MARYLAND
Health Care
Commission

Primary Care Workgroup

Primary Care Investment Strategy

Select State Comparison and Questions

JUNE 21, 2023

Overview

- MHCC set up virtual meetings with representatives from select states that have or are currently conducting studies to inform development of primary care investment targets
  - States included Colorado (“CO”), Delaware(“DE”), Oregon (“OR”) and Rhode Island (“RI”)
- Meetings took place in May and June
- A list of about 12 multiple part questions were sent to states in advance; the questions were broken down into 22 categories for this presentation
  - The questions were designed to discuss how the states arrived at their approach to setting a primary care investment target and lessons learned from the process that could inform our efforts
- Information provided in the slides is based on our understanding from informal conversations with representatives from these states and may not be factually correct

KEY TAKEAWAYS

Key Takeaways: State Primary Care Investment Strategy

1. **Provide an overview of the approach to establishing a primary care investment target.**

   Takeaway: States performed a study and analyzed data prior to setting an investment target

2. **Does the approach include a voluntary or required investment?**

   Takeaway: Some states favored a voluntary approach

3. **Is the increased investment phased in over time?**

   Takeaway: States phase in annual increases

4. **What role do stakeholders have in recommending policy related to primary care investment?**

   Takeaway: States engage stakeholder workgroups or committees to recommend policy related to investment

Key Takeaways: State Primary Care Investment Strategy

5. **Which state agency directs the primary care investment program?**

   Takeaway: In some states, the Health Insurance Commission directs the program oversight

6. **What is included in that agency's oversight activities?**

   Takeaway: In some states, the activities include conducting studies, making recommendations, and implementing annual investment changes, if needed

7. **Does this agency have authority over the health insurance market? If not, how do you engage the payers?**

   Takeaway: In some states, the agency that directs the program has authority

8. **Describe the policy levers available to the agency for primary care investment oversight.**

   Takeaway: Some states use legislation and regulation

Key Takeaways: State Primary Care Investment Strategy

9. **Are all payers required to make increased payments to primary care providers?**

   Takeaway: OR requires all payers; in others, only commercial payers are required to make a yearly increase

10. **Can a payer be exempted from participation?**

    Takeaway: Some states allow exemptions based on number of covered members

11. **Have standards been established related to how primary care providers can use additional investment funds?**

    Takeaway: Some states have standards; for example, in RI, payments must be utilized to support the development and maintenance of a care management function within the practice site

12. **Are the standards flexible guidelines or fixed requirements?**

    Takeaway: Some states have fixed requirements, see RI example above

Key Takeaways: State Primary Care Investment Strategy

13. **ERISA-protected self-insured employers represent what percent of the commercially insured?**

    Takeaway: The percent ranges from 10 – 50 percent

14. **How have you engaged ERISA-protected employers in the primary care investment initiative?**

    Takeaway: In most states it has been difficult to engage employers, but some employers participate in state policy workgroups

15. **Have you considered requiring payers to make upfront investment payments to practices to build and sustain infrastructure capacity?**

    Takeaway: Two required, two encouraged

16. **How do payers calculate patient enrollment/attribution to primary care providers?**

    Takeaway: Oregon created an attribution methodology and philosophical agreement, but it has not been universally adopted; in other states payers use their own attribution methodologies

Key Takeaways: State Primary Care Investment Strategy

17. **Primary care investment is typically shown as a percentage of total spending. Can you discuss what is included in your primary care investment equation?**

    Takeaway: Some state investment calculations include additional taxonomy codes, place of service codes, and prescription drug cost

18. **Is a total cost of care offset required to support increased investments in primary care?**

    Takeaway: DE and RI require lower non-primary care cost growth

19. **Are non-fee-for-service ("FFS") primary care investments included in the primary care spend algorithm?**

    Takeaway: Some states include investments such as health information technology ("HIT"), incentives to providers, and other methods like investments in loan forgiveness for training physicians

20. **How are primary care non-claims-based payments reported?**

    Takeaway: Some states use All-Payer Claims Databases ("APCDs") to report the data

