Public Law, Chapter 244

2024 Annual Report:

Primary Care Spending

Submitted to: Senator Bailey, Representative Perry, and Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services
Commissioner Lambrew, Department of Health and Human Services

CC: Colleen McCarthy Reid, Principal Legislative Analyst
Bethany Beausang, Senior Policy Advisor, Office of Governor Mills
MQF Primary Care Advisory Group

Submitted by: Karynlee Harrington, Director Maine Quality Forum

Date: February 22, 2024

Public Law 2019, Chapter 244, requires the Maine Quality Forum to develop an annual report on primary care spending in Maine using claims data from the Maine Health Data Organization. Please find attached a copy of our fifth annual report.

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Overview

Public Law 2019, Chapter 244, *An Act to Establish Transparency in Primary Care Health Care Spending*, requires the Maine Quality Forum (MQF) to submit an annual report on primary care spending in Maine as a percentage of total spending using data from the Maine Health Data Organization (MHDO), to the Joint Standing Committee on Health Coverage, Insurance and Financial Services and the Commissioner of the Department of Health and Human Services.(Attachment A)[1]

The Maine Quality Forum (MQF) contracts with the University of Southern Maine, Muskie School of Public Service with consultation from Judy Loren and McGuire Consulting Services, for the technical support in the preparation of this report.

Primary Care Spending estimates for CY 2022 reported in MQF's fifth annual report rely on analyses of both claims payment data and non-claims-based payments and other supplemental substance use disorder (SUD) data submitted by payors to the MHDO as defined in 90-590 Chapter 243*, Uniform Reporting System for Health Care Claims Data Sets*, and 90-590 Chapter 247, *Uniform Reporting System for Non-Claims Based Payments and Other Supplemental Health Care Data Sets*.[2,3] Throughout this report, the terms "payment" and "spending" are equivalent.

As in previous reports, this report provides a comprehensive estimate of primary care payments as reported in claims, non-claims and SUD reported payments. For the claims analyses, this represents the payors' paid amount and does not include any consumers' payments (e.g., copayments, coinsurance). To have comparable estimates across payors, the categories *total primary care estimates* and the *MaineCare primary care estimates* are presented as a range. As in prior reports, this report also includes claims-only analyses of primary care spending for telehealth services based on payor paid amounts, and analyses of commercially insured consumers' cost share as a portion of total allowed amounts (payor paid amounts plus consumer cost share amounts).

Enhancements to this year's MQF Primary Care Spending Report

<u>New baseline for 2021 and 2022</u> – Due to enhancements in the claims data submission requirements, a more precise method to identify primary care services provided by facility-based primary care providers has been developed. We reset the baseline of primary care spending estimates for 2021 using our new method. MQF's definition of primary care (all services provided by primary care providers, and specific primary care services provided by OB/GYNs and facility-based providers with a primary care specialty) can be found in *Attachment C.*

<u>County-level primary care spending estimates</u> – To begin to understand geographic differences in primary care spending across the state, this report has added county-level estimates of primary care spending rates in 2022 based on the members' county of eligibility.

<u>Estimates of enrolled members' primary care utilization by payor</u> – To provide context for understanding primary care spending as it relates to member enrollment trends and utilization of primary care services, this report includes both CY 2021 and CY 2022 member enrollment data reported by payors to MHDO and the percent of members that had at least one primary care visit.

The MQF primary care spending report is separate from the report on Behavioral Health Spending in Maine required under Public Law 2021, Ch 603. However, because some primary care practitioners may provide behavioral health services there is some overlap in the estimates where these services are included in both the primary care and BH spending estimates (overlap is approximately 4% for commercial and Medicare, and 16% for MaineCare in 2022).

MQF continues to monitor other state and national efforts to measure primary care investment to better align Maine's reporting with "best practice". This year's review confirmed that there still is no standardized definition

of primary care or total medical expenditures used for states' primary care investment estimates. There is considerable variability across states in:

- Which provider specialties are included as providing primary care (e.g., inclusion of behavioral health or OB/GYN for all or a portion of the services they provide),
- Whether the state uses a broad and/or narrow definition and how each of these are defined,
- When definitions are limited to specific procedures performed by primary care provider specialties, which procedures were included,
- What data sources and methods are used (e.g., aggregate payor claims reporting versus APCD claims databases), and
- What is included/excluded in the total expenditure denominator (e.g. pharmacy) to estimate primary care investment as a percentage of total medical expenditures.[5]

Several states have measured primary care spending within the broader context of total cost of care (CA, CT, DE, MA, OR, RI).[6-11] In fact, many states are moving beyond solely measuring primary care investment and moving toward other indicators to gauge the overall health and effectiveness of the primary care system. For example, several states are measuring primary care workforce capacity, access to and quality of care, and equity in primary care (e.g., CA, MA, RI, VT, WA).[6,9,11-13]

The variability in definitions and context across states limits the ability for states to compare and benchmark with one another. See *Attachment B* for a more detailed summary of state differences.

Primary Care Spending in Maine

Part I: Primary Care Spending Reported to MHDO (Claims, Non-Claims and Supplemental Data) and Geographic Primary Care Spending Variation

The Primary Care Spending estimates for calendar years 2021-2022 shown in Table 1 and Chart 1 of this report reflect the percent of payor payments reported to MHDO including claims, non-claims, and supplemental data per the requirements in 90-590 Chapter 243, *Uniform Reporting System for Health Care Claims Data Sets*, and non-claims-based payments and supplemental data as defined in Chapter 247, *Uniform Reporting System for Non-Claims Based Payments, and Other Supplemental Health Care Data Sets.*

The spending estimates are based on MQF's definition of Primary Care, which includes all services (except inpatient hospital services and services provided in an emergency department) for providers with one of the following primary taxonomy specialty codes. (See *Attachment C for the complete list*)

- Family Medicine (including subspecialties of Geriatric, Adult and Adolescent medicine)
- Internal Medicine
- General Medicine
- Pediatrics (including adolescent medicine)
- Geriatric medicine
- Naturopathic/homeopathic medicine
- Physician assistants*

* Some physician assistants and nurse practitioners with a primary care taxonomy but working with specialists may be included in the primary care estimate because they could not be separately identified in claims.

- Nurse practitioners (family, pediatrics, primary care, general medicine, adult health, and gerontology)
- Federally Qualified Health Centers (FQHCs) or Rural health centers (RHCs)
- Preventive medicine

For obstetrics and gynecology (including Nurse Practitioners) providers and attending providers in a hospital setting with any of the above primary care specialties, we only include selected primary care services (See *Attachment D* for the list of services included in these circumstances).

In reviewing data in this report and estimates in Chart 1 and Table 1, note the following caveats:

- Estimates are based on claims and non-claims data reported to MHDO, which include all of MaineCare and Medicare (includes both Medicare Advantage and Original Medicare) members and approximately 73 percent of commercially insured members.

- Commercial/ SEHC/MEABT Substance use disorder (SUD) data reported by commercial payors per the requirements in 90-590 Chapter 247 do not differentiate the portion paid to primary care and non-primary care. We estimated the portion of SUD paid to primary care based on a limited claims sample.

- MaineCare Non-claims and SUD data reported by MaineCare per the requirements in 90-590 Chapter 247 include payments for long term services and supports (LTSS). To have estimates comparable to other payors, we removed an estimated portion of MaineCare non-claims and SUD reported payments that may have been for LTSS, which were estimated as a range. Similar to commercial payors, we estimated the portion of SUD paid to primary care based on a limited MaineCare claims sample and show as a range. For a listing of what services are LTSS see *Attachment C* Table 5.

- Medicare estimates include both Original Medicare and Medicare Advantage payments. Original Medicare is not subject to 90-590 Chapter 243 and 247 requirements. Reported non-claims and SUD payments for Medicare only reflect those reported by Medicare Advantage plans.

- Absolute $s All payments shown in Table 1 are presented in millions (M) and billions (B). For example, $500,000,000 equals $500 (M) million dollars; $2,500,000,000 equals $2.5 (B) billion dollars.

2021 and 2022 New Baseline Primary Care Spending Estimates

- Based on claims, non-claims, and supplemental SUD data submitted to MHDO for calendar year 2022, the primary care percentage of total reported health care payments was **9.1% - 9.5%** across payors - **7.9% for commercial payors, 10.1 - 11.2% for MaineCare, and 9.3% for Medicare.**

