Maine Quality Forum

MEASURING TO IMPROVE

DATE: January 15, 2020

TO: Senator Sanborn, Representative Tepler and Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services

Commissioner Lambrew

FROM: Karynlee Harrington, Director Maine Quality Forum

CC: Senator L. Sanborn

Lisa Letourneau, DHHS

Kimberly Fox, Muskie

Members of the MQF Advisory Committee

RE: Primary Care Spending in State of Maine Report

Public Law, Chapter 244, requires the Maine Quality Forum to develop an annual report beginning January 15, 2020 on primary care spending using claims data from the Maine Health Data Organization. The report must also include information on the methods used to reimburse primary care providers from payers. Please find attached a copy of our first annual report.

Please don't hesitate to contact me directly with any questions. Karynlee

Maine Quality Forum
MEASURING TO IMPROVE

Public Law, Chapter 244

2020 Annual Report:

Primary Care Spending in State of Maine

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

Submitted by: Karynlee Harrington, Director Maine Quality Forum

Date: January 15, 2020

Under contract with the Maine Quality Forum (MQF), the University of Southern Maine, Muskie School of Public Service, Cutler Institute with consultation from Judy Loren, Inc., provided MQF technical support in the preparation of this report.

Table of Contents

Executive Summary

Public Law Chapter 244, *An Act to Establish Transparency in Primary Care Health Care Spending*, requires the Maine Quality Forum to annually submit a 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.

This first annual primary care spending report documents the process used to define and quantify primary care spending in Maine; and presents the results of the analyses of Maine primary care spending in calendar years 2016-2018 using Maine's All-Payer Claims Data (APCD).

Key Findings:

- Although the statute defined primary care at a high-level, much greater granularity is required to operationalize this definition to measure the percent of primary care spending using administrative claims data in terms of what provider types and specific services should be counted as primary care of the hundreds of billing codes reported in claims data.
- While other states and national organizations have produced estimates of primary care spending, there is no standard definition for primary care or method for calculating the percent of primary care spending of total expenditures used across states or nationally. This finding was further confirmed by the responses on the Maine insurer questionnaire collected for this report, who also use different definitions and identify different providers and/or specific services as primary care.
- For this initial report, we used the primary care definition in the statute as our general guide along with the results from an environmental scan of the literature, a Maine insurer questionnaire, and feedback from an Advisory Committee convened to assist us in developing a more granular definition.
- Given the lack of consensus nationally on how primary care is defined, for this initial report we present a range of primary care spending estimates using the following broad and narrow definitions of primary care:

  Broad definition (All services provided by primary care providers): Primary care is defined as 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) regardless of the specific procedure delivered.[i] The one exception was OB/GYN providers whose payments were only included as primary care for specific services. The specific list of primary care provider types for this definition, and the list of primary care services that were counted for OB/GYNs, can be found in *Attachment F* and were drawn from other state and national reports and/or were identified by at least one Maine insurer in their definition of primary care providers.

  Narrow definition (Specific primary care services provided by primary care providers): Primary care is defined as a specific set of services provided by health care professionals that have a primary care provider type (i.e. with a primary care-related specialty or taxonomy code). The specific list of procedures used for this definition can be found in *Attachment F* and were drawn from other state and national reports and/or were identified by at least one Maine insurer in their definition of primary care services. In other words, primary care in the narrow definition is a subset of the broad definition and

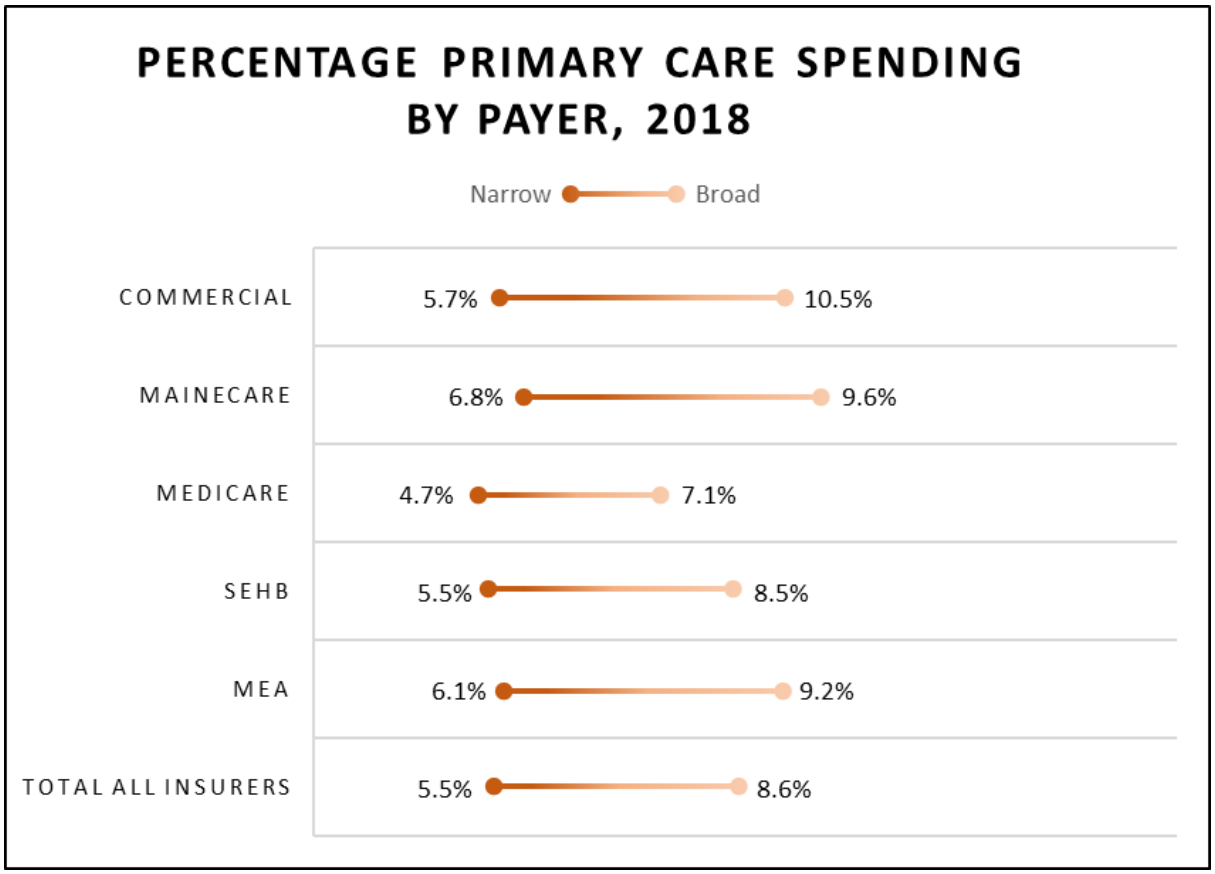
[i] Taxonomy codes are administrative codes set for identifying the provider type and area of specialization for health care providers. Each taxonomy code is a unique alphanumeric code that enables providers to identify their specialty at the claim level. See *Attachment F* for the full list of provider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

only includes a specific set of primary-care related procedures and activities provided by primary care providers to patients.

For both the broad and narrow definition, in concordance with P.L. Chapter 244, costs associated with services provided by primary care providers in hospital, urgent care, or emergency department settings were not counted as primary care spending.[ii] Following the recommendation of the Advisory Committee, primary care services provided in nursing and custodial care facilities were included as primary care services.

- Based on these two different definitions, 2018 primary care spending in Maine ranged from 5.5% to 8.6% overall across all payers and varied by insurance type as shown in Chart 1. Results from 2016 and 2017 are also included in the full report, but reveal that estimated primary care spending by both broad and narrow definition in Maine is relatively constant across the three-year period.

Chart 1. Percentage of Primary Care Spending by Payer, 2018



SEHB = State Employee Health Plan
MEA = Maine Educational Association Benefits Trust

[ii] We also excluded all Inpatient and emergency department services provided by a primary care provider even those that a Maine insurer had included in their list of primary care services they pay for.

Requirement and Overview of Process

Public Law Chapter 244

In 2019, the Maine legislature passed Public Law Chapter 244, *An Act to Establish Transparency in Primary Care Health Care Spending* requiring the Maine Quality Forum (MQF) to submit a report on primary care spending beginning January 15, 2020 and annually thereafter 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]

The legislation requires that the annual report include the percentage paid for primary care of total medical expenditures by commercial insurers, the MaineCare program, Medicare, and by health insurance plans contracted by the Maine State Employee Health Benefits and the Maine Education Benefits Trust based on claims data reported to the Maine Health Data Organization (MHDO).

In addition to reporting primary care spending, the new mandate requires MQF to report annually on the methods used by insurers to pay for primary care providers.

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

MQF contracted with the Muskie School of Public Service at the University of Southern Maine to produce this report. As part of this process, USM reviewed existing reports and consulted with other states and national organizations to assess best practices defining and reporting spending on primary care. Using the insight from other states' experiences, MQF developed a questionnaire that was sent to Maine's largest insurers to understand how they define primary care and the methods they use to pay primary care providers.

Advisory Committee: To help inform the development of this report, MQF also convened an Advisory Committee of key stakeholders to provide input specifically on the definition of primary care and the draft report. The Advisory Committee met October 10th. A copy of the Advisory Committee list of members, meeting agenda and summary notes, and Advisory Committee draft comments and MQF response can be found in *Attachments B, C, and D.*

Report Overview

This first annual report to the Department of Health and Human Services and the Joint Committee of Health Coverage, Insurance and Financial Services documents the process used to define and quantify primary care spending in Maine; and presents the results of the analyses of Maine primary care spending in calendar years 2016-2018 using Maine's All-Payer Claims Data (APCD).

