Maryland Primary Care Workgroup

An Overview of Activities to Advance Primary Care in Maryland & Nationally

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Meet the Team

Mary Jo Condon, MPPA, Principal Consultant, has supported multiple states in the development of care delivery and payment models that put primary care at the center. Recent projects include leading the Delaware Department of Insurance Office of Value-Based Health Care Delivery, designing a primary care payment model for Connecticut, and guiding Rhode Island systems of care through a collaborative process to identify care delivery requirements to support comprehensive primary care capitation. Ms. Condon was the lead author of "Investing in Primary Care: Lessons from State-Based Efforts," a 2022 report detailing the efforts of 17 states to increase primary care investment and orientation.

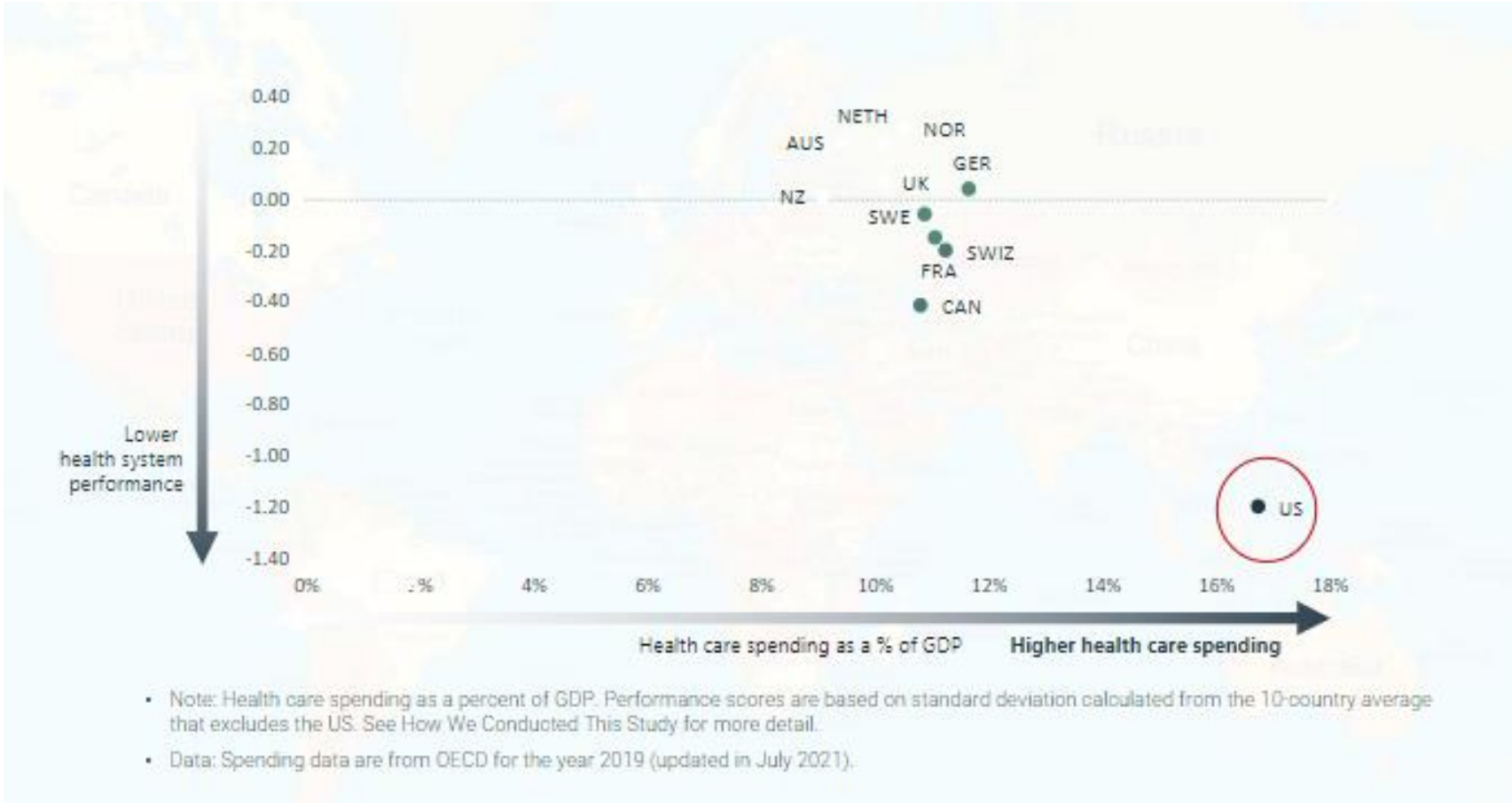
Brian Boates, MPH, CSM, Consultant, has assisted multiple states and nonprofit organizations on work related to data collection and reporting. Recent projects include overseeing all governance functions of the Rhode Island APCD, inclusive of database enhancements, data management vender oversight, budget management, and its data release program. Additionally, Mr. Boates has supported clients plan and develop integrated databases which have included claims and non-claims information, such has clinical and Social Drivers of Health information.

