Maine Quality Forum

MEASURING TO IMPROVE

Public Law, Chapter 244

2022 Annual Report:

Primary Care Spending

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

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MQF Primary Care Advisory Committee

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Date: February 15, 2022

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

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Executive Summary

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 to the Joint Standing Committee on Health Coverage, Insurance and Financial Services and the Commissioner of the Department of Health and Human Services.

The Maine Quality Forum (MQF) contracts with the University of Southern Maine, Muskie School of Public Service, Cutler Institute, with consultation from Judy Loren, to provide MQF with the technical support in the preparation of this report.

MQF's third annual primary care spending report is based on the methods and definitions of primary care agreed on by MQF's Primary Care Advisory Committee and reported in previous reports.[i,ii] For this and prior MQF reports the primary care spending estimates are based on insurer payments (i.e., plan paid amounts) reported in the Maine Health Data Organizations All Payer Claims Database. In addition, this report:

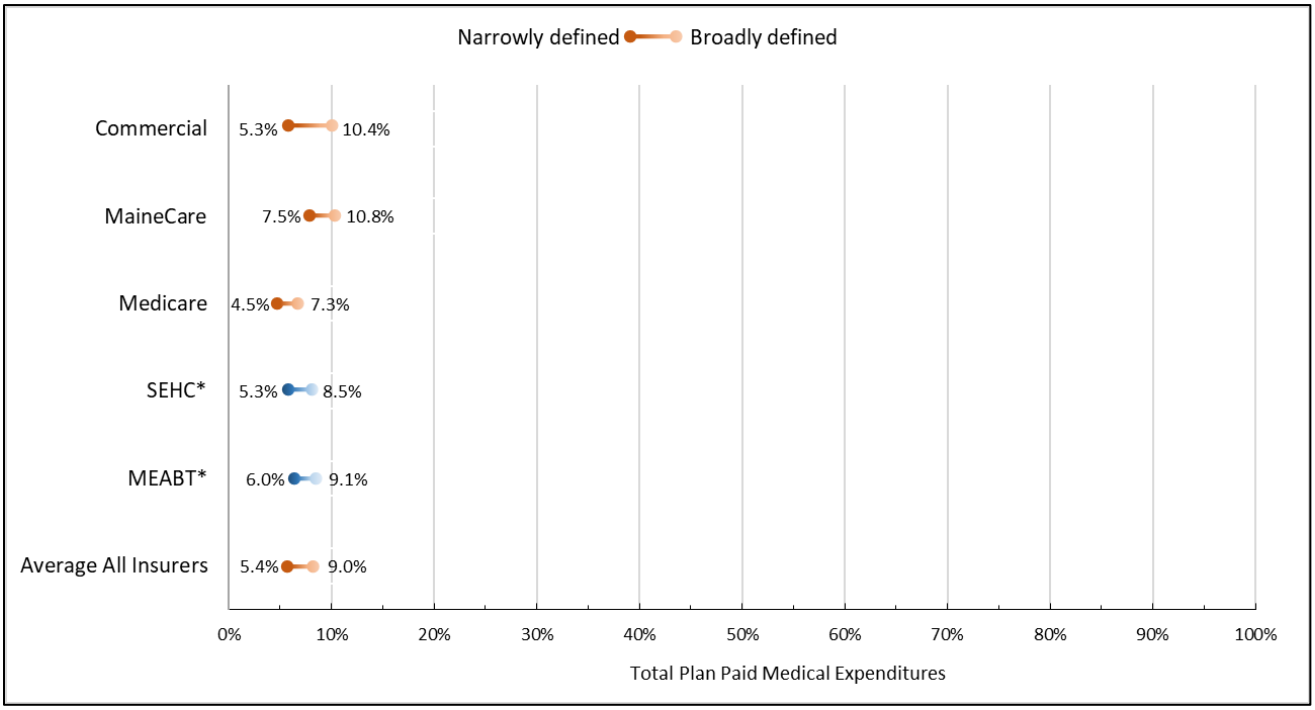
- Updates the environmental scan of other regional and national efforts to quantify primary care spending specifically focusing on how they include behavioral health, obstetrics, and gynecology (OB/GYN) and non-claims payments in their estimates,
- Presents updated results of MQF's claims-based analyses of primary care spending in Maine for CY 2020 as a percentage of spending and absolute dollars.
- Clarifies the narrow and broad definitions of primary care.

Key Findings:

- The environmental scan revealed there continues to be no standard definition of primary care used across states and there is significant variation in whether states include OB/GYN, behavioral health and/or non-claims-based payments in their primary care spending definitions and percent of total spending estimates. Most states include OB/GYN within their primary care definitions and fewer include behavioral health; and those states that included non-claims information differed in how this information was collected and reported.
- Using similar narrow and broad definitions as in previous MQF reports, Maine insurers paid on average approximately 5.4% applying the narrow definition of primary care; and 9.0% applying the broad definition of primary care of total medical spending as reported in the MHDO all-payer-claims data in 2020 (Chart 1).
- While there were some differences between payers, the average percentage of total expenditures spent on primary care remained relatively constant over the 3-year period from 2018-2020 using either definition.

[i] https://mhdo.maine.gov/_mqfdocs/MQF%20Primary%20Care%20Spending%20Report_Feb%202021.pdf
[ii] https://mhdo.maine.gov/_mqfdocs/MQF%20Primary%20Care%20Spending%20Report__Jan%202020.pdf

Chart 1. Primary Care Percentage of Total Claims-based Medical Expenditures by Payer, 2020



Data Source: MHDO APCD claims data; Reported medical spending reflects plan paid amounts
SEHC = State Employee Health Commission
MEABT = Maine Education Association Benefits Trust
* SEHC and MEABT are reported separately as required by PL Chapter 244 and are a subset of commercially insured.

- Prior to 2020, telehealth accounted for less than 1% of primary care spending. In 2020 telehealth accounted for 6.1% to 13.3% of primary care payments depending on the payer.
- Services provided by primary care providers in the broad definition only included: Injectable drugs (29% of paid claims) diagnostic procedures (15%), radiology (12%), and labs (8%).
- Primary care services provided by OB/GYN providers included in both the broad and narrow definition accounted for less than 10% of Maine's primary care claims-based spending and had minimal impact on primary care spending estimates. Excluding OB/GYN providers from the broad definition of primary care decreased MaineCare's primary care spending estimates by 0.2 and Commercial insurers by 0.3 percentage points. When excluding OB/GYN providers from the narrow definition of primary care, MaineCare's primary care spending estimates decreased by 0.1 and Commercial insurers by 0.4 percentage points.
- MaineCare, the MEABT, and SEHC voluntarily submitted their non-claims-based payments to MHDO for inclusion in this report. The non-claims-based primary care-related payments reported for 2020 for these three entities totaled approximately $34,000,000. Other commercial plans were asked to voluntarily submit their non-claims-based payments to MHDO for inclusion in this report, however they chose not to provide this data to MHDO without a state mandate. As such, MHDO's board of directors adopted a new rule in December 2021, 90-590 CMR Chapter 247, *Uniform Reporting System for Non-Claims Based Payments*, that now mandates the submission of non-claims-based payments beginning in 2022.

Requirement and Overview of Process

Public Law Chapter 244

In 2019, the Maine legislature passed Public Law 2019, Chapter 244, *An Act to Establish Transparency in Primary Care Health Care Spending* requiring the Maine Quality Forum (MQF) to submit an annual report on primary care spending to the Department of Health and Human Services and the Joint Committee of Health Coverage, Insurance and Financial Services of the Maine State legislature.[1] (*Attachment A*)

The legislation requires that the annual report include:

"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 (SEHC) and the Maine Education Association benefits trust (MEABT) and the average percentage of total medical expenditures paid for primary care across all payers" based on claims data reported to the Maine Health Data Organization (MHDO)."

The legislation defines primary care as "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 a patient may be referred to a specialist."

Lastly, Public Law Chapter 244 requires the Maine Quality Forum to consult with other state and national agencies and organizations to determine the best practices for reporting spending on primary care services by insurers.

Overview of Process and Changes from Second Annual Report

MQF convened its Primary Care Advisory Committee in the fall of 2021 where we reviewed results from MQF's second annual primary care report[2] and discussed the recommended changes in methodology for the third annual report based on our updated environmental scan. The group discussed how to include non-claims-based payments and other proposed modifications to how MQF define or present primary care spending.

Based on the recommendations of the Advisory Committee, the third annual report:

- Updates the environmental scan of primary care spending definitions in other states and nationally conducted for the first annual report[3] to assess the degree to which other state's primary care spending estimates include behavioral health, OB/GYN, and non-claims-based payments. As Maine state policymakers seek to benchmark Maine's primary care spending rates with other state efforts (e.g., LD 1196), the Advisory Committee requested that MQF continue to assess how Maine's primary care definition compares with other national and state efforts to help inform standardizing primary care spending definitions.
- Includes estimates of primary care spending percentages and adds total plan paid amounts for 2018, 2019 and 2020 for both narrow and broad definitions, with minor updates to provider types and services included in the narrow definition.
- Clarifies what is included in the narrow and broad definitions of primary care. As in prior reports, we included a list of all primary care provider taxonomies included in both broad and narrow definitions and the list of primary care procedures included in the narrow definition. For this report, we also have added a summary table of procedure codes provided by primary care providers that are counted in the broad definition that are not counted in the narrow definition. We also include a table showing the impact of including primary care services provided by OB/GYN practitioners in Maine's definition on total primary care spending estimates.

- Includes estimated non-claims-based payments voluntarily reported by insurers.
- Describes MHDO efforts to collect and report non-claims-based payments in future primary care spending reports including the rule change requiring the submission of non-claims based primary care and total payments to MHDO.
- A list of Advisory Committee members (*Attachment B*) and meeting agenda with summary notes (*Attachment C*) can be found in the Attachments.

Report Overview

This third annual report documents modifications to the year one process used to define and quantify primary care payments in Maine and presents the results of the analyses in calendar years 2018-2020. For this and prior MQF reports, the primary care spending estimates are based on insurer payments (i.e. plan paid amounts) reported in the Maine Health Data Organizations All Payer Claims Database. It should be noted that this report includes CY 2020 data and as such reflects the early impact of the COVID-19 pandemic. This year we have included the dollar amounts paid by the insurer for total medical expenditures and primary care to provide additional context when looking at primary care spending (Appendix F).

We also have added some context for interpreting the primary care spending estimates given questions raised by the Advisory Group, including:

- Information on the percentage of the insured population in Maine that is included in MHDO's APCD,
- Information on how primary care providers and services may be billed differently by payer and how these billing differences may affect claims-based estimates,[iii] and
- Information on the types of services provided by primary care providers in the broad definition that are not included in the narrow definition.

