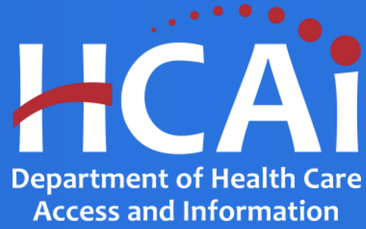

OHCA Investment and Payment Workgroup

December 20th, 2023

Agenda

9:00 a.m.	**1. Welcome and Updates**
9:05 a.m.	**2. Continue Discussion of Measuring Primary Care Claims-Based Spend**
10:10 a.m.	**3. Overview of Key Decisions for Setting a Target**
10:30 a.m.	**4. Adjournment**

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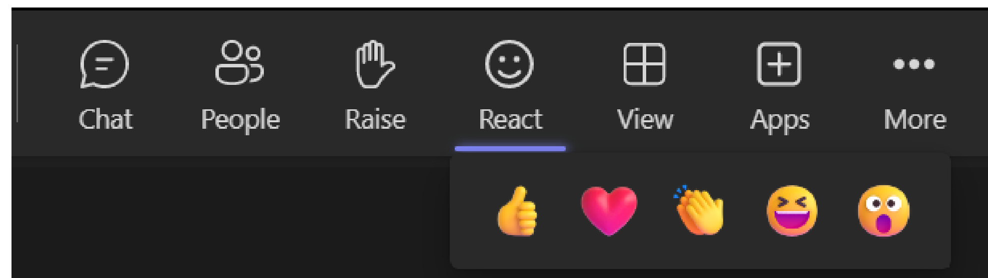
Meeting Format

- Workgroup purpose and scope can be found in the Investment and Payment Workgroup Charter
- Remote participation via Teams Webinar only
- Meeting recurs the third Wednesday of every month
- We will be using reaction emojis, breakout rooms, and chat functions:



Date:
Wednesday, December 20, 2023

Time
9:00 am PST

Microsoft Teams Link
for Public Participation:

Meeting ID: 231 506 203 671
Passcode: XzTN6r

Or call in (audio only):
+1 916-535-0978

Conference ID:
261 055 415#

Mid-Point Survey Results

Thank you for your feedback and suggestions. We look forward to finding ways to incorporate them into our work.

1. **Please rate the value of the meeting materials (presentations, documents, handouts, etc.).**

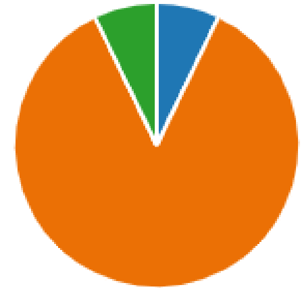
More Details

Not helpful (please elaborate be...	0
Somewhat helpful	3
Very helpful	11
Not sure	0

3. **Please rate the pace of the meetings.**

More Details

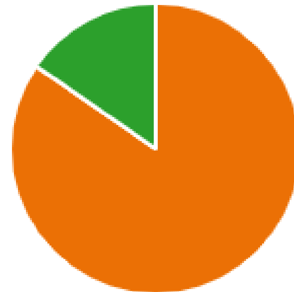
Too slow	1
About right	12
Too fast	1
Not sure	0



5. **Please rate the level of detail in presentations about each topic covered.**