Topics for Today

1. Primary Care: A National Look
2. Measuring Primary Care Spending
3. Appendix

Primary Care: A National Look

Health Care System Performance Compared to Spending

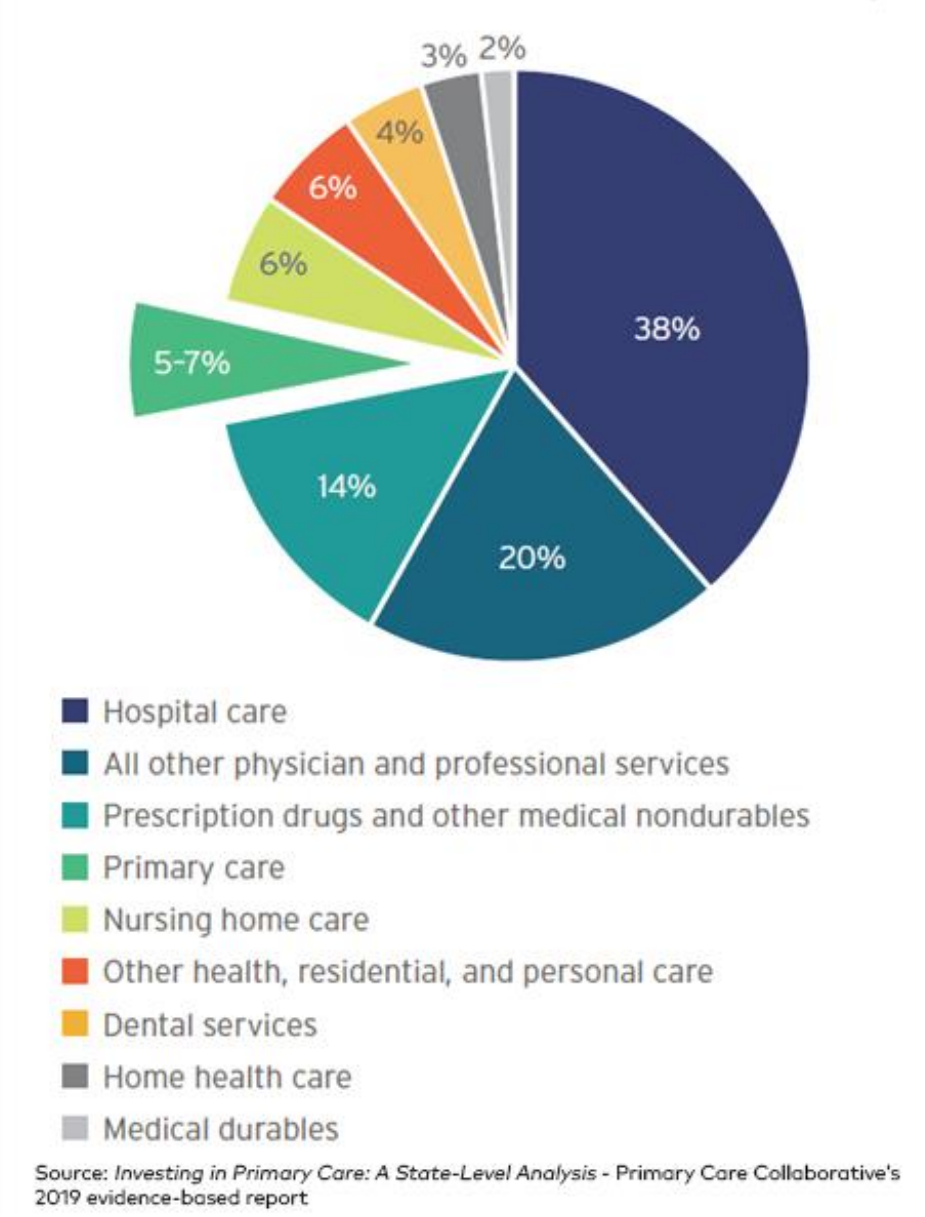


Compared to other high-income countries, the United States spends more than twice as much on health care per capita and experience worse outcomes on life expectancy, rates of chronic disease, and other critical measures.

Higher spending on primary care is one shared attribute of those other high-income countries.

Primary Care Spending in the U.S.

International spending on primary care is estimated to represent 12%-17% of total healthcare spending, compared to 5%-7% in the United States.



Source: *Investing in Primary Care: A State-Level Analysis* - Primary Care Collaborative's 2019 evidence-based report

Baillieu R, Kidd M, Phillips R, *et al*
The Primary Care Spend Model: a systems approach to measuring investment in primary care
BMJ Global Health 2019;**4**:e001601.

The Journey to Advanced Primary Care

Efforts to advance primary have been occurring for more than 50 years. Over the last decade, states have taken more leadership in developing policies and programs.

1967

The American Academy of Pediatrics introduces the term “medical home.”

1978

The Declaration of Alma-Ata is introduced at the International Conference on Primary Health Care.

1996

The Institute of Medicine (IOM) redefines primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community."

2002

The seven national family medicine organizations launch The Future of Family Medicine (FFM) project.

2005

Dr. Barbara Starfield publishes Contribution of Primary Care to Health Systems and Health.

2008

The National Committee for Quality Assurance (NCQA) launches medical home accreditation programs.

2010

The Patient Protection and Affordable Care Act (ACA) passes, includes numerous provisions for enhancing primary care and medical homes.

2012

At least 47 states have adopted policies and programs to advance the medical home, the National Academy for State Health Policy finds.