Analysis of Primary Care Spending in Maine

Claims-based Primary Care Spending

MQF's year three report is based on an analysis of MHDO's All-Payer Claims Data (APCD) for calendar year 2018 to 2020. Primary care spending estimates are based on insurers' primary care payments (plan paid amounts) as a percentage of total medical expenditures reported by insurers reporting claims data to MHDO. Table 1 shows the Percent of Primary Care Spending by Broad and Narrow Definitions, 2018-2020.

As required by PL 2019, Chapter 244 estimates of primary care spending are presented for commercial insurers, Medicaid, Medicare, and within commercially insured, those insured by the Maine Education Association Benefit Trust (MEABT) and the State Employee Health Commission (SEHC). The analyses shown in this report use the plan paid amount on claims for dates of service in the relevant year. A more detailed description of the methods used for this analysis can be found in *Attachment D*.

As shown in Table 1 and Chart 2,

- On average, in 2020, Maine insurers paid approximately 5.4% of total medical expenditures on primary care using the narrow definition; and 9.0% of total medical expenditures on primary care using the broad definition.

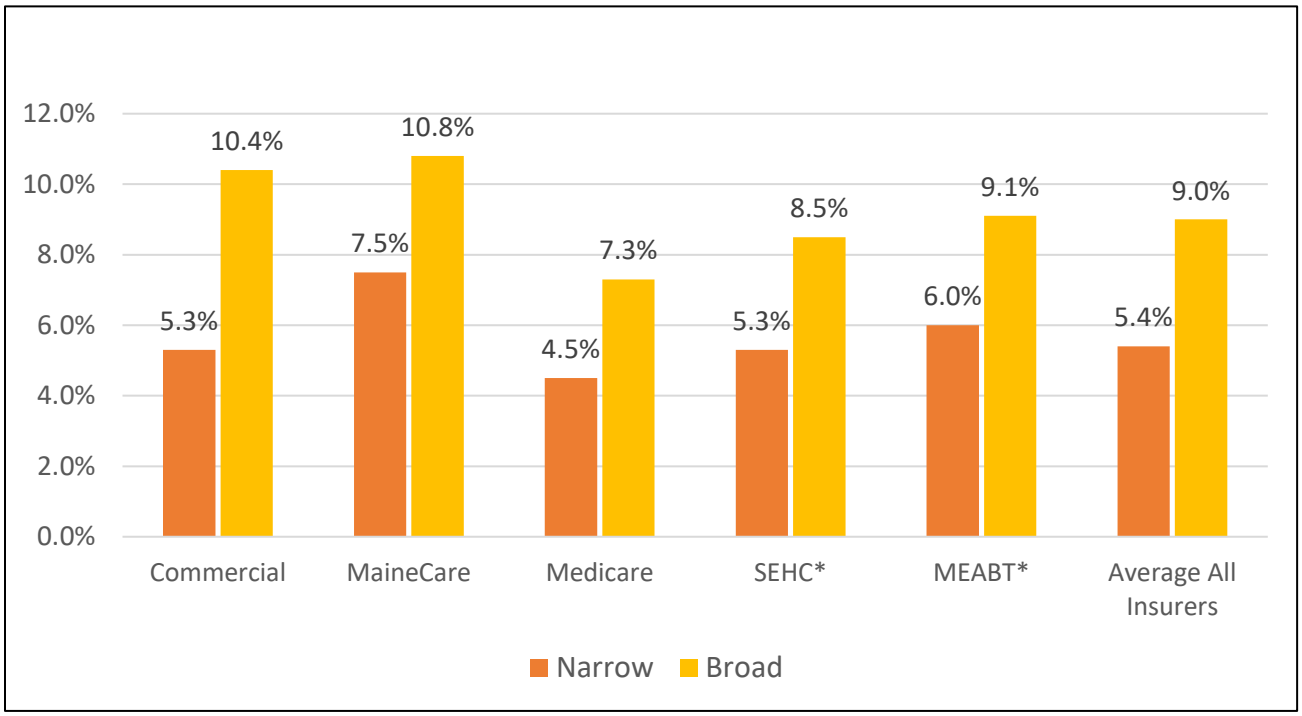
[iii] See *Attachment D* for more information.

- The primary care percentage of total claims-based expenditures on average for all insurers remained relatively constant over the 3-year period (2018-2020) for both broad and narrow definitions of primary care.
- Primary care spending as a percent of total medical expenditures varies by payer type. While somewhat differing based on narrow and broad definitions, Commercial payers and MaineCare consistently have higher rates of primary care spending than Medicare potentially due to the differences in the populations they serve.

Table 1. Primary Care as a Percentage of Total Claims-based Medical Expenditures by Payer, Broad and Narrow Definitions, 2018-2020

Primary Care Definition: (Narrow or Broad)	% Primary Care Spending by Payer					
	2018		2019		2020	
	Narrow	Broad	Narrow	Broad	Narrow	Broad
Commercial	5.6%	10.8%	5.6%	10.6%	5.3%	10.4%
MaineCare	7.4%	10.4%	7.6%	10.6%	7.5%	10.8%
Medicare	4.7%	7.0%	4.8%	7.4%	4.5%	7.3%
SEHC*	5.7%	8.7%	5.4%	8.7%	5.3%	8.5%
MEABT*	6.3%	9.3%	6.2%	9.3%	6.0%	9.1%
Average All Insurers	5.6%	8.9%	5.6%	9.1%	5.4%	9.0%

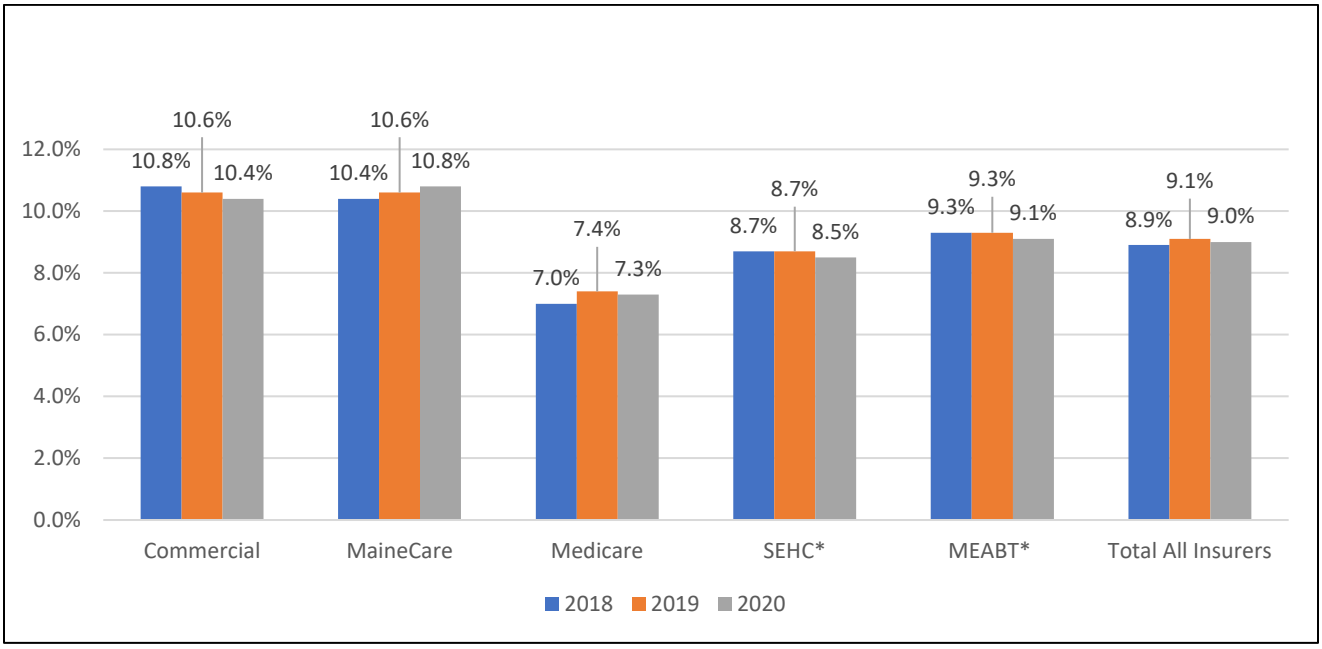
Chart 2. Primary Care as a Percentage of Total Claims-based Medical Expenditures by Payer, Narrow and Broad Definitions, 2020



Data Source: MHDO APCD claims data; Reported medical spending reflects plan paid amounts
SEHC = State Employee Health Plan
MEABT = Maine Education Association Benefits Trust
* SEHC and MEABT are reported separately as required by PL Chapter 244 and are a subset of commercially insured.

As shown in Chart 3, primary care as a percentage of total claims-based medical expenditures by payer did not change appreciably over the three years 2018-2020. While Commercial, SEHC, and MEABT saw a slight decline and MaineCare saw a slight increase in primary care spending rates over time, these differences are small and likely not significant.[iv] See *Attachment F* for absolute dollars used to estimate primary care spending rates.

Chart 3. Primary Care Percentage of Total Claims-based Medical Expenditures by Payer, Broad Definition, 2018-2020



Data Source: MHDO APCD claims data; Reported medical spending reflects plan paid amounts
SEHC = State Employee Health Plan
MEABT = Maine Education Association Benefits Trust
* SEHC and MEABT are reported separately as required by PL Chapter 244 and are a subset of commercially insured.

While the COVID-19 pandemic in 2020 affected health care use and spending in both primary and non-primary care services, it did not substantially affect the primary care spending percentage of total expenditures.

However, there were changes in the modality by which primary care services were delivered. As shown in Table 2, telehealth use for primary care expanded during the COVID-19 pandemic. Prior to 2020, telehealth accounted for less than 1% of primary care payments but increased in 2020 accounting for 6.1% to 13.3% of primary care payments. Commercial insurers saw the largest increase in primary care provided via telehealth. The increased use of telehealth was likely due to COVID-related provider office temporary closures for in-person services and telehealth policy leniencies put in place during the public health emergency.[v]

[iv] Differences in primary care spending estimates between payers or over time were not tested for statistical significance for this report but, based on Advisory Committee input, will be included in future reports.

[v] Prior to COVID, Medicare and most insurers 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 insurers to cover telehealth and reimburse at the same rate as in-person, that had not been the case previously.