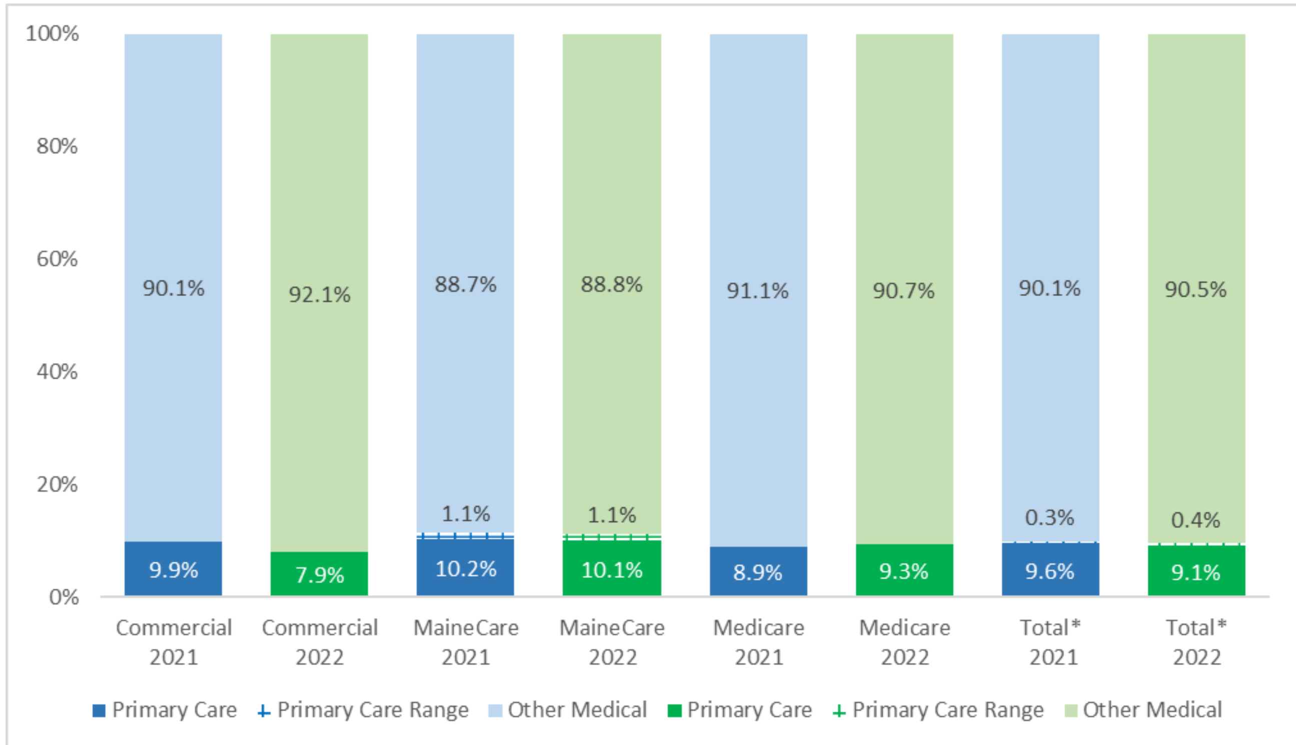
- Compared to 2021, MaineCare spent a similar percentage of total medical payments on primary care, while Medicare increased slightly, and commercial payors' percentage spent on primary care declined from 9.9% in 2021 to 7.9% in 2022.

- Year- to- year differences in reported commercially insured primary care spending levels relative to total medical spending may be due to changes in commercial enrollment and/or changes in the health needs of the insured members (e.g. see Table 2 for changes in member enrollment and primary care utilization). Further research is required to identify the reasons for the factors leading to the apparent decline.

- Total non-claims-based payments reported to MHDO for all payor categories in CY 2022 were $698 - $784M ($640 - $726M for MaineCare, $24M for Medicare Advantage, and $34M for commercial payors), which increased by 14% from total non-claims in 2021 ($614 - $690). Of these 2022 total non-claims-based payments, primary care-related payments represented $17M or 49.7% of total non-claims payments for commercial payors (down from 55% in 2021) and $45M or 6.1 - 7.0% of MaineCare's total non-claims (down from 7.4% - 8.4% in 2021).

- The total non-claims aggregate payments for substance use disorder (SUD) reported to MHDO for CY 2022 was $76M by commercial payors (up from $64M in 2021) and $189-$213M by MaineCare[†] (up from $165 - $186M in 2021. The estimated portion of SUD payments that were for primary care also increased for both commercial payors ($4M in 2022 up from $3M in 2021) and MaineCare ($19 - $33M in 2022 up from $17 - $29M).

Chart 1. Estimated Primary Care Payments as a Percentage of Total Payments by Payor, 2021-2022



* Total (Commercial, MaineCare, Medicare)

Data Source: MHDO 2021-2022 APCD claims data, SUD redacted data, non-claims-based payments.

[†] Excludes estimated LTSS payments

Table 1. Medical and Primary Care Payments and Percent Primary Care Spending (Claims, Non-Claims, SUD payments), CY 2021-2022

Payor Category	2021‡			2022		
	Total Dollars (M millions B billions)	Primary Care (M millions)	% Primary Care	Total Dollars (M millions B billions)	Primary Care (M millions)	% Primary Care
Commercial						
Claims	$1.98B	$182M	9.2%	$2.02B	$149M	7.4%
Non-claims	$40M	$22M	55.0%	$34M	$17M	49.7%
SUD	$64M	$3*M	5.0%*	$76M	$4*M	5.0%*
Total	$2.09B	$207M	9.9%	$2.13B	$170M	7.9%
MaineCare						
Claims	$1.30B	$153M	11.8%	$1.33B	$165M	12.4%
Non-claims	$573 - $649^M	$48M	7.4% - 8.4%^	$640-$726^M	$45M	6.1%-7.0%
SUD	$165 - $186^M	$17 - $29*M	8.9% - 17.5%^*	$189-$213^M	$19-$33*M	8.9%-17.5%^*
Total	$2.03 - $2.13B	$218 - $231M	10.2% - 11.3%	$2.16-$2.26B	$228-$242M	10.1%-11.2%
Medicare (Original and Medicare Advantage)**						
Claims	$3.15B	$278M	8.8%	$3.24B	$296M	9.2%
Non-claims ***	$1M	$1M	100.0%	$24M	$7M	29.7%
SUD^^	$19M	$0.94M	5.0%	$24M	$1M	5.0%
Total	$3.17B	$281M	8.9%	$3.29B	$305M	9.3%
SEHC						
Claims	$162M	$15M	9.4%	$155M	$11M	7.1%
Non-claims	$1M	$1M	98.5%	$2M	$2M	98.0%
SUD	$5M	$0.24*M	5.0%*	$6M	$0.29*M	5.0%*
Total	$168M	$17M	10.0%	$162M	$13M	7.9%
MEABT						
Claims	$320M	$34M	10.5%	$323M	$25M	7.6%
Non-claims	$3M	$3M	98.5%	$3M	$2M	65.2%
SUD	$9M	$0.44*M	5.0%*	$11M	$0.54*M	5.0%*
Total	$332M	$38M	11.3%	$337M	$27M	8.1%
Total (Commercial, MaineCare, Medicare) §						
Claims	$6.43B	$613M	9.5%	$6.59B	$610M	9.3%
Non-claims	$614-$690M	$71M	10.3%-11.6%	$698-$784M	$69M	8.7%-9.8%
SUD	$248-$269M	$21-$33M	7.7%-13.3%	$289-$313M	$24-$38M	7.6%-13.2%
Total	$7.29-$7.39B	$706-$718M	9.6%-9.9%	$7.58-$7.69B	$703-$717M	9.1%-9.5%

Data Source: MHDO 2021-2022 APCD claims data, SUD redacted data, non-claims-based payments.

‡ Changes in reported values for 2021 from last year's report result from updates to historical data and increased granularity in the fields identifying the provider of services on a claim.

* Total SUD data reported by commercial payors and MaineCare per current Chapter 247 requirements did not separate the portions paid to primary care and non-primary care. The estimated portion of SUD paid to primary care was derived based on a limited claims sample.

^ The total non-claims and SUD data reported by MaineCare per current Chapter 247 requirements include payments for long term services and supports (LTSS). To have estimates comparable to other payors, we removed an estimated portion of MaineCare total non-claims and SUD reported payments that may have been for LTSS. Both were estimated as a range.

**Medicare includes both original and Medicare Advantage claims payments. Original Medicare is not subject to requirements in Chapter 247, thus MHDO does not have non-claims-based payments for original Medicare, only for Medicare Advantage plans.

***Medicare non-claims estimated ranges are based on Medicare Advantage Plan data reported to MHDO.

^^SUD redacted claims shown are for Medicare Advantage Plans that reported to MHDO.