More Details

Too detailed/technical	0
About right	11
Too general	2
Not sure	0



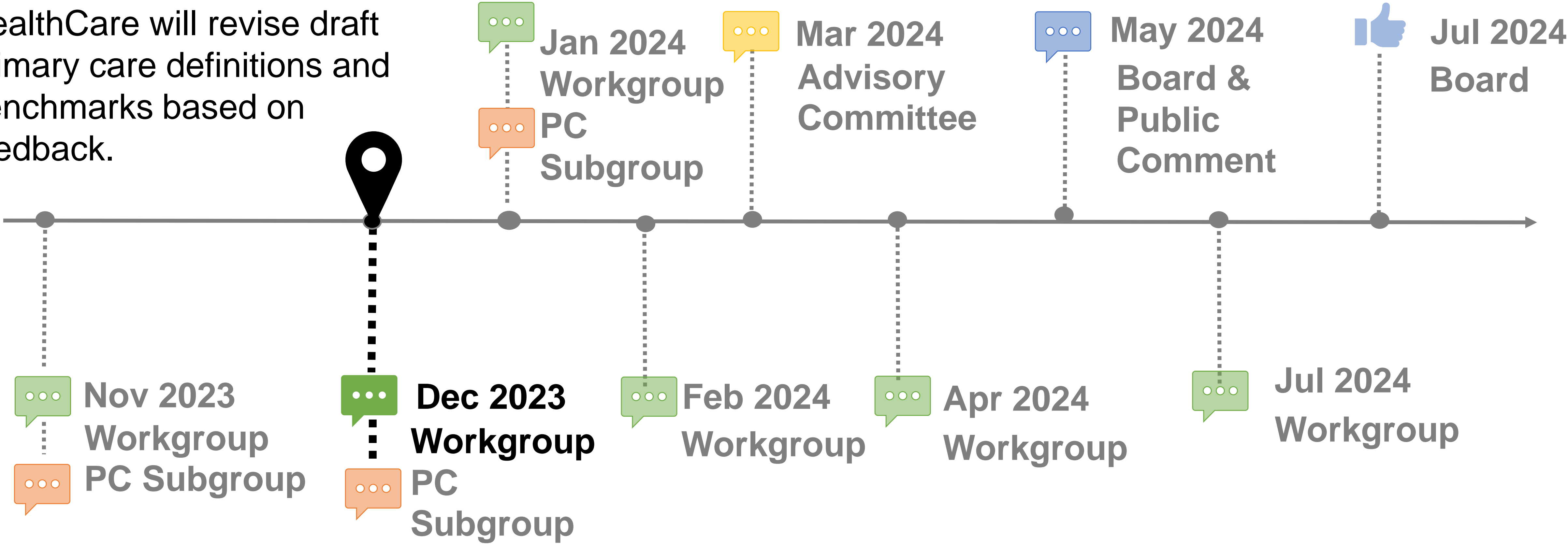
9. **Please rate the extent to which Workgroup members' feedback is reflected in OHCA's recommendations and proposals.**

More Details

Not reflected	0
Somewhat reflected	5
Well reflected	8
Not sure	0

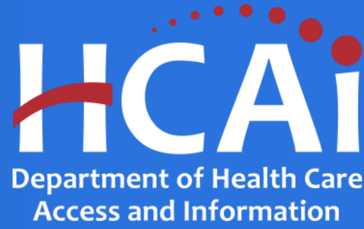
Timeline for Primary Care Work

Between each meeting, OHCA and Freedman HealthCare will revise draft primary care definitions and benchmarks based on feedback.



Provide Feedback

Board Approval



Continue Discussion of Measuring Primary Care Claims-Based Spend

Margareta Brandt, Assistant Deputy Director
Mary Jo Condon, Principal Consultant

Statutory Guidance on Primary Care Goals

Statutory Requirements
Promote improved outcomes for primary care, including, but not limited to, health care entities making investments in, or adopting models that do, any or all of the following: a. Promote the importance of primary care and adopt practices that give consumers a regular source of primary care. b. Increase access to advanced primary care models and adoption of measures that demonstrate their success in improving quality and outcomes. c. Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support. d. Leverage APMs that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health. e. Deliver higher value primary care services with an aim toward reducing disparities. f. Leverage telehealth and other solutions to expand access to primary care, care coordination, and care management. g. Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.

Health and Safety Code 127505(a.4)

Overview of Key Primary Care Investment Measurement Decisions for OHCA to Consider

1. **Include a narrow or broad set of providers?**
2. **Should the definition be limited to certain places of service?**
3. **Include a narrow or expanded set of services, or all?**
4. How to incorporate OB/GYN services and/or providers?
5. How to incorporate behavioral health services and/or providers?
6. Include or exclude pharmacy spending in denominator?

