Primary Care Spending in Oregon

A report to the Oregon State Legislature.

Oregon Health Authority

February 2016

Department of Consumer & Business Services

Summary and Key Findings

Senate Bill 231 (2015) requires the Oregon Health Authority (OHA) and the Department of Consumer and Business Services (DCBS) to report on the percentage of medical spending allocated to primary care by the following health care payers:

- Prominent carriers, defined as health insurance carriers with annual premium income of $200 million or more.
- Health insurance plans contracted by the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB).
- Medicaid coordinated care organizations (CCOs).

In addition to reporting on spending allocated to primary care, SB 231 requires OHA to convene a primary care payment reform collaborative. The collaborative will help OHA develop recommendations for assisting primary care providers and directing optimal resources to primary care.

This document is OHA's and DCBS's report to the Legislature on medical spending allocated to primary care. It presents information about primary care spending in calendar year 2014. It excludes prescription drug claims, health care payers not covered by SB 231, and health care spending by people who pay out of pocket, including people without insurance. The health care payers in this report provided health coverage for 2.3 million Oregonians, 59% of Oregon's population, in 2014.

Multiple factors can affect primary care spending by health care payers. These include health plan members' age and health status, distance from primary care providers, and other demographic factors that can affect utilization of primary care and other services. These factors, in addition to payers' spending decisions, can affect spending allocated to primary care.

This report will help policymakers and the public assess the resources allocated to primary care in Oregon and develop proposals for improving primary care. Specifically, it will inform the work of Oregon's primary care payment reform collaborative as it develops recommendations for assisting Oregon's primary care providers and methods for optimizing investment in primary care.

CCOs and commercial, Medicare Advantage, and PEBB and OEBB plans offered by prominent carriers spent $1.0 billion on primary care in 2014.

Prominent carriers spent $644 million, or 9% of total medical spending, on primary care. CCOs spent $382 million, or 13% of total medical spending, on primary care.

On average, CCOs allocated a greater percentage of total medical spending to primary care than any other type of health care payer.

On average, CCOs allocated 13% of total medical spending to primary care. By contrast, all other types of payers allocated 10% or less of total medical spending to primary care on average.

The percentage of total medical spending allocated to primary care varied substantially among payers.

Spending allocated to primary care ranged from 7% to 31% among CCOs, 3% to 16% among commercial plans, 5% to 16% among PEBB and OEBB plans, and 4% to 14% among Medicare Advantage plans.

On average, non-claims-based payments comprised a greater percentage of primary care spending by CCOs than by other payer types.

Non-claims-based payments are payments to a health care provider intended to incentivize efficient care delivery, reward achievement of quality or cost-savings goals, and build health care infrastructure and capacity. On average, 61% of primary care spending by CCOs was non-claims-based. By contrast, one-third of primary care spending by Medicare Advantage plans was non-claims-based. Across PEBB and OEBB plans and commercial plans, non-claims-based payments comprised only 6% and 3% of primary care spending, respectively.

Background

Primary care is the front line of Oregon's health care system. Primary care providers deliver preventive services like flu shots and cancer screenings, respond to new patient needs and undiagnosed conditions, and identify health problems before they become serious. They help patients navigate an increasingly complex health care system, coordinate care with specialists and other providers, and maintain relationships with patients over time. Primary care providers include physicians, physician assistants, nurse practitioners, and naturopathic health care providers. Research indicates that availability of primary care providers is associated with improved health outcomes, including reduced mortality rates, reduced rates of low birth weight and preventable hospitalizations, and increased self-rated health status.[1]

The Oregon Legislature enacted Senate Bill 231 (2015) to provide information about primary care in Oregon and strengthen Oregon's primary care infrastructure. SB 231 requires the Oregon Health Authority (OHA) and the Department of Consumer and Business Services (DCBS) to report the percentage of medical spending allocated to primary care by the following health care payers:

- Prominent carriers, defined as health insurance carriers with annual premium income of $200 million or more.
- Health insurance plans contracted by the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB).
- Medicaid coordinated care organizations (CCOs).