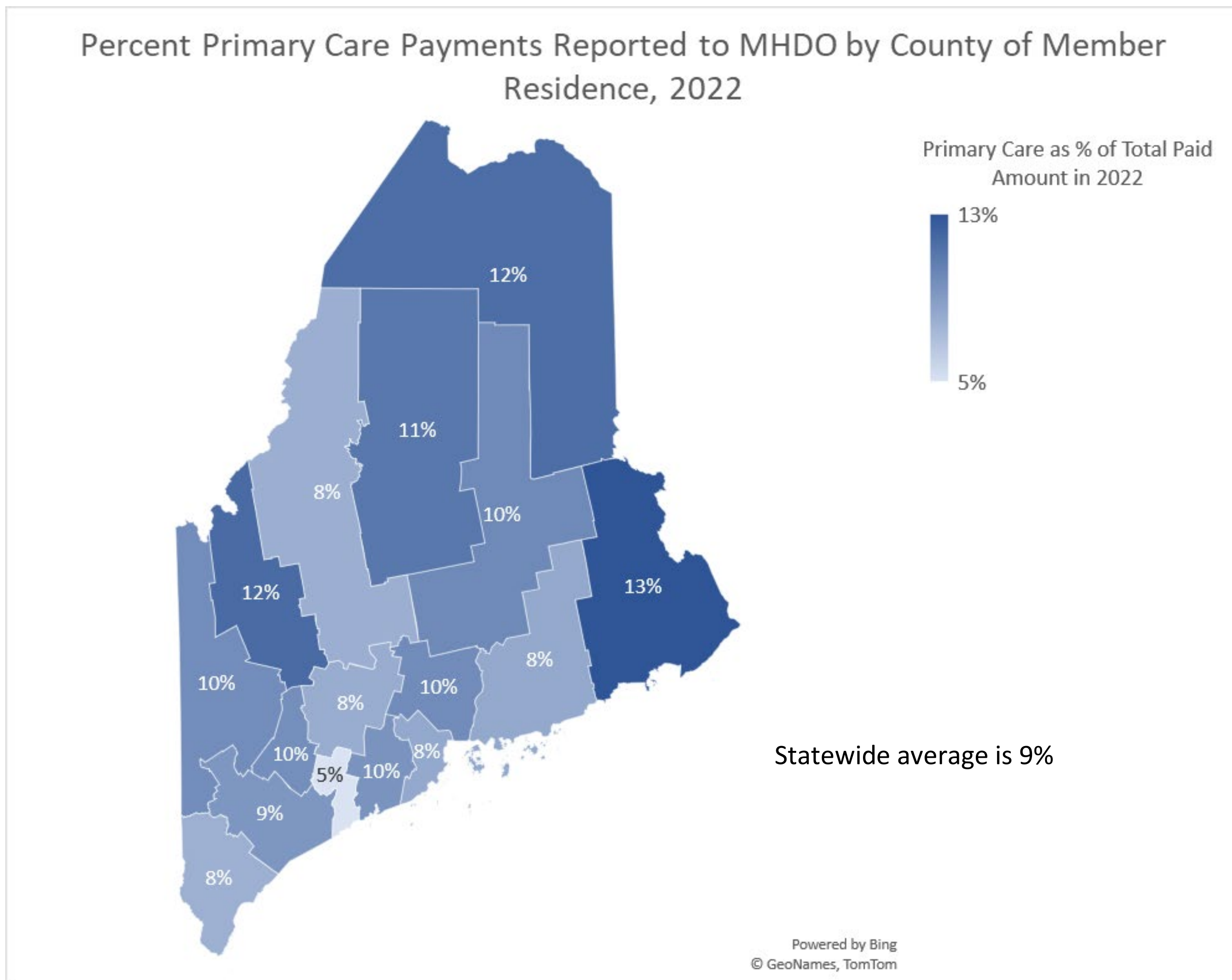
§ Totals reflect the sum of the payors reporting data to MHDO, which includes all public payors and the majority of commercial payors, but do not reflect total primary care and healthcare spending in the state.

Geographic Variation in Primary Care Spending Estimates

The estimated percent of primary care spending by members' county of residence varies ranging from a low of 5% in Sagadahoc County to 13% in Washington County (Figure 1), compared to the statewide average of 9%.

Many rural counties (e.g., Washington, Aroostook, Franklin, Piscataquis) had higher rates of primary care spending as a percent of total medical spending compared to other more populated counties. This may be due to differences in county demographics (e.g., age, gender, health status) that could affect need for and use of both primary care and non-primary care services, rural counties having less access to specialty and tertiary care and therefore less spending on non-primary care medical services (denominator), and/or greater reliance on FQHCs and RHCs for both primary and specialty care (numerator).

Figure 1.



Data Source: MHDO 2022 APCD claims data

Part II: Utilization of Primary Care Services

Various factors contribute to the primary care spending estimates reported including changes in the insured population and the use of primary care services.

Several studies have identified access to and continuity of primary care as a high-value opportunity to improve health outcomes while reducing total health care expenditures. Many public and private payors have pursued value-based insurance designs that promote greater use of primary care to improve early detection, disease prevention and chronic disease management to reduce unnecessary specialist care, hospitalizations and emergency department visits.[14,15] However, despite efforts to promote greater use of primary care, national data suggests a decline in primary care visits among insured persons.[16]

To begin to assess changes in primary care utilization by insured persons in Maine, new this year, we analyzed the proportion of insured members who accessed primary care (defined as having at least one claim with a service date in 2021 or 2022 to a primary care provider, as identified by our list of taxonomy codes) using newly available unique member IDs in MHDO APCD data to identify the same person across payors. The number of enrolled members by payor includes any member that had full medical insurance coverage for any month in 2021 or 2022, regardless of the number of months of eligibility. As some Maine residents may have been fully covered by more than one insurance plan (i.e., the dually-eligible or commercial Medicare Supplement plans), members enrolled at any month of the year may be duplicated across payors.

Table 2 shows the total enrolled members by payor and the percentage that had at least one primary care claim in 2021 and 2022. Consistent with regional and national trends,[17-20] between 2021 and 2022, the commercially-insured enrollment reported to MHDO declined by approximately 4% or 16,354 members, while the number of MaineCare eligible members increased by 8% or 27,351 members likely due to the federally mandated Medicaid continuous coverage requirement during the COVID-19 public health emergency and other MaineCare benefit expansions. Medicare eligible members remained constant. Declines in commercial enrollment are consistent with regional trends and may contribute to declines in total and primary care commercial payments (see Table 1).

Nearly three quarters of people with commercial insurance used primary care in both 2021 (75%) and 2022 (74%). A similar percentage of Medicare members used primary care, decreasing slightly from 77% in 2021 to 75% in 2022. Almost two thirds of MaineCare members used primary care in 2021 (68%) which declined slightly in 2022 (65%).

Table 2. Percent of Insured Members with Primary Care Claims by Payor, 2021-2022

	2021			2022		
Payor	**Members with a Primary Care Claim**	**Enrolled Members**	**% Members Utilizing Primary Care**	**Members with a Primary Care Claim**	**Enrolled Members**	**% Members Utilizing Primary Care**
Commercial	333,149	441,324	75%	314,606	424,970	74%
MaineCare	242,506	356,729	68%	248,539	384,080	65%
Medicare	318,397	414,510	77%	312,412	414,456	75%

Data Source: MHDO 2021 and 2022 APCD claims data

* Members may be counted in more than one payor category because they may be enrolled in multiple payors (approximately 10% of members in MHDO's data) or they could change payors during the year.

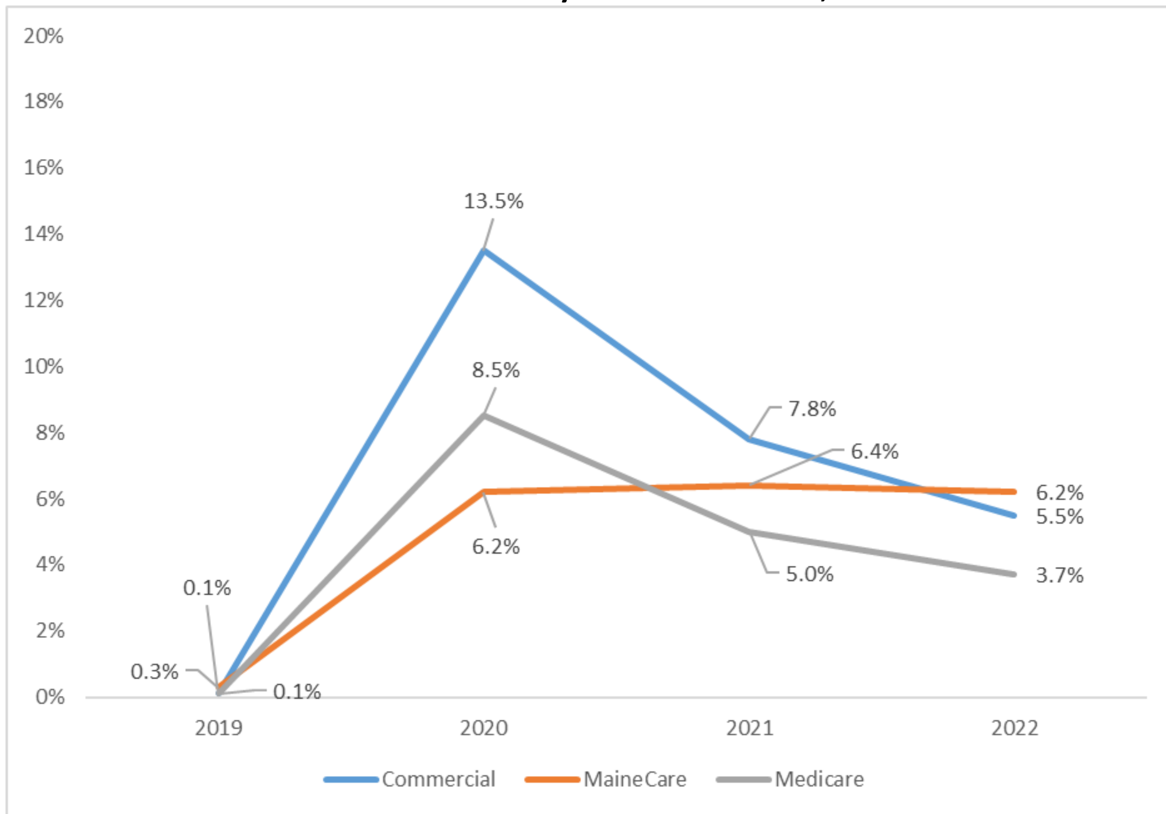
Part III: Telehealth and Consumer Cost Share Claims Analysis

Telehealth Claims Analysis

For the purposes of this report, we have defined telehealth broadly to encompass telecommunication technologies to provider health service from a distance including video/audio conferencing from a patient's home or medical office/facility, remote patient monitoring, and provider communications/E-consults. See Appendix D for the full list of telehealth procedure codes included. As shown in Chart 2, prior to 2020, telehealth accounted for less than 1% of primary care payments reported to MHDO for all payors but increased in 2020, accounting for 6.2% to 13.5% of primary care payments reported to MHDO across payors, with commercial payors seeing the largest increase in primary care provided via telehealth. As noted in prior reports, the increase in payments for telehealth was likely due to telehealth payment leniencies by Medicare, Medicaid, and commercial payors to ensure greater access to care during the COVID-19 pandemic.[‡]

In 2022, the percent of primary care payments for services delivered via telehealth as reported in MHDO claims data fell to half of what it had been in 2020 for commercial payors and Medicare but was comparable for MaineCare. Declines in commercial and Medicare telehealth use within primary care in 2021 and 2022 are consistent with national trends and are likely associated with not extending some COVID telehealth payment policies after the end of the public health emergency (PHE). MaineCare's comparable telehealth payment rates are likely due to MaineCare maintaining most of these flexibilities in telehealth coverage post-PHE.[21-25]

Chart 2. Telehealth as a Percent of Primary Care Paid Amount, 2019-2022



Data Source: 2019-2022 MHDO APCD claims data

‡ Prior to COVID-19, Medicare and most payors did not cover telehealth modality except in rural areas and for specific services and providers under certain conditions. MaineCare had much more comprehensive telehealth coverage but still had restrictions (e.g., in-person visit first, and audio only limits). At the start of the pandemic, Medicare and MaineCare basically extended telehealth coverage for all services, all providers, waiver consents/HIPAA requirements. Insurance rules in Maine were also modified to require commercial payors to cover telehealth and reimburse at the same rate as in-person.