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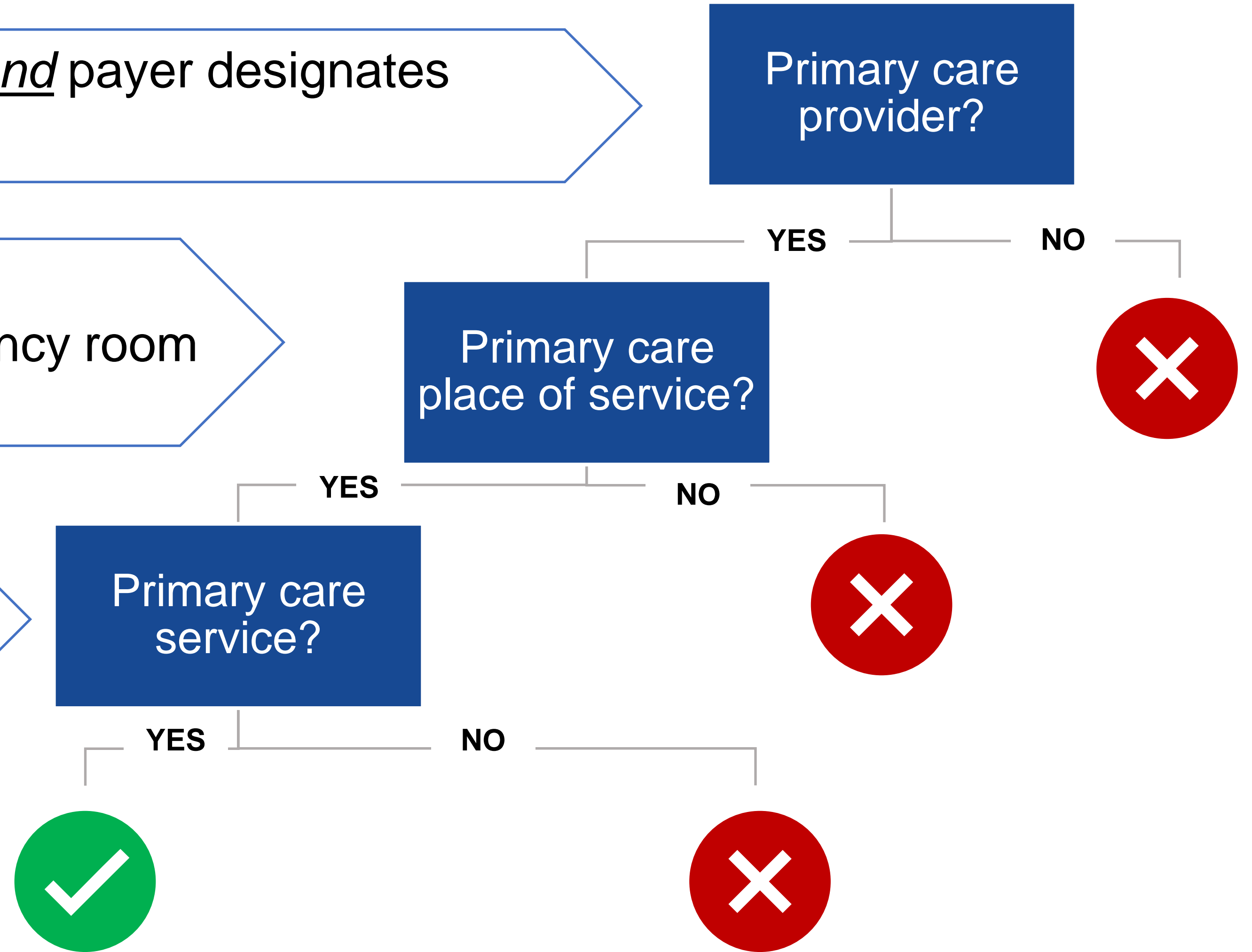
Primary Care Definitions Help Payers Know Which Spend to Include and Exclude

Provider taxonomy defined as primary care *and* payer designates provider as primary care*

Typically Included: Office, telehealth, home
Typically Excluded: Inpatient setting, emergency room
Often Debated: Urgent care, retail clinic

Services defined as being a part of primary care, often using a list of HCPCS/CPT codes or as any service provided by a primary care provider



*Payers typically identify primary care providers as those eligible for member assignment

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Summary of Primary Care Investment Measurement Decision Recommendations

1. **Include a narrow or broad set of providers?**

   Recommended: A broad definition of providers to align with statutory vision of team-based care.

2. **Should the definition be limited to certain places of service?**

   Recommended: A broad set of places of service to promote accessible, convenient primary care.

3. **Include a narrow or expanded set of services, or all?**

   Recommended: Include an expanded set of services with some restrictions to provide a comprehensive view of primary care service deliver while, minimizing the impact of imperfect categorization and inconsistency in provider data.

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Primary Care Provider Designations (PCP flag)

Some payers maintain lists of the providers they deem to be primary care providers. These flags can be used for assignment or to demonstrate network adequacy. Using this designation to further define primary care providers can help address shortcomings of provider taxonomy data but it's not perfect.

Opportunity	Considerations and Trade Offs
• Payers use their knowledge about physicians' day-to-day scope of practice to identify which physicians are practicing as primary care providers. • Helps address instances in which a provider may have multiple taxonomies, some of which are not primary care.	• Not all payers may have these lists readily available, or existing lists might not reflect network providers across all products. • The quality of the lists may vary greatly across payers. • To our knowledge, no current definition uses payer designation.

Include a Narrow or Broad Set of Providers?

Primary care definitions vary by the types of clinicians included. Taxonomy codes, which are alpha numeric codes representing a provider's specialty, identify the clinicians included.

Approach	Considerations and Trade Offs
Narrow: Typically includes family medicine, general practice, internal medicine, pediatrics, NP/PA, FQHC/RHC	• Narrow definition represents primary care providers that provide the vast majority of primary care services. • Nurses and other care team members rarely bill fee-for-service independently of another primary care provider. Therefore, including them may not be necessary.
Broad: May include additional providers such as clinical nurse specialists, adolescent medicine, and geriatricians	• These providers offer primary care services, often to populations needing more comprehensive primary care. • Including clinical nurse specialists and other members of the care team signals their importance. • Physician subspecialties such as adolescent medicine may function more as specialists than as primary care providers and it's difficult to determine when they are functioning in each capacity.