Key Takeaways: State Primary Care Investment Strategy

21. **What is the rationale for including general psychiatry and obstetrics and gynecology in the methodology?**

    Takeaway 1: Some definitions only include mental or behavioral health screening or when the service is provided as part of an integrated behavioral health arrangement

    Takeaway 2: Some states are trying to measure services provided when the OB/GYN is really acting as a primary care provider

22. **Were place of service codes considered for including in the methodology of a primary care definition?**

    Takeaway: Some states include place of service codes like urgent care or school-based

THANK YOU!

APPENDIX

STATE COMPARISON TABLES

(1) Approach to Establishing Investment Target

Colorado	Delaware	Oregon	Rhode Island
• Established the Primary Care and Payment Reform Collaborative (PCPRC), which has the authority to collect primary care and all payer data directed by HB 191233 • Initially did not have an ideal target number in mind • Level of investment among carriers varied from seven percent on the high end and three percent at low end	• Requirement based on analysis of investment needed to achieve care transformation goals and ability to offset increased spending via slower non-professional price growth • Compliance integrated with rate review process; based only on attributed members of providers in care transformation	• The Legislature enacted Senate Bill 231 (2015) and House Bill 4017 (2016), which required Oregon Health Authority (OHA) to convene a Primary Care Payment Reform Collaborative • SB 934 (2017) required health insurance carriers and Coordinated Care Organizations to allocate at least 12 percent of their health care expenditures to primary care by 2023 • Payers have been reporting on their primary care investment for the last few years; first reporting was voluntary, now required	• Implemented broad statutory mandates to lower costs and improve quality under the Affordability Standards • Completed a health insurance rate review and a study of high performing health care payers

(2) Voluntary Target vs. Required Investment

Colorado	Delaware	Oregon	Rhode Island
• Requires commercial carriers to increase investments in primary care spending by one percentage point annually from 2021-2023	• Initial voluntary target of 12 percent did not result in substantial increases in payment • Requirements now in place for commercial fully-insured; phased in over time (8.5 percent in 2023, 10 percent in 2024, 11.5 percent in 2025)	• Required increase by one percent annually with a goal of 12 percent of total expenditures by 2023	• Initial voluntary target was set at five percent and ended up around 10 percent • Annual primary care expenses required to be at least an amount calculated as 10.7 percent of its annual medical expenses for all insured

(3) Investment Increase Timeline

Colorado	Delaware	Oregon	Rhode Island

• Increased investment is phased in yearly	• Phased in over time
	  • 8.5 percent in 2023
	  • 10 percent in 2024
	  • 11.5 percent in 2025
		• Commercial carriers that did not meet the 12 percent target were required to increase spending by one percentage point each year until 2023	• Initially phased in by recommending one percent per year for four years (2010-2014)
			• Currently, annual primary care expenses required to be at least an amount calculated as 10.7 percent of its annual medical expenses for all insured

(4) Stakeholders Role In Investment Policy

Colorado	Delaware	Oregon	Rhode Island
• PCPRC publishes annual recommendations	• Primary Care Reform Collaborative meets monthly and quarterly to weigh in on primary care policy	• Payers and providers are involved in policy recommendations	• Multi-payer transformation program • Shifts in spending from payers also guide policy

(5) Directing State Agency

Colorado	Delaware	Oregon	Rhode Island
• Colorado's Division of Insurance ("DOI") directs primary care investment oversight	• The Department of Health and Social Services ("DHSS") and the Department of Insurance ("DOI") lead different aspects of primary care reform	• OHA directs the primary care investment program	• Office of the Health Insurance Commissioner ("OHIC") directs primary care investment and oversight

(6) Agency's Oversight Activities

Colorado	Delaware	Oregon	Rhode Island
• The PCPRC makes recommendations, and the insurance commissioner approves and implements recommendations	• DHSS leads work with providers and care delivery design • DOI regulates carrier investment requirements	• Studies and implements annual investment changes if needed	• Studies and implements annual investment changes if needed • Shifts in spending from payers also guide policy