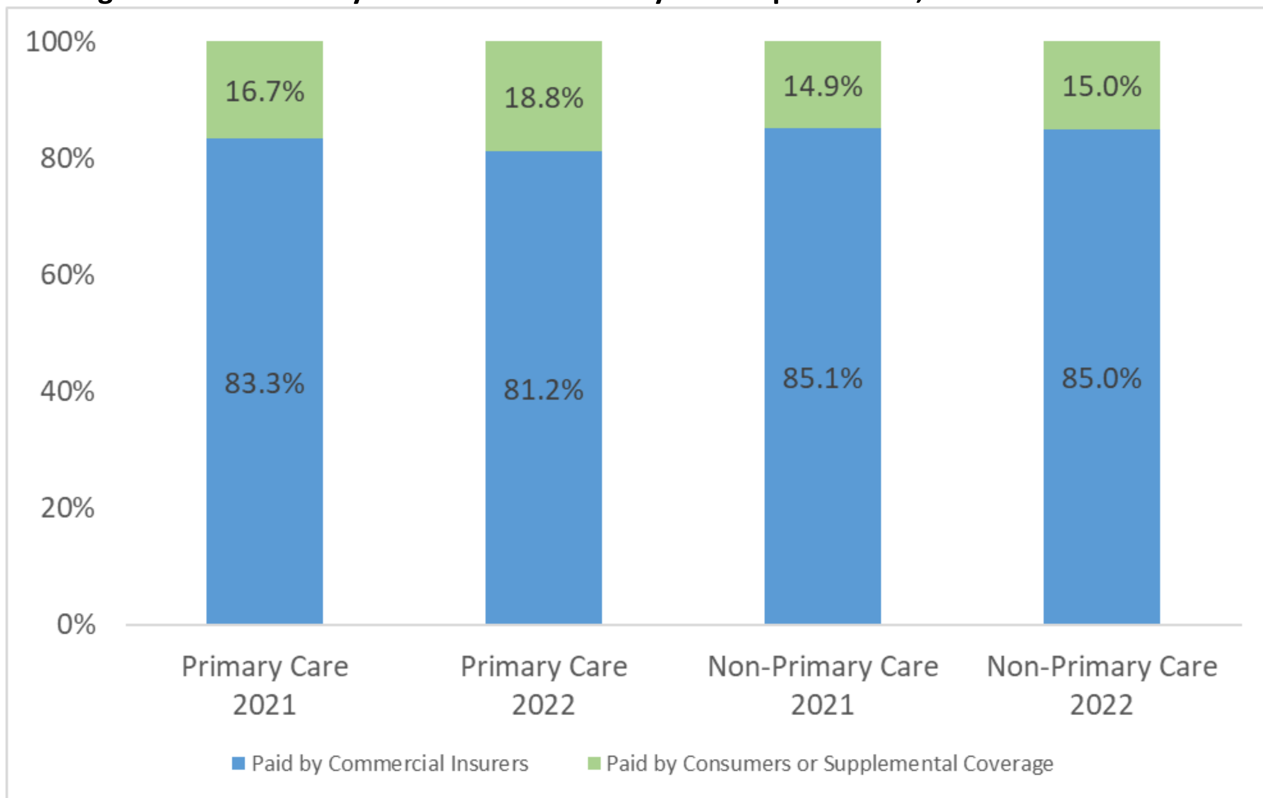
Commercial Payors Share and Consumer Payments for Primary Care and All Other Medical Expenditure

Chart 3 reflects how claims payments for primary and non-primary care medical expenditures reported in MHDO claims data are shared between commercial plans and the consumer (including consumer's supplemental coverage). This analysis is based on commercially insured consumer's cost share as a portion of total allowed amounts (payor paid amounts plus consumer cost share amounts).

Key Findings:

- In 2022, commercial insurance payor paid approximately 81% of the primary care claims payments, while approximately 19% was paid out-of-pocket by consumers (or their supplemental coverage), which was higher than commercially insured consumers cost share for non-primary care (15%).
- The percentage of primary care payments paid by commercially insured consumers (or supplemental coverage plans) increased from 16.7% in 2021 to 18.8% in 2022.

Chart 3. Percentage of Total Payments Paid by Commercial Payors and Consumers or Supplemental Coverage Plans for Primary Care and Non-Primary Care Expenditures, 2021-2022



Data Source: 2021-2022 MHDO APCD claims data

Conclusion and Future Considerations

The ongoing data improvements made to 90-590 Chapter 247, *Uniform Reporting System for Non-Claims Based Payments and Other Supplemental Health Care Data Sets,* adopted by the MHDO board of directors has allowed MQF to produce a comprehensive report of primary care spending in Maine to include both claims and non-claims-based spending, which we first presented as a new baseline in last year's annual report and have updated in this year's report. While we used similar definitions and methods in this report, new data reported identifying attending providers working within facilities has allowed us to refine and more accurately include primary care services delivered by primary care providers in these settings that was not previously possible.

As in last year's report, primary care estimates of aggregate substance use disorder (SUD payments) are presented as a range as SUD data reported by commercial payors in the most current Chapter 247 data do not differentiate the portion of the SUD data paid to primary care and non-primary care providers. MHDO's board of directors recently adopted changes to Chapter 247, which include our recommendation to require payors to report total non-claims-based payments and supplemental SUD payments separately for primary care and behavioral health care as well as in total. This change goes into effect with the payors reporting in January 2025, which will further improve the accuracy of estimates in the future.

The primary care spending estimates in this report are based on the data currently available through the Maine Health Data Organization (which represents approximately 90% of the insured population), and our definition of primary care. Based on feedback from a few members of the MQF Primary Care Spending Advisory Committee, we may want to consider some refinements to our definition of primary care in our next annual report if supported by the claims data. For example, since we define primary care based on provider taxonomy and procedure codes, non-facility, professional payments could include Nurse Practitioners (NP) and Physician Assistants (PA) with a primary care taxonomy who work in a specialist office. We may want to exclude these NPs and PAs from our primary care spending estimates. To do that we need additional data elements in the MHDO claims data. We will discuss how best to approach this issue with the Maine Health Data Organization, and the change in our definition of primary care with the advisory committee for future reporting.

In CY 2022, there was a decline in primary care spending as a percent of total spending overall and particularly for commercial payors. Primary care spending as a percent of total spending is strongly affected by changes in both primary care and non-primary care utilization and spending. Various factors may be contributing to changes in primary and non-primary care spending including but not limited to improvements in the data allowing greater precision in identifying primary care and non-primary care providers and services, changes in provider reimbursement or billing practices, service price and intensity, or changes in enrollment, service use, demographics (i.e., age, gender, rural/urban residence), and disease prevalence among insured members. Further research is needed to understand the reason for this decline.

As noted in our environmental scan, many states are moving beyond solely measuring primary care investment and toward other methods for gauging the overall health and effectiveness of the primary care system. For example, several states are measuring primary care workforce capacity, access, quality of care, and equity in primary care (e.g., CA, MA, RI, VT, WA).[6,9,11-13]

This report provides some general insight into member enrollment, primary care utilization, and county variations in primary care spending. How these factors might contribute to shifts in primary care spending or total spending requires further research and analysis.

We welcome the opportunity to discuss shifting the direction of our annual primary care spending reports to better support policy discussions specific to primary care in the state of Maine.

Attachments: Supporting Documentation

A. **Public Law Chapter 244**
B. **Overview of Primary Care Definitions Used in Other States**
C. **Methodology for Estimating Primary Care Spending**
D. **Primary Care Provider Taxonomy Codes, Procedure Codes for OB/GYN and Attending Providers, and Telehealth Codes in Primary Care Spending Analyses**
E. **Endnotes**

Attachment A – Public Law Chapter 244

APPROVED	CHAPTER
JUNE 7, 2019	244
BY GOVERNOR	PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND NINETEEN

S.P. 421 - L.D. 1353

An Act To Establish Transparency in Primary Health Care Spending

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §6903, sub-§13-B is enacted to read:

13-B. Primary care. "Primary care" means regular check-ups, wellness and general health care provided by a provider with whom a patient has initial contact for a health issue, not including an urgent care or emergency health issue, and by whom the patient may be referred to a specialist.