Note: Discussion of OB-GYN and/or BH providers will occur on following slides.

Example: Impact of Narrow Versus Broad Provider Definition

- The impact of a narrower provider definition is ***more limited*** than a narrower service definition.
- The impact of including or excluding geriatrics is likely to be greater for Medicare and Medicaid.
- The impact of including/excluding OB-GYN will be discussed in a future slide.

Commercial Primary Care Fee-for-Service Spending as a Percent of Total Spending (2014)	
PCP Taxonomies by Definition	Mean (Range)
Definition A. Family medicine, general internal medicine, general pediatrics, or general practice*	**5.8%** (4.5 - 7.6)
Definition C. Definition A, plus nurse practitioner, physician's assistant, geriatrics, adolescent medicine, or gynecology*	**6.4%** (4.6– 8.6)

**and designated by health insurer as a PCP*

Standardizing the Measurement of Commercial Health Plan Primary Care Spending, 2017. Milbank Memorial Fund.

Which Providers Do Other Definitions Include?

Please note provider restrictions would be paired with place of service and service restrictions.

All or Nearly All Include (90%+)*	**Most Include (~75%)***	**Some Include (~25% to 50%)***

• Family Medicine
• Internal Medicine
• General Practice
• Pediatrics
• Federally Qualified Health Center
• Physician Assistant
    • Medical
• Nurse Practitioner
    • Adult Health
    • Family
    • Pediatrics
    • Primary Care
• Primary Care & Rural Health Clinics
	• Adult Medicine
	• Geriatrics
	• Adolescent Medicine
	
	Potential inclusion of behavioral health and OB-GYN providers will be discussed later.
		• Nurse, non-practitioner
		• Certified clinical nurse specialist
		    • Adult Health
		    • Community/Public Health
		    • Pediatrics
		    • Chronic Health
		    • Family Health
		    • Gerontology
		• Hospice and Palliative Medicine
		• Preventive Medicine
		• Sleep Medicine
		• Naturopathic Medicine
		• Obesity Medicine
		• Sports Medicine
		• Social Worker

Feedback from Subgroup

- Mixed opinions on using payer primary care provider designation. Some said it may better identify those providers practicing primary care. Others raised concerns regarding the inconsistency of payer processes and definitions.

- Members shared an interest in distinguishing those primary care providers who are providing continuity of care from those providing episodic care but appreciated data does not easily allow for this analysis.

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Recommended Provider Taxonomies

Please note provider restrictions would be paired with place of service and service restrictions.

All or Nearly All Include (90%+)	Most Include (~75%)	Some Include (~25% to 50%)

✓ Family Medicine
✓ Internal Medicine
✓ General Practice
✓ Pediatrics
✓ Federally Qualified Health Center
✓ Physician Assistant
    ✓ Medical
✓ Nurse Practitioner
    ✓ Adult Health
    ✓ Family
    ✓ Pediatrics
    ✓ Primary Care
✓ Primary Care & Rural Health Clinics
	✓ Adult Medicine
	✓ Geriatrics
	✓ Adolescent Medicine
	
	Potential inclusion of behavioral health and OB-GYN providers will be discussed later.
		✓ Nurse, non-practitioner
		✓ Certified clinical nurse specialist
		    ✓ Adult Health
		    ✓ Community/Public Health
		    ✓ Pediatrics
		    ✓ Chronic Health
		    ✓ Family Health
		    ✓ Gerontology
		✓ Hospice and Palliative Medicine
		✓ Preventive Medicine
		• ~~Sleep Medicine~~
		• ~~Naturopathic Medicine~~
		• ~~Obesity Medicine~~
		• ~~Sports Medicine~~
		Exclude

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Questions for Discussion

- Would a combination of provider taxonomy and payer primary care provider designation (PCP flag) be a feasible solution that data submitters could implement?
- Is the quality, availability, and consistency of the payer designation (PCP flag) data sufficient to be incorporated into the primary care provider identification process as a secondary filter i.e., require provider have an OHCA designated provider taxonomy and a payer PCP flag?
- Regarding the recommended ***included*** provider taxonomies, are there any you would recommend ***excluding***?
- Regarding the recommended ***excluded*** provider taxonomies, are there any you would recommend ***including***?

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Include All Places of Service or Restrict?

The discussion of whether to include certain places of service as primary care raises questions about how to balance the need for access and continuity of care.