In addition to reporting on spending allocated to primary care, SB 231 requires OHA to convene a primary care payment reform collaborative. The collaborative will consist of health care consumers, representatives of primary care providers and provider organizations, health insurance carriers and employers offering self-insured health plans, DCBS, and the federal Centers for Medicare and Medicaid Services. It will help OHA develop and share best practices for providing technical assistance to primary care providers and reimbursement methods that direct greater resources and investment toward primary care.

To prepare this report, OHA and DCBS made a special effort to collect complete information on primary care spending and total medical spending by the health care payers covered in SB 231. This effort ensured that the report includes the following types of payments used to pay for health care services:

- Claims-based payments: Payments to health care providers for services reported on health care claims. Information about claims-based payments made by Oregon's major health care payers is available from OHA's All-Payer, All-Claims Reporting Program (APAC).
- Non-claims-based payments: Payments to health care providers intended to incentivize efficient care delivery, reward achievement of quality or cost-savings goals, and build primary care infrastructure and capacity. Information about non-claims-based payments is not available from APAC.

To collect information about non-claims-based payments for this report, OHA and DCBS adopted the following temporary Oregon Administrative Rules:

- OAR 836-053-1500 through 836-053-1510, effective October 20, 2015: These rules define prominent carriers and require carriers to report non-claims-based primary care spending and total medical spending.
- OAR 409-027-0010 through 409-027-0030, effective November 5, 2015: These rules require CCOs to report non-claims-based primary care spending and total medical spending.

The rules define non-claims-based spending that prominent carriers and CCOs must report and include a specialized reporting template that each prominent carrier and CCO must submit to provide the information.

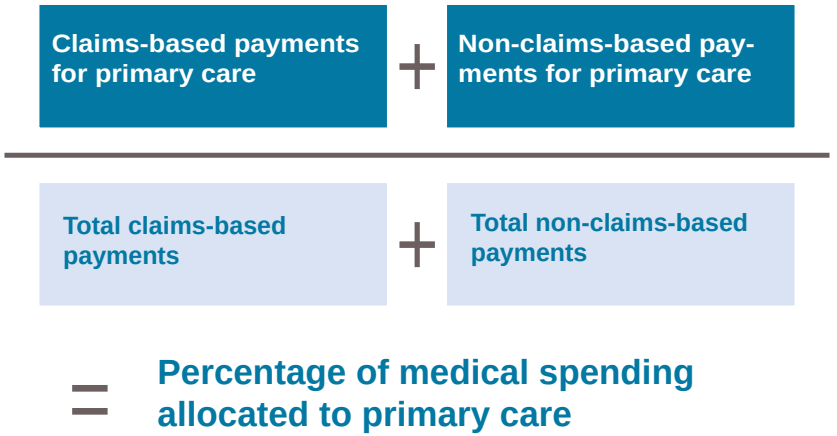
[1] Rhode Island Department of Health. 2012. *Impact of Primary Care on Healthcare Cost and Population Health: A Literature Review.*

Primary Care Spending: What's Included?

Consistent with the definition of primary care in SB 231, this report includes the following types of primary care spending:

1. **Claims-Based Payments:** Payments to primary care providers or provider organizations for primary care services rendered to health plan members. These payments are based on paid medical claims reported by health care payers. They exclude prescription drug payments.
2. **Non-Claims-Based Payments:** Payments to primary care providers or provider organizations that are intended to incentivize efficient care delivery, reward achievement of quality or cost-savings goals, and build primary care infrastructure and capacity.

To calculate percentage of total medical spending allocated to primary care, the sum of claims-based and non-claims-based payments to primary care providers is divided by the sum of total claims-based and non-claims based payments to all providers (illustrated at right).



Claims-Based Payments

Payments to primary care providers and practices:

Primary care providers

- Physicians specializing in primary care, including family medicine, general medicine, obstetrics and gynecology, pediatrics, general psychiatry, and geriatric medicine
- Naturopathic and homeopathic providers
- Physician's assistants
- Nurse practitioners

Primary care practices

- Primary care clinics
- Federally Qualified Health Centers (FQHCs)
- Rural health centers

For primary care services:

- Office or home visits
- General medical exams
- Routine medical and child health exams
- Preventive medicine evaluation or counseling
- Health risk assessments
- Routine obstetric care, including delivery
- Immunizations
- Other preventive medicine