Sec. 2. 24-A MRSA §6951, sub-§12 is enacted to read:

12. Primary care reporting. Beginning January 15, 2020 and annually thereafter, the forum shall submit to the Department of Health and Human Services and the joint standing committee of the Legislature having jurisdiction over health coverage and health insurance matters a report on primary care spending using claims data from the Maine Health Data Organization and information on the methods used to reimburse primary care providers requested annually from payors, as defined in Title 22, section 8702, subsection 8. The report must include:

A. Of their respective total medical expenditures, the percentage paid for primary care by commercial insurers, the MaineCare program, Medicare, the organization that administers health insurance for state employees and the Maine Education Association benefits trust and the average percentage of total medical expenditures paid for primary care across all payors; and

B. The methods used by commercial insurers, the MaineCare program, Medicare, the organization that administers health insurance for state employees and the Maine Education Association benefits trust to pay for primary care.

Sec. 3. Maine Quality Forum to conduct health spending reporting study. The Maine Quality Forum, established in the Maine Revised Statutes, Title 24-A, section 6951, shall consult with other state and national agencies and organizations to determine the best practices for reporting spending on primary care services by insurers. For

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purposes of this section, "primary care" means regular check-ups, wellness and general health care provided by a health care provider with whom a patient has initial contact for a health issue, not including an urgent care or emergency health issue, and by whom the patient may be referred to a specialist.

Attachment B – Overview of Primary Care Definitions used in Other States

	Data Source	Definition	PC Spend Percentage	PC Spend Target	Other Measures
CA[6]	Integrated Healthcare Association (IHA) data set. (commercially insured adults)	All services provided by pediatricians, internists, GPs, family practitioners, NPs, and PAs with a PC focus. For practitioners with a hospice and palliative care, community health, or school health focus, only certain primary care–oriented services were included.	Primary care (PC) spending percentage averaged 7.5%, with a range from 3.5% to 12.7%. (2018, commercial)	New legislation will set spending benchmarks for PC and BH	Performance measures (clinical quality composite score, overall patient experience, adjusted acute ED utilization, and adjusted total cost of care).
CT[7]	Payors submit total medical expenses data which include claims and non-claims payments	Definition built on NESCSO; narrow definition (specific codes and providers)	PC spend statewide was 5.1% in 2021, meeting target of 5.0% (analysis excluded Medicare FFS).	2022 target: 5.3%	THCE and TME (compared to benchmarks)
DE[8]	Insurance carriers complete the Affordability Standards Data Submission (ASDS) Excel template.	PC services performed by primary care providers in primary care places of service. All three criteria must be met.	2023 projections show 7% primary care investment for total medical spend.	The required level of investment increases by 1.5% annually until reaching 11.5% in 2025.	Total medical spending, providers participating in care transformation activities.
MA[9]	Primary Care and Behavioral Health expenditure data submitted by payors to CHIA. Non-Claims payments made for incentive programs, capitation, risk settlements, care management related to the provision of primary care services.	PC defined using a list of procedure codes delivered by specific provider types deemed primary care.	PC spending for 2020 ranged from 4.6% (Medicare Advantage) – 7.3% (commercial).	Legislation introduced/ under consideration in 2023 would establish a multistakeholder Primary Care Board with a goal of increasing primary care spend to 12-15% of overall health care expenditures.	Health care cost growth benchmark, capacity of the pc workforce and pipeline, metrics focused on access and quality of care, assessing equity in the system.
OR[10]	All Payer All Claims (APAC) Data and non-claims-based payments are gathered from a reporting template completed by carriers and CCOs.	Specific primary care provider organizations, provider types, procedure codes and service types.	Commercial: 12.5%; Medicaid CCO: 11.1%; Medicare Advantage: 9.7%; PEBB/OEBB: 13.0% (2021)	12% by 2023	Total cost of care (THCE and TME)
RI[26]	2x per year, payors submit PC spending and total medical expenses (TME), excluding long-term care, using Excel templates.	Services must be performed by a PC provider delivering care at a PC site of care in order for spending to be included in OHIC's primary care spend obligation. Included provider taxonomy and payment codes are based on the NESCSO 2020 definition.	4.8% (2021, commercial, claims-only)[27]	Affordability Standards, effective June 2020, directed commercial payors to annually spend at least 10.7% of their total medical expenses on primary care.	Total Health Care Expenditures (THCE), 9 ACO core measures that address three domains (chronic illness, BH, and preventative care), payor and provider (ACOs) performance compared to cost growth targets (overall costs not PC).

	Data Source	Definition	PC Spend Percentage	PC Spend Target	Other Measures
UT[28]	Utah APCD, Non-claims excluded.	Measured in two different ways (based on MQF 2020 report): • All services performed by primary care providers (broad measure). • Specific primary care services performed by primary care providers (narrow measure).	Narrow: 5.2 – 12.3%, Broad: 8.1% - 17.1% (2021 data, included CHIP, commercial, Medicaid, Medicare Part C, and combined)	No	PC spend by age groups; hospitalizations and ED visits
VA[29]	VHI 2021 All Payer Claims Database (commercial, Medicare, Medicaid)	a four-quadrant approach to define primary care based on provider type and services	Reporting both narrow and broad definitions (3.1 – 5.7%)	No	PMPM expenditures by type of service, total cost of care, regional variation in spending. Will be partnering with Robert Graham Center at AAFP to pilot a NASEM-based PC accountability scorecard.
VT[12]	Claims and non-claims	From 2020 report: PC taxonomies and CPT codes for primary care services.	5.9% (2018, claims-based only and excludes OB/GYN and BH), 1.8% non-claims PCP spending.	No	Total cost of care, primary care access.
WA[13]	All-Payer Claim Database Data collection methods may have captured some non-claims-based expenditures.	For the 2019 report that measured PC expenditures, a narrow and broad definition of providers and services was created.	4.4 – 5.6% (2018, narrow and broad)	No	Total cost of care by county, access to care
Freedman Healthcare LLC (Condon, et al. 2022)[5]	• Recommends having a common definition. • 11 states, plus two multi-state reports are cited.	Various	Percentage of health care dollars invested in PC ranged from 4.2% to 13.9%	Recommended	NA

Attachment C – Methodology for Estimating Primary Care Spending and Use by Enrolled Members

To determine the percentage of total healthcare payor payments that are for primary care in Maine, we used the Maine Health Data Organization's (MHDO) all-payer claims data (APCD) for claims-based payments, and Chapter 247 information collected from payors about payments made outside of claims (non-claims-based payments) as well as information about claims that were redacted before submission to the MHDO due to SUD-related codes (SUD redacted). The following describes the methods used to estimate primary care spending for these data sources.

Primary Care Definition: claims, non-claims and supplemental data

As in prior MQF reports, primary care definitions are based on:

- Language in P.L. Chapter 244, Sec. 2. 24-A MRSA §6903, sub-§13-B,
- Methods and definitions used in the prior annual reports and recommendations for future reporting,
- Consultation with the MQF Primary Care Spending Advisory Committee on proposed changes to Maine's definitions.

For the first annual report, MQF sent a questionnaire to Maine's six largest payors asking how they define primary care, whether they offer non-claims payments or incentives for primary care and whether they track these payments to inform potential future non-claims reporting to the state. We vetted other national and state definitions and those reported by Maine payors with the MQF Primary Care Spending Advisory Committee.

Given the lack of a standard primary care definition, MQF previously reported a range of primary care spending estimates using narrow and broad definitions, using taxonomy codes for primary care providers and specific procedure codes for primary care services identified from the environmental scan and/or where at least one payor identified them in its definition on the Maine payor survey. With the inclusion of non-claims data that lacked the specificity of claims for the narrow definition, MQF's 4th annual report only reported based on the broad definition, which included all services delivered by provider specialties in Attachment D excluding services delivered by these specialties in an inpatient or emergency department setting, as required by Chapter 244 and a specific set of primary care services provided by OB/GYN specialties.

For this 5th annual report, we used the same definitions with the exception that, due to improved provider-level data reported to MHDO (i.e. attending provider fields on facility claims)), we modified our method for facility-based primary care to include specific primary care services delivered by attending providers with a primary care taxonomy/specialty, similar to the method used for OB/GYN providers. As this is a modified definition based on newly available attending provider fields not previously available on facility-based claims, results will differ from prior MQF reports and should not be compared. As specialty information on claims is evolving and improving over time there is a degree of uncertainty in all estimates and reported figures should be viewed as estimates rather than pinpoint calculations.

Table 4. Primary Care Providers

Family medicine (including subspecialties of Geriatric, Adult, and Adolescent)	Physician assistants[§]
Internal medicine	Nurse practitioners (family, pediatrics, primary care, general medicine, adult health, gerontology)
General medicine	Federally Qualified Health Centers (FQHCs)[**]
Pediatrics (including adolescent medicine)	Rural health centers
Geriatric medicine	Preventive medicine
Naturopathic/homeopathic medicine	Obstetrics and gynecology (includes NP) – **only for selected primary care services**

The list of procedure codes included in the definition of primary care when delivered by an OB/GYN specialty and by primary care specialties acting as attending providers on facility claims is the same as prior years and can be found in *Attachment D*. Generally, they include:

- Office visits (includes Medicare/Medicaid clinic visits)
- Home visits
- Preventive Visits
- Immunizations and injections
- Transitional Care Management
- Chronic Care Management
- Telehealth Services

For claims analyses, as in previous reports, we also separately analyzed primary care services delivered via telehealth, the percentage of consumer or supplemental payor cost share and payor paid amount relative to total primary care and medical care claim payments. Specific codes used to identify services delivered via telehealth are included in *Attachment D*.