Environmental Scan and Consultation with States and Other National Organizations

National and Other States

To inform Maine's process of defining primary care to identify the payments made to primary care providers, we first examined literature and studies from other states and national and regional organizations that have taken the lead on measuring how much is paid for primary care. In addition, we consulted with organizations and other states to learn about more detailed methodologies and efforts underway to establish a uniform definition of what provider types and services are considered primary care and on what total medical expenditures primary care spending estimates are based across states to allow benchmarking.

As of November 2019, we identified seven states (Rhode Island, Oregon, Colorado, Connecticut, Vermont, Massachusetts, and Washington) that have defined and/or are in the process of estimating how much is paid in their respective states on primary care. Two others (Delaware and California) are in the preliminary stages of the process. Among the seven states that have conducted an analysis, none have defined primary care in the same way (Table 1).

Payments to primary care providers, such as through insurance claims, alternative payments such as incentive payments for high quality, or salaries, varies between states, based on differences in payment models (e.g. managed care vs. fee for service (FFS)). Primary care has been defined differently by states in terms of primary care provider types and/or specific primary-care related procedures/CPT codes or ICD diagnostic codes included.[iii] For example, Rhode Island, unlike Oregon, omits from their definition of primary care providers, OB/GYNs, behavioral health providers, and homeopaths.[2-4] Other states (WA) show broad and narrow estimates of primary care spending based on different definitions of primary care provider types included. Some states have required insurers to report non-claims payments to the state and include these payments in their estimates of primary care spending (RI, OR). Similarly, what states define as total spending on which their primary care spending estimates are based can also vary. Some states limit total spending to only the insurers' paid amounts for inpatient and outpatient medical services. Others include prescription drugs or the total paid amount including the consumer cost-share.

As shown in Table 1, given these differences in definitions, the percentage of primary care spending *as defined by each state* ranges from 4.7% (Connecticut State Employee Plan) to 12.5% (Oregon's Medicaid plans).

Milbank Memorial Fund[iv], a foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience, recommends measuring the primary care spending rate as the "the proportion of a health care system's resources that it devotes to primary care". Milbank has funded research to provide states guidance in measuring the percentage of medical spending paid to primary care providers. This research used different broad and narrow definitions to enable commercial health plans to calculate provider-based and provider/service-based primary care spending. Detailed specifications included four specific definitions of primary care providers and one specific definition of primary care services. The study found that measuring primary care spending using claims data submitted by health plans (like Maine's APCD) is feasible, but not always a complete record of payments as most APCD's do not collect data on payments that are non-claims based, for example incentive payments. Primary care spending estimates, which varied by insurer and methodology, are shown in Table 1.[5]

The Patient-Centered Primary Care Collaborative[v] a not-for-profit multi-stakeholder membership organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and

[iii] See Glossary (*Attachment G*) at end of report for definitions of CPT procedure and ICD-10 diagnostic codes.
[iv] https://www.milbank.org/focus-areas/primary-care-transformation/
[v] https://www.pcpcc.org/

the patient-centered medical home, analyzed primary care spending across 29 states and nationally using data from the Medical Expenditure Panel Survey (MEPS). Using a narrow and broad definition of primary care providers the Collaborative produced a national average of 5.6% applying the narrow definition and 10.2% applying the broad definition, as seen in Table 1. The study's authors recommend a consensus definition to allow for comparisons, benchmarking across states, and to help guide policies towards primary care investment.[2]

The New England States Consortium Systems Organization (NESCSO), a non-profit organization governed by the New England State Health and Human Services agencies and the University of Massachusetts Medical School, has been collaborating with several New England states (including Maine) to develop a multi-state report on primary care spending across all payers. NESCSO intends to use a standardized definition of primary care providers and services, including CPT Codes and non-claims based payments. The proposed primary care spending definition being developed by NESCSO builds upon the methodologies outlined in the Milbank study referenced above as well as state-specific input based on their work in this area (i.e. MA, VT, CT referenced in Table 1).

As previously stated, our research confirms that there is no standardized definition of primary care providers and services. However, through NESCSO's work and others, there is a desire to create a consensus definition that could be applied in different states and nationally for comparison purposes.

Table 1. Definitions of Primary Care: What's Been Done in Other States and Nationally?

	Provider Types					Primary Care Specific Procedure Codes	Data Source			Definition of Total Spending	Primary Care Spending Percentage
	General primary care[††]	NP/PA[‡‡]	OB-GYN	BH[§§]	Other[***]	CPT codes by provider type	APCD/ Claims	Non-claims based	Other Source [†††]		
RI*[2,6-8]	●	●		If paid for PC service on PC fee schedule	geriatrics osteopaths	●	●	●	Payer reported	All payments to RI facilities and providers including Rx, BH, labs, and imaging	Commercial 11.5% (2016)
OR*[3,4]	●	●	●	●	naturopaths, homeopaths, geriatrics, FQHCs, RHCs	●	●	●		Total claims-based payments + total non-claims based payments (includes specialty care, mental health care, hospitalizations (excludes Rx)	Commercial 13.4% Medicaid(CCO) 16.5% Medicare Advantage 10.6% Public employee and educators 12.2% (2017)

*State mandate requires non-claims based reporting

[††] General primary care may include family medicine, internal medicine, general practitioners and pediatricians.

[‡‡] NP = nurse practitioner; PA = physician assistants

[§§] BH = behavioral health provider

[***] Other provider types may include geriatrics, naturopaths, and osteopaths

[†††] Other data sources may include insurer reported payments, MEPS survey data, etc.

	Provider Types					Primary Care Specific Procedure Codes	Data Source			Definition of Total Spending	Primary Care Spending Percentage
	General primary care††	NP/PA‡‡	OB-GYN	BH§§	Other***	CPT codes by provider type	APCD/ Claims	Non-claims based	Other Source †††		
CO*[9]	●	●	●	●	naturopaths, homeopaths, geriatrics, FQHCs, RHCs	●	●			Total claims-based payments which includes payments for some capitation encounters, calculated using carrier-reported FFS equivalents	Commercial 6.18% Medicaid 6.40% Medicare Advantage 4.86% Medicare FFS 2.6% (2018)
CT[6,10]	●	NP only	●	●	geriatrics	●	●			All members who had medical coverage during the measurement year X number of months these members had commercial medical coverage.	State Employee Health Plan 4.7% (2017)
MA[6,‡‡‡]	●					●					Commercial 6.6% (2015)

* State mandate requires non-claims based reporting

‡‡‡ Massachusetts data is limited to information provided by NESCSO.

		Provider Types					Primary Care Specific Procedure Codes	Data Source			Definition of Total Spending	Primary Care Spending Percentage
		General primary care[††]	NP/PA[‡‡]	OB-GYN	BH[§§]	Other[***]	CPT codes by provider type	APCD/ Claims	Non-claims based	Other Source [†††]		
VT*[6,11,12]		●	●	●		naturopaths, osteopaths, geriatrics	●	●	●		Total ACO expenditures by payer	Claims-based Medicaid 13% Fully insured 5% Self-funded 6% Medicare 4% (2017)
WA[13]	N^^	●	●			naturopath, FQHC, RHC	●	●			All medical claims including in-patient hospitalizations and pharmacy claims (excludes Medicare FFS and Medicaid FFS)	4.4% (2018)
	B^^	●	●	●	●	homeopaths, midwife, clinical nurse specialists, RNs	●	●				5.6% (2018)
Milbank[5]	N^^	●	●	●		●	●			Payer reported	Total medical and Rx spending	4.6% PPO 4.8% HMO (2014)
	B^^	●	●	●		●				Payer reported		7.1% PPO 7.6% HMO (2014)

		Provider Types					Primary Care Specific Procedure Codes	Data Source			Definition of Total Spending	Primary Care Spending Percentage
		General primary care[††]	NP/PA[‡‡]	OB-GYN	BH[§§]	Other[***]	CPT codes by provider type	APCD/ Claims	Non-claims based	Other Source [†††]		
Reid, et. al[14]	N^^	●					●	●			Total medical and prescription spending nationally	Medicare FFS 2.12% (2015)
	B^^	●	●	●		geriatrics		●				4.88% (2015)
PCPCC/ Graham Center[2]	N^^	●				geriatrics				MEPS [§§§]	Sum of billed expenditures for office-based outpatient, hospitalizations, ED visits, prescription meds, vision, dental, home health, other medical category	5.6% (2011-2016)
	B^^	●	●	●	●	nurses, geriatrics				MEPS [****]		10.2% (2011-2016)

^^ N = Narrow; B = Broad. National studies and WA report primary care spending estimates by narrow and broad definitions that differ in terms of which provider types and/or specific primary care services are included.

[§§§] MEPS = Medical Expenditure Panel Survey, an annual survey of approximately 35,000 U.S civilians.

[‡‡] General primary care may include family medicine, internal medicine, general practitioners and pediatricians.

[§§] NP = nurse practitioner; PA = physician assistants

[***] BH = behavioral health provider

[+++] Other provider types may include geriatrics, naturopaths, and osteopaths

[‡‡‡] Other data sources may include insurer reported payments, MEPS survey data, etc.

Maine Insurer Questionnaire

The new mandate requires the Maine Quality Forum to collect information on the methods used by Maine insurers to reimburse primary care providers. To gather this information, the Maine Quality Forum developed a questionnaire that asked insurers including MaineCare to describe how they currently define primary care in terms of primary care provider types, primary care services, and to describe other methods used to make non-claims-based payments. A list of provider types and primary care services codes (i.e. CPT/HCPCS codes) were provided to insurers to select from based on a review of the literature regarding provider types and codes used to define primary care (see *Environmental Scan* discussion and Table 1 above). See *Attachment E* for a copy of the Insurer Questionnaire. In August 2019, the questionnaire was sent to the eight largest insurers in Maine. Six insurers (75% response rate) responded to the questionnaire. Tables 2-4 show the results of the insurer questionnaire.