Approach	Considerations and Trade Offs
Restrict: These definitions may exclude care provided at retail clinics, schools, and urgent care facilities from primary care.	• Tends to focus on the importance of primary care continuity and coordination • May disproportionately undercount care received by those with poorer access
Include All: These definitions do not restrict based on place of service.	• More complete picture of primary care • Might discourage efforts to increase delivery of coordinated, person-centered care

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Example: Including All Places of Service or Restrict

Data from Delaware, Maine, and Maryland has found most primary care is provided within traditional primary care settings, such as offices and clinics. However, a growing portion of care is being delivered at retail clinics, urgent cares, at home and via telehealth.

Delaware also found Medicaid members were most likely to access care from non-traditional primary care settings such as urgent care.

Frequency of commercial primary care visits in Maryland by place of service, 2021

Place of Service	Percent of Primary Care Visits
Provider Office	82.1%
On-Campus – Outpatient Hospital	6.0%
Urgent Care	5.9%
Telehealth	5.4%
Other	0.6%

Maryland Health Care Commission, Primary Care Investment Models Results, 2023

Which Places of Service Do Other Definitions Include?

Please note place of service restrictions would be paired with provider and service restrictions.

All or Nearly All Include (~100%)	Some Include (~70%)	Few Include (~30%)
• Office • Telehealth • School • Home • Federally Qualified Health Center • Public Health • Rural Health Clinic • Worksite • Walk-in Retail Health Clinic • Urgent Care Facility	• Homeless Shelter • Indian Health Service • Tribal Facility • Correctional Facility • Assisted Living Facility • Group Home • Mobile Unit	• Inpatient • Emergency Room

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Feedback from Subgroup

- Some members shared concerns about including urgent care and retail clinics due to lack of continuity. Others felt these places of service are important to include because of their growing use.
- Some members had an interest in excluding episodic telehealth not provided by the patient’s regular source of care but recognized the added analytic complexity.
- Members appreciated seeing inclusion of tribal and correctional facilities but questioned whether data would be available to support analysis. The data OHCA will collect from the Indian Health Service will be aggregated and may not be available by service category. At this time, spending information from correctional facilities will not be available.

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Recommended Places of Service

Please note place of service restrictions would be paired with provider and service restrictions.

All or Nearly All Include (~100%)	Most Include (~75%+)	Some Include (>70%)	Few Include* (>25%)
✓ Office ✓ Telehealth ✓ School ✓ Home ✓ Federally Qualified Health Center ✓ Public Health & Rural Health Clinic ✓ Worksite	✓ Walk-in Retail Health Clinic • ~~Urgent Care Facility~~ **Exclude**	✓ Homeless Shelter ✓ Assisted Living Facility ✓ Group Home ✓ Mobile Unit ✓ Indian Health Service** ✓ Tribal Facility** ✓ Correctional Facility**	• ~~Inpatient~~ • ~~Emergency Room~~ **Exclude**

*Percentage based on definitions with restrictions. ** Sufficient data not available at this time.

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Questions for Discussion

- Do you agree with excluding care provided at certain places of service?
- Regarding the recommended ***included*** places of service, are there any you would recommend ***excluding***?
- Regarding the recommended ***excluded*** provider taxonomies, are there any you would recommend ***including***?

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Include a Narrow or Expanded Set of Services, or All?

Services paid via claims are defined using current procedural terminology (CPT) codes and other procedure codes.

Approach	Considerations and Trade Offs
Narrow: Core primary care services (e.g., office visits, preventive care, vaccine administration)	• Standard services that are clearly primary care and commonly delivered by primary care providers; supports comparability • Lacks a comprehensive view of primary care • New investment likely to be focused on core service delivery
Expanded: Expanded list of primary care services (e.g., minor procedures and screenings)	• Better reflects comprehensiveness of primary care • Not all primary care providers offer some of these services • Place of service restrictions can help narrow focus
All: Include all services performed by a primary care provider	• "All services" not often used as the base for primary care targets • Robust provider directory helpful; imperfect taxonomy impact is higher • Broader equals higher baseline; may result in less "new" investment • Less comparability of results • Place of service restrictions can help narrow focus