Table 2. Telehealth as a Percent of Primary Care Paid Amount and Claim Count, 2018-2020

	2018		2019		2020	
Primary Care	% of Paid Amount	% of Claim Count	% of Paid Amount	% of Claim Count	% of Paid Amount	% of Claim Count
Commercial	0.1%	0.1%	0.1%	0.2%	13.3%	10.7%
Medicaid	0.1%	0.2%	0.3%	0.4%	6.1%	9.8%
Medicare	0.1%	0.2%	0.1%	0.3%	8.5%	9.3%

Data Source: MHDO APCD claims data; Reported medical spending reflects plan paid amounts

How MQF Defines Primary Care

MQF reports primary care spending based on two definitions of primary care: A Broad Definition and a Narrow Definition. What is the same about these two definitions is the identification of the type of providers that are considered primary care (See Table 3). The difference between the Narrow and Broad definitions are the services that are included and counted as primary care; thus, impacting the estimated percent of spending on primary care.

Broad Definition = **The Broad definition** includes **all services** provided by primary care providers (as identified below in Table 3)

Narrow Definition = **The Narrow definition includes a subset of services provided by primary care providers (as identified below)**

Primary care providers included in both the broad and narrow primary care definitions include all the following provider taxonomy codes (Table 3).

Table 3. Primary Care Providers in Both Broad and Narrow Definitions of Primary Care

Family medicine (including subspecialties of Geriatric, Adult, and Adolescent)	Physician assistants[vi]
Internal medicine	Nurse practitioners (family, pediatrics, primary care, general medicine, adult health, gerontology)
General medicine	Federally Qualified Health Centers (FQHCs)[vii]
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 primary care provider taxonomies is consistent with prior MQF reports with two additional taxonomy codes in this year's report that were identified by MaineCare.

MQF includes OB/GYN providers but **only for selected primary care procedures codes** in both its broad and narrow definitions. As noted above, the Advisory Committee raised the question about how much OB/GYN providers' primary care services were contributing to the overall Maine estimate of primary care spending.

As shown in Table 4, primary care services provided by OB/GYN providers included in both the broad and narrow definition accounted for less than 10% of Maine's primary care claims-based spending and had minimal to no impact on primary care spending estimates. Excluding OB/GYN providers from the broad definition of primary care only decreased MaineCare's primary care spending estimates by 0.2 percentage points (10.8% to 10.6%) and Commercial insurers by 0.3 percentage points (10.4% to 10.1%). When excluding OB/GYN providers from the narrow definition of primary care, MaineCare's primary care spending estimates only decreased by 0.1 percentage points (7.5% to 7.4%) and Commercial insurers by 0.4 percentage points (5.3% to 4.9%).

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

[vii] 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 payers, we were unable to consistently separate/exclude FQHC behavioral health services from primary care services in claims.

Table 4. Primary Care as Percentage of Total Spending if OB/GYN Providers for Selected Services are Omitted vs Included, Broad and Narrow Definitions, 2020

	Commercial		MaineCare		Medicare	
Definition	**OB/GYN for selected services OMITTED**	**OB/GYN for selected services INCLUDED (Current Definitions)**	**OB/GYN for selected services OMITTED**	**OB/GYN for selected services INCLUDED (Current Definitions)**	**OB/GYN for selected services OMITTED**	**OB/GYN for selected services INCLUDED (Current Definitions)**
Broad Definition	10.1%	10.4%	10.6%	10.8%	7.3%	7.3%
Narrow Definition	4.9%	5.3%	7.4%	7.5%	4.5%	4.5%

Data Source: MHDO APCD claims data; Reported medical spending reflects plan paid amounts

Narrow Definition: Subset of Services included in calculating spending estimates

The list of procedure codes included in the narrow definition of primary care is essentially the same as prior years with a few minor exceptions (i.e., additional telehealth codes). As for prior MQF reports, specific procedure codes used in the narrow definition were drawn from other state and national primary care report definitions or were identified by Maine insurers in their response to a MQF questionnaire. The complete list of primary care specific service procedure codes used to identify primary care payments using the narrow definition 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

Key Differences in the Services included in the Broad Definition vs. the Narrow Definition

The rate of primary care spending using the broad definition of primary care is twice as large as the narrow definition among Commercial payers. MaineCare shows a smaller differential (43% more payments), and Medicare is in between the two (62% more).

In previous reports, MQF noted that the following types of services accounted for the greatest portion of primary care claims in the broad but not narrow definition: family planning services, diagnostic imaging, laboratory tests (e.g., HbA1Cs), and injectable drugs.[2,3]

Table 5 shows the top categories of procedures representing the largest portion of claims and paid amounts included in our broad definition that are not included in the narrow definition in 2020. Key findings include:

- Injectable drugs supplied by primary care providers, not included in the narrow definition of primary care procedures, accounted for 29% of the difference in the primary care paid amounts between broad and narrow definitions.[viii]
- Other procedures delivered by and paid to primary care providers under the broad definition that were not included as primary care procedures in the narrow definition include diagnostic procedures (15%), radiology (12%), and labs (8%).
- Laboratory tests constituted the largest proportion of primary care claims (48%) not included in the narrow definition, but only accounted for 8% of primary care paid amounts in the broad but not narrow definition.

Table 5. Services Provided by Primary Care Providers Not included in Narrow Definition, 2020

Service*	% of Claims	% of Paid Amount	Example
Injectable drugs	9%	29%	Pembrolizumab, infusion services[ix]
Diagnostic procedures	2%	15%	Colonoscopy, endoscopy, arthroscopy
Radiology	6%	12%	Diagnostic mammography, CT abdomen
Labs, including venipuncture	48%	8%	Venipuncture, Lipid panel, comprehensive metabolic panel
DME	8%	6%	CPAP, oxygen delivery
Insertion, removal	2%	3%	Venous access device, Cardiac rhythm monitor
Cardiac evaluation	3%	3%	ECG, Echocardiography
Minor surgery	3%	3%	Destruction of benign lesion
Patient management	2%	2%	Observation care
Eye and ear procedures	1%	2%	Remove ear wax
PT, OT, assessment	2%	2%	Therapeutic exercises
All other procedures	13%	14%	New procedures, temporary codes
TOTAL	**100%**	**100%**	

***** The categories shown reflect groupings of procedure codes publicly available through CMS. "All other" procedures reflect an aggregated total of all other procedures and associated categories representing less than 1-2% of either broadly defined primary care claims or paid amounts.
**A list of procedures included is available upon request.
Note: Some claims that are linked to Primary Care Providers include only Revenue codes, no procedure codes. They account for about 5% of the additional services.

Data Source: MHDO APCD claims data; Reported medical spending reflects plan paid amounts

[viii] While costs of medications dispensed by a pharmacy and paid by a prescription drug plan are excluded from our APCD claims analyses, injectable drugs and other medications administered directly by providers, often referred to as "J-codes", are paid by a medical plan and therefore are included in medical claims and costs. As noted in this table these costs can be substantial, both for Primary Care and for Non-Primary Care providers and may merit further discussion whether to exclude from both primary care and non-primary care medical expenditures for future analyses.

[ix] Chemotherapy Infusion services are often provided by Hospitalists, who have taxonomy codes consistent with primary care.

Non-Claims-based Primary Care Spending

Non-claims-based payments are defined as amounts paid to providers that are for something other than a fee-for-service claim. These payments may include but are not limited to Capitation Payments, Care Management/ Care Coordination/Population Health Payments, Electronic Health Records/Health Information Technology Infrastructure/Other Data Analytics Payments, Global Budget Payments, Patient-centered Medical Home Payments, Pay-for-performance Payments, Pay-for-reporting Payments, Primary Care and Behavioral Health Integration Payments, Prospective Case Rate Payments, Prospective Episode-based Payments, Provider Salary Payments, Retrospective/Prospective Incentive Payments, Risk-based Payments, Shared-risk Recoupments, and Shared-savings Distributions.[x]

As noted in the environmental scan, while some states are collecting non-claims payment information from insurers, there is currently no standardized approach for how to collect this data. In December 2021, MHDO's Board of Directors adopted a new rule that governs the collection of non-claims-based payments, 90-590 CMR Chapter 247, Uniform Reporting System for Non-Claims Based Payments, which will require reporting by Maine insurers in August 2022.[4] The substance of the rule is based on recommendations for uniformity in defining primary care and non-claims-based payments developed by Milbank Memorial Fund.[5] Non-Claims based payments will be included in future MQF primary care spending annual reports. MHDO is also currently working with the National Association of Health Data Organizations and the APCD Council to encourage development of a national standard on how to define and collect non-claims-based payments.

To include non-claims-based payment estimates in the 3rd annual report, MQF sent a questionnaire to Maine's insurers asking them to voluntarily share aggregated non-claims-based payments for calendar year 2020 (1/1/20-12/31/20).

MaineCare, MEABT, and SEHC voluntarily agreed to submit to MHDO their non-claims-based data. The non-claims-based primary care related payments reported for 2020 by these three entities totaled approximately $34,000,000 (or 11% of all non-claims payments reported). Future MQF reports will look at the impact of non-claims-based payments on primary care spending in a more comprehensive way now that there is a state mandate for the submission of non-claims-based payments to MHDO.

State of Maine Activity Related to Primary Care Spending

During Maine's First Regular Session of the 130th Maine Legislature, the Joint Standing Committee on Health Coverage, Insurance and Financial Services (HCIFS) carried over LD 1196, *An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health*, to the second regular session. Congruently the HCIFS committee requested the Maine Medical Association to convene a stakeholder group to facilitate further discussion on the bill, share information, and solicit input with a directive to report recommendations back to the committee in January 2022. MQF was one of the organizations asked to participate in the LD 1196 Stakeholder group.

The findings in MQF's second annual primary care spending report were highlighted and provided the foundation for Maine's spending in several presentations by national experts, including the presentation made by Zirui Song, MD, PhD, Associate Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School; Assistant Professor of Medicine and Internal Medicine Physician, Department of Medicine, Massachusetts General Hospital.

MQF compared the definition of primary care proposed in LD 1196 and how that differs from the definition MQF has used to estimate the percentage of primary care spending in Maine. A side-by-side comparison is in

[x] This definition of non-claims-based payments was used in the questionnaire that was sent to Maine insurers in 2021.

Attachment G. Agreement on a definition of primary care both in terms of which provider types and/or specific procedures should be included in Maine's definition of primary care would be helpful for future reporting.