Definition of Primary Care by Provider Type and Primary Care Services

As indicated in Table 2, all Maine insurers indicated they use primary care provider type to define primary care but differed somewhat in what provider types they include. All insurers defined the following provider types as primary care providers: family medicine, internal medicine, pediatrics, general medicine, and nurse practitioners. Most insurers also included geriatrics, physician assistants, and OB/GYN specialties as primary care providers. Half of the responding insurers also defined federally qualified health centers/rural health centers (FQHC/RHC) as primary care providers. One insurer includes certified nurse midwives, Indian Health Services, and school health clinics as primary care providers.

Table 2. Primary Care Provider Types Used by Maine Insurers to Define Primary Care

Provider Type	Insurer 1	Insurer 2	Insurer 3	Insurer 4	Insurer 5	Insurer 6	Total
Family Medicine	X	X	X	X	X	X	6
Internal Medicine	X	X	X	X	X	X	6
Pediatrics	X	X	X	X	X	X	6
General Medicine	X	X	X	X	X	X	6
Geriatrics		X*	X	X	X	X	5
OB/GYN		X	X		X	X	4
Physician Assistant	X	X	X	X	X		5
Nurse Practitioner	X	X	X	X^	X	X	6
FQHC/RHC	X		X	X^			3
Other							
Certified Nurse Midwife			X				1
Indian Health Service			X				1
School Health Clinic			X				1

*Geriatric providers may be considered a specialist if they do not request to be a PCP

^ NP if appropriately licensed; FQHC/RHC practicing physicians at these facilities only

As shown in Table 3, half of the insurers (3 of the 6 insurers) reported that they also use CPT/HCPCS procedure codes to define and/or reimburse primary care.[xiii] Only two insurers reported using specific ICD10 diagnosis codes to reimburse primary care.

[xiii] While one of the insurers reported not using CPT/HCPCS codes to define primary care, they also provided a list of specific codes they use so these codes have been included in the claims analysis.

For those insurers who define primary care by specific services, the most common procedure codes were for: office visits, preventive visits, and immunizations and injections. Fewer insurers reported including CPT/HCPCS codes for home visits and telehealth services in their definition of primary care and less identified transitional care management, chronic care management, and advanced care planning.

Table 3. CPT/HCPCS codes Used by Maine Insurers to Define and/or Reimburse Primary Care

CPT/ HCPCS*	Insurer 1	Insurer 2	Insurer 3	Insurer 4	Insurer 5	Insurer 6	Total
Office Visits	X	X	X	X			4
Home Visits		X	X	X			3
Transitional Care Management	X	X					2
Chronic Care Management		X					1
Advance Care Planning		X					1
Preventive Visits	X	X	X	X			4
Telehealth Services (e.g. telephone, non-face to face preventive/office visits)	X	X		X			3
Immunizations and Injections (please list codes)	X	X	X	X			4
Other HCPCS codes (please list):	X	X	X				3
ICD10 Diagnosis codes (please list):	X		X				2
Does Not Define PC Services				X	X	X	3

* At least one CPT/HCPCS code used in category

Non-Claims based Payments

Insurers were asked in the questionnaire to report on their use of non-claims-based payments for primary care. Payments that are not captured in claims data may include capitated or salary primary care payments, risk-based payments, practice-level payments (e.g. Patient Centered Medical Homes, Health Homes), and other provider incentives. More detailed definitions of these non-claims-based payments can be found in the Glossary *(Attachment G)*.

For each type of non-claims-based payment insurers utilized, they were asked if they track the estimated total payments, and if they track the percentage of these payments that support primary care.

As shown in Table 4, the most common non-claim-based payment for primary care used by the largest Maine insurers that responded to the questionnaire are provider incentives or risk-based payments.

Four of the six insurers reported incurring expenses related to provider incentives to support primary care with one additional insurer reporting other related work. All insurers that offer provider incentives indicated that they do track estimated total payments for these incentives, but only three insurers track the percentage of provider incentive payments that support primary care.

The next most common non-claims based payment for primary care is risk-based payments. Half of the insurers use risk-based payments.

Only one insurer reported using practice-level payments, but they do not specifically track the percentage of these payments that support primary care.

Most insurers reported that they do not provide HIT-related payments for reporting or data integration to support primary care.

All six insurers reported that they do not use capitated or salary primary care payments to support primary care.

Since these non-claims based payments are not processed as a claim, they are not included in Maine's APCD and therefore are not included in the primary care payment estimates in this report.

Table 4. Non-Claims Based Payments Used by Maine Insurers (n=6 Maine insurers)

Type of Non-Claims-Based Payment	Do you currently incur the following non-claims based expenditure to support primary care?	Do you track your estimated total payments ($) for these expenditures?	Do you track the percentage of these payments that support primary care?
Capitated or Salary Primary Care Payments	100% No	100% No	100% No
Risk-Based Payments	50% Yes	50% Yes	50% Yes
	33% No	33% No	33% No
	17% Other	17% Other	17% Other
Practice-level payments (e.g. Patient Centered Medical Homes, Health Homes)	17% Yes	17% Yes	
	67% No	67% No	83% No
	17% Other	17% Other	17% Other
Provider Incentives	67% Yes	83% Yes	50% Yes
	17% No	17% No	50% No
	17% Other		
HIT-related payments for reporting or data integration			17% Yes
	83% No	83% No	83% No
	17% Other	17% Other	

Two insurers provided information about other non-claims-based expenditures to support primary care, such as a program that targets the integration of behavioral health in primary care, health equity, or care transitions, as well as having value-based initiatives that have staff and data to focus on the full continuum of care using actionable data from claims to improve provider engagement and improved patient health. One insurer indicated they have initiatives to support members in accessing primary care that are not paid to primary care practices including product design innovations such as limited number of free visits and caps on cost sharing, as well as expanding access to telehealth services.

Analysis of Primary Care Spending in Maine

Defining Primary Care

To determine the amount of spending on primary care in Maine using the Maine Health Data Organization's all payer claims data (APCD), we defined primary care based on the following:

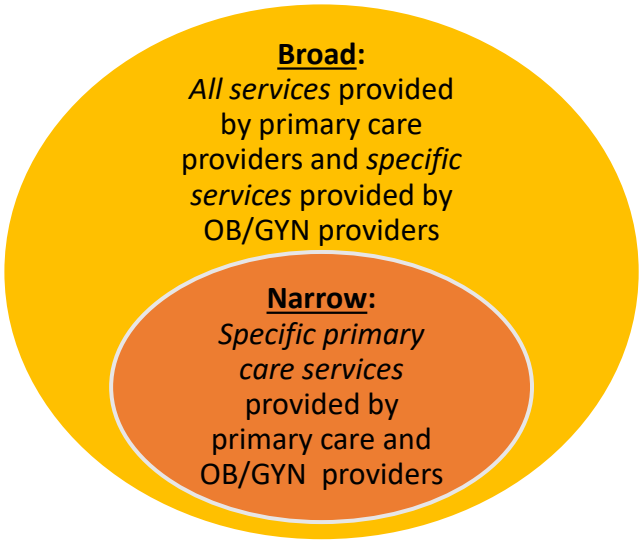
- Language in P.L. Chapter 244, Sec. 2. 24-A MRSA §6903, sub-§13-B
- Consultation with the Advisory Committee
- Information collected on the insurer questionnaire and
- Environmental scan of other states and national organization best practices

Consistent with our research on how others have calculated primary care spending and reflecting differences in primary care definitions used by Maine insurers, we concluded that it was important to provide a range of primary care spending estimates based on a broad and narrow definition of primary care as defined below.

Broad definition (All services provided by primary care providers): Primary care is defined as 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) regardless of the specific procedure delivered.[xiv] The one exception was OB/GYN providers whose payments were only included as primary care for specific services. The specific list of primary care provider types for this definition, and the list of primary care services that were counted for OB/GYNs, can be found in *Attachment F* and were drawn from other state and national reports and/or were identified by at least one Maine insurer in their definition of primary care providers.

Narrow definition (Specific primary care services provided by primary care providers): Primary care is defined as a specific set of services provided by health care professionals that have a primary care provider type (i.e. with a primary care-related specialty or taxonomy code). The specific list of procedures used for this definition can be found in *Attachment F* and were drawn from other state and national reports and/or were identified by at least one Maine insurer in their definition of primary care services. In other words, primary care is defined as a subset of the broad definition and only includes a specific set of primary-care related services provided by primary care providers to patients.

For both the broad and narrow definition, in concordance with P.L. Chapter 244, costs associated with services provided by primary care providers in hospital, urgent care, or emergency department settings were not counted as primary care spending.[xv] Following the recommendation of the Advisory Committee, primary care services provided in nursing and custodial care facilities were included as primary care services.



[xiv] 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 F* for the full list of provider specialty taxonomy codes.

[xv] We also excluded all Inpatient and emergency department services provided by a primary care provider even those that a Maine insurer had included in their list of primary care services they pay for.

Who are primary care providers?

For this report (for both broad and narrow definitions), primary care providers are defined the same way, as provider types specializing in primary care that were identified in other state and national studies or for which at least one Maine insurer who completed the MQF Questionnaire indicated they included as a primary care provider.[xvi] Specifically, these included:

- Family medicine
- Internal medicine
- General medicine
- Pediatrics (including adolescent medicine)
- Geriatric medicine
- Naturopathic/homeopathic medicine
- Physician assistants[xvii]
- Nurse practitioners (family, pediatrics, primary care, general medicine, adult health, gerontology)
- Federally Qualified Health Centers (FQHCs)
- Rural health centers
- Preventive medicine
- Obstetrics and gynecology (includes NP)[xviii]

What are primary care services?

