Office/OutPt Visit New 15-29 Min
99203	Office/OutPt Visit New 30-44 Min
99204	Office/OutPt Visit New 45-59 Min
99205	Office/OutPt Visit New 60-74 Min
99211	Office/OutPt Visit Est

Code	Description
99212	Office/OutPt Visit Est 10-19 Min
99213	Office/OutPt Visit Est 20-29 Min
99214	Office/OutPt Visit Est 30-39 Min
99215	Office/OutPt Visit Est 40-54 Min
99241	Office Or Other OutPt Consultations 15 Min
99242	Office Or Other OutPt Consultations 30 Min
99243	Office Or Other OutPt Consultations 40 Min
99244	Office Or Other OutPt Consultations 60 Min
99245	Office Or Other OutPt Consultations 80 Min
99339	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 15-29 Min
99340	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 30 Min
99341	Home Visit New Pt 20 Min
99342	Home Visit New Pt 30 Min
99343	Home Visit New Pt 45 Min
99344	Home Visit New Pt 60 Min
99345	Home Visit New Pt 75 Min
99347	Home Visit Established Pt 15 Min
99348	Home Visit Established Pt 25 Min
99349	Home Visit Established Pt 40 Min
99350	Home Visit Established Pt 60 Min
99358	Prolong Service W/O Contact
99359	Prolong Serv W/O Contact Add 30 Min
99360	Standby Service
99366	Team Conf W/ Pt By Healthcare Prof 30 Min W/Physician
99367	Team Conf W/Out Pt By Healthcare Prof 30 Min W/Physician
99368	Team Conf W/Out Pt By Healthcare Prof 30 Min W/Out Physician
99374	Home/Nursing Facility Visits 15-29 Min
99375	Home/Nursing Facility Visits 30 Min
99376	Care Plan Oversight/Over
99377	Supervision Hospice Patient/Month 15-29 Min
99378	Supervision Hospice Patient/Month 30 Minutes/>
99381	Init Pm E/M New Pat Infant
99382	Init Pm E/M New Pat 1-4 Yrs
99383	Prev Visit New Age 5-11
99384	Prev Visit New Age 12-17
99385	Prev Visit New Age 18-39

Code	Description
99386	Prev Visit New Age 40-64
99387	Office Visit - New Pt 65+ Yrs
99391	Periodic Pm Reeval Est Pat Infant 1>
99392	Prev Visit Est Age 1-4
99393	Prev Visit Est Age 5-11
99394	Prev Visit Est Age 12-17
99395	Prev Visit Est Age 18-39
99396	Prev Visit Est Age 40-64
99397	Per Pm Reeval Est Pat 65+ Yr
99401	Preventive Counseling Indiv 15 Min
99402	Preventive Counseling Indiv 30 Min
99403	Preventive Counseling Indiv 45 Min
99404	Preventive Counseling Indiv 60 Min
99406	Behav Chng Smoking 3-10 Min
99407	Behav Chng Smoking > 10 Min
99408	Audit/Dast 15-30 Min
99409	Alcohol/Substance Screen & Intervention >30 Min
99411	Preventive Counseling Group 30 Min
99412	Preventive Counseling Group 60 Min
99420	Administration and interpretation of health risk assessments
99429	Unlisted Preventive Service
99441	Phys/Qhp Telephone Evaluation 5-10 Min
99442	Phone E/M Phys/Qhp 11-20 Min
99443	Phys/Qhp Telephone Evaluation 21-30 Min
99444	Online E/M by Phys/QHP
99446	Interprofessional Electronic Health Assessment 5-10 Min
99447	Interprofessional Electronic Health Assessment 11-20 Min
99448	Interprofessional Electronic Health Assessment 21-30 Min
99449	Interprofessional Electronic Health Assessment 31 Min <
99451	Interprofessional Electronic Health Assessment 5 Min >
99452	Interprofessional Electronic Health Record Referral Service(S) Provided By A Treating Physician Health Care Professional, > 16 Min
99461	Initial Evaluation And Management Of Newborn Outside Of Hospital
99483	Assmt & Care Planning Pt W/Cognitive Impairment
99484	Care Mgmt Svc Bhvl Health Conditions 20 Min
99487	Complex Care W/O Pt Visit 60 Min
99489	Complex Chronic Care Addl 30 Min