Environmental Scan

Update of National and State Activities to Define and Measure "Primary Care Spending"

For prior MQF reports, we have conducted an extensive review of efforts underway nationally and in other states to measure primary care investment to ensure Maine's definition is in general alignment with other initiatives. In addition to a review of the literature, we consulted with organizations and other states to learn about efforts to establish a uniform definition of which providers and types of services or procedures are considered primary care to allow for benchmarking. Based on MQF's extensive review, we found most state and national reports 'derived' their initial primary care definitions from early work conducted by Michael Bailit on behalf of the Milbank Foundation to establish a standardized primary care definition.[6] However, in operationalizing this definition for the purposes of estimating primary care spending percentages in administrative claims, each report interpreted **who to count as primary care providers, which specific primary care services to include** and **what to include in the total medical spending denominator** slightly differently. For example, while most state and national reports consistently included Internal Medicine, Family Medicine, Pediatrics, and General Practice in their lists of provider taxonomies to include as primary care providers, many states included other provider taxonomies in their definition of primary care (e.g., NPs, PAs, Geriatric medicine, FQHCs/RHCs, OB/GYNs providing primary care services, behavioral health providers).

Many national and state reports present ranges of primary care spending estimates by broad and narrow definitions where the specifications for how broad and narrow primary care definitions are defined vary depending on whether they use a provider-based or service-based definition. For example, in the Primary Care Collaborative's cross-state analyses using FairHealth commercial insurance claims data, which uses only a provider-based definition, the narrow definition captured spending, "related to services provided by primary care physicians, specifically family and internal medicine, pediatrics, and general practice physicians, in offices and outpatient settings" while its broad definition "includes all of the clinicians, services, and settings in the narrow definition of primary care and adds other members of the primary care clinical team, including services provided by nurse practitioners (NPs), physician assistants (PAs), geriatricians, adolescent medicine specialists, and gynecologists in addition to all services provided by IM, FM, Peds, GM providers."[7]

In contrast, like MQF's prior reports, most states use a provider-based definition for their broad definition and a service-based definition for narrow. The universe of primary care providers is the same, but for broad they include all services provided by these providers, and for narrow they limit the calculation of primary care spending to only specific services delivered by these providers (e.g., preventive care, office visits). The list of specific services included in narrow definitions also varied by state. State reports also differ in what they count as total cost of care in their denominator for calculating primary care spending, with some using the total paid amount or plan paid amount and including or excluding pharmacy claims with medical claims.

Based on the environmental scan, MQF concluded ***there is no standardized primary care (numerator) or total cost of care (denominator)*** to use to calculate Maine's primary care spending estimates from claims.[3]

For this 3rd annual report, we updated our review of other primary care spending reporting and benchmarking efforts underway in other states and nationally, focusing specifically on how OB/GYN, behavioral health, and non-claims-based payments are counted in estimating primary care spending. We focused on these issues specifically in response to questions raised by MQF's Primary Care Advisory Committee. See Table 6, **Summary of How State Definitions of Primary Care Differ: Inclusion/Exclusion of OB/GYN, Behavioral Health, and Non-Claims-based Payments.** More detailed findings can be found in *Attachment H*.

As summarized in Table 6, our updated environmental scan revealed that:

- At least 11 states are now measuring primary care spending as a percent of commercial and/or Medicaid total medical spending or have announced an intent to do so.
- Definitions of what primary care provider taxonomies and/or specific primary care procedures are included in these states broad and narrow definitions continue to vary making apples-to-apples comparison for benchmarking across states or with Maine primary care spending rates difficult.
- Most states that produce estimates of primary care spending include OB/GYN services that are performed by a primary care provider (PCP) in their definitions of primary care (CA, CT narrow) and/or include primary care specific services delivered by an OB/GYN provider (CO, MA, OR, RI, UT, VT, WA broad). Four state or multi-state reports excluded OB/GYN altogether (DE, MD, NESCSO broad and narrow) or excluded them from their primary care narrow definition (WA, PCC).
- Five state or national reports excluded behavioral health services from their primary care definitions entirely (CA, DE, UT, NESCSO, PCC). Three included behavioral health services that are provided by a PCP (CT, MD, RI) and four (OR, CO, VT, RI) include behavioral health providers integrated within primary care or BH providers that accept the responsibilities of primary care.
- In 2020 Massachusetts began requiring commercial health plans including self-insured plans to separately report summary-level claims and non-claims payments made for behavioral health and primary care to the state.[8] Using a hierarchical assignment method, commercial plans report behavioral health and primary care claims and non-claims payments at the managing physician group level. Behavioral health payments were defined by a combination of principal diagnoses, procedure, and place of service or revenue codes; primary care was defined based on a list of CPT/HCPCS codes by specific primary care provider types (including OB/GYN providers).
- Nine states included non-claims-based payments that support primary care but differed in which types of non-claims payments are collected and reported (e.g., payers versus provider-level). There is currently no standardized approach for how to collect non-claims data although Maine has been participating in different efforts within NESCSO and the National Health Data Organization to establish a national standard.[9] States that currently collect and report non-claims payments total and/or primary care payments have each developed their own method, either building off states that have been collecting this data for a longer period, improving data specifications based on reported data and/or adapting general categories or definitions recommend by the Milbank Foundation. MHDO also consulted these sources and met with CO/OR officials regarding their experience and changes to non-claims-based data collection to inform MHDO's proposed rule change for future non-claims reporting in Maine.

Table 6. Summary of How Definitions of Primary Care Differ: Inclusion/Exclusion of OB/GYN, Behavioral Health, and Non-Claims-based Payments

		OB/GYN		Behavioral Health		Non-Claims-based Payments
		PCP → OB/GYN Service	OB/GYN → PC Service	PCP → BH Service	BH Provider → PC Service	
CA[10]		✓	—	—	—	✓
CT[11]	Narrow	✓	—	—	—	✓
	Broad	✓	✓	—	—	
CO[12]		✓	✓	✓	✓	✓
DE[13]		—	—	—	—	✓
ME	Narrow	✓	✓	—	—	✓
	Broad	✓	✓	—	—	
MA[14,15]		✓	✓	✓[xi]	✓	✓
MD[16]		—	—	—	—	—
OR[17,18]		✓	✓	✓	✓	✓
RI[19,20]		—	—	—	—	✓
UT[21]		✓	✓	✓	—	—
VT[22,23]		✓	✓	—	—	✓
WA[24]	Narrow	✓	—	—	✓ (NP)	—
	Broad	✓	✓	✓	✓	
NESCSO[25,xii]	Definition 1 selected services included	—	—	—	—	✓
	Definition 2 all services included	—	—	—	—	
PCC[7]	Narrow	✓	—	—	—	—
	Broad	✓	✓ (OB only)	—	—	

Column 1 = PCPs delivering OB/GYN services; Column 2 = OB/GYNs delivering primary care services
Column 3 = PCPs delivering behavioral health services; Column 4 = Behavioral health providers delivering a primary care service

[xi] MA reports behavioral health separately from primary care.

[xii] NESCSO measured OB/GYN services provided by OB/GYN providers and OB/GYN services provided by primary care providers separately. The report included non-claims payment data for states that required reporting.

Conclusion and Future Considerations

The findings in this third annual report show that, on average primary care spending based on what is reported to MHDO in claims data represents a range of 5%-9% depending on the definition used, broad vs narrow. When the definition of primary care is limited to include a specific set of procedures provided by primary care providers (i.e., the narrow definition), the estimated primary care spending rate is almost half the spending rate when you count all services provided by those primary care providers (i.e., the broad definition). By contrast, the impact of including other providers offering primary care services (e.g., OB/GYN primary care services) has minimal impact on overall primary care spending rates.

As there is no standard definition of primary care nationally, for this and prior reports MQF has used both a narrow and broad definition of primary care, drawing from evolving best practice and with input from our Advisory Committee. Further drill down analyses of the broad definition in this report revealed some services being performed by primary care providers (e.g., hospitalists billing under primary care taxonomy codes for chemotherapy treatments) that may warrant further review. For future reports, we will continue to work with the Advisory Committee to refine MQF's primary care definitions as appropriate within the constraints of provider billing practices and what is reported in claims, with the goal of moving toward a single definition.

The 2020 claims data reported to MHDO suggests that the impact of the COVID-19 pandemic has not changed the percent of payments made to primary care regardless of the two definitions used by MQF. While there was some variation within payers, across payers, on average, (when using either the broad or narrow definition) primary care spending rates remained relatively constant. The expansion in telehealth codes and providers that can be reimbursed for telehealth services resulted in increased use of telehealth in 2020 relative to before the pandemic, and may have helped maintain access to primary care when in-person care was not available.[26]

In further investigations for this report, we also noted cross-year differences in claims data between or within payors that suggest using caution in interpreting trends over time. For future analyses, MQF will consider testing for statistical significance and applying adjustments for other underlying trends in enrollment, utilization, inflation, and other factors which may also contribute to differences in primary care and non-primary care spending.

The impact of adding non-claims-based payments into the calculation to estimate the percentage of payments made for primary care will be part of MQF's year four primary care spending report. What we know is there are investments being made to improve and support primary care in the form of non-claims-based payments as documented by the entities that voluntarily submitted their non-claims-based payments for primary care for this report. The inclusion of these payments will improve the accuracy of our estimates.

Attachments: Supporting Documentation

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

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 – Advisory Committee Members

Sarah Calder
MaineHealth

Rob Chamberlin, MD
MaineHealth ACO

Ned Claxton, MD
Maine State Senator

Jon Fanburg, MD
American Academy of Pediatrics

Deborah Halbach
Maine Academy of Family Physicians

Peter Hayes
Healthcare Purchaser Alliance of Maine

Jennifer Kent
Maine Education Association Benefits Trust

Neil Korsen, MD
MaineHealth

Lisa Letourneau, MD
Maine Department of Health and Human Services

Andrew MacLean
Maine Medical Association

Lisa Harvey McPherson
Northern Light Health

Dan Morin
Maine Medical Association

Katherine Pelletreau
Maine Association of Health Plans

Michelle Probert
Maine DHHS, Office of MaineCare Services

Darcy Shargo
Maine Primary Care Association

Trevor Putnoky
Healthcare Purchaser Alliance of Maine

Beth Wilson, MD
MaineHealth

Samuel Zager, MD
Maine State Representative

Attachment C – Public Law Ch. 244 Advisory Committee Meeting Summary Notes

October 26, 2021 | *1:00 – 2:00 PM* | Via Zoom

Purpose

Convene Advisory Committee charged with providing input to the Maine Quality Forum on the development of the annual report on primary care spending in Maine.