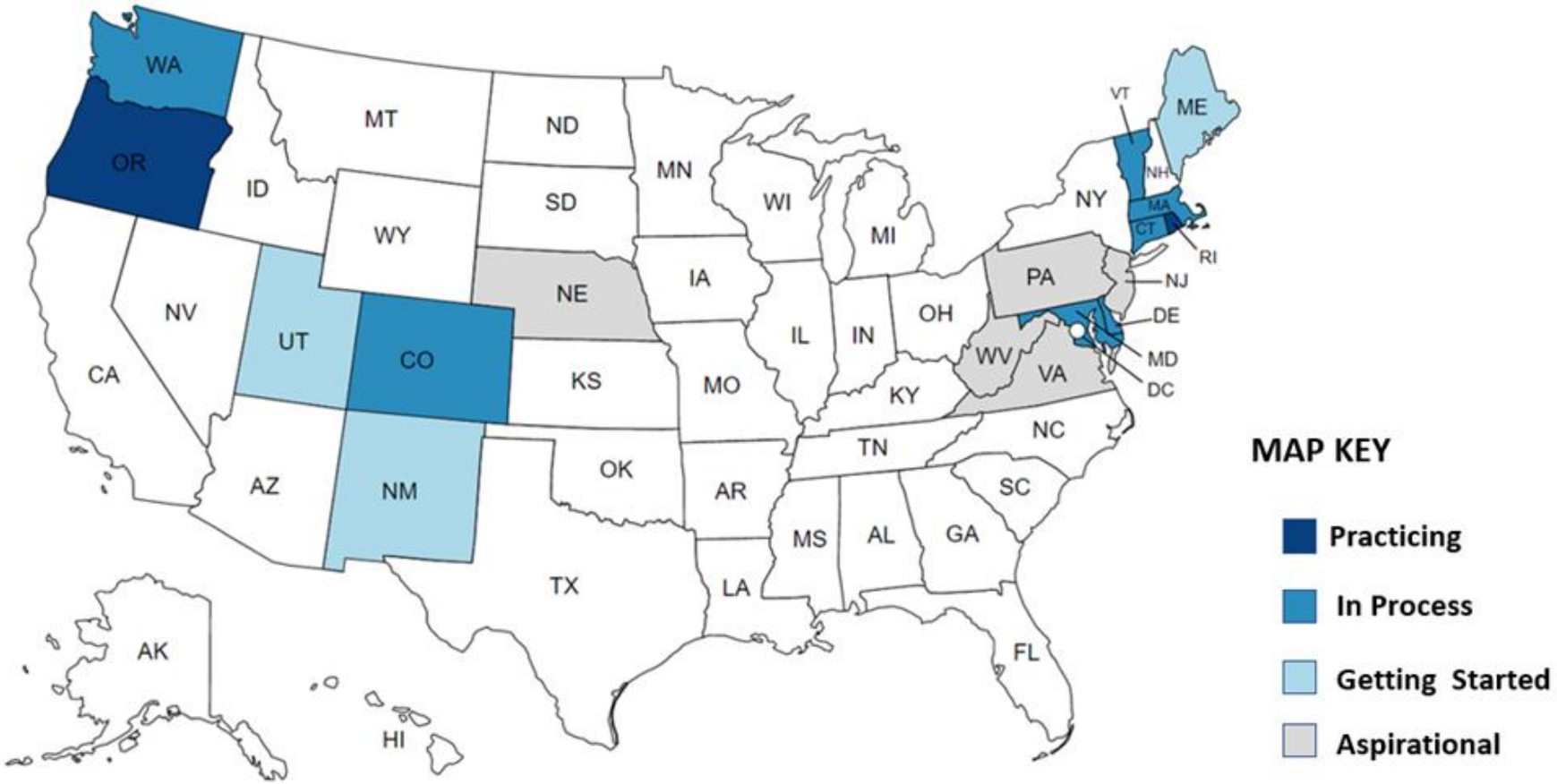
2021

The National Academies of Sciences, Engineering and Medicine’s *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* puts forth an evidence-based plan for implementing high-quality primary care in the United States.

2021

Primary Care First is a voluntary five-year alternative payment model that rewards value and quality by offering an innovative payment structure to support the delivery of advanced primary care, based on the principles underlying the existing Comprehensive Primary Care (CPC) and Comprehensive Primary Care Plus (CPC+) model designs.