Non-Claims-Based Payments

Payments to primary care providers and practices:

- Capitation payments and provider salaries
- Risk-based payments
- Payments for patient-centered primary care home or patient-centered medical home recognition
- Payments to reward achievement of quality or cost-savings goals
- Payments aimed at developing capacity to improve care for a defined population of patients, such as patients with chronic conditions
- Payments to help providers adopt health information technology, such as electronic health records
- Payments or expenses for supplemental staff or activities, such as practice coaches, patient educators, patient navigators, or nurse care managers

Data and Limitations

Health care spending information in this report was obtained from two sources:

Information about claims-based payments is from the All-Payer, All-Claims Reporting Program (APAC).

APAC collects information about health care claims and encounters from health insurance carriers with more than 5,000 members in Oregon, all CCOs, and all OEBB and PEBB plans. This information includes services rendered by health care providers, amounts paid to providers, and provider attributes such as specialty and practice address. APAC does not collect information about non-claims-based payments to providers.

Information about non-claims-based payments is from a specialized reporting template completed by carriers and CCOs.

Because APAC does not collect information about non-claims-based payments, OHA and DCBS developed a specialized reporting template to collect this information. The template required carriers and CCOs to report non-claims-based primary care spending and total spending in six categories for 2014. In addition, it required carriers and CCOs to report total months of enrollment for 2014, allowing for calculation of spending per member, per month. Reporting requirements in the template were incorporated into temporary Oregon Administrative Rules 836-053-1500 through 836-053-1510 and 409-027-0010 through 409-027-0030.

Rulemaking, data collection, and data analysis for this report were accomplished within a seven-month timeframe. Carriers and CCOs had less than two months from the time the temporary rules were published to report non-claims-based payments on the specialized reporting template.

07/01/2015:	SB 231 becomes effective
10/20/2015:	Temporary rules for prominent carriers become effective
11/05/2015:	Temporary rules for CCOs become effective
12/31/2015:	Deadline for payers to submit non-claims-based payment data
02/01/2016:	Deadline for report to the Oregon Legislature

The following limitations should be noted when interpreting this report:

- **A limited timeframe provided little time to clarify reporting requirements.** Temporary rules provided basic definitions of non-claims-based spending that carriers and CCOs were required to report. Carriers and CCOs were invited to request additional detail regarding these definitions. However, the two-month timeframe between rules publication and the reporting deadline afforded relatively little time for clarification. As a result, it is likely that carriers and CCOs used their best judgment to interpret the reporting rules, and that non-claims-based spending may not be directly comparable across carriers and CCOs.
- **Due to the limited timeframe, non-claims-based spending was not extensively validated.** Preliminary validation of non-claims-based spending reported by CCOs was carried out using CCOs' financial records. However, non-claims-based spending could not be extensively validated against other data sources prior to the reporting deadline.
- **This report excludes primary care spending by some health care payers.** These include health insurance carriers with annual premium income of less than $200 million in 2014, self-insured employers, Medicaid fee-for-service, Medicare fee-for-service, and other federal health insurance programs. The report also excludes commercial plan spending by one prominent carrier and Medicare Advantage plan spending by two prominent carriers due to issues with claims-based data. In addition, the report excludes primary care spending by people who pay out of pocket, including people without insurance.
- **Multiple factors can affect primary care spending by carriers and CCOs.** Age and health status, distance from primary care providers, and other demographic factors can affect utilization of primary care and other services by health plan members. These factors, in addition to carriers' and CCOs' spending decisions, can affect spending allocated to primary care.
- **Names of carriers and CCOs are masked due to carrier concerns about disclosing proprietary information.** See Page 18 for a complete list of carriers and CCOs included in this report.

See Methodology for additional information about data collection and analysis.

Health Care Payers in this Report

A health care payer is an organization that pays doctors, hospitals, and other health care providers for care and services received by a person with health care coverage. This report provides information about primary care spending by two types of health care payers: prominent carriers and coordinated care organizations (CCOs). The report presents information separately for three types of health insurance plans offered by prominent carriers: commercial plans, Medicare Advantage plans, and PEBB and OEBB plans.