Attendees

ADVISORY COMMITTEE MEMBERS IN ATTENDANCE:

Sarah Calder, Rob Chamberlain MD, Marco Cornelio MD, Jonathan Fanburg MD, Deborah Halbach, Katherine Harris, Lisa Harvey-McPherson, Peter Hayes, Jennifer Kent, Neil Korsen MD, Barbara Leonard, Lisa Letourneau MD, Andrew MacLean, Katherine Pelletreau, Michelle Probert, Joanne Rawlings-Sekunda, Adam Richards, Darcy Shargo, and Beth Wilson MD

OTHER ATTENDEES & STAFF: Karynlee Harrington, Anna Wright, Kimberley Fox, Carolyn Gray, Jennifer MacKenzie, Catherine McGuire, Chinonye Anumaka, and Judy Loren

AGENDA	DISCUSSION SUMMARY
Welcome	
• **Introductions**	Karynlee Harrington welcomed the attendees and reviewed the agenda for the meeting. Each attendee introduced themselves to the group. Karynlee thanked the University of Southern Maine and Judy Loren who under a cooperative agreement have provided guidance and expertise in working with MHDO's claims data and producing the annual report.
• **Review Requirements of Public Law Chapter 2019, Ch. 244** (Karynlee Harrington)	Maine Quality Forum is required to produce an annual report on primary care spending and submit it to the commissioner of DHHS and the legislative committee on Health Coverage and Insurance and Financial Services. The report must measure the percentage paid for primary care by payers in the state using claims data from the Maine Health Data Organization and include methods used by payers to reimburse primary care providers. Data is to be presented by commercial insurance, MaineCare, Medicare, and two employer groups – State Employee Plan and Maine Education Association Benefit Trust. MQF submitted the first report in January of 2020. Today's meeting is to help guide the development of our year three report.

AGENDA	DISCUSSION SUMMARY
• **Review Role of the Advisory Committee** (Karynlee Harrington)	The Advisory Committee provides input to the MQF on the development of the annual report, including the methods used to define primary care and identifying issues for MQF to consider. After we meet today, staff will begin drafting the 3rd annual report. We plan to produce a draft report in December for the Advisory Committee to review. We will finalize/submit the report by the middle of January 2022.
Recap Years 1 and 2, Recent Activity	
• **Highlights of Years One and Two Reports** (Kimberley Fox)	Kim Fox highlighted the key differences between the first and second annual reports. • 1st report – We assessed how to define primary care and conducted a scan of best practices from other states and national reports. We also surveyed the Maine insurers on how they define primary care and asked them about non-claims-based payment methods used to reimburse primary care providers. We developed definitions and got input form the Advisory Committee, including the addition of some taxonomy codes. The report used all payer claims data from 2016 through 2018. We included both a narrow and broad definition of primary care. The list of providers is included in the report. For OB/GYN, we only included services provided for specific primary care services. The narrow definition was an intersection between those provider types and specific primary care services. • 2nd report – The second report included an updated environmental scan of regional and national efforts. Maine also participated in NESCSO's regional report (which included all the New England states), which tried to standardize a definition of primary care. We tried to align our efforts with that definition. We also looked at the national Primary Care Collaborative report, which developed primary care spending estimates across states using Fair Health data. In both cases, the findings aligned closely to MQF's primary care spending estimates based on our definition, even when the definitions varied slightly. Our analysis used 2017 to 2019 data. • The 2nd MQF annual report analyzed APCD data from 2017 to 2019. The definitions of primary care were similar to the first annual report, with the exception of one added taxonomy code to be consistent with NESCSO. In 2019, the percentage of primary care spending on average across all payers was 9.1% using the broad definition. There was variation across payers. In terms of narrow and broad, there were some larger differences between payers. • Neither the first or second MQF primary care spending reports included non-claims-based payments as MHDO had not been collecting them. The NESCSO report attempted to add those payments on a voluntary basis.

AGENDA	DISCUSSION SUMMARY
• **Review Current Status of Committee's Recommendations** (Karynlee Harrington)	• **Non-Claims-Based Payments:** MQF's first annual report included a recommendation to the MHDO that they develop a rule to collect non-claims-based payments to help support a more accurate reporting of the investment in primary care. The MHDO Board held a public hearing in September 2021 on a new proposed rule, Chapter 247, *Uniform Reporting System for Non-Claims-Based Payments*. There were no substantive public comments during or after the hearing regarding these requirements. If all goes as planned at the November 4 MHDO board meeting, the board will vote on adopting the new requirement and it will go into effect in 2022. The data submitted under the rule will not be a part of the third annual MQF report but will be included in the year four report. • The MQF sent out a request to the largest payers in the state asking them to submit aggregate level information regarding non-claims-based payments by November 1. The request for data is like the data that payers will be required to submit under Chap. 247 once it is enacted. We hope to use the voluntary data submissions in our year three report. As discussed with this group at length it is important that the reporting on primary care spending reflect both the claims-based and non-claims-based payments. The annual report has understated the primary care spending because it doesn't include both types of payments. Based on what we get for responses to our request, we will decide whether and how to incorporate this information into the year three report. • **Race/Ethnicity and Other Social Determinants of Heathcare:** Another recommendation from the Advisory Group was for MQF to look at primary care spending by race and ethnicity. Karynlee explained that the MHDO claims data is currently not the best MHDO data set for these data elements. The year three report will not include a breakdown of spending by race and ethnicity. However, MHDO is looking at how to leverage the comprehensive race and ethnicity data that is collected and submitted by hospitals in their data submissions to MHDO. Karynlee also shared with the group that the MHDO board is considering proposed changes to Rule Ch. 120, *Release of Data to the Public*, which would move the race and ethnicity data elements to a less restricted category of release so that a broader group of MHDO approved data users may access these data. This is a major substantive rule which means after the board provisionally adopts the proposed changes, the rule will go to the legislature. If all goes as planned the proposed changes will go into effect sometime in 2022.
• **Key changes for the third annual report**	Kim Fox reviewed the proposed key changes for MQF's third annual report. She explained that MQF is suggesting few changes because of anticipated changes to 2020 data caused by the pandemic (e.g., reduced in-person primary care, increased telehealth use, etc.). • <u>Using broad definition:</u> We suggest limiting the analysis to the broad definition. This would include the full list of taxonomy codes, with all services by primary care providers and just specific services provided by OB-GYNs.

AGENDA	DISCUSSION SUMMARY
	From a policy perspective, the broad definition may come closer to what we want to be counting as primary care. Nationally, there has been more focus on the broad definition. The narrow definition shows a smaller percentage of primary care spend and includes those procedure codes that we've identified as primary care; these codes are always changing. • Telehealth: If we continue to use the intersection of provider taxonomy codes with procedure codes, we will add new telehealth codes that were introduced during the pandemic. • Drill downs by age and consumer cost share: We included these analyses in the year two report. For consumer cost share, we only show results by commercial insurers. We suggest not including these in the upcoming report because of the potential changes in 2020 data but may want to include these again in a future year. • Environmental scan: We intend to look at states that include behavioral health in their primary care estimates to keep abreast of how that's being done elsewhere to inform Rep. Sam Zager's amendment to LD 1196, to potentially include behavioral health in primary care estimates in Maine. • Nonclaims based payments: Depending on responses to the insurer questionnaire, we will either include these payments in aggregate or we will discuss this in our narrative.
• **Discussion**	Karynlee opened the meeting to discussion with the Advisory Group. The discussion focused on the best way to define primary care, the importance of establishing a trendline, and benchmarking with other states when possible. **Broad versus narrow definition recommendation** • Several members (Wilson, Letourneau, Chamberlain) expressed concern with the recommendation to only report spending for the broad definition; and supported continuing to report spending for both the narrow and broad definitions. If they were to pick only one, it would be the narrow definition as the most realistic representation of what primary care is doing. While some specialists might provide primary care services/screenings, it's not what is meant by increasing investment in primary care (Wilson). Other members (Korsen, Chamberlain, Cornelio) noted there may be primary care taxonomies captured in the broad definition that are providing some non-primary care services (e.g., family physicians work in sport's medicine and may be doing some procedures that are more specialized). Further detailed information on what services are included in the broad definition compared to the narrow definition would help to explain differences (Chamberlain). o *Kim Fox and Karynlee Harrington clarified the distinction between the narrow and broad. Provider taxonomies are the same in both definitions. The difference is that the broad includes all services (with the exception of OB/GYNs which are only included for specific primary care services) and the*

AGENDA	DISCUSSION SUMMARY

narrow only includes specific services provided by primary care providers (as detailed in the MQF report-list of CPT codes included). Primary care services provided by other specialists are not included in either MQF's narrow or broad definition.

- Other members (Hayes, Pelletreau) indicated they would choose the broad definition or if narrow only, would need more explanation of what services were included in the broad definition provided by primary care provider taxonomies, not included in the narrow definition. While we are measuring the total spending on primary care, can we also measure what we are spending it on (i.e., preventative, diagnostic, etc.)?
    - *Karynlee and Judy Loren confirmed that we can query the data based on the different procedure codes and can include the list of codes included in the broad definition that are not included in the narrow definition for the Y3 report. Kim noted that we have narratively described the types of services in the broad definition not in the narrow definitions. In last year's MQF primary care spending report, examples included family planning services, diagnostic imaging, lab imaging.*

- Other members (Fanburg, Harvey-McPherson) commented on the importance of keeping a consistent definition(s) to measure trends over time.

Alignment with other state definitions for benchmarking

- Other members (Peter Hayes, Korsen) suggested Maine should align with other states that policymakers are considering/modeling Maine's LD 1196 legislation on (RI, CT, MA) to allow us to benchmark and compare primary care spending estimates on an apples-to-apples basis. In the next round of the report, Hayes suggested maintaining trend lines we've had and clarifying what is in our numbers and how that might be different from other states. We are using this to figure out spending targets in Maine so the greatest service would be to include enough details to answer different stakeholders' interests. The data needs to be easy enough to know when we are talking apples to apples and when we aren't. If there is confusion within the Committee, this will also happen when there is a more public debate.
    - *Kim Fox noted that there still is no standard definition of primary care. All the states use slightly different definitions. For example, the Primary Care Collaborative that used FAIR Health data across states reported both broad and narrow, but both were defined by provider taxonomies not services (e.g., Narrow – all services provided by Internal Medicine, General Medicine, Family practice, and Pediatrics, Broad - added other providers supporting primary care Nurse Practitioners, Physician Assistants, gynecologists). Regionally, Maine's broad and narrow definitions are closely aligned with NESCSO's definition as Maine helped inform their definition.*

AGENDA	DISCUSSION SUMMARY

	• Others (Wilson, Leonard) raised the issue of potential differences when comparing Maine to other states (e.g., rurality) that may require Maine's definitions to reflect our primary care 'real world' practice. Dr. Wilson said she would prefer HRSA's definition which defines primary care as Family Medicine, General Internal Medicine and General Pediatrics only. Barbara Leonard asked whether the broad definition ensures a more complete group of providers are represented across the state, especially those in rural areas and/or for individuals who are under-served.
	  ○ *Karynlee confirmed that these providers (e.g., RHCs, FQHCs) are included in both narrow and broad definitions.*
	
	Inclusion of OB/GYNs in definition of primary care
	
	• Some members raised concerns re including OB/GYN in primary care definition (Wilson, Letourneau). Others (Pelletreau) did not recommend removing because some women do use as their primary care provider and it would impact interpretation of spending trend (Harvey-McPherson, Hayes). Still others recommended reporting separately (Wilson) and/or looking at national/other state (OR/RI) benchmarks and how they handle OB/GYN in their analyses. (Hayes, Korsen).
	  ○ *Kim Fox reminded everyone that there is no consensus definition although we have tried to be consistent with others. Oregon does include OB/GYNs in their definition, but many do this differently. It's tough to benchmark with other states for that reason.*
	  ○ *Karynlee said that we can help clarify any confusion around OB/GYNs by discussing it in the narrative, indicating how much of primary care spending is associated with OB/GYN inclusion and updating our environmental scan of how other states have included it/or not in their definitions.*

Next Steps and Timeline	
	Karynlee said that our next step will be to pull together a draft report, using the direction we received today. • We will work to get this draft out by the week of 12/13. • Committee feedback will be due by 12/22. If this timeline changes, we will let you know. • We plan to submit the final report by Jan. 15, but this may be delayed if there are changes that take more time. Karynlee asked the Committee to send any additional comments via email, before thanking everyone and adjourned the meeting.