Code	Description
99490	Chron Care Mgmt Srvc 20 Min
99491	Chronic Care Management Services At Least 30 Min
99492	1St Psyc Collab Care Mgmt
99493	Sbsq Psyc Collab Care Mgmt
99494	1St/Sbsq Psyc Collab Care
99495	Trans Care Mgmt 14 Day Disch
99496	Trans Care Mgmt 7 Day Disch
99497	Advncd Care Plan 30 Min
99498	Advncd Care Plan Addl 30 Min
1000F	Tobacco Use Assessed
1220F	Pt Screened For Depression
3016F	Pt Screened For Unhlthy Alcohol Use
3085F	Suicide Risk Assessed
4004F	Pt Tobacco Screen And Cessation Intervention
4290F	Pt Screened For Injection Drug Use (Hiv)
G0008	Admin Influenza Virus Vaccine
G0009	Admin Pneumococcal Vaccine
G0010	Admin Hepatitis B Vaccine
G0101	Cancer Screen; Pelvic/Breast Exam
G0102	Prostate Cancer Screening; Digital Rectal Examination
G0179	Phys Re-Cert Mcr-Covr Hom Hlth Srvc Re-Cert Prd
G0180	Phys Cert Mcr-Covr Hom Hlth Srvc Per Cert Prd
G0181	Home/Nursing Facility Visits W/Out Pt Medicare Approved
G0182	Hospice Facility Visits Medicare Approved
G0396	Alcohol/Subs Misuse Intervention 15-30 Min
G0397	Alcohol/Subs Misuse Intervention 30 Min <
G0402	Welcome to Medicare visit
G0403	Ekg For Initial Prevent Exam
G0404	Ekg Tracing For Initial Prev
G0405	Ekg Interpret & Report Prev
G0436	Smoke Tob Cessation Cnsl As Pt; Intrmed 3-10 Min
G0437	Smoking & Tob Cess Cnsl As Pt; Intensive >10 Min
G0438	Ppps, Initial Visit
G0439	Ppps, Subseq Visit
G0442	Annual Alcohol Screen 15 Min
G0443	Brief Alcohol Misuse Counsel
G0444	Depression Screen Annual 15 Min
G0463	Hospital Outpt Clinic Visit
G0466	FQHC Visit, New Pt

Code	Description
G0467	FQHC Visit, Established Pt
G0468	FQHC Preventive Visit
G0505	Cognition and functional assessment
G0506	Comprehensive Asses Care Plan Chronic Care Mgmt Services
G0513	Prolong Preventive Services, First 30 Min
G0514	Prolonged Preventive Service Addl 30 Min
G2211	Office and Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on
H0049	Alcohol/Drug Screening
Q0091	Obtaining Screen Pap Smear
S0610	Annual Gynecological Examine New Pt
S0612	Annual Gynecological Examine Established Pt
S0613	Annual Breast Exam
S4981	Insertion Of Levonorgestrel-Releasing Intrauterine Sys
S9117	Back To School Visits
T1015	Clinic Service All-Inclusive

Table 5: NUCC Taxonomy Codes

Code	Description
101Y00000X	Counselor Behavioral Health
103T00000X	Psychologist
104100000X	Social Worker
207RA0000X	Adolescent Medicine - Internist
2080A0000X	Pediatric Adolescent Medicine
261Q00000X	Clinic/Center
261QC1500X	Community Health Clinic/Center
261QP0905X	Public Health; State or Local Clinic/Center
363L00000X	Nurse Practitioner
363LC1500X	Nurse Practitioner- Community Health
261QF0400X	Federally Qualified Health Center (FQHC)
261QR1300X	Clinic/Center, Rural Health
261QP2300X	Clinic/Center, Primary Care
363LP0200X	Nurse Practitioner, Pediatrics
207R00000X	Internal Medicine
207Q00000X	Family Medicine
207RG0300X	Internal Medicine, Geriatric Medicine
208000000X	Pediatrics
363AM0700X	Physician Assistant, Medical
363LA2200X	Nurse Practitioner, Adult Health

Code	Description
363LF0000X	Nurse Practitioner, Family
363LP2300X	Nurse Practitioner, Primary Care
207QA0505X	Family Medicine, Adult Medicine
207QG0300X	Family Medicine, Geriatric Medicine
207QA0000X	Family Medicine, Adolescent Medicine
207RA0000X	Internal Medicine, Adolescent Medicine
207VG0400X	Gynecology
363LG0600X	Nurse Practitioner, Gerontology
363LP0808X	Nurse practitioner, psychiatric
363LW0102X	Nurse Practitioner- Women's Health
363LX0001X	Nurse Practitioner- Obstetrics & Gynecology
367A00000X	Advanced Practice Midwife
207V00000X	Obstetrics & Gynecology
207VG0400X	Obstetrics & Gynecology, Gynecology
367A00000X	Midwife, Certified Nurse
176B00000X	Midwife

Table 6: CMS Place of Service Codes

Code	Description
3	School
4	Homeless Shelter
5	Indian Health Service Free- standing Facility
6	Indian Health Service Provider- based Facility
7	Tribal 638 Free- standing Facility
8	Tribal 638 Provider-based Facility
9	Prison/Correctional Facility
10	Telehealth Provided in Patient’s Home
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
26	Military Treatment Facility
27	Outreach Site/ Street
50	Federally Qualified Health Center
71	Public Health Clinic
72	Rural Health Clinic

APPENDIX C: TASK FORCE MEETING MATERIALS & PUBLIC COMMENTS

Background readings, meeting materials, and meeting minutes can be found at https://medicaid.ncdhhs.gov/meetings-notices/committees-and-work-groups/primary-care-payment-task-force

The Task Force received two public comments that commended the Task Force's efforts to improve the state of primary care in North Carolina and suggested the Task Force:

- Consider and support independent primary care practices, specifically.
- Consider the role value-based care and accountable care models play in primary care in the recommendations.
- Consider recommending streamlining administrative processes and reducing regulatory burdens to alleviate the administrative burden on independent primary care offices.

APPENDIX D: DECISION TREE FOR IDENTIFYING CLAIMS-BASED PRIMARY CARE SPEND