Prominent Carriers

Prominent carriers are health insurance carriers that offer health plans to individuals and employers. For the purpose of reporting on spending allocated to primary care, prominent carriers were defined by temporary Oregon Administrative Rule 836-053-1505 as health insurance carriers with annual premium income of $200 million or more. According to this definition, there were eight prominent carriers in 2014.

Prominent carriers offer the following types of health plans:

- Commercial health plans: Group plans for employers and individual plans for people without employer-sponsored health insurance.
- Medicare Advantage plans: Plans where the federal Medicare program pays part of the premium. The overwhelming majority of people covered by Medicare Advantage plans are age 65 and older.
- PEBB and OEBB plans: Health plans offered to public employees and educators. The Public Employees Benefit Board and Oregon Educators Benefit Board contract with insurance companies to offer these plans.

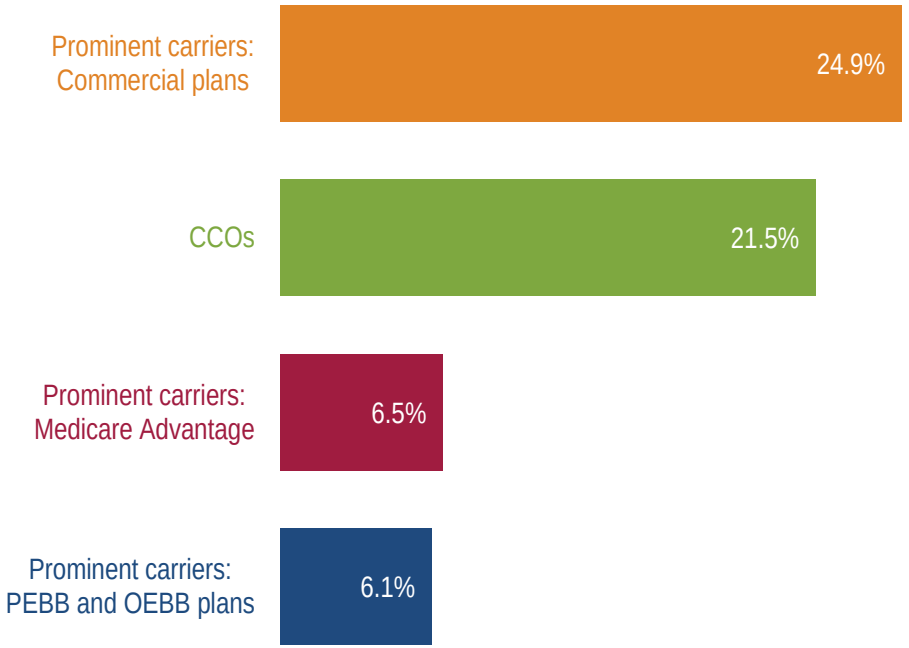
Because commercial, Medicare Advantage, and PEBB and OEBB plans have very different benefit structures and member demographics, this report presents enrollment and spending separately for each type of plan.

Coordinated Care Organizations (CCOs)

CCOs are local organizations that provide physical, mental, and dental health care using global budgets that grow at a fixed rate. CCOs are accountable for the health outcomes of populations they serve. CCOs are part of Oregon's Medicaid program, which provides health coverage for Oregonians with incomes at or below 138 percent of the federal poverty level. There were 16 CCOs in 2014 (enrollment and spending for the two CCOs associated with Pacific Source Community Solutions are reported together).

See Page 18 for the complete list of carriers and CCOs included in this report.

PERCENTAGE OF OREGON'S POPULATION COVERED BY HEALTH CARE PAYERS IN THIS REPORT: In 2014, prominent carriers and CCOs provided coverage for 2.3 million Oregonians, 59% of Oregon's population.[2]