ISSUE	MQF RESPONSE
Narrow versus Broad definition: • The Advisory group members largely expressed a preference to continue to report both the broad and narrow definitions to allow us to measure trend over time. • Members also requested more information on what services were included in the broad definition but not in the narrow in order to assess whether or not to limit to one or the other or to modify services included in either one in future reports.	We will continue to report both the broad and narrow definitions of primary care for the year three report. We will also include the list of specific procedure codes included in the narrow definition and describe procedures/services provided by primary care providers in the broad definition that are not captured in the narrow definition.
Consistent Definitions to benchmarking with other states: • Members also commented on the importance of Maine's definitions aligning with other states/regional (e.g., RI, MA, CT) definitions to allow benchmarking on an apples-to-apples basis.	Prior reports have sought to align Maine's definitions with NESCSO and other states to the extent possible, recognizing that there is no standard definition of primary care. For the Y3 report, we will update the environmental scan included in the first MQF annual primary care spending report, focusing on differences in the definitions between states and other national reports related to inclusion of behavioral health (per LD 1196 amendment), OB/GYN, and off-claims based payments.
Inclusion of OB/GYN in primary care definition: • Members suggested taking out OB/GYN or showing separately. • Others expressed concern about removing OB/GYN because many women use them as their primary care provider and because it would cause a disruption in Maine's data trend ((Harvey MacPherson, Korsen)	We will add a discussion about how much of the total is attributed to the OB/GYN inclusion and will also investigate whether and how other states have included OB/GYN as part of our updated environmental scan.

Attachment D – Methodology for Estimating Primary Care Spending

To determine the percentage of total healthcare payer expenditures for primary care in Maine using the Maine Health Data Organization's (MHDO) all payer claims data (APCD) for the third annual report, we reviewed our primary care definitions based on the following:

- Language in P.L. Chapter 244, Sec. 2. 24-A MRSA §6903, sub-§13-B,
- Methods and definitions used in the prior two 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 6 largest insurers 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 insurers with the MQF Primary Care Spending Advisory Board. Given the lack of a standard primary care definition, MQF reported a range of primary care spending estimates using narrow and broad definitions. For both narrow and broad definitions, taxonomy codes for primary care providers and specific procedure codes for primary care services were identified from the environmental scan and/or where at least one insurer identified them in its definition on the Maine insurer survey.

For this report, we identified services delivered via telehealth and provided a separate break out by primary care providers. Criteria for identification of services delivered via telehealth are included in Attachment E.

Data Source

Information for calendar years 2018-2020 from Maine's APCD maintained by the MHDO was used to conduct this study. The Maine APCD contains claims and enrollment information for commercial insurance carriers, third party administrators, pharmacy benefit managers, dental benefit administrators, MaineCare (Maine's Medicaid and CHIP program), and Medicare.[xiii]

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.

[xiii] Medicare Advantage plans and regular fee-for-service Medicare are included.

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[xiv];
- Claims for health care policies issued for specific diseases, accident, injury, hospital indemnity, disability, long-term care, vision, [xv] coverage of durable medical equipment;
- Claims related to Medicare supplemental, [xvi] 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 Supreme Court ruling[xvii], 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.

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 Medicaid claims for Maine members and approximately 70% of the Commercially insured population in Maine.,

In the preparation of this report, MQF was informed by MHDO that one commercially insured carrier did not submit all medical claims for CY 2020 due to a programming issue. As unsubmitted claims were likely to be randomly distributed across primary care and non-primary care medical claims paid and unlikely to impact the **percentage** of primary care spending by this carrier, we maintained their claims data that had been submitted for CY 2020 in the Commercially insured estimates. However, absolute commercial insurer paid amounts for primary care and total medical expenditures and members enrollment in 2020 will be lower because of underreporting by this carrier.

This study used medical claims (CY 2018-2020), excluding dental and pharmacy claims. Additionally, MaineCare long-term services and support (LTSS)[xviii] 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 has been modified from prior year's based on additional information (i.e., non-claims supplemental hospital payments) provided by the Office of MaineCare Services (OMS).

The MHDO's APCD contains information about the payer for the health care service. This information was used to categorize claims paid for the following populations: commercial (excluding Medicare Advantage); Medicaid; Medicare (including both Medicare Advantage and Fee-for-service plans). Additionally, as required by the

[xiv] 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.

[xv] Quality review of the data has identified the submission of some of these types of plans. We have deleted these from this analysis

[xvi] Quality review of the data has identified the submission of some of these types of plans. We have deleted these from this analysis

[xvii] *Gobeille v. Liberty Mutual Insurance Company*, US Supreme Court Decision that Employee Retirement Income Security Act (ERISA) standards preempt state reporting requirements.

[xviii] MaineCare long-term services and supports (LTSS) expenditures for Medicaid were excluded based on an estimated percentage of LTSS service costs to the total Medicaid service costs (excluding pharmacy and dental) conducted by the Muskie School. LTSS services include providers billing nursing home, residential care, home and community-based care services, private duty nursing, etc.

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

Medical claims contain identifiers (National Provider Identifiers (NPI)) for multiple levels of providers. To determine whether the provider of a claim met the definition of a Primary Care Provider, the billing and servicing provider NPIs s were examined to find the Individual provider and their primary taxonomy code. If both billing and servicing providers were organizations, the servicing provider was used. Once a single provider was identified for each claim, the taxonomy code was determined using a copy of the National Provider and Payer Enumeration System (NPPES) database maintained in the MHDO Enclave data management system (updated 11/2021).

Primary Care provider identification relies on our ability to identify a taxonomy code from the list in the table below for the rendering/servicing provider or organization on a claim. In the claims submitted to the APCD, hospital affiliated providers and FQHC/RHCs that bill on a facility claim type (UB-04) often 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[xix], we were not able to establish a reliable mechanism for identification of primary care services for claims that specified only a hospital as the provider. Thus hospital-based primary care providers who bill under the hospital NPI with no individual rendering/servicing information provided are not included in our primary care estimates. As a result of some of these anomalies in provider billing practices on claims, primary care spending estimates may understate total primary care spending.

Identification of Primary Care Services

Both professional (1500 claim form) and facility (Uniform Billing Form (UB-04)) claim types were examined to find procedure codes included in the narrow definition of primary care services.[xx] The lists of primary care taxonomy and procedure codes were developed from studies done by other states including Rhode Island, Oregon, Colorado, Connecticut, Massachusetts and Vermont, Millbank and NESCSO, as well as the results from the state insurer questionnaires collected as part of this study. Primary care services provided in hospice, nursing and custodial care facilities were included based on the guidance of the Advisory Committee.

While some states use ICD-10 diagnosis codes to identify primary care, the lack of methodological clarity on how these are incorporated led to their not being included as part of the definition of Primary Care in this study.

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

Broad definition (All services provided by primary care providers): The Broad definition of Primary care includes all services provided by health care professionals that have a primary care taxonomy code with the exception of services delivered in an inpatient or emergency department setting.[xxi] For OB/GYN providers, in

[xix] 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 narrow definition of primary care.

[xx] 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.

[xxi] Taxonomy codes are administrative codes set for identifying the provider type and area of specialization for health care providers. Each taxonomy code is a unique alphanumeric code that enables providers to identify their specialty at the claim level. See *Attachment D* tables for the full list of provider specialty taxonomy codes used as Primary Care.

both the broad and narrow definitions, we only counted specific primary care services they provided. The list of primary care provider taxonomies for this definition, and the list of primary care services that were counted for OB/GYNs, can be found in *the tables below.*

Narrow definition (Specific primary care services provided by primary care providers): The Narrow definition of Primary care includes a specific set of services (found in table below) provided by health care professionals that have a primary care taxonomy code, again with the exception of those services delivered in an inpatient or emergency department setting. The list of procedures used for this definition is identical to last year's report with the addition of a few telehealth codes.

Identification of Telehealth Delivered Services

Claim lines associated with delivery of services via telehealth were identified using specific procedure code modifiers (GT, 95), place of service (POS) code (02) or procedure codes provided in *Attachment E*. 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 insurers during the measurement year that meet the inclusion criteria identified above. For the insurers that provided the information, non-claims-based payments were added to their estimates.[xxii] The denominator, or base for the calculation of Primary Care percentage, was the sum of plan paid amounts for all medical (not pharmacy or dental) claims used in this study (see *Data Source*, above).

For the primary care numerator for the broad and narrow definitions, were the sum of the plan paid amounts on claim lines that met the definition criteria for broad (i.e., ***all services provided by primary care providers*** *based on taxonomy codes*) and narrow (i.e., ***selected services identified as primary care*** *provided by these primary care providers*).

We included insurer payments made in any month in the calendar year. No consideration was given to the length of time a member was covered by health insurance during the measurement year.

[xxii] 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.

Primary Care Provider Type Taxonomy Codes and Description Included in Broad and Narrow Definitions

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[xxiii]	
207V00000X	Physician, Obstetrics and Gynecology
207VG0400X	Physician, Gynecology
363LW0102X	Nurse Practitioner, Women's Health
363LX0001X	Nurse Practitioner, Obstetrics and Gynecology

[xxiii] For OB/GYN taxonomy codes, we only included payments for primary care services listed in narrow definition.