(7) Agency's Health Insurance Market Authority

Colorado	Delaware	Oregon	Rhode Island
• The PCPRC makes recommendations, and the insurance commissioner approves and implements recommendations	• The DOI has authority over the health insurance market	• The agency does not have authority over the health insurance market, but the Department of Consumer Business Services does have authority	• OHIC does have authority

(8) Investment Oversight Policy Levers

Colorado	Delaware	Oregon	Rhode Island
• HB 221325 gives DOI authority to align primary care alternative payment models to drive value-based care	• Senate Bill 227 is intended to address the need to improve the current status by increasing investment in primary care	• Senate Bill 231 (2015) and House Bill 4017 (2016) to provide information about primary care and strengthen primary care infrastructure	• OHIC has set Affordability Standards to support primary care, transform healthcare delivery, and change the way care is paid for

(9) Increased Payment Requirement

Colorado	Delaware	Oregon	Rhode Island
• All commercial payers are required to make a yearly one percent increase	• Only applies to commercial fully insured	• All payers are required to make increased payments	• All commercial payers

(10) Payer Exemption

Colorado	Delaware	Oregon	Rhode Island
• Below 10,000 covered members, but none currently have less than the required number	• Fewer than 250 members in a market segment	• Portfolio is a certain market size	• Below 10,000 covered members

(11) Established Standards for Investment Fund Use

Colorado	Delaware	Oregon	Rhode Island
• Standards have not been established • Discussion about standards will begin next year	• There are no standards established but providers must be engaging in care transformation activities to be included in the carrier's required level of spending	• There are standards but they are not prescriptive	• Payments must be utilized to support the development and maintenance of a care management function within the practice site

(12) Flexibility of Standards

Colorado	Delaware	Oregon	Rhode Island
• Standards have not been established	• General and not prescriptive	• Standards are flexible	• Standards are flexible

(13) Market Share ERISA-Protected Self-Insured Employers

Colorado	Delaware	Oregon	Rhode Island
• The healthcare market is split, 33 percent self-funded, 33 percent commercial, and 33 percent public insurance	• ERISA and other self-insured represent more than 50 percent of the market	• About 36 percent of insured whose data is collected in APCD	• Around 10 percent per 2016 data

(14) ERISA-Protected Self-Insured Employers Engagement

Colorado	Delaware	Oregon	Rhode Island
• There has not been success engaging employers	• It is difficult to engage at this time • State employees are aligned in primary care goals, but do not have an investment requirement	• ERISA-protected employers are represented as stakeholders in the primary care payment reform collaborative	• There is a focus to create strategies that spill over into self-funded policies

(15) Required Upfront Investment Payments

Colorado	Delaware	Oregon	Rhode Island
• Upfront investment payments are encouraged but not required • A lot of payers are doing on their own • This may be written in legislation as a requirement in future years	• Upfront investment payments are encouraged but not required	• CPC+ required a per member per month payment ("PMPM") • The state is including PMPM as part of the model	• The current structure includes Medicare fees, infrastructure payments, and bonus payments • Driving toward primary care capitation payments

(16) Patient Enrollment/Attribution to Primary Care Providers

Colorado	Delaware	Oregon	Rhode Island
• Payers do not currently disclose this information • State would like to align these calculations, but payers currently use different approaches - some prospective, some retrospective • There is conversation about transparency and discussion of legislation regarding these calculations	• Payers use their existing attribution methodology • Varies by payer	• A 2019 report has the attribution methodology and philosophical agreement laid out, but it has not been universally adopted	• Payers use their existing attribution methodology