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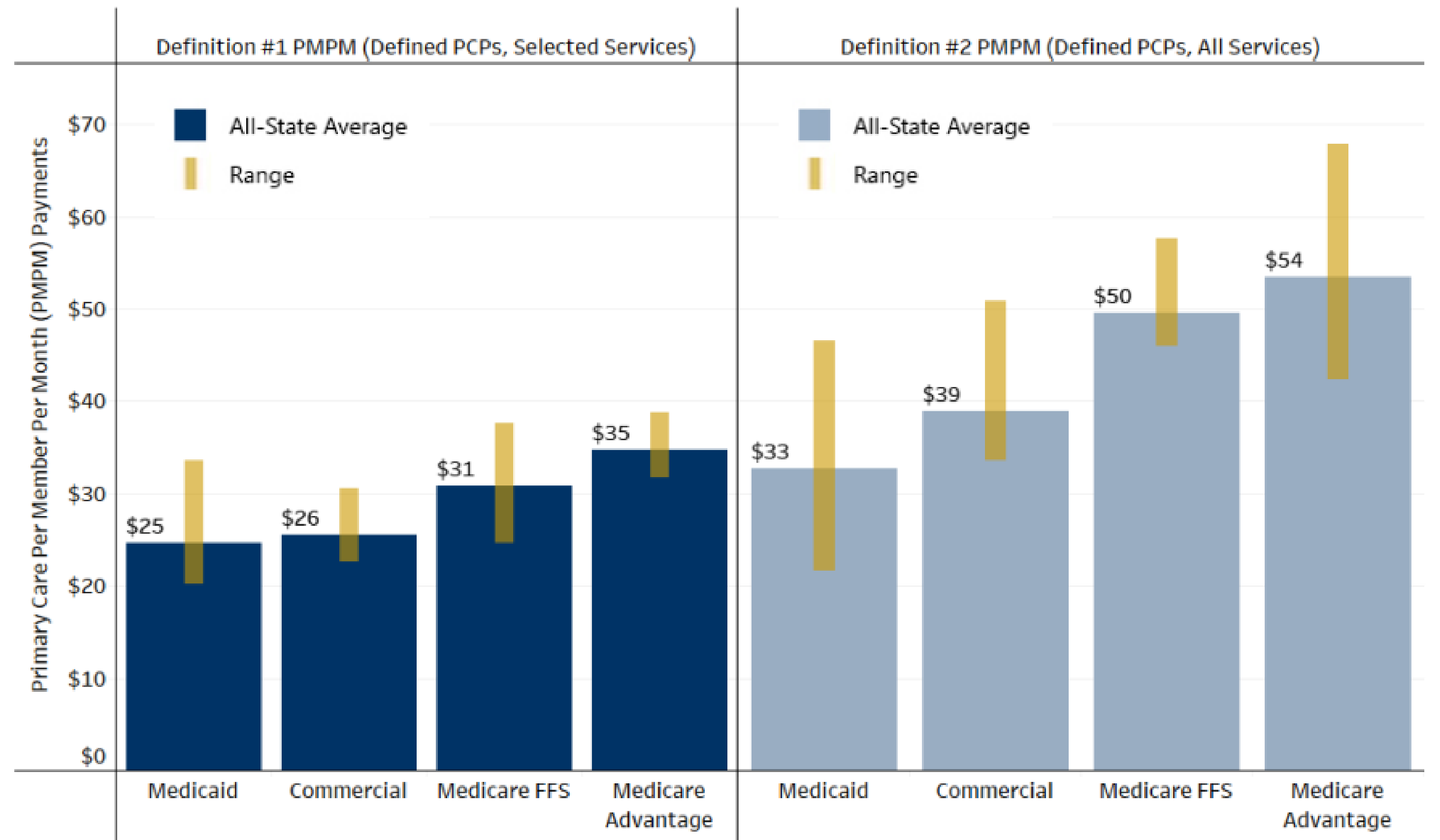
Example: Impact of Expanded Set of Services Versus All Services by Payer Type

NESCSO found less variation in primary care spend by payer type when using a defined list of services. This was particularly true when comparing Medicaid and commercial. This was likely due to differences in service mix across payer types.

Another reason may be imperfect provider data. The broader the primary care definition, the greater the impact of specialists who may be mistakenly counted as primary care providers.



Which Services Do Other Definitions Include?

The table below shows examples of categories of CPT codes used in primary care investment definitions. Please note service restrictions would be paired with place of service and provider restrictions. Potential inclusion of behavioral health and OB-GYN services will be discussed later.

All or Nearly All Include (85%+)*	Most Include (~50% to 75%)	Some Include (~10% to 50%)
• Office visit • Home visit • Preventive visits • Immunization administration • Transitional care & chronic care management • Health risk assessment • Advanced care planning	• Interprofessional consult (e-consult) • Team conference w or w/o patient • Prolonged preventive service • Domiciliary or rest home care/ evaluation • Hospital outpatient clinic visit	• Minor tests and procedures (e.g., skin lesions, cyst removal, abscess drain, skin tag removal, injections, spirometry, EKGs/ECGs) • Group visits • Remote patient monitoring • Labs • Immunizations**

*Percentage based on definitions with service restrictions. **Refers to immunization product not administration, which is in the first column.

Feedback from Subgroup

- Several members expressed an interest in a modular approach. They recognized some complementary analysis could occur through the Health Care Payments Data program.
- Several members shared an interest in a definition that included a comprehensive view of primary care, including as many services as possible given they were rendered by primary care providers.
- Members said difficulties accurately identifying primary care providers made it more difficult to recommend a set of included services.