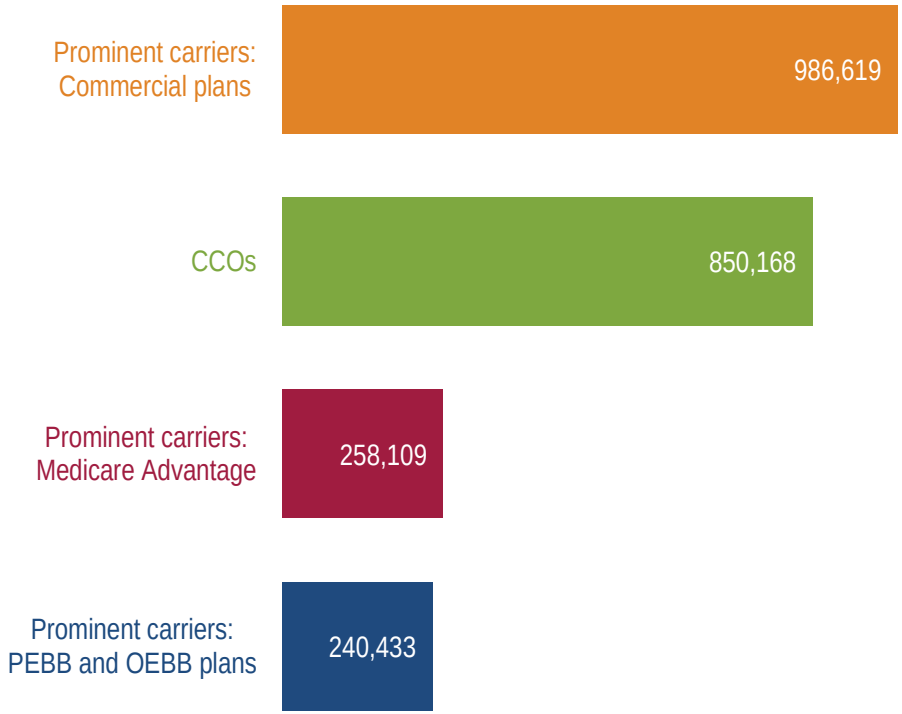
[2] Oregon's estimated population was 3,962,565 as of June 30, 2014. Population Research Center, Portland State University.

Enrollment and Total Primary Care Spending

The graphs on this page show enrollment, total primary care spending, and total non-primary-care spending by prominent carriers and CCOs in calendar year 2014. Enrollment is reported as number of unique people enrolled in June 2014. On the graph at right, the dark part of each bar shows total primary care spending and the light part of each bar shows non-primary care spending. The number to the right of each bar shows total medical spending.

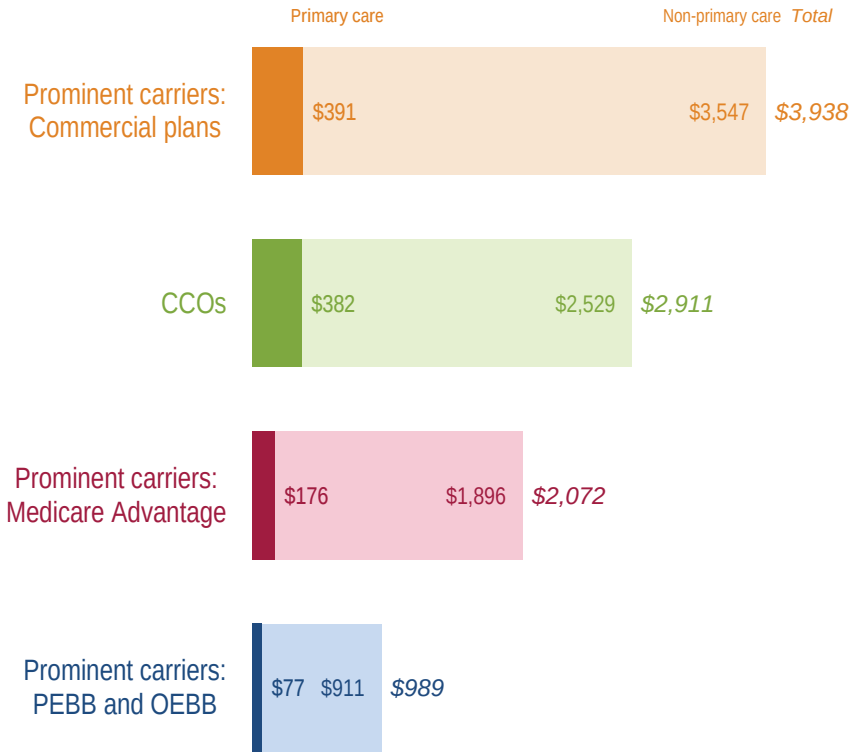
ENROLLMENT: In June 2014, 1.5 million Oregonians were enrolled in commercial, Medicare Advantage, and PEBB and OEBB plans offered by prominent carriers.