Current Efforts to Advance Primary Care Nationally



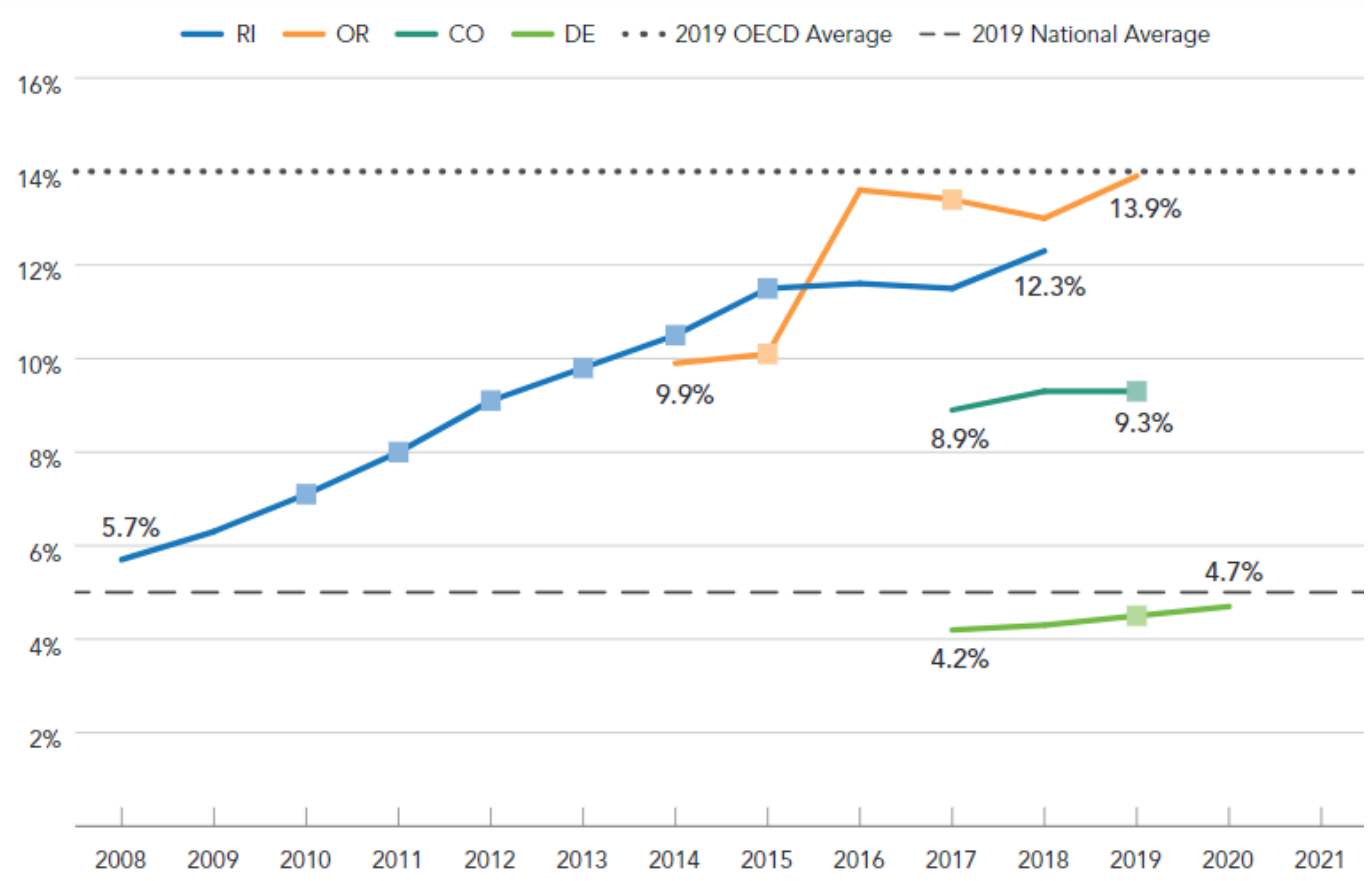
MAP KEY

- **Practicing**
- **In Process**
- **Getting Started**
- **Aspirational**

Source: Author analysis of primary care investment reports publicly available on state governmental websites. Current as of December 2021.

This map shows states actively working to advance primary care. Activities include engaging stakeholders, measuring primary care spending, setting care delivery goals and redesigning primary care payments. Complete definitions of each category in the map key can be found on the next slide.

Examples of States Requiring Increases in Primary Care Spending



OREGON MILESTONES

2015 Law passed that requires reporting of primary care spend percentage by payer.

2017 Carriers/CCOs required to allocate at least 12% to primary care in 2023.

DELAWARE MILESTONES

2019 PCRC set target to increase primary care investment to 12%.

2022 Carriers required to increase primary care spend to 7%, then 1.5% a year until 11.5%.

RHODE ISLAND MILESTONES

2010–2014 Carriers required to increase by 1% per year.

2015 Carriers required to spend at least 10.7% on primary care.

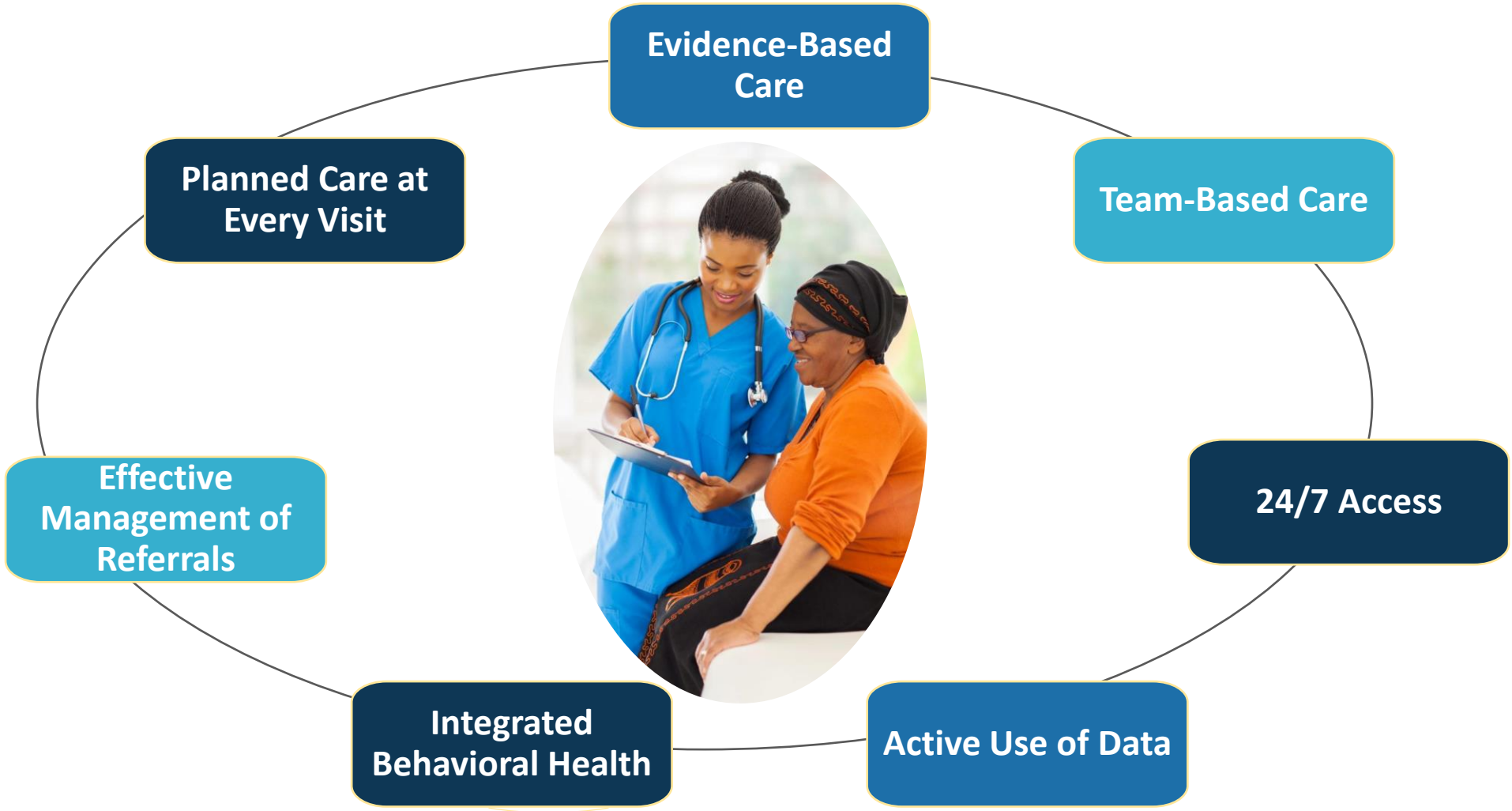
COLORADO MILESTONE

2019 Primary care spending first reported; 1% increase not required until 2022 and 2023.

Source: Analysis of primary care investment reports publicly available on state governmental websites.