For the narrow definition of primary care, the list of specific procedure codes was drawn from studies done by other states as well as the results from the state Insurer questionnaire, and input from the Advisory Committee.[xix]

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

A complete list of primary care provider taxonomy codes and primary care specific service procedure codes used to identify the payments to primary care providers are included in *Attachment F.*

Methods

We analyzed data from Maine APCD for calendar years 2016-2018 to estimate the percentage paid for primary care of total medical expenditures for commercial insurers, Medicaid, Medicare, the Maine Educational Association Benefit Trust (MEABT) and the State Employee Health Plan.

The Maine APCD contains claims and enrollment information for commercial insurance carriers, third party administrators (voluntary submissions), MaineCare (Maine's Medicaid program), and Medicare for Maine

[xvi] Includes all primary care providers regardless of subspecialty, due to limitations of subspecialty provider reporting methods within claims.
[xvii] Some physician assistants working with specialists may be included in the primary care estimate because they could not be separately identified in claims.
[xviii] While some other states also include behavioral health and psychiatry as part of primary care, no Maine insurer included them in their definition, and based on guidance from the Advisory Committee, behavioral health providers were excluded.
[xix] While one state (OR) and Maine insurers (2) indicated using ICD-10 diagnoses codes in some cases in addition to procedure codes to identity primary care, the lack of methodological clarity on how these codes were used led to our excluding them from our definition in this report.

residents. Established under state statute in 2003, Maine's APCD includes pharmacy, medical and dental claims data and in 2018 represented over 90% of Maine's insured population.

Total medical expenditures and the percentage paid for primary care identified in this study include payments made by insurers during the measurement year for all enrolled members' regardless of their length of eligibility or enrollment within that measurement year. Deductibles, co-pays, co-insurance and out-of-pocket costs paid by the member are not included since they were not paid by the insurer. Primary care services for people without insurance and services paid with cash by patients who did not file an insurance claim are not included in the APCD and were not included in this analysis. As indicated above, non-claims-based payments made by the insurers to primary care providers through performance incentives or other mechanisms are not included in this analysis.

Total medical expenditures includes only medical claims for CY 2016-2018. Costs for dental care, pharmacy, and long term care were not included. Provider NPI (billing and rendering) were used to identify primary care specialties.[xx] Both professional (1500 claim form) and facility (Uniform Billing Form (UB-04)) claim types were examined to identify the primary care services for the narrow definition.[xxi]

See *Attachment F* for more details on the data source, exclusion criteria and lists of taxonomy and CPT codes included.

Summary of Findings

Using the methodology described above and detailed in *Attachment F,* on average, using the narrow definition, Maine insurers spent an average of 5.6% across the three years. Using the broad definition of primary care, Maine insurers spent on average approximately 8.6% of total medical expenditures across the three-year period on primary care (Table 5).

The rate of primary care spending overall by broad and narrow definition and by payer across the 3-year period has remained relatively constant (Table 5).

As shown in Table 5, primary care spending as a percent of total medical expenditures by narrow and broad definition does vary across 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.

Relative to commercial insurers generally, the SEHB has slightly lower rates of primary care spending using either the broad or narrow definition, while the Maine Education Association (MEA) has comparable or slightly higher or lower primary care spending depending on the definition.

[xx] The National Provider Identifier (NPI) found on the claim was used to look-up taxonomy codes in a copy of the National Provider and Payer Enumeration System (NPPES) database last updated October 2019 and maintained in the MHDO Enclave data management system.

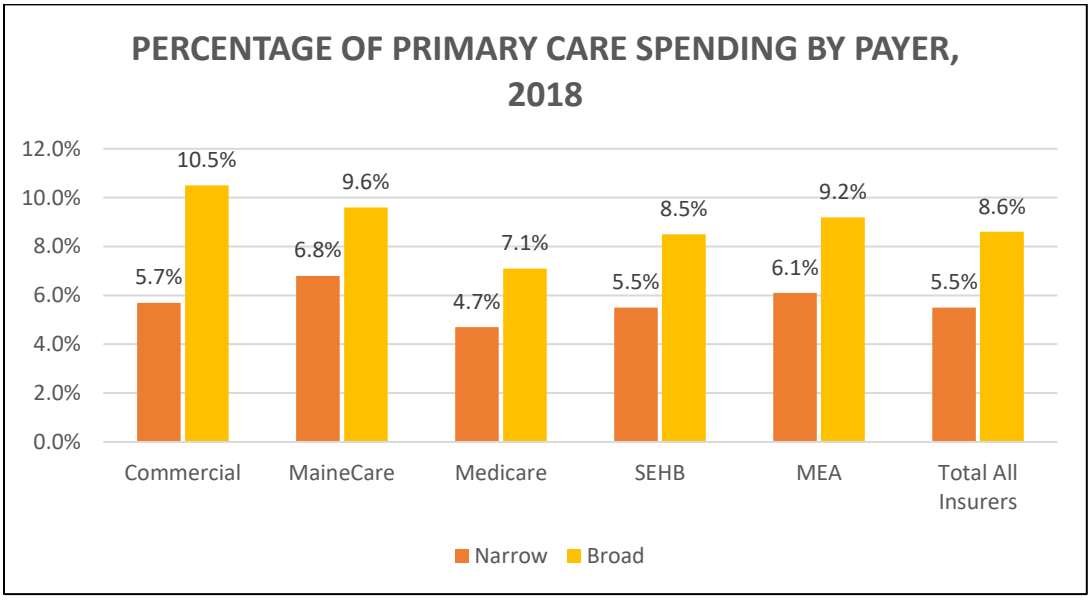
[xxi] Inclusion of facility claims allowed for the identification of facility fees associated with primary care including hospital associated providers, who use both professional and facility claims, as well as federally qualified (FQHC) and rural (RHC) health care facilities, who use only facility claims.

Table 5. Percentage of Total Medical Expenditures Spent on Primary Care by Narrow and Broad Definitions

Primary Care Definition: (Narrow & Broad)	% Primary Care Spending by Payer					
	2016		2017		2018	
	Narrow	Broad	Narrow	Broad	Narrow	Broad
Commercial	6.0%	10.9%	6.0%	10.9%	5.7%	10.5%
MaineCare	7.0%	9.2%	7.2%	10.0%	6.8%	9.6%
Medicare	4.6%	6.8%	4.8%	6.9%	4.7%	7.1%
SEHB	5.4%	9.3%	5.7%	10.1%	5.5%	8.5%
MEA	6.0%	10.5%	6.4%	11.0%	6.1%	9.2%
Total All Insurers	5.6%	8.6%	5.6%	8.7%	5.5%	8.6%

SEHB = State Employee Health Plan
MEA = Maine Educational Association Benefits Trust

Chart 2. Percentage of Primary Care Spending by Payer, 2018



SEHB = State Employee Health Plan
MEA = Maine Educational Association Benefits Trust

As shown for 2018 in Chart 2, the differences in broad and narrow definitions of primary care spending estimates range from two thirds to nearly twice as high for some payers depending on whether you use the broad definition (including all services provided by primary care providers) or narrow definition (only counting payments for specific services deemed as primary care by those primary care providers).

Examples of services provided by primary care providers that were included in the broad definition but were not included in the narrow vary, but those that contributed the greatest amount in terms of spending include family planning services, diagnostic imaging, laboratory tests (e.g. HbA1Cs), injectable drugs among other services.

Conclusion and Future Considerations

This first Primary Care Spending report provides a baseline estimate of primary care spending in Maine using both a narrow and broad definition of primary care. While the narrow and broad definitions are consistent with the definition in P.L. 244 and generally align with best practices nationally and with definitions provided by Maine insurers, there is no standard definition that is consistently used. Future reports should continue to reassess the definitions developed and adopted nationally of primary care.

This initial analysis revealed that the level of complexity involved in quantifying primary care spending is challenging. Different definitions may be used depending on the purpose behind defining primary care spending. For this report, we elected to provide a range of estimates based on narrow and broad definitions, but future reports may be more specific with additional guidance and direction from policymakers.

Since primary care utilization and costs are heavily influenced by the population's needs, future reports may consider including more detailed breakdowns by age, sex, health risk, and geography (i.e. rural/urban) or control for these factors, to better explain variation in primary care spending. Future reports may also consider including utilization or per unit costs as other explanatory variables for variation in primary care spending.[xxii]

Other considerations for future reporting raised by Advisory Committee members, include investigating other states associated primary care payment policy changes or inclusion of patient-out-of-pocket payments, which were beyond the legislative mandate for this initial report, but could be included in future reports if requested (see *Attachment D*).

Finally, as noted earlier in this report, non-claims based payments are not processed as a claim or reported to the MHDO and therefore are not included in the primary care payment estimates in this report. As several Maine insurers reported, their investment in primary care via non-claims based payments (i.e. incentive payments) is significant and should be factored into total payments. Collection of non-claims based payments is something that the Maine Health Data Organization may want to pursue for future reporting.

[xxii] Advisory Committee members agreed that more detailed demographic analyses would be helpful for future reports (see *Attachment D*).