Understanding consumer cost-sharing is relevant in reporting total payments for primary care services. The challenge in measuring consumer cost sharing in all-payer claims data is that the amount that the primary claims processor assigns to the consumer may be paid by additional benefits the consumer has, such as a supplemental plan or membership in two primary plans. This kind of overlap is likely to be particularly large for the population covered by both Medicare and MaineCare, also known as the dually eligible, where MaineCare covers most or all of the members' Medicare out of pocket expenses. As entered in the APCD, the primary claim shows any amount owed to the provider that the plan does not cover as a consumer expense. Secondary processing may show those same amounts paid by another plan on a separate claim making it difficult to isolate which

[§] Some physician assistants working with specialists may be included in the primary care estimate because they could not be separately identified in claims.

[**] While other states have included behavioral health and psychiatry within their list of primary care providers, based on the guidance of the MQF Advisory Committee, behavioral health providers are not included in MQF's definition of primary care providers for the purposes of estimating primary care spending. However, due to the lack of rendering or servicing provider identification on FQHCs' claims, FQHC estimates may also include behavioral health providers integrated in the FQHC primary care practice model. Given differences in FQHC billing for MaineCare and commercial payors, we were unable to consistently separate/exclude FQHC behavioral health services from primary care services in claims.

payments come out of patients' pockets. Since Medicare and MaineCare eligible beneficiaries are more likely to have supplemental policies, we focused our consumer cost-sharing analysis on commercial claims only.

After the third annual primary care spending report was submitted, legislation was passed requiring a similar report on Behavioral Health Spending in Maine (Public Law 2021, Ch 603).[4] The primary care spending and the behavioral health care spending reports will be separate reports. Note that some services provided by a primary care provider as defined by our list of taxonomy codes and/or service codes also have a primary diagnosis of Behavioral Health and therefore will be part of both calculations. In 2022, four percent of commercial and Medicare primary care payments had a behavioral health primary diagnosis. The overlap between primary care and behavioral health is higher for MaineCare where 16% of MaineCare primary care payments were for a behavioral health primary diagnosis.

Claims Data Source and Method

Information for calendar years 2021-2022 from Maine's APCD maintained by the MHDO was used to calculate the claims-based portion of overall Primary Care spending and for telehealth and consumer cost-share analyses.

The Maine APCD contains claims and enrollment information for commercial insurance carriers, third party administrators, pharmacy benefit managers, dental benefit administrators, MaineCare, and Medicare.[††] Only medical claims (not dental or pharmacy) were included in the total for this study.

The submission of claims data to the MHDO is governed under the terms and conditions defined in 90-590 CMR Chapter 243, Uniform Reporting System for Health Care Claims Data Sets.

As defined in 90-590 CMR Chapter 243, MHDO's APCD does not include claims information from:

- Claims processors with less than $2 million per calendar year of Maine adjusted premiums or claims processed[‡‡];
- Claims for health care policies issued for specific diseases, accident, injury, hospital indemnity, disability, long-term care, vision [§§], coverage of durable medical equipment;
- Claims related to Medicare supplemental [***], and Tricare supplemental; and
- Claims for workplace injuries covered by worker's compensation insurance.

The self-funded ERISA plans in Maine are exempt from the state mandate to submit information to the MHDO due to a Supreme Court ruling[†††], but many of the largest self-funded ERISA plans in the State voluntarily submit claims data to the MHDO.

Additionally, the APCD does not include information about Mainers who are uninsured or any health care that is not covered by insurance.

[††] Medicare Advantage plans and regular fee-for-service Medicare are included.
[‡‡] With the exception of self-funded ERISA plans which are not required to report but may voluntarily submit their data. *Gobeille v. Liberty Mutual Insurance Company*, US Supreme Court Decision that Employee Retirement Income Security Act (ERISA) standards preempt state reporting requirements.
[§§] Quality review of the data has identified the submission of some of these types of plans. We have deleted these from this analysis.
[***] Quality review of the data has identified the submission of some of these types of plans. We have deleted these from this analysis.
[†††] *Gobeille v. Liberty Mutual Insurance Company*, US Supreme Court Decision that Employee Retirement Income Security Act (ERISA) standards preempt state reporting requirements.

Maine's APCD is a large representative sample of data as it includes claims data for approximately 90% of Maine's insured population including 100% of Medicare and MaineCare claims for Maine members and approximately 70% of the commercially insured population in Maine.

This study used medical claims (CY 2021-2022), excluding dental and pharmacy claims. Additionally, for MaineCare total payments, long-term services and support (LTSS) are excluded based on an estimate of the percentage of total costs these services represent in each year. The MaineCare LTSS estimate used for this report aligns with the Office of MaineCare Services (OMS) definition of long-term services and supports used in their alternative payment methodology (APM). LTSS estimates were based on payments associated with the policy sections from the MaineCare Benefits Manual (MBM) noted in Table 5.[30]

Table 5. MaineCare LTSS Policy Sections

Section	Title
2	Adult Family Care Services
12	Consumer Directed Attendant Services
18	Home and Community-Based Services (HCBS) for Adults with Brain Injury
19	Home and Community Benefits (HCBS) for the Elderly and Adults with Disabilities
20	Home and Community Based Services (HCBS) for Adults with Other Related Conditions
21	Home and Community Benefits (HCBS) for Members with Intellectual Disabilities or Autism Spectrum Disorder
26	Day Health Services
29	Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder
40	Home Health Services
50	ICF-MR Services
67	Nursing Facility Services
96	Private Duty Nursing and Personal Care Services
97	Private Non-Medical Institution Services (PNMI) Appendix C and F
102	Rehabilitative Services

The MHDO's APCD contains information about the payor for the health care service. This information was used to categorize claims paid for the following types of payors: commercial (excluding Medicare Advantage); MaineCare; Medicare (including both Medicare Advantage and Fee-for-service plans). Additionally, as required by the legislation, claims for two plan sponsors were tabulated: the Maine Education Association Benefit Trust (MEABT) and the State Employee Health Commission (SEHC).

Primary Provider Identification on Claims

Medical claims contain identifiers (National Provider Identifiers (NPI)) for multiple levels of providers. To determine whether the main provider of a claim met the definition of a Primary Care Provider, the billing, servicing, rendering and operating provider NPIs s were examined to find an Individual provider and their primary taxonomy code. If all of those providers were organizations, the servicing provider was used as the main provider. The Attending provider was used separately.

For both the main provider and the attending provider, the taxonomy code (medical specialty of the provider) was determined using the primary taxonomy as identified for that NPI in a copy of CMS's National Plan and Provider Enumeration System (NPPES) database maintained in the MHDO Enclave data management system

(updated 10/2023). NPPES is a free national directory of providers populated by specialty as indicated by the providers at the time of NPI registration, which providers can update at any time.[31] While the best source of specialty information available, NPPES primary taxonomy information may not be regularly updated or reflect the current primary specialty of the practicing provider so primary care taxonomy assignments and estimates must be viewed as having a margin of error.

Primary Care identification starts with associating a claim with a taxonomy code from the provider taxonomy list in *Attachment D*. In the claims submitted to the APCD, hospital affiliated providers and FQHC/RHCs that bill on a facility claim type (UB-04) sometimes do not provide an individual rendering/servicing provider and bill for services with only the NPI of the hospital or FQHC/RHC. While we decided to include all claims (except dental) billed by an FQHC/RHC[‡‡‡], we were not able to establish a reliable mechanism for identification of primary care services for claims that specified only a hospital as the main provider and did not specify an attending provider. Thus hospital-based primary care providers who bill under the hospital NPI with no individual rendering/servicing/attending information provided are not included in our primary care estimates. As a result, primary care spending estimates may be understated.

Identification of Primary Care Services by OB/GYN and Attending providers on Facility Claims

If the main provider on a claim had an OB/GYN taxonomy, or the main provider did not have a Primary Care taxonomy code and the attending provider did, a set of procedure codes was used to determine whether the claim was included as Primary Care.[§§§] The lists of primary care taxonomy and procedure codes were identified from other state, regional and national studies, as well as the results from the state payor questionnaires collected in prior years by MQF.

Primary care services provided in hospice, nursing and custodial care facilities were also included based on the guidance of the Advisory Committee.

Health care services provided in hospital inpatient situations, emergency departments and urgent care facilities were excluded from Primary Care as mandated by the legislation.

Identification of Telehealth Delivered Services

Claim lines associated with delivery of services via telehealth were identified using specific procedure code modifiers, place of service (POS) codes or procedure codes (e.g. HEDIS, CMS, MaineCare) and are shown in *Attachment D*. The costs on these claim lines were attributed to telehealth delivery.

Identification of Costs

As mandated by the legislation, medical and primary care costs identified in this study include payments by payors for claims incurred during the measurement year that meet the inclusion criteria identified above. For the payors that provided the information, non-claims-based payments were added to their estimates.[****] The denominator, or base for the calculation of Primary Care percentage, was the sum of plan paid amounts for all

[‡‡‡] All medical care provided by FQHCs, excluding dental services, was included as primary care. Therefore, Behavioral Health (BH) services provided by FQHCs are included in primary care. While we can identify the BH services from the MaineCare claims, we could not reliably identify them in the commercial claims. For consistency, all FQHC care is included in the definition of primary care.