Note: State definitions and total cost of care differ which contributes to differences in spending percentages.

Functions of Advanced Primary Care*



These functions are adapted from Primary Care First (PCF). PCF is a multi-payer, national program from the Centers for Medicare and Medicaid Services (CMS) designed to improve primary care through high value capabilities and payment innovation. Its aims and approaches are similar to the Maryland Primary Care Model.

*Adapted from Primary Care First definition of comprehensive primary care

Measuring Primary Care Spending

Typical Data Sources Used to Measure Primary Care Spending

Stakes take one of three approaches measure primary care spending.

1. Use the data they already collect in an all-payer claims database (APCD).

2. Use their statutory authority to require submission of a unique data set from payers using a standard template.

3. Use both sources.

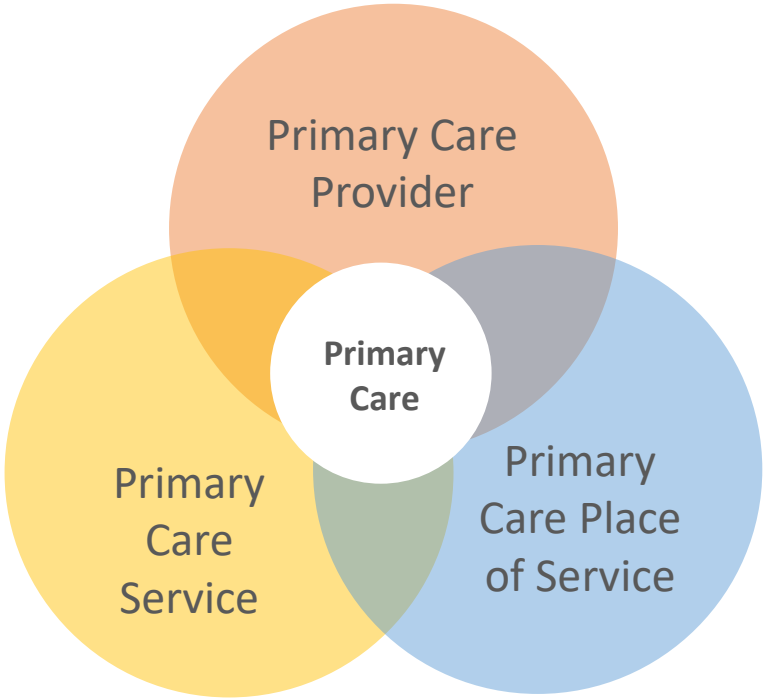
APCD Benefits

- Payers do not have submit any additional data
- APCDs “in-house measurement” helps ensure technical specifications are followed in a consistent way

Template Benefits

- May include data from members of self-insured plans
- Typically includes non-claims payments

Defining Primary Care: Numerator



Most Common: Family medicine, general practice, internal medicine, pediatrics, NP/PA, geriatrician, FQHC/RHC

Less Common: Nurse, OB-GYN, behavioral health clinician

Most Common: Office visits, preventive visits, vaccine admin, screenings, care coordination and management

Less Common: Procedures, behavioral health, maternity

Most Common: Office, telehealth (home or other), walk-in retail clinic, FQHC/RHC, home

Less Common: Worksite, urgent care, school

Defining Primary Care: Numerator

Framework	OR	RI	CO	CT	DE	MA	VT	ME	CA/IHA
Health Care Payment Learning and Action Network	✓		✓		✓				
Homegrown					✓	✓	✓	✓	
Milbank Memorial Fund / Bailit Health		✓		✓				✓	✓

Challenges of Measuring Non-Claims Payment

- 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.

Non-claims matter: NESCSO found that including non-claims payments increased primary care spending between 0.2% (for Connecticut) to 4.5% (for Massachusetts).

Defining Primary Care: Denominator

Although stakeholders often focus on the services and providers included in the numerator, decisions regarding the denominator often have even greater impact on the result.

Retail Pharmacy in the Denominator:

- States that include pharmacy in the denominator typically do so to align with other definitions of total cost of care currently in use.
- Pharmacy spending is typically inflated since it does not deduct rebates, which is estimated at more than 25% of total pharmacy spend.
- This may be good; higher denominator equals higher primary care spending target. It can also generate push back that is hard to dispute.

Differing Services Across Payer Types:

- Payer types (e.g., Medicaid, Medicare, Commercial) differ in benefits offered, reimbursement structure and service utilization.
- These differences result in differences in total cost of care and, in turn, primary care spending as a percent of total cost of care.
- Standardizing covered services is an important first step to achieving more equitable comparisons.

THE END

Appendix

Leadership and Partnerships by State

Design/Develop Measure/Monitor Implement/Enforce

	AGENCIES, ORGANIZATIONS, AND WORKGROUPS		CORE FUNCTIONS								
			INVESTMENT TARGET			CARE TRANSFORMATION			PAYMENT INNOVATION		
	NAME	TYPE	💡	📐	✔	💡	📐	✔	💡	📐	✔
CO	**Lead: Division of Insurance**	**OA**			✔						
	Center for Improving Value in Health Care	APCD		✔			✔			✔	
	Primary Care Payment Reform Collaborative	WG	✔			✔			✔		
CT	**Lead: Office of Health Strategy (OHS)**	**OA**	✔				✔			✔	
	Dept. of Public Health	OA				✔			✔		
	Insurance Dept.	OA				✔			✔		
	CT All-Payer Claims Database	APCD		✔							
	OHS Stakeholder Workgroups	WG	✔			✔			✔		
	Dept. of Social Services/Medicaid	P				✔	✔		✔		
	Office of the State Comptroller	P	✔			✔	✔	✔	✔		
DE	**Lead: Dept. of Insurance**	**OA**	✔	✔	✔				✔	✔	✔
	Lead: Health Care Commission	**WG**				✔	✔	✔	✔	✔	✔
	DE Health Information Network	APCD		✔							
	Primary Care Reform Collaborative	WG				✔	✔	✔			
	State Employee Benefits Committee*	P				✔	✔	✔	✔	✔	✔
	Division of Medicaid and Medical Assistance*	P				✔	✔	✔	✔	✔	✔
MA	**Lead: Center for Health Information and Analysis**	**APCD**	✔	✔	✔[†]		✔			✔	
	Health Policy Commission	WG			✔						
MD	**Lead: Health Services Cost Review Commission**	**OA**	✔	✔	✔	✔	✔	✔	✔	✔	✔
	MD Health Care Commission	OA/ APCD		✔		✔	✔				
	MD Insurance Administration	OA			✔			✔			✔
	MD Primary Care Program	OA				✔		✔[‡]	✔		✔[‡]
	Care Transformation Organizations	Other						✔[‡]			✔[‡]