Attachments: Supporting Documentation

A. Public Law Chapter 244

B. Advisory Committee Members

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

D. Advisory Committee Feedback to Draft Primary Care Spending Report

E. Insurer Questionnaire

F. Methodology for Estimating Primary Care Spending Percentage

G. Glossary

H. Endnotes

Attachment A – Public Law Chapter 244

APPROVED	CHAPTER
JUNE 7, 2019	244
BY GOVERNOR	PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND NINETEEN

S.P. 421 - L.D. 1353

An Act To Establish Transparency in Primary Health Care Spending

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

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

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

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

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

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

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

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

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
MaineHealth ACO

Jon Fanburg, MD
American Academy of Pediatrics

Renee Fay-LeBlanc
Greater Portland Health

Sara Fitzgerald
Maine Purchasers Alliance

Peter Hayes
Healthcare Purchaser Alliance of Maine

Rebecca Hemphill
Maine Chapter American College of Physicians

Ruta Kadonoff
Maine Health Access Foundation

Neil Korsen, MD
MaineHealth

Lisa Letourneau, MD

Andrew MacLean
Maine Medical Association

Lisa Harvey McPherson
Northern Light Health

Joan Orr
QUALIDIGM

Katherine Pelletreau
Maine Association of Health Plans

Joanne Rawlings-Sekunda
Maine Bureau of Insurance

Linda Sanborn
Maine State Senator

Darcy Shargo
Maine Primary Care Association

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

Maine Quality Forum
MEASURING TO IMPROVE

Public Law Ch. 244 Advisory Committee Meeting

Summary Notes

October 10, 2019 | 3:30 – 5:00 PM | 151 Capitol Street, Augusta, ME

Purpose

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

Attendees

IN PERSON: Senator Linda Sanborn, Lisa Letourneau, Neil Korsen, Lisa Harvey McPherson, Joan Orr, Andrew McLean, Joanne Rawlings-Sekunda, Darcy Shargo, Sarah Calder, and Stephen Corral.

VIA PHONE: Katherine Pelletreau, Renee Fay-LeBlanc, Sara Fitzgerald Jon Fanburg,

STAFF: Karynlee Harrington, Judy Loren, Kim Fox, Carolyn Gray, Jenny MacKenzie, Cathy McGuire, and Tom Merrill.

AGENDA ITEM	Discussion Summary
Welcome	
Introductions (Karynlee Harrington)	Karynlee Harrington welcomed the members of the group and provided an overview of the requirements of Public Law Chapter 244 and the charge of the advisory group. Karynlee also explained that she has contracted with Muskie and Judy Loren to help her with developing the report and to provide technical expertise and guidance.

AGENDA ITEM	Discussion Summary
Background Behind LD 1353 (Senator Linda Sanborn and Lisa Letourneau)	Senator Linda Sanborn provided background on the legislation and why she introduced the bill to the legislature. She explained the need for increased investment in primary care to improve health outcomes, increase satisfaction and lower overall healthcare costs. As an example, she referenced that other countries with higher percentages of primary care investment, have much lower total health care costs. She also described Rhode Island's experience, as one of the first states to measure and invest in greater primary care spending 10 years ago, and how total health care expenditures had decreased dramatically as primary care spending has increased. Lisa Letourneau provided background on the national context and her involvement with the Patient-Centered Primary Care Collaborative (PCPCC) workgroup. The group has been discussing primary care investment and what percentage spend is sufficient. An increasing number of states have passed legislation to assess primary care spending and some have set targets for value-based purchasing efforts of a minimum percentage of primary care spending. In Maine, determining the percent spent on primary care is a starting point to increased primary care investments.
Reporting Requirements of Public Law Chapter 244 (Karynlee Harrington)	MQF is required to submit an annual report to the legislature beginning January 15, 2020. The APCD claims data will be used to calculate the percentage of primary care spending in Maine and the report will also include the insurers' methods for reimbursing primary care. The law includes a high-level definition of primary care that explicitly excludes urgent care and emergency department visits. Our process to date has involved two steps: An environmental scan of how other states and national organizations have defined primary care to inform our claims analyses and Gathering information through a survey of Maine's largest insurers on how they define primary care using information identified in the environmental scan to inform the questionnaire.
Role of the Advisory Committee (Karynlee Harrington)	MQF is looking for feedback from the Advisory Committee on the proposed approach and primary care definitions identified from these sources to calculate the percentage of total medical spending spent on primary care in Maine. Karynlee proposed a schedule of two meetings of the Advisory Committee before the January report deadline. Group agreed to be flexible and do as much via e-mail as possible.

AGENDA ITEM	Discussion Summary
Defining Primary Care	
Working Definition Based on Insurer Survey and Literature Review (Kim Fox)	Kim Fox from the University of Southern Maine described the process for arriving at the initial primary care definition used for the preliminary claims analyses as summarized in the PowerPoint slide deck. Environmental scan: Six states have undertaken similar work to calculate primary care spend. While there is some overlap in what states define as primary care in terms of the provider types and specific services included, there is no standard definition. Both the numerators (i.e. what is included/counted as primary care) and the denominators (i.e. what is included in the definition of total health care spending) can vary across states. Benchmarks from these states are included in the PPT slide presentation for ballpark comparison, but Kim noted they are not directly comparable given different definitions used. Several national studies funded by the Milbank Memorial Fund and the PCPCC have also moved toward developing a standard definition of primary care. Specifications from these studies also informed the identification of provider types and service codes for the analyses. Insurer survey: Insurers were asked about what provider types, specific services and non-claims based payments they use to define primary care using general categories that have been used in other states and allowing them to indicate other codes they may use. For non-claims based payments, insurers were asked to indicate the degree to which they use and currently measure the categories of non-claims based payments that Rhode Island, Oregon and other states require insurers to report to the Dept. of Insurance. Based on 5 out of 8 Maine insurers' surveyed, most payers use similar definitions to those identified in other states in terms of provider type (e.g. include family medicine, pediatrics, internal medicine) and services as shown in slides. Related to non-claims based payments, there is a lot of variability between payers, but no Maine insurer uses capitated or salary based payments. Several use some form of risk-based payments or provider incentive payments that are not counted in claims. Karynlee stressed the importance of accounting for these non-claims based payments. Based on a recent conversation with a large insurer that provides non-claims based, per member per month payments to primary care that is paid out for about 80% of the members. These amount to millions of dollars and aren't currently captured by MHDO. Collecting

AGENDA ITEM	Discussion Summary
	data on alternative payment models is being discussed by the National Association of Health Data Organizations. They will be discussing ways to standardize collection among the states. We need to figure out how to capture this and the MHDO Board will need to provide some direction. Kim Fox also had recently participated in a meeting of New England States (NESCO), which is working to create a standardized definition across the New England states including non-claims based payments. In Rhode Island where they have required insurers to submit data on non-claims based payments, these account for about 50% of their primary care spend.
Summary of Claims Analysis to Date (Kim Fox)	From these sources, USM and consultant, Judy Loren conducted a preliminary analysis of 2017 APCD data using the definition of primary care provider types that provide specific primary care services. Findings are presented by commercial insurers, Medicaid and Medicare. Per one advisory group member question, it was clarified that Medicare Advantage is included in the analysis, but Medigap supplemental plans were excluded. Preliminary results are shown in the slide deck separately for when primary care provider types are limited to those identified by all Maine insurers and when OB/GYNs and Psychiatrists providing primary care services are also included. Results are based on the intersection of specific primary care provider types that provided specific services (e.g. HCPCS/CPT codes) defined as primary care. Based on these definitions, the preliminary analyses shows a primary care spending estimate of 5.2% on average overall when OB/GYN and psychiatry are excluded, and a slightly higher percentage when primary care services billed by OB/GYN and Psychiatry are included. The presentation slides also show other services provided by primary care providers that are not included in the specific primary care service list used for this analyses by payer and the associated percentage of total spend. The analytic team asked for input from the Advisory group on whether these services should/should not be included. The table below summaries the issues/questions and how they will be addressed.
Next Steps and Timeline	
	Minutes from today's meeting and questions for the Advisory Committee to weigh in on will be shared next week. The Advisory Committee should provide any additional feedback to MQF by November 1.

SUMMARY OF ISSUES RAISED AND NEXT STEPS

ISSUE	Action to Address	OUTCOMES/NEXT STEPS
Provider types - Lisa Harvey McPherson and Jonathan Fanburg recommended that geriatricians and adolescent medicine be included in provider types. Judy Loren noted that both were included. Adolescent medicine does not have separate taxonomy codes but are included under pediatrics.	No additional action required	Clarify adolescent medicine and geriatrics are included in the final report.
Inclusion of NPs/PAs working with specialists - Lisa Letourneau asked whether the estimates included all NPs and PAs as some of them can be providing specialty services. Judy Loren indicated a cross section was used to identify the claims with the taxonomy codes for the providers but PAs do not have a separate taxonomy code so some specialty could be included.	No additional action required	Explain in the final report that some PAs working with specialists may be included in primary care spend estimate because they could not be separately identified in claims.
Psychiatry – Lisa L raised concerns that inclusion of psychiatry may overstate primary care spend as they use the office visit code for specialty visits, but should not be considered a primary care service.	No additional action required	Psychiatry will be excluded from the definition of primary care.
Family planning and other primary care services not in current definition. Judy Loren clarified that family planning clinics providing primary care services are included in our definition. Kim Fox indicated that CPT codes change frequently so limiting to a specific set of service codes can miss newer codes (e.g. for this analyses insurer identified many immunizations and injection codes not identified in other studies). This analysis excluded other primary care services provided by primary care providers (e.g. those associated with an emergency department or inpatient setting) but also excludes other services the Committee may want to count as primary care	The Muskie School will investigate how/if other states have included these non-primary care services and if they only include administration costs or the cost both of administration and the equipment. Judy Loren indicated it is not always clear if the claim is for the procedure or the equipment so may be difficult to distinguish. Judy Loren will run additional analyses of other primary care services not in current definition by primary care providers and OB/GYN to assess frequency of family planning in primary care settings or OB/GYN.	Recommend excluding family planning services and labs for this initial report to Advisory Group because: It is in alignment with most of other states as confirmed by Muskie additional investigation. Most family planning services (i.e. contraception such as IUD) are being performed by Ob/GYNs and our current definition already includes primary care services delivered at family planning clinics.