In the same year, 850,168 Oregonians were enrolled in CCOs.



TOTAL PRIMARY CARE SPENDING ($ MILLION): In 2014, commercial, Medicare Advantage, and PEBB and OEBB plans spent $644 million on primary care out of $7.0 billion in total medical expenses.

In the same year, CCOs spent $382 million on primary care out of $2.9 billion in total medical expenses.



Total primary care spending excludes commercial spending by Carrier 2 and Medicare Advantage spending by Carrier 2 and Carrier 7 due to issues with claims-based data. See Page 18 for a complete list of carriers and CCOs included in this report and Methodology for data details.

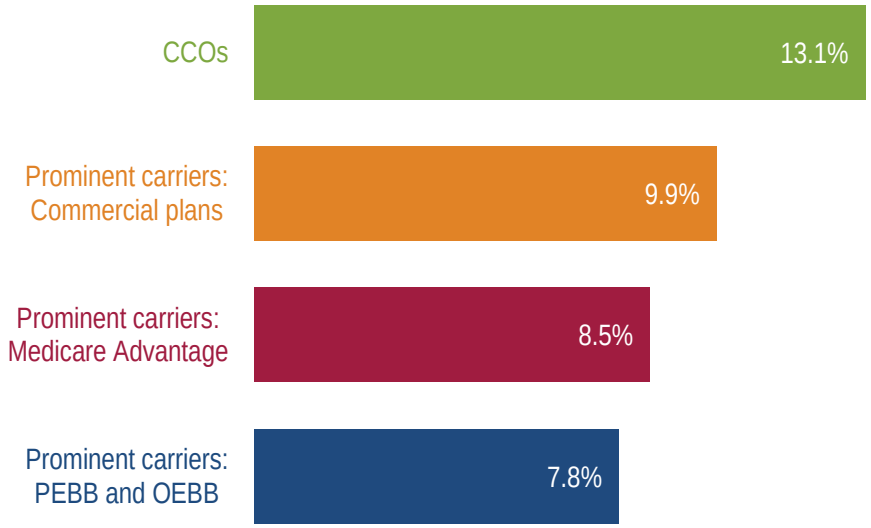
Primary Care Spending: Percentage of Total Medical Spending and Per-Member, Per-Month (PMPM)

The graphs on this page show two measures of medical spending allocated to primary care by prominent carriers and CCOs in calendar year 2014:

- **Percentage of total medical spending allocated to primary care.** This measure allows for comparison of spending allocated to primary care as a share of total medical spending, regardless of total dollars spent.
- **Per-member, per-month (PMPM) primary care spending compared with PMPM non-primary-care spending.** This measure represents the average amount paid to health care providers in a month for each member with coverage. It is defined as (primary care spending + non-primary-care spending) ÷ total months of enrollment in the calendar year. It allows for comparison of dollars per person spent on primary care and other types of care. On the graph at right, the dark part of each bar shows PMPM primary care spending and the light part of each bar shows PMPM non-primary-care spending. The number to the right of each bar shows total PMPM medical spending.