[§§§] Inclusion of facility claims allowed for the identification of facility fees associated with primary care including hospital associated providers, who use both professional and facility claims, as well as federally qualified (FQHC) and rural (RHC) health care facilities, who use only facility claims.

[****] MaineCare non-claims-based payments included Prospective Interim and Supplemental Payments to critical access and select general acute care hospitals. These facilities are paid on a cost settlement basis and are not reflected in the APCD claims data.

medical (not pharmacy or dental) claims used in this study (see *Data Source*, above) plus non-claims based and SUD redacted amounts.

The Primary Care amount (the numerator of the percentage calculation) is the sum of the plan paid amounts on claim lines that met the definition criteria for primary care plus the portion of non-claims expenditures that went to primary care and an estimated portion of SUD redacted claims that would fall into the definition of Primary Care.

We included payor payments made for services that occurred any time during the calendar year and paid up to at least six months after the service was provided. No consideration was given to the length of time a member was covered by health insurance during the measurement year.

Percent of Members with Primary Care

New to the report this year is an analysis showing the proportion of eligible members who accessed primary care in 2021 or 2022 (had at least one claim with a service date in 2021 or 2022 to a primary care provider that was not in the Inpatient or Emergency Room setting, or for one of the services performed by an OB/GYN provider or attending provider that was counted as primary care). This calculation relied on the Person ID in the MHDO APCD, which uses identification information available only to the MHDO and not made public to assign a unique anonymous identifier to the same person across changes in coverage. The number of enrolled members by payor is the number of distinct Person IDs that had full medical insurance coverage for any month in 2021 or 2022, regardless of the number of months of eligibility. Maine residents may be covered by more than one insurance plan. For example, a large portion of those with Medicare also have MaineCare benefits (i.e. the dually-eligible) or commercial Medicare Supplement plans. As a result, members fully enrolled at any month of the year may be duplicated across payors.

Primary Care by County

Another new analysis breaks down the overall percentage of claims-based payments going to primary care to the county level. Both the total medical amount paid by payors through claims and the amount paid to primary care providers on those claims were assigned to the county of the member's residence. The calculation excludes payments associated with members whose residence is unknown or out of state (a tiny portion of the total APCD). It does not factor in any non-claims-based payments.

Non-Claims Data Source and Method

As required by Chapter 247, *Uniform Reporting System for Non-Claims Based Payments and Other Supplemental Health Care Data Sets*, commercial and MaineCare payors are to report annually to MHDO the amounts paid to healthcare providers that are not included in claims submissions to the MHDO. Non-claims payment information as submitted shows the total amount as well as the amount paid for primary care, and the amount paid for behavioral health care. CMS, the payor for Medicare FFS, does not submit information about payments made outside of claims.

For 2022, the majority of payors (those that account for 95% of the claims-reported dollars) submitted non-claims information. The primary care spending estimates include both claims and non-claims 2022 data.

Estimating primary care percent in SUD: Chapter 247 does not require payors to identify the portion of aggregated SUD redacted payments that went to Primary Care providers. To include these in the calculation, we estimated the percentage of SUD redacted claims that would also qualify as primary care, based on observation of non-redacted SUD claims submitted to MHDO by commercial payors, at 5%. MaineCare primary care percent of SUD was based on analyses of estimates observed in a limited non-redacted claims sample.

MaineCare LTSS exclusion method: MaineCare covers a broader range of services than either commercial or Medicare plans. The additional services are often referred to as LTSS (long-term services and supports). To make the MaineCare numbers more comparable to other payor types, we estimated and removed the amount of LTSS in the medical claims and in the non-claims and SUD payment aggregates. The estimates are based on analysis of other data sources and were developed with the assistance of the Office of MaineCare Services. These estimates resulted in some uncertainty in the calculation of primary care as a percent of total medical costs for MaineCare and thus are shown as a range.

Medicare estimates: Original Medicare is not subject to Chapter 247 requirements. Reported non-claims and SUD payments for the Medicare payor type reflect those reported by Medicare Advantage plans, which are operated by commercial payors. Original Medicare does not redact SUD payments; these are included in claims.

Attachment D – Primary Care Provider Taxonomy Codes, Procedure Codes for OB/GYN and Attending Providers, and Telehealth Codes in Primary Care Spending Analyses

Primary Care Provider Type Taxonomy Codes and Description

Primary Care	
261QF0400X	Federally Qualified Health Center
261QP2300X	Primary Care Clinic
261QR1300X	Rural Health Clinic
261Q00000X	Clinic/Center when POS or bill type of FQHC
207Q00000X	Physician, Family Medicine
207R00000X	Physician, General Internal Medicine
175F00000X	Naturopathic Medicine
208000000X	Physician, Pediatrics
208D00000X	Physician, General Practice
363L00000X	Nurse Practitioner
363LA2200X	Nurse Practitioner, Adult Health
363LF0000X	Nurse Practitioner, Family
363LG0600X	Nurse Practitioner, Gerontology
363LP0200X	Nurse Practitioner, Pediatrics
363LP2300X	Nurse Practitioner, Primary Care
363A00000X	Physician Assistants
363AM0700X	Physician Assistants, Medical
207RG0300X	Physician, Geriatric Medicine
207QG0300X	Family Practice Geriatrics
207QA0505X	Family Practice Adult
207QA0000X	Family Practice Adolescent
175L00000X	Homeopathic Medicine
2083P0500X	Physician, Preventive Medicine
364S00000X	Certified Clinical Nurse Specialist
163W00000X	Registered Nurse, Non-Practitioner
163WG0000X	General Practice Registered Nurse
OB/GYN Codes[††††]	
207V00000X	Physician, Obstetrics and Gynecology
207VG0400X	Physician, Gynecology
363LW0102X	Nurse Practitioner, Women's Health
363LX0001X	Nurse Practitioner, Obstetrics and Gynecology

[††††] For OB/GYN providers only a specific set of services provided by these provider specialties are included.

Procedure (HCPCS) Codes Used for OB/GYN and Attending Providers

Procedure Codes for OB/GYN and Attending Providers	
Procedure Codes	**Description**
Immunizations and Injections	
90281	Immune Globulin
90287	Botulinum antitoxin, equine, any route
90288	Botulism immune globulin, human, for intravenous use
90291	Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use
90296	Diphtheria antitoxin, equine, any route
90371	Hepatitis B immune globulin
90375 - 90376	Rabies immune globulin
90384 - 90386	Rho(D) immune globulin
90389	Tetanus immune globulin
90393	Vaccinia immune globulin
90396	Varicella-zoster immune globulin
90399	Unlisted immune globulin
90460 - 90461	Immunization through age 18, including provider consult
90465 - 90466	Immunization administration younger than 8 years of age
90467 - 90468	Immunization administration younger than age 8 years
90471 - 90472	Immunization by injection/oral/intranasal route
90473 - 90474	Immunization administration by intranasal or oral route
90476 - 90477	Adenovirus vaccine
90581	Anthrax vaccine
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer,
90587	Dengue vaccine
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine
90621	Meningococcal recombinant lipoprotein vaccine
90625	Cholera vaccine
90630	Influenza virus vaccine
90632 - 90633	Hepatitis A vaccine, pediatric/adolescent dosage-2
90634	Hepatitis A vaccine, pediatric/adolescent dosage
90636	Hepatitis A and hepatitis B vaccine
90644	Meningococcal conjugate vaccine
90645 - 90648	Hemophilus influenza b vaccine
90649 - 90650	Human Papilloma virus (HPV) vaccine
90651	Human Papilloma virus vaccine
90653 - 90661	Influenza virus vaccine
90662	Flu
90663 - 90664	Influenza virus vaccine
90665	Lyme disease vaccine

Procedure Codes for OB/GYN and Attending Providers	
Procedure Codes	**Description**
90666 - 90668	Influenza virus vaccine
90669 - 90670	Pneumococcal conjugate vaccine
90672 - 90674	Influenza virus vaccine
90675 - 90676	Rabies vaccine
90680 - 90681	Rotavirus vaccine
90682	Influenza virus vaccine
90685 - 90689	Influenza virus vaccine
90691	Typhoid vaccine
90696	DtaP-IPV
90697	DTaP-IPV-Hib-HepB
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine,
90700	DTaP
90701	DTP
90702	Diphtheria and tetanus toxoids (DT)
90703	Tetanus toxoid adsorbed
90704	Mumps virus vaccine
90705	Measles virus vaccine
90706	Rubella virus vaccine
90707	Measles, mumps and rubella virus vaccine (MMR)
90708	Measles and rubella virus vaccine
90710	Measles, mumps, rubella, and varicella vaccine (MMRV)
90712 - 90713	Poliovirus vaccine
90714 - 90715	Tetanus, diphtheria toxoids adsorbed
90716	Varicella virus vaccine
90717	Yellow fever vaccine
90718	Tetanus and diphtheria toxoids (Td) adsorbed
90719	Diphtheria toxoid,
90720	Diphtheria, tetanus toxoids
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib)
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV)
90725	Cholera vaccine
90727	Plague vaccine,
90732	Pneumococcal polysaccharide vaccine
90733	Meningococcal polysaccharide vaccine
90734	Meningococcal conjugate vaccine
90735	Japanese encephalitis virus vaccine
90736	Zoster (shingles) vaccine