SUMMARY OF ISSUES RAISED AND NEXT STEPS

(e.g. family planning, labs). Neil Korsen said it's important to align the definition with what was done in other states. Should family planning services (procedure codes for IUDs) be included? Should labs be included?	Muskie will also investigate how other states have included labs in their estimates.	While there may be some specific labs or family planning services that should be included with primary care, the research required to identify them individually does not align with the timing of when the report is due to the Legislature. As such we recommend including in the methodological notes in the final report that these services were excluded.
OB/GYN services are only for those services considered primary care. Staff confirmed OB/GYN costs only include primary care services provided by OB/GYN	No additional action required	Clarify in the final report.
ISSUE	Action to Address	OUTCOMES/NEXT STEPS
Rural Hospitals: Was cost-based reimbursement captured for rural hospitals? Smaller hospitals are hiring providers in order to get reimbursed indirectly for primary care. This is a way they fund primary care. David Winslow could help sort out the issue around provider based reimbursement.	Determine if CAHs need to be treated/counted differently due to cost-based reimbursement and/or explained in report. Staff will reach out to David Winslow and Lisa Harvey McPherson to get more information on cost-based reimbursement of CAHs to inform how primary care services provided in these settings are captured.	David Winslow confirmed that there is a cost adjustment at the end of the year from the public payers to the critical access hospitals. However, since the settlement amount doesn't account for primary versus specialty care, it should not change the percentage spent on primary care. Showing percentages instead of total dollar will cancel out this issue. Staff recommends addressing this by clearly explaining in the final report that the distribution to primary care will be the same regardless inclusion/non-inclusion of the cost settlement.
LTC facilities: Group agreed that services by primary care providers provided in LTC facilities should be included.	Include the Medicaid in residential non-SNF locations, as long as the services are primary care.	LT residential non-SNF codes where primary care providers were providing primary care services will be added into the definition in the final report.

SUMMARY OF ISSUES RAISED AND NEXT STEPS

Hospice: Is there a separate code for hospice if there is a PCP billing for the service? Judy confirmed that hospice was not included in the analysis, but may be captured under home visits.	Lisa Harvey McPherson offered to look into this question further and will provide hospice codes if they are not included under home visits.	Staff confirmed that hospice services provided by PCPs identified by Lisa Harvey McPherson had been included in the code list and will clarify in the final report.
Facility Fees: Are the facility fees for the provider based reimbursement captured? Is cost based reimbursement the same as for the FQHCs and critical access hospitals? What about enhanced payments that come in through Medicaid for the medical homes? Judy confirmed that facility fees are captured but not alternative payment models.	Lisa Letourneau suggested breaking out the facility fees. Karynlee confirmed that we can differentiate facility versus professional fees in the claims data. A revised analysis will be run by professional/facility to assess whether to report these separately.	An analysis of primary care costs by facility and professional fees shows that most of the facility fees are going to FQHCs and RHCs for Medicare and Medicaid, but is not a significant percentage for Commercial. Staff recommends including these fees as primary care and explaining the decision in the final report.
Duals: Do other states look at the data set for the dually eligible population?	Kim Fox did not recall any states or other reports separating out the dual population, but will confirm.	Staff recommends not separating out the dual population, which is in alignment with other states.
Occupational Health: Is occupational health included without the worker's comp? Some of these codes are billed through primary care and might appear in the commercial insurance. Karynlee confirmed that there are no worker's comp claims in the APCD.	No additional action required	
Charity/free care: Is charity or free care included? Is there a way to capture the value of that? Karynlee said that this analysis is just capturing what was spent, so that wouldn't be included.	No additional action required	

Attachment D - Advisory Committee Feedback to Draft Primary Care Spending Report

In December 2019, MQF shared a draft of the Primary Care Spending Report with members of the Advisory Committee along with a request for input. The comments received from Advisory Committee members and their associates representing Maine stakeholder organizations are listed below. Individual names of respondents have been removed. Based on some of the comments, language in the report has been edited for clarity. Maine Quality Forum's responses to these comments are included below.

	Comment	Maine Quality Forum Response
1	**MAINEHEALTH:** In the "Future Considerations" section, you wrote that there is opportunity for further evaluating variation in primary care spending based on demographic factors. I agree. It would also be interesting to include what other states have done after they started this process. What did they do with that once they got to an accepted definition of primary care? For example, you captured information about how primary care is paid for in table 4. Did other states do anything with that? Do we have any future considerations related to that, especially in context of CMS's new Primary Care First model which practices in Maine are eligible for? Were there other next steps in other states?	• Language was added to "Future Considerations" indicating Advisory Committee member support for further analyses based on demographic factors (see page 18). • Please refer to the section of the report titled *"Environmental Scan and Consultation with States and Other National Organizations"* for an explanation of the research conducted to inform the methodology used in this report. As required by Public Law Chapter 244, MQF consulted with other state and national organizations to determine the best practices for reporting spending on primary care services by insurers. As part of our methods, we consulted with organizations and other states to learn more about their detailed methodologies and efforts underway to establish a uniform definition of what provider types and services are considered primary care and how they have evolved over time, as summarized in Table 1. Analyses of how other states have used primary care definitions or primary care spending reporting to inform policy or payment changes was beyond the mandated scope of this initial report, but could be considered for future reports, if requested. • Further information on state policy activities may also be found on the Primary Care Collaborative website (https://www.pcpcc.org) and the Milbank Memorial Fund website (https://www.milbank.org/focus-areas/primary-care-transformation/), which we added to footnotes in the report. • Public Law Chapter 244 required MQF to assess Maine insurer's methods for reimbursing primary care providers. We did not review Medicare's new payment models (e.g. the Primary Care First model) or its implications on primary care spending in this report, but if requested by the legislature, this could be included in future reports. Further information on CMS's Primary Care First program can be found at https://innovation.cms.gov/initiatives/primary-care-first-model-options/ for those organizations interested in participating.

	Comment	Maine Quality Forum Response
2	**MEHAF:** The approach taken and the decisions made seem logical and practical given the definitional challenges and the constraints established by the charge spelled out in the law. The primary concern I would have is just that the interpretations drawn from this need to carefully and consistently acknowledge that what is being studied and reported is limited to what third party payers are spending. Particularly when it comes to looking at trends over time as reporting continues on an annual basis, I think it will be important to acknowledge that changes in coverage rates, coverage types and potentially in benefit design with regard to patient cost-sharing requirements may cause some artifacts that should not be misinterpreted. I recognize that the charge did not include looking at out of pocket costs and that the data source limits your ability to do so, but it would certainly make a nice complement to these analyses if it were possible to examine these costs as well.	• As indicated in this comment, as specified by Public Law Chapter 244, MQF was required to report "of their respective total medical expenditure, the **percentage paid for primary care by commercial insurers**" and other specified payers. The legislation did not reference patient out of pocket spending. However, patient out-of-pocket costs including copayments, coinsurance, and deductible payments are included in the Maine APCD and patient spending on primary care could be included in or separately shown for future reports.
3	**MAFP #1:** I view this initial draft report as an *excellent* start for defining and quantifying primary care spending in Maine. Providing a range from broad to narrow definition of primary care is reasonable. It is telling, as this report documents, that there is no consensus on the definition of primary care among the seven other states that have such statutes for quantifying it. I can tell tremendous time, experience, knowledge, and talent went into this report's preparation. But since we're being asked for input, and given the short	

	Comment	Maine Quality Forum Response
	timeline, here are some thoughts upon my quick reading: One consideration is one of comprehensiveness. This report looks at claims data either of • specific codes (e.g. office visit, home visit, etc), or • specific specialties (e.g. Family medicine, Pediatrics, sometimes OB-Gyn), but the interconnectedness of the codes might also help refine the definition of primary care. The research of Barbara Starfield, Leiyu Shi, and others seems to demonstrate that the *comprehensiveness* in providing specific elements of care is part of the value of primary care. An analogy would be that when I rent a car, I don't rent a steering wheel and a drivers seat and a drive shaft and all the other parts. The connection of the parts bestows much more value to me as a driver than a garage-full of the components. Vaccination is by one of the approaches described in this report a primary care deliverable, so administering a vaccine is delivering primary care. One could argue, though, that doing a tetanus or flu vaccination in a pharmacy or even the ER is less comprehensive care than administering the same vaccine in a primary care office where a range of issues (depression, headache, tobacco dependence, domestic violence, that suspicious-looking "mole" on a patient's arm, etc.) can be discovered and addressed. I am reminded of the middle-aged man who once came to see me for his ankle pain; we got talking about other aspects of health, which led to a discovery of an early-stage colon cancer (it was cured by surgeon, and the patient has outstanding	• Per your comment and Comment 5 below, we clarified the broad and narrow definitions in the final report (see pages 14). • The more comprehensive definition of primary care is captured in the **broad definition** used in this report, which includes all services provided by a primary care provider (with the exception of OB/GYNs for whom we limit payments for a specific list of primary care services). The **narrow definition** used in this report, which is a subset of the broader definition, does interconnect primary care specialty type with specific primary care services or procedures. See Attachment F for the list of primary care provider types and primary care services used in this report. As required by Chapter 244, both narrow and broad definitions exclude services provided by primary care providers in an inpatient, emergency department, or urgent care setting in the estimate of primary care spending.