Narrow Definition Primary Care Service Procedural Terminology (HCPCS) Codes and Description

Procedure Codes included in the Narrow Primary Care Definition	
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 included in the Narrow Primary Care Definition	
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
90738	Japanese encephalitis virus vaccine,

Procedure Codes included in the Narrow Primary Care Definition	
Procedure Codes	**Description**
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
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
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

Procedure Codes included in the Narrow Primary Care Definition	
Procedure Codes	**Description**
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
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

Procedure Codes included in the Narrow Primary Care Definition	
Procedure Codes	**Description**
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
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

Procedure Codes included in the Narrow Primary Care Definition	
Procedure Codes	**Description**
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)

Attachment E – Telehealth Codes Included in Telehealth Analysis

Procedure Codes Used in Telehealth Analysis*	Description
2 (Place of Service)	Health services are received through Telecommunications technology
GT (Modifier)	Via interactive audio and video telecommunication systems
95 (Modifier)	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
99446-99449	Interprofessional Telephone/Internet/Electronic Health Record Consultations
99451-99452	Interprofessional Telephone/Internet/Electronic Health Record Consultations
0188T-O1189T	Remote Real-Time Interactive Video-conferenced Critical Care Services
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 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
Q3014	Telehealth originating site facility fee
T1014	Telehealth transmission, per minute, professional services bill separately
G2025	Payment for a telehealth distant site service furnished by a rural health clinic (rhc) or federally qualified health center (fqhc) only
S9110	Telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month
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
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

Procedure Codes Used in Telehealth Analysis*	Description
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
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
99441-99444	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

*Most codes used a Modifier.

Attachment F – Total Plan Paid Medical and Primary Care Expenditures and Percent Primary Spending by Broad and Narrow Definitions, 2018-2020

Payer		2018		2019		2020	
		Total $ (millions)	% of Total	Total $ (millions)	% of Total	Total $ (millions)	% of Total
Commercial							
TOTAL EXPENDITURES		$1,782		$1,904		$1,781	
PRIMARY CARE EXPENDITURES	***Broad***	$193	**10.8%**	$201	**10.6%**	$186	**10.4%**
	Narrow	$100	**5.6%**	$106	**5.6%**	$94	**5.3%**
MaineCare							
TOTAL EXPENDITURES		$1,068		$1,215		$1,204	
PRIMARY CARE EXPENDITURES	***Broad***	$112	**10.4%**	$129	**10.6%**	$130	**10.8%**
	Narrow	$79	**7.4%**	$92	**7.6%**	$91	**7.5%**
Medicare							
TOTAL EXPENDITURES		$2,681		$2,797		$2,599	
PRIMARY CARE EXPENDITURES	***Broad***	$188	**7.0%**	$206	**7.4%**	$190	**7.3%**
	Narrow	$127	**4.7%**	$133	**4.8%**	$117	**4.5%**
SEHC*							
TOTAL EXPENDITURES		$154		$161		$145	
PRIMARY CARE EXPENDITURES	***Broad***	$13	**8.7%**	$14	**8.7%**	$12	**8.5%**
	Narrow	$9	**5.7%**	$9	**5.4%**	$8	**5.3%**
MEABT*							
TOTAL EXPENDITURES		$300		$314		$284	
PRIMARY CARE EXPENDITURES	***Broad***	$28	**9.3%**	$29	**9.3%**	$26	**9.1%**
	Narrow	$19	**6.3%**	$19	**6.2%**	$17	**6.0%**
Average All Insurers							
TOTAL EXPENDITURES		$5,531		$5,916		$5,585	
PRIMARY CARE EXPENDITURES	***Broad***	$493	**8.9%**	$536	**9.1%**	$505	**9.0%**
	Narrow	$307	**5.6%**	$331	**5.6%**	$301	**5.4%**

Data Source: MHDO APCD claims data; Reported medical spending reflects plan paid amounts
SEHC = State Employee Health Commission
MEABT = Maine Education Association Benefits Trust
* SEHC and MEABT are reported separately as required by PL Chapter 244, but are a subset of commercially insured.

Attachment G - Comparison between LD 1196 Primary Care Definition and Definition used for MQF's Primary Care Spending Report (under PL Ch 244)

December 2021

The following language describing primary care and/or behavioral health care was drawn from the PL Chapter 244 and LD 1196 legislation.

Public Law Chapter 244 – An Act To Establish Transparency in Primary Health Care Spending[1] defined primary care as:

> "… 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."

Through guidance from the Advisory Committee and an environmental scan of best practices in other states and nationally, MQF further defined primary care as described in the following tables.

LD 1196 - An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health[27] defined behavioral health and primary care separately as follows*:*

(1) "Behavioral health care" means mental health services, including community-based or peer support treatments for substance use disorder provided by licensed health care practitioners providing services within their scope of practice, regardless of practice setting.

"Behavioral health care" also includes provider loan repayments and services such as health information technology services, recruitment services and practice transformation services that support the practitioners described in this subparagraph in the delivery of behavioral health care services.

(2) "Primary care" means care provided by:

a) Primary care practitioners, including family physicians, internists, pediatricians and geriatricians, except when practicing inpatient care or when practicing in an emergency department or stand-alone urgent care clinic;

b) Obstetrician-gynecologists who assume responsibility for a patient's general primary care according to the gynecologic and nongynecologic standards of the United States Preventive Services Task Force or its successor organization except when practicing inpatient care or in an emergency department or stand-alone urgent care clinic;

c) Physicians or surgeons of any specialty when providing general or reproductive care to special populations or in special circumstances, including, but not limited to, in clinics for persons who are homeless or indigent, federally qualified health centers, home-based palliative care, school-based health centers and general clinics focusing on traditionally marginalized populations such as indigenous or other people of color, immigrants, asylum-seekers, migrant workers, persons who are marginalized on the basis of gender identity or sexual orientation, victims of human trafficking, incarcerated individuals and victims of declared natural or human-caused disasters; and

d) Advanced practice clinicians providing the services described in subparagraphs (a) to (c).

"Primary care" also includes provider loan repayments and services such as health information technology services, recruitment services and practice transformation services that support the practitioners described in this paragraph in the delivery of primary care services."

Table A compares providers and services specified in *LD 1196 - An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health* with the list of providers and services used for the PL Chapter 244 required annual MQF Primary Care Spending report.

Table A. Comparison of Primary Care Provider Types included in Primary Care Definition

Provider Types	MQF Primary Care Spending Report**	LD 1196***
	Broad and Narrow Definition	
Federally Qualified Health Center	•	•
Primary Care Clinic	•	•
Rural Health Clinic	•	Not Specified
Physician, Family Medicine	•	•
Physician, General Internal Medicine*	•	•
Naturopathic Medicine	•	Not Specified
Physician, Pediatrics	•	•
Physician, General Practice	•	•
Nurse Practitioner*	•	•
Nurse Practitioner, Adult Health*	•	•
Nurse Practitioner, Family*	•	•
Nurse Practitioner, Pediatrics*	•	•
Nurse Practitioner, Primary Care*	•	•
Physician Assistants*	•	•
Physician, Geriatric Medicine	•	•
Family Practice Geriatrics	•	•
Family Practice Adult	•	•
Family Practice Adolescent	•	•
Homeopathic Medicine	•	Not Specified
Physician, Preventive Medicine	•	Not Specified
Certified Clinical Nurse Specialist	•	Not Specified
Registered Nurse, Non-Practitioner	•	Not Specified
Physician, Obstetrics and Gynecology	•****	•*****
Physician, Gynecology	•****	•*****
Nurse Practitioner, Women's Health*	•****	•*****
Nurse Practitioner, Obstetrics and Gynecology*	•****	•*****

Provider Types	MQF Primary Care Spending Report**	LD 1196***
	Broad and Narrow Definition	
School-based Health Centers	•	•
Behavioral Health Providers	-	Not included in PC definition, BH captured separately
Physicians or Surgeons of any specialty	-	•******

Table B. Comparison of Primary Care Service Types included in MQF Narrow Primary Care Definitions

Primary Care Services	MQF Primary Care Spending Report	LD 1196***
	Narrow Definition	
Office Visits	•	Not specified
Home Visits/Hospice	•	Home-based palliative care to special populations
Preventive Visits	•	Not specified
Immunizations and Injections	•	Not specified
Transitional Care Management	•	Not specified unless falls under practice transformation services that support primary care
Chronic Care Management	•	Not specified except per above
Telehealth Services	•	Not specified except per above
General or reproductive services for homeless or indigent, indigenous, people of color, immigrants, asylum-seekers, migrant workers, persons who are marginalized on the basis of gender identity or sexual orientation, victims of sex trafficking, incarcerated individuals and victims of declared natural or human-caused disasters	Not specified by population. If primary care providers provided services to these populations, they would be included in the broad and narrow definitions for specific services.	"General services" is not clearly defined but likely includes all primary care services. Since 1196 also includes reproductive and other surgeon/physician specialty for these populations these would not be in MQF's primary care definition
Mental health services, including community-based or peer support treatments for substance use disorder provided by a licensed health care practitioners providing services within their scope of practice, regardless of practice setting	Screening for alcohol and substance abuse included if provided by PC provider	

Table C. Comparison of Other Payments included in Primary Care Definition

Other Payments	MQF Primary Care Spending Report	LD 1196***
Provider Loan Repayments and Services	Aggregate non-claims-based payments will be reported as specified in Chap. 247 in future reports. This may include some of 1196 other payments (e.g., electronic health records/health information technology infrastructure/other data analytic payments, and Patient centered medical home payments) but does not include provider loan repayments and recruitment services as currently defined.	Includes these services that support the practitioners described above in Table A for primary care. Also includes these payments for behavioral health care providers in BH definition.
Recruitment Services		
Health Information Technology Services		
Practice Transformation Services		

*The asterisks by some provider types indicate where the provider name was not specifically referenced in the 1196 definition but where we interpreted the provider fell within an MQF primary care provider type. For example, 1196 includes 'Internist' in their definition, which we interpreted as falling under 'General Internal medicine" in MQF's definition. Similarly, 1196 "Advanced Practice Clinicians providing the services described in subparagraphs (a) to (c)", we interpreted as including all Nurse Practitioners and Physician Assistants in MQF's primary care definition.

**MQF's Broad definition includes *all services provided by health care professionals* that have a primary care provider type (i.e., with a primary care-related specialty or taxonomy code) except for OB/GYNs for which only a specific set of primary care services were included (see Table B). MQF's Narrow definition only includes the specific set of services in Table B provided by primary care provider types. Both broad and narrow definitions exclude any urgent care or emergency services.