Procedure Codes for OB/GYN and Attending Providers	
Procedure Codes	**Description**
90738	Japanese encephalitis virus vaccine,
90739 - 90740	Hepatitis B vaccine (HepB)
90743 - 90744	Hepatitis B vaccine
90746 - 90747	Hepatitis B vaccine
90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib)
90749	Unlisted vaccine/toxoid
90750	Zoster (shingles) vaccine
90756	Influenza virus vaccine
90785	add-on code specific for psychiatric service
91300 - 91316	COVID immunization
0001A – 0004A	COVID immunization
0011A – 0013A	COVID immunization
0021A – 0022A	COVID immunization
0031A	COVID immunization
0034A	COVID immunization
0041A - 0042A	COVID immunization
0044A	COVID immunization
0051A – 0054A	COVID immunization
0064A	COVID immunization
0071A – 0074A	COVID immunization
0081A – 0083A	COVID immunization
0091A – 0094A	COVID immunization
0104A	COVID immunization
0111A – 0113A	COVID immunization
0124A	COVID immunization
0134A	COVID immunization
0144A	COVID immunization
0154A	COVID immunization
0164A	COVID immunization
Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes chemotherapy and other highly complex drug or highly complex biologic agent administration)	
96160 - 96161	Administration of health risk assessment (replaces 99420 as of 1/1/2017)
96372 - 96374	Therapeutic, prophylactic, or diagnostic injection
Non-face-to-Face Non-Physician Services	
98966 - 98968	Non-physician telephone services
98969	Online assessment, mgmt. services by non-physician
Evaluation and Management Services	
Office Visits	
99201 - 99205	Office or outpatient visit for a new patient
99211 - 99215	Office or outpatient visit for an established patient

Procedure Codes for OB/GYN and Attending Providers	
Procedure Codes	**Description**
99241 - 99245	Office or other outpatient consultations
Home/NH Visits	
99304 - 99310	Nursing Facility Care
99315 - 99316	Nursing Facility Care
99318	Nursing Facility Care
99324 - 99328	Domiciliary or rest home Custodial Care
99334 - 99337	Domiciliary or rest home Custodial Care
99339 - 99340	Domiciliary or rest home multidisciplinary care planning
99341 - 99346	Home visit for a new patient
99347 - 99350	Home visit for an established patient
99354 - 99359	Prolonged Service Office Visit
99360	Standby service
99367	Medical team conference
G0181 – G0182	Physician or allowed practitioner supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician or allowed practitioner development and/or revision of care plans
S9110	Telemonitoring of patient in their home, including all necessary equipment, patient education and support
Preventive Visits	
96110	Developmental screen
99381 - 99385	Preventive medicine initial evaluation
99386 - 99387	Initial preventive medicine evaluation
99391 - 99397	Preventive medicine periodic reevaluation
99401 - 99404	Preventive medicine counseling and/or risk reduction intervention
99406 - 99409	Smoking and tobacco use cessation counseling visit (Alcohol/Substance Abuse Screening)
99411 - 99412	Group preventive medicine counseling and/or risk reduction intervention
99420	Administration and interpretation of health risk assessments
99429	Unlisted preventive medicine service
99441 - 99443	Telephone calls for patient mgmt.
99444	Non-face-to-face on-line Medical Evaluation
99446 - 99452	Interpersonal telephone/internet/EHR consultation
99487	Chronic Care Management
99490 - 99491	Chronic Care Management
99495 - 99496	Transitional care management service
99497 - 99498	Advance Care Planning
G0102	Prostate cancer screening; digital rectal examination
G0108 – G0109	Diabetes outpatient self-management training services
G2025	Payment for telehealth distant site service at RHC or FQHC only
G0406	Follow up inpatient consultation, 15 minutes with patient via telehealth

Procedure Codes for OB/GYN and Attending Providers	
Procedure Codes	**Description**
G0407	Follow up inpatient consultation, 25 minutes with patient via telehealth
G0408	Follow up inpatient consultation, 35 minutes with patient via telehealth
G0472	Hepatitis C antibody screening
G0475	HIV antigen/antibody, combination assay, screening
G0476	Pap test add-on
G8420	BMI is documented within normal parameters
G8427	Med review
G8482	Influenza immunization administered or previously received
G8709	Patient prescribed antibiotic
G8711	Patient prescribed antibiotic for documented medical reason
G8730 – G8731	Pain assessment documented
G8950	BP reading documented
G9903	Patient screened for tobacco use and identified as a non-user
G9964	Patient received at least one well-child visit with a pcp during the performance period
G9965	Patient did not receive at least one well-child visit with a pcp during the performance period
G9966	Children who were screened for risk of developmental, behavioral and social delays
G9967	Children who were NOT screened for risk of developmental, behavioral and social delays
Q3014	Telehealth originating site facility fee
S0610	Annual gynecological exam, established patient
S0612	Annual gynecological exam, new patient
S0613	Annual gynecological exam; clinical breast exam without pelvic
T1014	Telehealth transmission per minute, professional services billed separately
Other Primary Care HCPCS Codes (Medicare/Medicaid)	
G0008	Administration of influenza virus vaccine
G0009	Administration of influenza virus vaccine
G0103	PSA screening
G0101	CA screen;pelvic/breast exam
G0123	Screen cerv/vag thin layer
G0145	Scr c/v cyto,thinlayer,rescr
G0151	Hhcp-serv of pt,ea 15 min
G0166	Extrnl counterpulse, per tx
G0202	Screening mammography digital
G0249	Provide inr test mater/equip
G0279	Tomosynthesis, mammo
G0283	Elec stim other than wound
G0299	Hhs/hospice of rn ea 15 min
G0399	Home sleep test/type 3 porta
G0402	Welcome to Medicare visit
G0438	Annual wellness visit

Procedure Codes for OB/GYN and Attending Providers	
Procedure Codes	**Description**
G0439	Annual wellness visit
G0424	Pulmonary rehab w exer
G0442	Annual alcohol screening
G0443	Brief alcohol misuse counsel
G0444	Annual depression screening
G0447	Face to face Behavioral Counseling for Obesity
G0454	Md document visit by npp
G0463	Hospital Outpatient Clinic Visit (Medicare)
G0466	FQHC Visit, new patient
G0467	FQHC Visit, established patient
G0468	FQHC Preventive visit
G0480	Drug test def 1-7 classes
G0481	Drug test def 8-14 classes
G0483	Drug test def 22+ classes
G0498	Chemo extend iv infus w/pump
G0500	Mod sedat endo service >5yrs
G8400	Pt w/dxa no results doc
G8978	Mobility current status
G8979	Mobility goal status
G9162	Lang express current status
G9163	Lang express goal status
G9197	Order for ceph
G9551	Abd imag no les,kid/livr/adr
G9557	Ct/cta/mri/a no thyr <1.0cm
G9655	Toc tool incl key elem
G9656	Pt trans from anest to pacu
G9771	Anes end, 1 temp >35.5(95.9)
G9775	Recd 2 anti-emet pre/intraop
G9968	Pt refrd 2 pvdr/spclst in pp
G9969	Pvdr rfrd pt rprt rcvd
G9970	Pvdr rfrd pt no rprt rcvd
T1015	Clinic visit, all-inclusive(FQHC)

Telehealth Codes Included in Telehealth Analysis

Procedure Codes*	Description
2 (Place of Service)	Health services are received through Telecommunications technology
10 (Place of Service)	Telehealth Place of Service Code
FR (Modifier)	Procedure modifier
FQ (Modifier)	Procedure modifier
GT (Modifier)	Via interactive audio and video telecommunication systems
G0 (Modifier)	Procedure modifier
GQ (Modifier)	Procedure modifier
93 (Modifier)	Procedure modifier
95 (Modifier)	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
98966-98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment
99421-99423	Online Digital Evaluation and Management Services
98970 - 98972	Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days
98980	Remote monitoring PLUS interacting with patient
98981	Addl time
99441-99443	Telephone E/M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
99446-99449	Interprofessional Telephone/Internet/Electronic Health Record Consultations
99451-99452	Interprofessional Telephone/Internet/Electronic Health Record Consultations
99457	QHP service; 20 minutes of Non F2F and F2F time spent in analysis and via synchronous communication with patient the findings or care plan
99458	Add-on code; full additional 20 minutes for services described in 99457
0188T-0189T	Remote Real-Time Interactive Video-conferenced Critical Care Services
G0071	Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (rhc) or federally qualified health center (fqhc) practitioner and rhc or fqhc patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an rhc or fqhc practitioner, occurring in lieu of an office visit; rhc or fqhc only
G0181	Physician or allowed practitioner supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician or allowed practitioner development and/or revision of care plans
G0182	Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including

Procedure Codes*	Description
	telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more
G0406-G0408	Follow-up inpatient consultation, limited, physicians typically spend [15, 25, 35] minutes communicating with the patient via telehealth
G0425-G0427	Telehealth consultation, emergency department or initial inpatient, typically [30, 50, 70] minutes communicating with the patient via telehealth
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
G0508-G0509	Telehealth consultation, critical care
G2010	Remote evaluation of recorded video and/or images submitted by an established patient, including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report e/m services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
G2025	Payment for a telehealth distant site service furnished by a rural health clinic (rhc) or federally qualified health center (fqhc) only
G2061-G2063	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; [5-10, 11-20, 21+] minutes
G2252	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 11–20 minutes of medical discussion
Q3014	Telehealth originating site facility fee
S9110	Telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month
T1014	Telehealth transmission, per minute, professional services bill separately

*Most codes used a Modifier.

Attachment E – Endnotes

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