	Comment	Maine Quality Forum Response
	prognosis). In order words, the whole is greater than the sum of the parts. Another consideration is that the models seems to look only at care delivered to individuals, rather than the care to larger units, like families. Perhaps it's too much of a technical hurdle, but I would argue that a family doctor delivering a baby in a family--in which the other kids and adult males are also under the care of the doctor--is providing more primary care *to the family* than the OB-Gyn specialist or the pediatrician who are submitting the same procedure codes for their share of the family members' care. Delivery to the whole is greater than the sum of delivery to the parts. Lastly, the report cites models that seems to group all NPs together as either inside or outside of primary care. I would argue that an NP in a primary care office should be counted differently than one in a Derm office, for the purposes of this reporting.	• Although this is an interesting question regarding what is the best way to deliver primary care to families, for this report MQF was tasked with estimating the percent of total expenditures spent on primary care not investigating best methods for delivering primary care. Based on our review of other states methods, none have examined primary care by family unit, only payments to insured individuals. However, if a family member provided services by a family physician is covered by insurance and a claim was submitted for these services, those primary care-related costs would be included in these estimates. • Given limitations of claims data and provider specialty designations, we were unable to distinguish between NPs practicing in primary care settings versus in specialty offices. The specialty of the servicing provider on a claim is derived from their enrollment with the National Plan & Provider Enumeration System (NPPES). While this system allows for differentiation among various types of Nurse Practitioners (e.g., Adult Health, Critical Care Medicine, or Psychiatric/Mental Health), the NPPES nor claims specify where the NP was practicing at the time a claim is submitted. Billing information identifies the organization, but most billing organizations have multiple brick-and-mortar locations, and many have both primary care and specialty care practices. It is not possible to know consistently how or where a NP or other provider was working at the time of a particular service. For this report, we only included Nurse Practitioners who registered with a specialty related to Primary Care (see *Attachment F*).
4	**GREATER PORTLAND HEALTH:** One question about the narrow vs broad definition of primary care…I am wondering if we should be making a stronger recommendation about which definition should be used moving forward? It seems like perhaps that is one of the things the advisory committee should do?	• Public Law Chapter 244 does not require MQF to make a recommendation on which primary care definition is preferable so we have not included a recommendation in the report. For future reports, should the legislature request it, we can work with the Advisory Committee to make explicit recommendations for future reports.
5	**MAFP #2:** After reviewing the Report, I find it to be slightly vague and generalized with respect to defining Primary Care Spending. More work is needed to define this challenging issue. Nevertheless, I fully	• We have clarified the broad and narrow definitions in the final report (see page 14). The more comprehensive definition of primary care is captured in the broad definition used in this report, which includes all services provided by a primary care provider (with the exception of OB/GYNs for whom we limit payments for a specific list of primary care services). The narrow definition used in this report, which is a subset of the broader definition, does interconnect

	Comment	Maine Quality Forum Response
	agree that a lot of hard work went into generating this document. We need to take into an account that this is the first Report and for that reason it provides a baseline estimate of Primary Care Spending in Maine. Few highlights and comments: 1. There is no standardized way for calculating the percentage of Primary Care Spending. This needs to be researched more adequately. 2. There is no consensus on how Primary Care is defined. The Report establishes 2 categories: Broad (includes all services provided by health care professionals with a primary care related specialty or taxonomy code) and Narrow (primary care related specialty or taxonomy code). There is definitely more work needed to narrow down and reassess the definition of Primary Care. We need to work on clearly defining who are the primary care providers and what are the primary care services? 3. According to the statistics provided in the Report, the Percentage of Primary Care Spending by Payer for 2018 in Maine ranged from 5.5% to 6.8% across all payers and varied by insurance types. Using the narrow category, the Primary Care Spending was highest for MaineCare, MEA and followed by Commercial insurances. 4. More work needs to be devoted to investigate specific populations i.e.	primary care specialty type with specific primary care services or procedures. See *Attachment F* for the list of primary care provider types and primary care services used in this report. As required by P.L. Chapter 244, both narrow and broad definitions exclude services provided by primary care providers in an inpatient, emergency department, or urgent care setting in the estimate of primary care spending. • As indicated in the report, we used a detailed methodology in preparing this report to identify all available specifications that have been used nationally and in other states for defining primary care. Based on this comprehensive review of all available best practice evidence, we found no consensus on how primary care is defined for claims analyses. At the recommendation and guidance of the Advisory Committee, we aligned the definition used for this report as much as possible with existing methods by showing estimates of the percent of primary care spending using a broad and narrow definition. • As stated in the "*Key Findings",* there is no consensus or standardized definition for defining primary care and the field is evolving. Research into how best to define and measure primary care spending is limited. Organizations such as the Milbank Memorial Fund and the Primary Care Collaborative are continuing to support research in this area that MQF will continue to monitor to inform future reports. • Language was added to *"Future Considerations*" indicating Advisory Committee member support for further analyses based on demographic factors (See page 18).

	Comment	Maine Quality Forum Response
	rural/urban, health risks, age, sex, socioeconomic determinants etc.	
6	**MAINE PRIMARY CARE ASSOCIATION:** One quick note for you—I just noticed this morning on re-reading this that on pg 16 there's a footnote (and in one other place I think), there's a note about FQHCs and RHCs billing for facility fees. Neither of those provider types bill for facility fees. That reference applies only to hospital based physicians. That note needs to be corrected before the report is shared with the Legislature.	We edited the footnotes (see page 16 and 41) to clarify that "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."

Attachment E – Insurer Questionnaire

Maine Quality Forum
Questionnaire-LD 1353
August 2019

1. Please describe if and/or how you currently define primary care providers and the specific services that you reimburse for primary care for payment, reporting, or incentive purposes:

    a. Primary care provider types: please check all provider types below that you consider as primary care providers:

        ☐Family medicine
        ☐Internal medicine
        ☐ Pediatrics
        ☐ General medicine
        ☐ Geriatrics
        ☐ Ob-Gyn
        ☐ Physician Assistant
        ☐ Nurse Practitioner
        ☐ FQHC/RHC
        ☐ Other (please list): _____

        ☐ We do not specifically define primary care providers within our plan

    b. Primary care services: If you use specific CPT, HCPCs or ICD10 codes to define and/or reimburse primary care please check which codes you use or provide the specific codes in a spreadsheet that you submit with this questionnaire.

        CPT/ HCPCs
        ☐Office Visits
        ☐ 99201-99205
        ☐ 99211-99215
        ☐ 99241-99245
        ☐ Other (please list): _____

        Home Visits
        ☐ 99339-99345
        ☐ 99347-99350
        ☐ Other (please list): _____

        Transitional Care Management
        ☐ 99495, 99496

Chronic Care Management
- 99490, 99491, 99487

Advance Care Planning
- 99497, 99498

Preventive Visits
- ☐ 99381-99387
- ☐ 99391-99397
- ☐ 99401-99404
- ☐ 99406-99409
- ☐ 99411, 99412
- ☐ 99420-99429
- ☐ 99495, 99496
- ☐ 96160-96161
- ☐ 96110
- ☐ Other (please list): _____

Telehealth Services (e.g. telephone, non-face to face preventive/office visits)
- ☐ 98966-98969
- ☐ 99441-99443
- ☐ 99444
- ☐ Other (please list): _____

Other – please provide codes used
- ☐ Immunizations and Injections (e.g. 90460-90461, 90471-90474): _____
- ☐ Other HCPCS codes (e.g. G0438, G0439, G0442; G0444; G0447) (please list): _____

ICD10 diagnosis codes (e.g. Z000, Z0012) (please list): _____

☐ We do not use ICD10 to define and/or reimburse primary care

☐ We do not use HCPCS to define and/or reimburse primary care

☐ We do not specifically define primary care services within our plan

2. In the table below, please indicate your response by checking the appropriate box specific to what (if any) non-claims-based payments you make for the provision of primary care services:

Non-Claims-Based Payments	Do you currently incur the following non- claims based expenditure to support primary care?	Do you track your estimated total payments ($) for these expenditures?	Do you track the percentage of these payments that support primary care?
Capitated or Salary Primary Care Payments • Capitation or salary arrangements with primary care providers or practices not billed or captured through claims. *Example: Fixed dollar payments for a defined set of services are paid to a provider for each person cared for by the capitated provider.*	☐Yes ☐No ☐Other-explain	☐Yes ☐No ☐Other-explain	☐Yes ☐No ☐Other-explain
Risk-Based Payments • Risk-based payments to primary care providers or practices that are not billed or otherwise captured through claims. *Example: Year-end reconciled PMPM payments/penalties (upside or downside) made to the billing provider based on performance relative to contracted measure targets, e.g. wellness visit rate, flu shot compliance, or chronic care gap closure.*	☐Yes ☐No ☐Other-explain	☐Yes ☐No ☐Other-explain	☐Yes ☐No ☐Other-explain
Practice-level payments (e.g. Patient Centered Medical Homes, Health Homes) • Practice-level payments such as payments to Patient-Centered Primary Care Homes (PCMH), Health Homes for provision of comprehensive primary care services; payments based upon PCMH recognition; or payments for participation in proprietary or other multi-payer medical -home or specialty care practice initiatives. *Example: A per-member-per-month payment based on a practice's PCMH tier level.*	☐Yes ☐No ☐Other-explain	☐Yes ☐No ☐Other-explain	☐Yes ☐No ☐Other-explain
Provider Incentives • Prospective incentive payments to primary care	☐Yes ☐No ☐Other-explain	☐Yes ☐No ☐Other-explain	☐Yes ☐No ☐Other-explain

Non-Claims-Based Payments	Do you currently incur the following non- claims based expenditure to support primary care?	Do you track your estimated total payments ($) for these expenditures?	Do you track the percentage of these payments that support primary care?
providers or practices aimed at developing capacity for improving care for a defined population of patients. • Retrospective incentive payments to primary care providers or practices based on performance aimed at decreasing cost or improving value for a defined population. *Example: Bonus payments to a provider when the provider meets the predetermined baseline or target of medical service use, such as a specified vaccination rate.*			
HIT-related payments for reporting or data integration • Payments for Health Information Technology (HIT) structural changes to primary care practices such as electronic records and data reporting capacity from those records. *Example: A carrier pays the electronic health record licensing fee for a practice.*	☐Yes ☐No ☐Other-explain	☐Yes ☐No ☐Other-explain	☐Yes ☐No ☐Other-explain

3. Please describe any other non-claims-based expenditures you currently incur to support primary care providers or practices (e.g. investments in loan forgiveness for training providers, flu clinics, rewards for provider reporting, or workforce expenditures for supplemental staff/activities integrated into the practice such as practice coaches/patient educators/patient navigators/nurse care managers):

4. Please describe any other non-claims-based expenditures you incur as an insurer to support members in accessing primary care that are not paid to primary care practices (e.g. technical assistance to practices, home visits, mobile fairs, member incentives, direct-to-consumer primary care telehealth services):

Please e-mail the completed questionnaire to Linda.Adams@maine.gov **by close of business Friday August 30, 2019. We thank you in advance for your attention to this matter. Karynlee**

Attachment F – Methodology for Defining Primary Care

Data Source

Information for calendar years 2016-2018 from Maine's All Payer Claims Database (APCD) maintained by the Maine Health Data Organization (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.[xxiii] The largest self-funded plans in Maine, exempt from the state mandate to submit information to the MHDO due to Supreme Court ruling[xxiv], voluntarily submit claims data to the MHDO.