(17) Investment Calculation

Colorado	Delaware	Oregon	Rhode Island
• Affordability initiatives underway so there will be an update to this measurement • Claims data has been broken out between traditional primary care spending and with additional taxonomies and place of service for primary care delivery • Percentage of medical expenses allocated to primary care by insurers, Health First Colorado Medicaid, and Child Health Plan Plus	• FFS and Non-FFS • FFS based on CPT, taxonomy and place of service • Similar to New England States Consortium Systems Organization for FFS but includes minor procedures • Non-FFS is broken out into primary care and non-primary care categories; aligned with state benchmark program • Denominator excludes prescriptions	• The sum of claims-based and non-claims-based payments to primary care providers is divided by the sum of total claims-based and non-claims-based payments to all providers • As the denominator, total payments include all payments for members including specialty care, hospitalizations and more. • However, total payments do not include prescription drugs	• Claims-level definition of primary care spending and taxonomy codes to define a primary care provider • Direct primary care expenses: The sum of all claims-based and non-claims-based primary care payments excluding health information exchange (“HIE”) payments for CurrentCare and Patient Centered Medical Home (“PCMH”) administration payments to support the operations of CTC-RI • Indirect primary care expenses: the sum of all HIE payments for CurrentCare and PCMH administration payments

(18) Require Total Cost of Care Offset

Colorado	Delaware	Oregon	Rhode Island
• No	• Lower non-professional price growth offset is required	• No	• Cost of care offset is required for large health systems

(19) Include Non-FFS in Primary Care Spend

Colorado	Delaware	Oregon	Rhode Island
• Infrastructure investments are included	• Up to one percent of the carriers' 8.5 percent primary care investment can be internal and external investments in HIT and other infrastructure	• Indirect spend including infrastructure and capacity building spending are included • Supplemental workforce payment • Payments for patient centered medical home recognition	• Non-FFS investments are part of the algorithm and include HIT, PCMHs, CurrentCare (the state's HIE, incentives to providers, and other methods like investments in loan forgiveness for training physicians

(20) Reporting and Analyzing Care Non-Claims-Based Payments

Colorado	Delaware	Oregon	Rhode Island
• APCD tracks non-claims and claims-based spending	• Reported through APCD	• Utilizes APCD, which tracks Value Based Care Delivery spending • Oregon Health Authority non-claims reporting template	• All non-claims data is provided to the OHIC and analyzed annually under Total Health Care Expenditures and the Total Medical Expense

(21) General Psychiatry and Obstetrics and Gynecology

Colorado	Delaware	Oregon	Rhode Island
• Taxonomy service codes are counted if they are associated with the same building address as a primary care provider • Trying to measure services provided when the OB/GYN is really acting as a primary care provider	• They are excluded from the definition	• Including these specialties was part of the legislative process, but there has been a lot of push back for having those areas included	• They are excluded from the definition

(22) Place of Service Codes

Colorado	Delaware	Oregon	Rhode Island
• Included • Urgent care was not included or considered	• Included	• Excluded	• Excluded

Questions For Colorado Only

(1) Have all payers met the 2023 goal of offering at least one APM that includes prospective payments for advanced primary care delivery?
• Most payers have met the 2023 goal • This metric was added last year as a prospective payment flag for the data
(2) Colorado intends for future investments in primary care to be primarily directed through non-fee-for-service mechanisms.
• The yearly investment requirement has shown carriers that investment should be flowing through non-fee for service mechanisms toward activities that support practice transformation to enable providers to better deliver advanced primary care
(3) Discuss the transition approach.
• There has been encouragement and guidance towards this transition, but no hard guardrails have been implemented
(4) The PCPRC recommends implementing a target for the percentage of covered lives receiving care under an APM, starting in 2025. Explain the rationale for this approach.
• Shifting to a more facing consumer lens to reporting metrics which includes how many covered lives are impacted rather than just cost • This approach includes increased access to team base care, whole person care
(5) PCPRC recommends that increased investments support the delivery of high-quality care and that providers should be held accountable for doing so. Elaborate on the process for assessing providers' use of the increased investments funds.
• There has been an ongoing discussion regarding assessing the use of funds • There needs to be a certain amount of flexibility on both sides and taking into account the balance needed • Alignment, common targets, and how standards can be set need to be determined as well as to define what accountability means