* Function only corresponds to organization's own population.
† Only for compliance of submission timelines.
‡ Implementation only.
§ Coordinates with the Primary Care Council to address primary care workforce shortages.

Notes: APCD is all-payer claims database; OA is oversight agency; P is purchaser; WG is appointed workgroup. Icon sources: The Noun Project (Wahyu Adam Pratama, Mahdalenyy, and Lemon Liu).

-Investing in Primary Care: Lessons from State-Based Efforts, CHCF, April 2022

Leadership and Partnerships by State (Con'd)

Design/Develop Measure/Monitor Implement/Enforce

	AGENCIES, ORGANIZATIONS, AND WORKGROUPS		CORE FUNCTIONS								
			INVESTMENT TARGET			CARE TRANSFORMATION			PAYMENT INNOVATION		
	NAME	TYPE									
ME	**Lead: Maine Quality Forum (MQF)**	**OA**	✔	✔							
	Maine Health Data Organization	APCD			✔						
	MQF Primary Care Spending Advisory Committee	WG	✔								
NM	**Lead: Primary Care Council**	**WG**	✔	✔		✔			✔		
	Graduate Medical Education Expansion Review Board	WG				✔§					
OR	**Lead: Dept. of Consumer and Business Services**	**OA**			✔						
	Lead: Oregon Health Authority	**OA/P/APCD**	✔	✔	✔						
	▸ OR Educators Benefit Board	P			✔			✔			✔
	▸ Public Employees' Benefit Board	P			✔			✔			✔
	▸ Medicaid Care Coordination Organizations	Other			✔*			✔‡			✔‡
	Primary Care Payment Reform Collaborative	WG	✔	✔		✔	✔		✔	✔	
RI	**Lead: Office of the Health Insurance Commissioner**	**OA**	✔	✔	✔	✔	✔	✔	✔	✔	✔
	Medicaid	P			✔			✔			✔
	Office of Employee Benefits	P			✔			✔			✔
	Care Transformation Collaborative	Other				✔	✔	✔	✔		
VT	**Lead: Green Mountain Care Board / Dept. of Health Access**	**OA**	✔	✔	✔	✔	✔	✔	✔	✔	✔
	VT Health Care Uniform Reporting and Evaluation System	APCD		✔							
WA	**Lead: Office of Financial Management**	**OA**	✔	✔							
	WA All-Payer Claims Database	APCD		✔							
	Primary Care Expenditures Stakeholder Group	WG	✔								
	WA Health Care Authority	P		✔		✔	✔	✔	✔	✔	✔

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Overview and Approaches to Non-Claims Payments

	PRACTICING		IN PROCESS					GETTING STARTED	
	OR	RI	CO	CT	DE	MA	VT	ME	CA/IHA
Framework									
Health Care Payment Learning & Action Network	✔		✔		✔				
Homegrown					✔	✔	✔	✔	
Milbank Memorial Fund / Bailit Health		✔		✔				✔	✔
Non-Claims Payment Collected									
Capitation									
▸ All services						✔			
▸ All services, primary care separated	✔	✔	✔	✔	✔			✔	✔
Care management									
▸ All services						✔			
▸ All services, primary care separated	✔	✔	✔	✔	✔			✔	✔
Incentive programs									
▸ All services						✔			
▸ All services, primary care separated	✔	✔	✔	✔	✔			✔	✔
Population-based payment									
▸ Comprehensive	✔	✔	✔	✔	✔			✔	✔
▸ Condition-specific	✔	✔	✔	✔	✔			✔	
▸ Integrated finance / delivery system	✔	✔	✔	✔	✔			✔	✔
Payments for upside/downside risk programs									
▸ Shared savings/losses	✔	✔	✔	✔	✔	✔	✔	✔	✔
Pay for									
▸ Reporting	✔	✔	✔	✔	✔			✔	✔
▸ Performance	✔	✔	✔	✔	✔			✔	✔

Notes: IHA is Integrated Healthcare Association. The **Oregon** All Payer All Claims Reporting Program (APAC) provides a public-facing non-claims payment arrangement dashboard at **visual-data.dhsoha.state.or.us**. **Rhode Island and Connecticut**: Payers and/or providers submit estimate of the percentage of non-claims payments allocated to primary care. **Colorado**: Non-claims payments made to providers with primary care taxonomy are classified as primary care investment. **Delaware** collects non-claims payments two ways: based on the Health Care Payment Learning & Action Network approach and using a homegrown approach. The homegrown approach designates certain categories of payments as part of primary care investment. **Massachusetts**: Each non-claims category is reported separately for primary care services, behavioral health services, and all other types of services. The MA definition includes pay for performance and reporting in a single "Incentive Payments" category. The MA definition includes all population-based payments under capitation. **Vermont** uses a homegrown approach and includes at least a portion of some categories of payments as primary care investment. Vermont's homegrown categories include Blueprint for Health PCMH, Comm. Health Team, Spoke, Women's Health Initiative, and Support & Services at Home. While these categories do not match those in the table, the dollars are used to support many of the same functions. **Maine**: Payers submit estimated non-claims payments, members, and member months for primary care and non-primary care providers in aggregate for each product. See **90-590 CMR Chapter 247: Uniform Reporting System for Non-Claims-Based Payments** (PDF), Maine Health Data Organization, December 12, 2021. **California/IHA**: Payers/providers submit estimate of the percentage of non-claims payments allocated to primary care.