Health care claims processors must submit periodically (typically monthly) to the MHDO a complete health care claims data set for all members who are Maine residents. The submissions include files with member eligibility, medical claims, pharmacy claims, and/or dental claims information.

The APCD does not include claims information from:

- Claims processors with less than $2 million per calendar year of Maine adjusted premiums or claims processed;
- Claims for health care policies issued for specific diseases, accident, injury, hospital indemnity, disability, long-term care, vision, coverage of durable medical equipment;
- Claims related to Medicare supplemental, Tricare supplemental, or other supplemental if claims are not considered to be primary; and
- Claims for workplace injuries covered by worker's compensation insurance.

Additionally, the APCD does not include information about Mainers who are uninsured or any health care that is paid out-of-pocket.

This study used Medical claims (CY 2016-2018), excluding long term care[xxv], dental and pharmacy claims.

The 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 legislation, claims for two plan sponsors were tabulated: the Maine Educational Association Benefit Trust (MEABT) and the State Employee Health Plan.[xxvi]

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 IDs were examined to find the Individual provider. If both billing and servicing providers were organizations, the servicing provider was used. Once a single provider was identified for each claim, the

[xxiii] Medicare Advantage plans and regular fee-for-service Medicare are included.
[xxiv] *Gobeille v. Liberty Mutual Insurance Company*, US Supreme Court Decision that Employee Retirement Income Security Act (ERISA) standards preempt state reporting requirements.
[xxv] Long term services and supports (LTSS) from Medicaid were excluded based on a percentage allocation of these services from the total Medicaid service costs based on estimates using the Muskie School's MaineCare claims database.
[xxvi] Due a problem in the data, the second quarter of 2017 was excluded for the State Employee Health Plan.

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 (October 2019 update).

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.[xxvii] The lists of primary care specialties 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 indicated using 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): Primary care is defined as 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) regardless of the specific procedure delivered. [xxviii] The one exception was OB/GYN providers whose payments were only included as primary care for specific services. The specific list of primary care provider types for this definition, and the list of primary care services that were counted for OB/GYNs, can be found in *Attachment F* and were drawn from other state and national reports and/or were identified by at least one Maine insurer in their definition of primary care providers.

Narrow definition (Specific primary care services provided by primary care providers): Primary care is defined as a specific set of procedures and activities performed by health care professionals with a primary care-related specialty or taxonomy code. The specific list of procedures used for this definition can be found in *Attachment F* and were drawn from other state and national reports and/or were identified by at least one Maine insurer in their definition of primary care services. In other words, primary care is defined as a subset of the broad definition and only includes a specific set of primary-care related services provided by primary care providers to patients.

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. Deductibles, co-pays, co-insurance and out-of-pocket costs paid by the patient are not included. Non claims based payments were not considered in this analysis. The denominator, or base for the calculation of Primary Care percentage, was the sum of paid amounts for all medical (not pharmacy or dental) claims used in this study (see *Data Source*, above). For the narrow definition, the numerator for the analysis was the sum of the plan paid amounts on claim lines that met the narrow definition criteria.

[xxvii] 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.

[xxviii] 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 F* for the full list of provider specialty taxonomy codes.

No consideration was given to the length of time a member was covered by health insurance during the measurement year.

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
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
363LP0200X	Nurse practitioner, pediatrics
363LP2300X	Nurse practitioner, primary care
363A00000X	Physician assistants
363AM0700X	Physician assistants, medical
207RG0300X	Physician, geriatric medicine
175L00000X	Homeopathic medicine
2083P0500X	Physician, preventive medicine
364S00000X	Certified clinical nurse specialist
163W00000X	Nurse, non-practitioner
OB/GYN Codes (For OB/GYN taxonomy codes, we only included payments for primary care services listed in narrow definition table below)	
207V00000X	Physician, obstetrics and gynecology
207VG0400X	Physician, gynecology
363LW0102X	Nurse practitioner, women's health
363LX0001X	Nurse practitioner, obstetrics and gynecology

Narrow Definition Primary Care Service Procedural Terminology (CPT)® 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 - 99360	Prolonged Service Office Visit
99360	Standby service
99367	Medical team conference
Preventive Visits	
96110	Developmental screen
99381 - 99385	Preventive medicine initial evaluation
99386 - 99387	Initial preventive medicine evaluation
99391 - 99397	Preventive medicine periodic reevaluation
99401 - 99404	Preventive medicine counseling and/or risk reduction intervention
99406 - 99409	Smoking and tobacco use cessation counseling visit (Alcohol/Substance Abuse Screening)
99411 - 99412	Group preventive medicine counseling and/or risk reduction intervention

Procedure Codes included in the Narrow Primary Care Definition	
Procedure Codes	**Description**
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
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
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
S0610	Annual gynecological exam, established patient
S0612	Annual gynecological exam, new patient
S0613	Annual gynecological exam; clinical breast exam without pelvic
Other Primary Care HCPCS Codes (Medicaid/Medicare)	
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

Procedure Codes included in the Narrow Primary Care Definition	
Procedure Codes	**Description**
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
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 G – Glossary[xxix]

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.

CPT (Current Procedural Terminology) Code: A uniform set of codes used to report various medical, surgical and diagnostic procedures provided to a patient by health care providers. CPT codes are then used by the insurance companies to decide the reimbursement fee for services provided by the health care provider. The American Medical Association (AMA) maintains and holds all the copyrights for this 'U.S. standard coding and billing' medical procedure.

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 has its own coding guidelines but works in conjunction with the AMA's CPTs. HCPCS includes three separate levels of codes: Level I codes consist of the AMA's CPT codes and is numeric. Level II codes are the HCPCS alphanumeric code set and primarily include non-physician products, supplies, and procedures not included in CPT.

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 (MEA): A benefit plan that provides health insurance to Maine public school employees and their families.

Maine State Employees Health Plan (MEHP): A health insurance plan that provides health insurance for employees of Maine State Government.

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

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

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 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. For more information, see *Attachment E – Insurer Questionnaire.*

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 F – 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 Employees Health Plan and Maine Education Association Benefits Trust are the two largest self-insured employers in Maine.

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.

Attachment H – Endnotes

1. An Act To Establish Transparency in Primary Health Care Spending, P.L 2019, ch. 244, §Sec. 1 - 3, 24-A MRSA §6903, §6951.
2. Jabbarpour Y, Greiner A, Jetty A, et al. *Investing in Primary Care: A State-level Analysis.* Washington, DC: Robert Graham Center; July 2019.
3. Koller CF, Khullar D. Primary Care Spending Rate - A Lever for Encouraging Investment in Primary Care. *The New England Journal of Medicine.* 2017;377(18):1709-1711.
4. Oregon Health Authority. *Primary Care Spending in Oregon: A Report to the Oregon State Legislature.* February 2019.
5. Bailit MH, Friedberg MW, Houy ML. *Standardizing the Measurement of Commercial Health Plan Primary Care Spending.* New York, NY: Milbank Memorial Fund; July 2017.
6. NESCSO Primary Care Workgroup. Improving Primary Care: Building Blocks for Success and Opportunities for State Collaboration. 3rd Annual New England Meeting on Regional Opportunities for State Government in Health Care Oversight and Regulation; October 18-19, 2018; York, ME
7. State of Rhode Island and Providence Plantations. *Office of the Health Insurance Commissioner Regulation 2.* December 12, 2016.
8. Rhode Island Office of the Health Insurance Commissioner. *Primary Care Spending in Rhode Island.* 2012.
9. Center for Improving Value in Health Care (CIVHC). *Primary Care Spending Report for 8.27.19* August 2019.
10. Schaefer M., personal communication, October 7, 2019.
11. Green Mountain Care Board. *2019 Budget Guidance and Reporting Requirements for Vermont Certified Accountable Care Organization: One Care Vermont, ACO, LLC.* Montpelier, VT June 13 2018.
12. Vermont Green Mountain Care Board. Measurement of Primary Care Spend - Background. Senate Committee on Health and Welfare; February 15, 2019; Montpelier, VT.
13. Office of Financial Management. *Primary Care Expenditures: Summary of Current Primary Care expenditures and Investment in Washington.* Olympia, WA December 2019.
14. Reid R, Damberg C, Friedberg MW. Primary Care Spending in the Fee-for-Service Medicare Population. *JAMA Internal Medicine.* 2019.