*** LD 1196 defines primary care practitioners as family physicians, internists, pediatricians, geriatricians, and OB/GYNs who assume responsibility for patient's general primary care except when practicing inpatient care or when practicing in an emergency department or stand-alone urgent care clinic, physicians or surgeons of any specialty when providing general or reproductive care to special populations or in special circumstances, and advanced practice clinicians within the primary care and OB/GYN areas indicated. 1196 does not delineate any specific services provided by these provider types within their definitions of primary care but includes all services provided by the providers in Table A, except "when practicing inpatient care or in the emergency department or stand-alone urgent care clinic." which is similar to MQFs broad definition.

**** Included for specific services only (See Table B).

***** Includes OB/GYNs, "who assume responsibility for a patient's general primary care according to the gynecologic and nongynecologic standards of the United States Preventative Task Force or its successor organization except when practicing inpatient care or in the emergency department or stand-alone urgent care clinic."

******Only included when providing general or reproductive care to special populations or in special circumstances, as described in Table B.

Attachment H – How Definitions of Primary Care Differ: Inclusion/Exclusion of OB/GYN, Behavioral Health, and Non-claims-based Payments

		OB/GYN	Behavioral Health	Non-claims-based Payments
CA[10]		Included procedures if performed by a PCP	Excluded	Collected from provider organizations
CT[11]	Narrow	• Included routine non-specialty gyn. procedures if performed by a PCP • Excludes routine primary care and non-specialty gynecological services delivered by OB/GYNs and midwifery	Excluded	Insurers submit total medical expenses data which include claims and non-claims payments
	Broad	Includes routine non-specialty gyn. services if performed by a PCP and routine primary care and non-specialty gyn. services delivered by an OB/GYN or midwife		
CO[12]		Includes OB/GYN providers performing specific primary care services (e.g., routine obstetric care, excluding delivery)	Behavioral health providers with a specified taxonomy code that deliver care that is integrated with primary care	Includes the annual Alternative Payment Model (APM) files submitted by carriers that are involved in alternative payments to providers
DE[13]		Excluded	Excluded	Non-FFS payments made to support primary care (Primary Care Incentive Programs, Primary Care Capitation, and Primary Care, Care Management)
MA[14,15]		Obstetric Visits: All payments made for the professional components of routine obstetric care, as well as OB/GYN evaluation and management services (only reported as primary care when the Obstetric Visit CPT codes are present on the claim)	• Reported separately from primary care • Includes inpatient, outpatient, ED and observation, prescription drugs	Incentive Programs, Capitation, Risk Settlements, Care Management, Other Non-Claims (further subcategorized into Behavioral Health, Primary Care, and All Other)
ME		Included in both Broad and Narrow definitions: • Provider types: Physician, OB/GYN; Physician, Gynecology; NP, women's health; NP, OB/GYN • Select primary care services/procedures only	Excluded (Due to the lack of rendering or servicing provider identification on FQHCs' claims, Federally Qualified Health Center estimates may include behavioral health providers integrated in the FQHC primary care practice)	Non-FFS payments made to support primary care (see page 10 of this report for more details)
MD[16]		Excluded	Excluded	Excluded

		OB/GYN	Behavioral Health	Non-claims-based Payments
OR[17,18]		• Providers include: Physician, OB/GYN; NP, women's health; NP, OB/GYN • Services include routine obstetric care excluding delivery (60 percent of payment amount reported on claims is included to represent non-delivery services)	• Providers include: Physician, general psychiatry, Physician, child and adolescent psychiatry, • Services include: health risk assessments, counseling, care management for BH conditions, psychiatric collaborative care management, etc.	Non-claims-based payments is gathered from a reporting template completed by carriers and CCOs. Required to report total months of enrollment for CY. This allows for calculation of non-claims-based spending per member per-month.
RI[19,20]		Excluded	Excluded	Primary Care Capitation APM contracts, Performance Incentives for High Quality Care, payments to support population health and practice infrastructure, etc.
UT[21]		Included for specific services only	Excluded	Excluded
VT[22,23]		Included (procedure codes used to identify primary care services by OB/GYNs)	Excluded	Blueprint for Health dollars (Patient Centered Medical Home, Community Health Team, Spoke and Women's Health Initiative payments) for primary care services rendered
WA[24]	Narrow	• Providers include: NP, women's health; NP, OB/GYN • Select primary care services/procedures only	• Providers include: NP, Psychiatric/Mental Health • Select primary care services/procedures only	Excluded (Officially, although data collection methods may have captured some non-claims-based expenditures)
	Broad	• Providers include: Physician, OB/GYN; Midwife • Services include: Vaginal Delivery, Antepartum & Postpartum Care Procedures; Cesarean Delivery Procedures; Delivery Procedures After Previous Cesarean Delivery	• Providers include: Psychoanalyst, Psychologist, Social Worker, Mental Health Counselor, Addition Medicine, etc. • Services include: Psychiatric Care Management	
NESCSO[25]	Definition 1 selected services included Definition 2 all services included	Excluded (OB/GYN services provided by OB/GYN providers and OB/GYN services provided by primary care providers were measured separately)	Excluded	Included non-claims payment data for states that required reporting
PCC[7]	Narrow	Excluded	Excluded	Not included (FAIR Health uses claims data only)
	Broad	Included OB/GYN		

Attachment I – Glossary [xxiv]

Claim: Communication from a health care provider to a health care payer requesting payment for services rendered by the provider. A claim includes information about the patient's diagnoses, the procedures performed by the provider, the amount the payer and patient will pay for the service under a health insurance plan, and — in the case of a paid claim — the amount paid by the payer.

Commercial health plan: Group or individual health insurance plan offered by a health insurance carrier.

Federally Qualified Health Center (FQHC): Safety net providers that primarily provide services furnished in an outpatient clinic. FQHCs include community health centers, migrant health centers, health care for the homeless, health centers, public housing primary care centers, and health center program "lookalikes." They also include outpatient health programs or facilities operated by a tribe or tribal organization or by an urban Indian organization. FQHCs are paid based on the FQHC Prospective Payment System (PPS) for medically-necessary primary health services and qualified preventive health services furnished by a FQHC practitioner.

Fee for Service (FFS): A method of paying providers for covered services rendered to members. Under Maine's fee-for-service system, the provider is paid for each discrete service provided to a patient.

Healthcare Common Procedure Coding System (HCPCS): A uniform set of codes that represent health care procedures, service, supplies and products which may be provided to Medicare and Medicaid beneficiaries and to individuals enrolled in private health insurance programs. HCPCS includes two levels of codes: Level I codes consist of the AMA's CPT® codes. Level II codes are maintained by CMS and primarily include non-physician products, supplies, and procedures.

Health care payer: Health insurance plan or health coverage program that pays doctors, hospitals and other health care providers for care and services received by a person with health care coverage. A health care payer includes commercial and public plans such as Medicaid and Medicare.

International Statistical Classification of Diseases and Related Health Problems (ICD) 10 Codes: A uniform set of codes used to describe a disease and identify the diagnosis of a particular medical condition, so that the patient, health care provider as well as the insurance payer can better comprehend the medical condition under treatment.

Maine Education Association Benefits Trust (MEABT): A benefit plan that provides health insurance to Maine public school employees and their families.

Maine State Employee Health Commission (SEHC): Maine State Employee Health Commission ("SEHC") is a self-insured health benefit plan that covers State of Maine and University of Maine System employees and non-Medicare retirees, and their families.

MaineCare: Maine's Medicaid and Children's Health Insurance (CHIP) program. Medicaid provides low-income children, pregnant women, and parents with health insurance coverage for little or no cost. The program also covers low-income elderly and people with disabilities. Adults without children may be eligible through the non-categorical waiver, but the Maine expansion program was implemented in July 2018.

Non-claims-based payment: Payment to a health care provider intended to motivate efficient care delivery, reward achievement of quality or cost-savings goals, and build health care infrastructure and capacity. Non-claims-based payments are not payments for specific services rendered by a provider and reported on a health

[xxiv] Definitions partially sourced from: Oregon Health Authority. *Primary Care Spending in Oregon: A Report to the Oregon State Legislature.* February 2019.

care claim, although they may be awarded based on information reported on claims. *Non-claims-based payments are not included in this report.* Examples of non-claims-based payments may include capitated or salary primary care payments, risk-based payments, practice-level payments (e.g., Patient Centered Medical Homes, Health Homes), and provider incentives.

Primary care: Health care that includes general exams and assessments, preventive care and care coordination. Primary care providers respond to new patient needs and undiagnosed conditions, help patients navigate the health system, and maintain relationships over time. For purposes of reporting on medical spending allocated to primary care under P.L. Chapter 244, we used the broad definition of all services provided by primary care providers and the narrow definition of a specific set of health care services delivered by specific types of primary care providers (see *Attachment D – Methodology for Defining Primary Care* for details).

Rural Health Clinics (RHCs): The Rural Health Clinic (RHC) program is intended to increase access to primary care services for patients in rural communities. RHCs can be public, nonprofit, or for-profit healthcare facilities. To receive certification, they must be located in rural, underserved areas. They are required to use a team approach of physicians working with non-physician providers such as nurse practitioners (NP), physician assistants (PA), and certified nurse midwives (CNM) to provide services. The clinic must be staffed at least 50% of the time with a NP, PA, or CNM. RHCs are required to provide outpatient primary care services and basic laboratory services.

Self-insured employer: Employer that sets aside funds to pay for health care expenses of employees rather than buying a group health insurance plan offered by a private insurance company. Primary care spending by self-insured employers that voluntarily submit data to the APCD are included in this report. The Maine State Employee Health Commission and Maine Education Association Benefits Trust are the two largest self-insured employers in Maine.

Supplemental plan: An additional health insurance plan that helps pay for healthcare costs that are not covered by a person's regular health insurance plan. These costs include copayments, coinsurance, and deductibles. There are many different types of supplemental health insurance, including vision, dental, hospital, accident, disability, long-term care, and Medicare supplemental plans. There are also supplemental health insurance plans for specific conditions, such as cancer, stroke, or kidney failure. Some types of supplemental health insurance may also be used to help pay for food, medicine, transportation, and other expenses related to an illness or injury.

Taxonomy Code: The Healthcare Provider Taxonomy Code Set is a hierarchical code set that consists of codes, descriptions, and definitions designed to categorize the type, classification, and/or specialization of health care providers. The Code Set consists of two sections: Individuals and Groups of Individuals, and Non-Individuals. The Code Set is a Health Insurance Portability and Accountability (HIPAA) standard code set. As such, it is the only code set that may be used in HIPAA standard transactions to report the type/classification/specialization of a health care provider when such reporting is required. Each taxonomy code is a unique alphanumeric code that enables providers to identify their specialty at the claim level.

Total Medical Expenditures: The total plan paid claims-based medical expenditures excluding pharmacy, long-term care, and dental expenditures.

Attachment J – Endnotes

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