Recommended Services

The table below shows examples of categories of CPT codes used in primary care investment definitions. Please note service restrictions would be paired with place of service and provider restrictions. Potential inclusion of behavioral health and OB-GYN services will be discussed later.

All or Nearly All Include (85%+)*	Most Include (~50% to 75%)	Some Include (~10% to 50%)
✓ Office visit ✓ Home visit ✓ Preventive visits ✓ Immunization administration ✓ Transitional care & chronic care management ✓ Health risk assessment ✓ Advanced care planning	✓ Interprofessional consult (e-consult) ✓ Team conference w or w/o patient ✓ Prolonged preventive service ✓ Domiciliary or rest home care/ evaluation ✓ Hospital outpatient clinic visit	✓ Minor procedures (e.g., skin lesions, cyst removal, abscess drain, skin tag removal, spirometry, EKG/ECG) ✓ Group visits ✓ Remote patient monitoring ✓ Labs ✓ Injections • ~~Immunizations**~~ **Exclude**

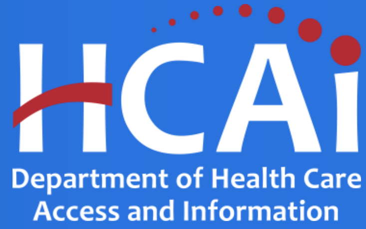
*Percentage based on definitions with restrictions. **Refers to immunization product, not administration.

Questions for Discussion

- Regarding the recommended ***included*** services, are there any you would recommend ***excluding***?

- Are there any categories of services not listed that you would like to discuss?

- Do you agree with the rationale for excluding immunization products (not administration)?



Overview of Key Decisions for Setting a Benchmark

Margareta Brandt, Assistant Deputy Director

Primary Care & Behavioral Health Investments

Statutory Requirements

- Measure and promote a sustained systemwide investment in primary care and behavioral health.
- Measure the percentage of total health care expenditures allocated to primary care and behavioral health and **set spending benchmarks. Spending benchmarks for primary care shall consider current and historic underfunding of primary care services.**
- Include an analysis of primary care and behavioral health spending and growth, and relevant quality and equity performance measures, in the annual report.
- Consult with state departments, external organizations promoting investment in primary care and behavioral health, and other entities and individuals with expertise in primary care, behavioral health, and health equity.
- Benchmarks and public reporting shall consider differences among payers and fully integrated delivery systems, including plan or network design or line of business, the diversity of settings and facilities through which primary care can be delivered, including clinical and nonclinical settings, the use of both claims-based and non-claims-based payments, and the risk mix associated with the covered lives or patient population for which they are primarily responsible.

Health and Safety Code 127505(a-d)

Primary Care & Behavioral Health Investments

Statutory Requirements
Promote improved outcomes for primary care, including, but not limited to, health care entities making investments in, or adopting models that do, any or all of the following: a. Promote the importance of primary care and adopt practices that give consumers a regular source of primary care. b. Increase access to advanced primary care models and adoption of measures that demonstrate their success in improving quality and outcomes. c. Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support. d. Leverage APMs that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health. e. Deliver higher value primary care services with an aim toward reducing disparities. f. Leverage telehealth and other solutions to expand access to primary care, care coordination, and care management. g. Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.

Health and Safety Code 127505(a.4)

Key Decisions for Setting a Primary Care Benchmark

1. Set a benchmark based on the percent of total medical expense allocated to primary care or a per member, per month cost?

2. Set a single benchmark or set benchmarks by payer type?

3. Set a single benchmark across adults and pediatric populations or separate goals for adults and pediatrics?

4. Set an absolute benchmark, a relative improvement benchmark, or a stairstep benchmark?

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How Other States Address Key Decisions

	CT	DE	RI	OR	CO
Percentage or Per Member, Per Month (PMPM)	%	%	%	%	%
Single Benchmark for All Payer Types?	Yes	Yes	Yes	Yes	Yes
Combined Adult and Pediatric Benchmark	Yes	Yes	Yes	Yes	Yes
Absolute or Relative Improvement?	Absolute (Stairstep)	Absolute (Stairstep)	Absolute (Previously Relative)	Absolute	Relative