-Investing in Primary Care: Lessons from State-Based Efforts, CHCF, April 2022

Historical Primary Care Spending in Maryland

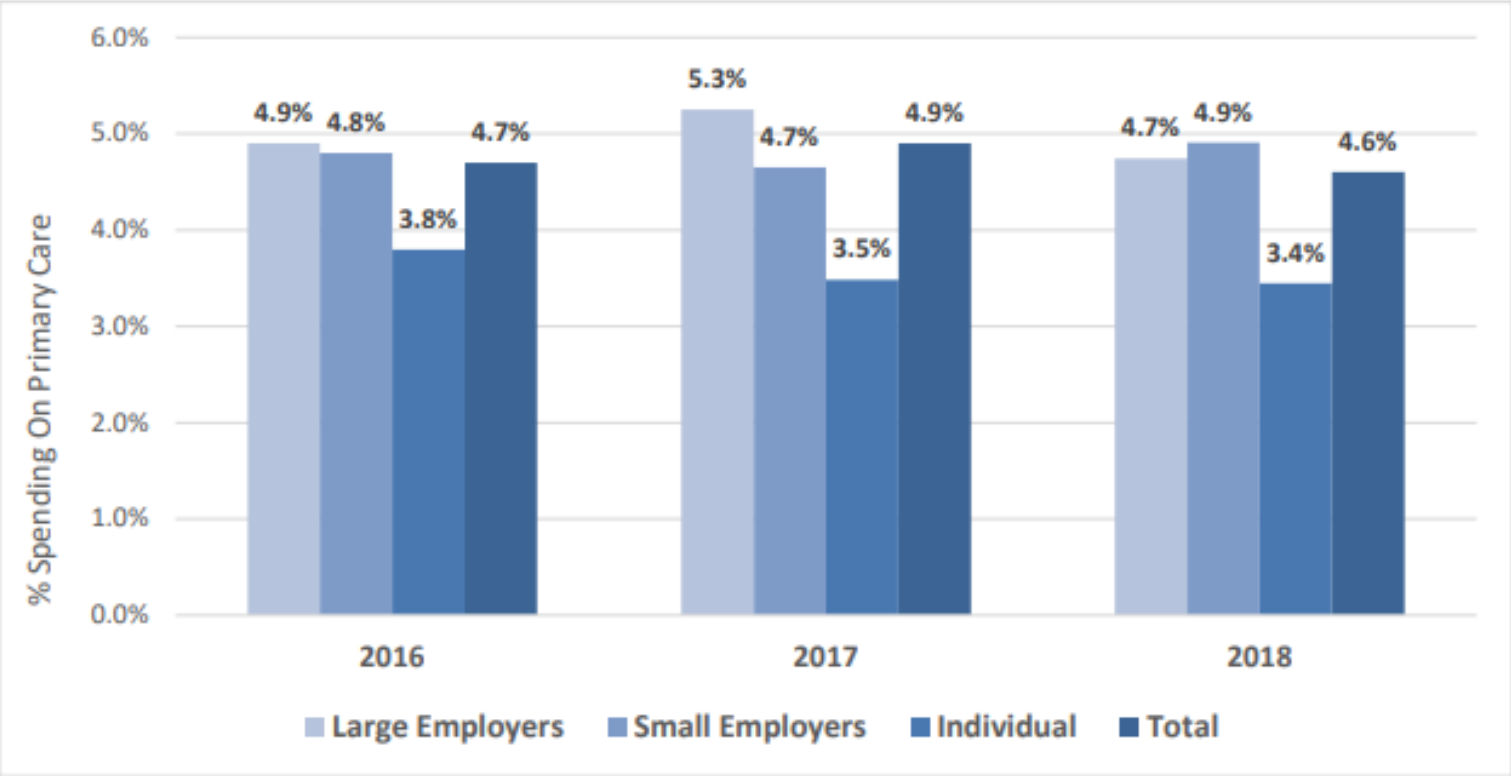
Primary Care Spending In Maryland

> "A priority of MHCC is to support advanced primary care and practice transformation to improve coordinated care delivery and health outcomes."
>
> *PRIMARY CARE SPENDING RELATIVE TO TOTAL MEDICAL AND OUTPATIENT PRESCRIPTION DRUG SPENDING IN MARYLAND'S PRIVATELY INSURED MARKETS, 2018*

- MHCC measured primary care spending in its 2018 report, *"Primary Care Spending Relative to Total Medical and Outpatient Prescription Drug Spending in Maryland's Privately Insured Market"*
- In this report, primary care spending is defined as the cost (including provider reimbursement and insured member out of pocket amounts) of preventive services, including wellness programs, and the treatment of common illnesses rendered by physicians in an office or an outpatient facility setting.
- In Maryland, primary care spending was 4.6% of all medical and outpatient prescription drug spending in 2018, which was comparable to national benchmark percentages of 6.0% (4.6% - 7.6%) for PPO plans and 6.5% (3.1% - 9.2%) for HMO plans. National benchmarks were reported by the Milbank Memorial Fund.

Primary Care Spending In Maryland

Exhibit 1: Annual Primary Care Spending vs. Total Medical and Outpatient Prescription Drug Spending by Market: 2016 – 2018



-PRIMARY CARE SPENDING RELATIVE TO TOTAL MEDICAL AND OUTPATIENT PRESCRIPTION DRUG SPENDING IN MARYLAND'S PRIVATELY INSURED MARKETS, 2018

Maryland experienced a steady decline in spending on primary care in the individual market from 3.8% in 2016 to 3.4% in 2018. This may be attributed to the exit of relatively healthier enrollees who are more likely to use mostly primary care services.