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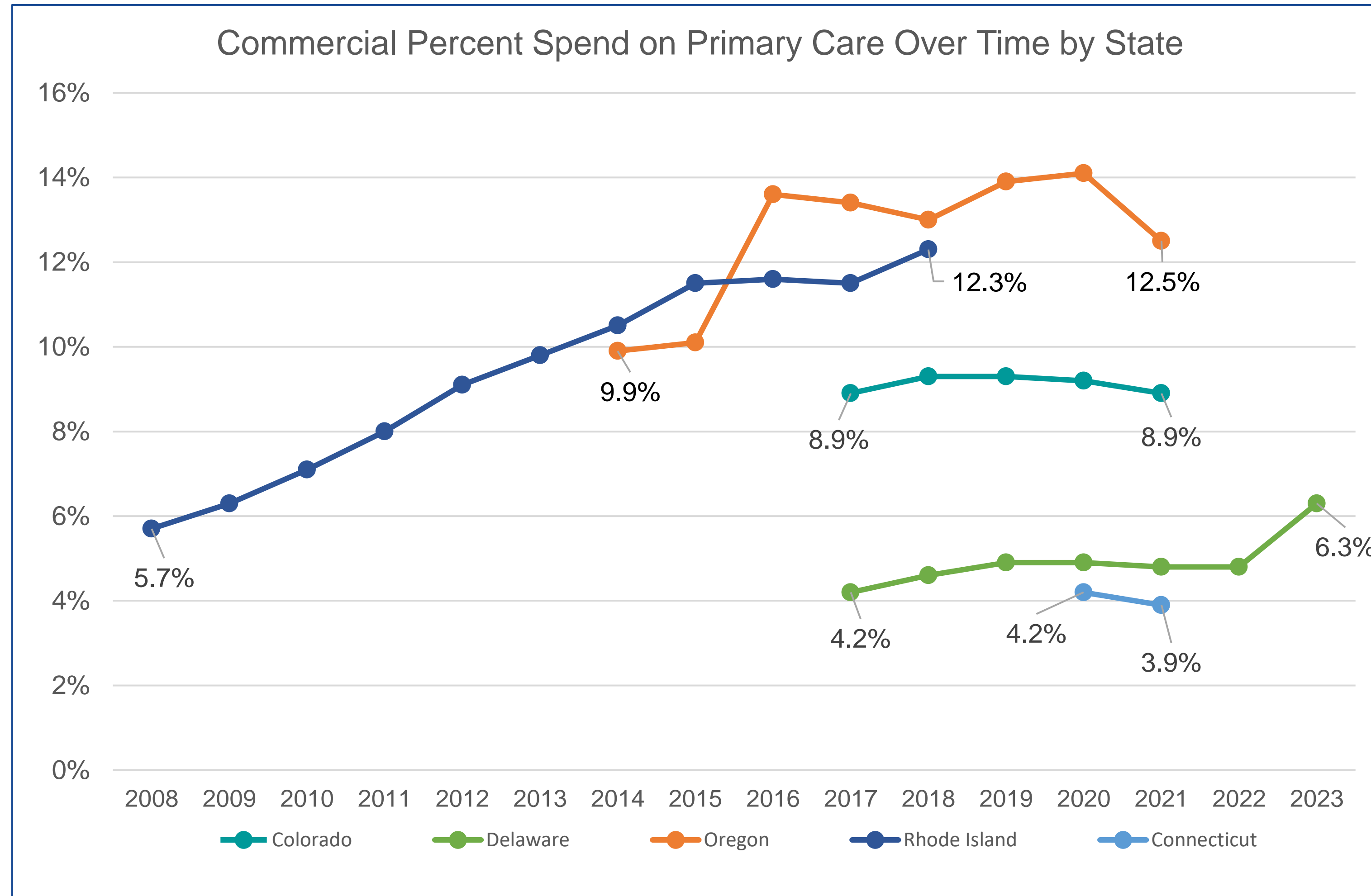
Most States See Investment Increase



Note: State definitions and total cost of care differ, which contributes to differences in investment percentages. Delaware's definition changed slightly in 2022. The Delaware 2023 figure is a projection.

Lessons Learned from Other States

- Need for multi-payer alignment; 4 of 5 states with investment requirements only focus on commercial or Medicaid, not both or Medicare Advantage.
- Sustainable delivery transformation requires multi-payer investment to support all populations in access to high-value primary care. It's hard, especially for small providers.
- Difficulty reallocating spending to fund primary care investment in the short-term.
- Concerns that basing primary care benchmarks on percent total medical expense is difficult to achieve, lacks consistency across populations, and may be inflationary.
- Difficulty determining how much of additional non-claims investment reached primary care, particularly risk settlement payments.

Questions for Discussion

- Do you have initial thoughts on the four key questions introduced today?
- Are there other key decisions you would like to discuss regarding primary care investment benchmark development?

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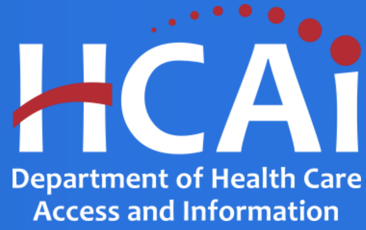

Adjournment