Primary Care Spending In Maryland

Exhibit 3: : Annual Primary Care Spending vs. Total Medical and Outpatient Prescription Drug Spending by Product: 2016 – 2018

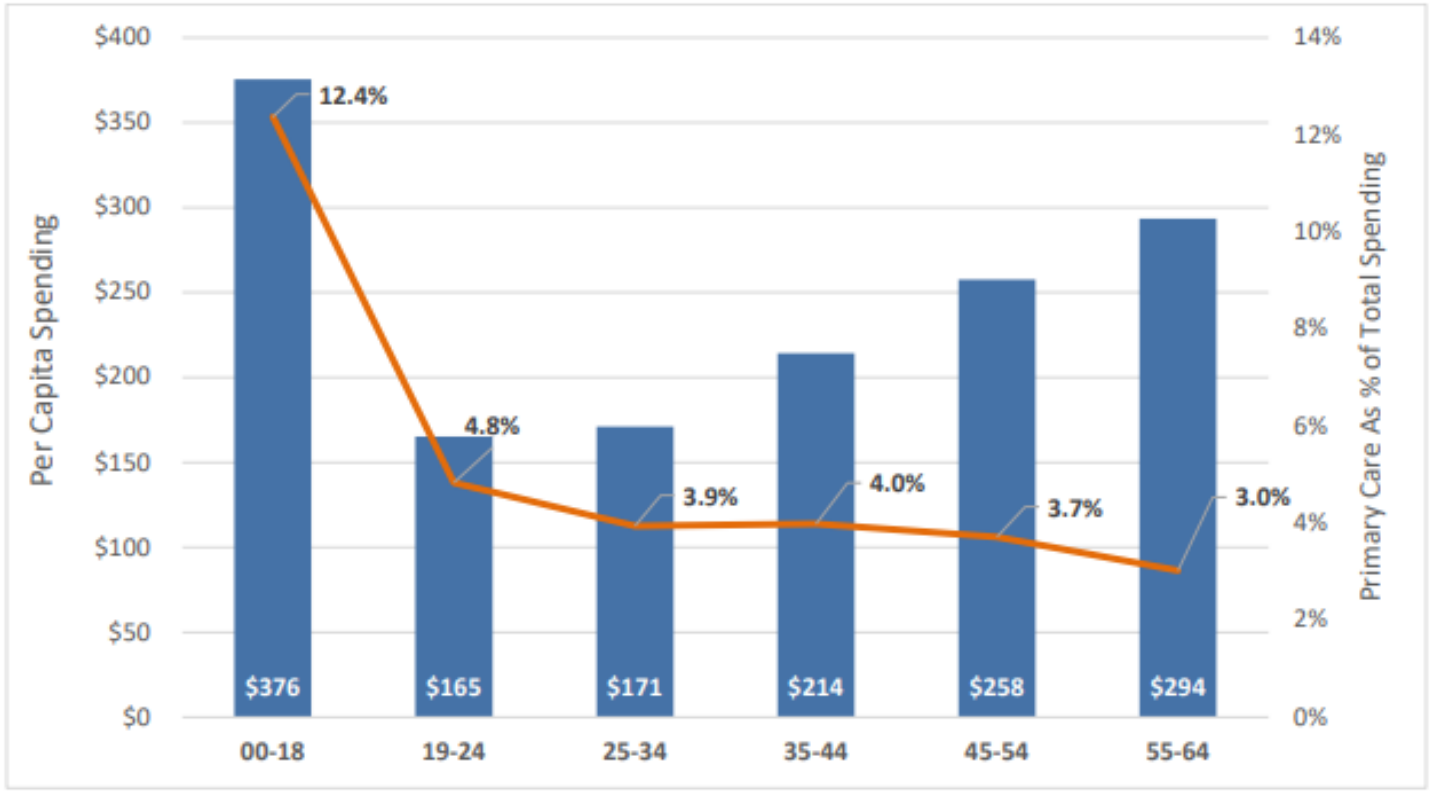
Product	2016	2017	2018
Annual Primary Care Spending Per Member			
PPO	$258	$262	$276
EPO	$208	$230	$199
HMO	$233	$238	$261
POS	$258	$244	$257
All Products	**$240**	**$246**	**$261**
Annual Primary Care Spending as a % of Total Spending			
PPO	4.5%	5.0%	4.2%
EPO	4.4%	5.2%	4.6%
HMO	5.1%	5.0%	5.0%
POS	4.4%	4.4%	4.9%
All Products	**4.7%**	**4.9%**	**4.6%**

-PRIMARY CARE SPENDING RELATIVE TO TOTAL MEDICAL AND OUTPATIENT PRESCRIPTION DRUG SPENDING IN MARYLAND'S PRIVATELY INSURED MARKETS, 2018

- PPO and EPO plans spent 4.2% and 4.6% on primary care services in 2018, respectively, while HMO plans spent 5%. This is comparable to the national average.
- Annual primary care spending for all products combined increased substantially from 2017 to 2018, by about 6%, compared to a 2.5% increase from 2016 to 2017.

Primary Care Spending In Maryland

Exhibit 2: Annual Primary Care Spending vs. Total Medical and Outpatient Prescription Drug Spending by Age Group, 2018



-PRIMARY CARE SPENDING RELATIVE TO TOTAL MEDICAL AND OUTPATIENT PRESCRIPTION DRUG SPENDING IN MARYLAND'S PRIVATELY INSURED MARKETS, 2018

- The percent annual spending on primary care was highest (12.4%) for ages 0-18 years.
- Average annual primary care expense increases from 19 to 64, but primary care spending compared as a percentage of overall spending declines with age, from 12.4% to 3.0%.
- There are no significant differences in primary care spending by gender.