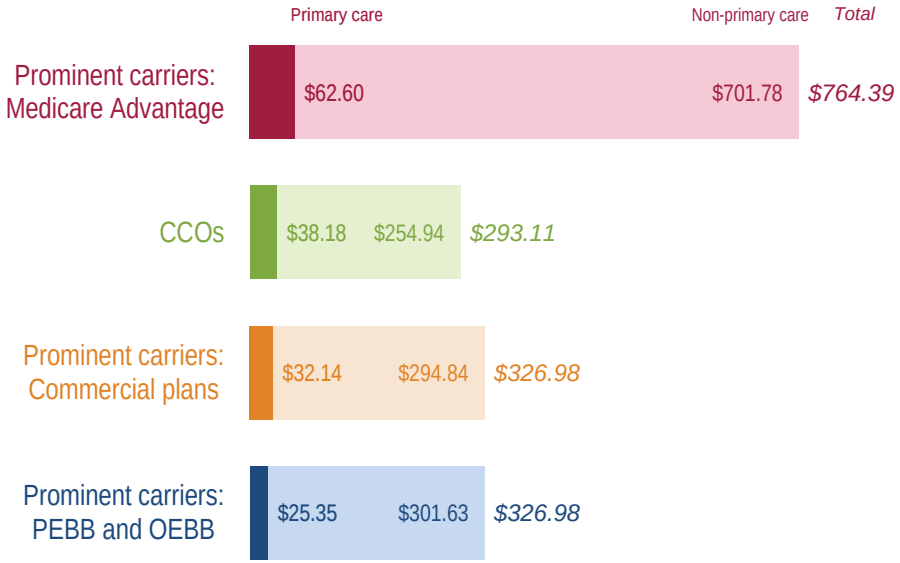
PERCENTAGE OF TOTAL MEDICAL SPENDING ALLOCATED TO PRIMARY CARE: In 2014, CCOs allocated 13% of total medical spending to primary care on average.

Commercial, Medicare Advantage, and PEBB and OEBB plans allocated 10% or less of total medical spending to primary care on average.



PER-MEMBER, PER-MONTH (PMPM) PRIMARY CARE SPENDING: In 2014, PMPM primary care spending ranged from $25 for PEBB and OEBB plans to $63 for Medicare Advantage plans on average.

Non-primary care spending ranged from $255 PMPM for CCOs to $702 PMPM for Medicare Advantage plans on average.



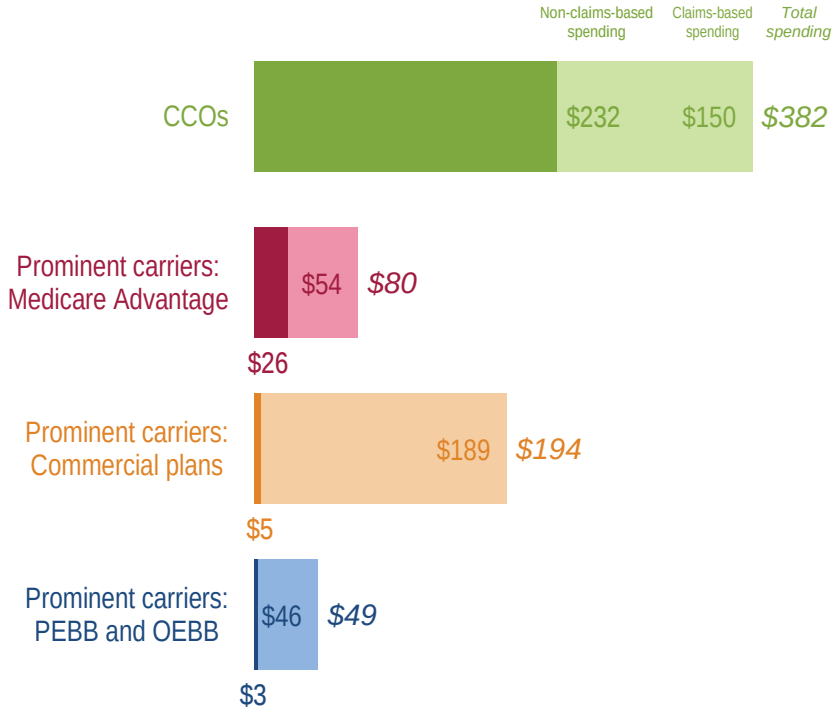
Excludes commercial spending by Carrier 2 and Medicare Advantage spending by Carrier 2 and Carrier 7 due to issues with claims-based data. See Page 18 for a complete list of carriers and CCOs included in this report and Methodology for data details.

Primary Care Spending: Claims-Based and Non-Claims-Based Spending

The graphs on this page show total claims-based and non-claims-based primary care spending and claims-based and non-claims-based primary care spending as a percentage of total primary care spending. Non-claims-based payments are payments to health care providers intended to incentivize efficient care delivery, reward achievement of quality or cost-savings goals, and build primary care infrastructure and capacity. On the graph at left, the dark part of each bar shows total claims-based spending and the light part of each bar shows total non-claims-based spending. The number to the right of each bar shows total primary care spending.

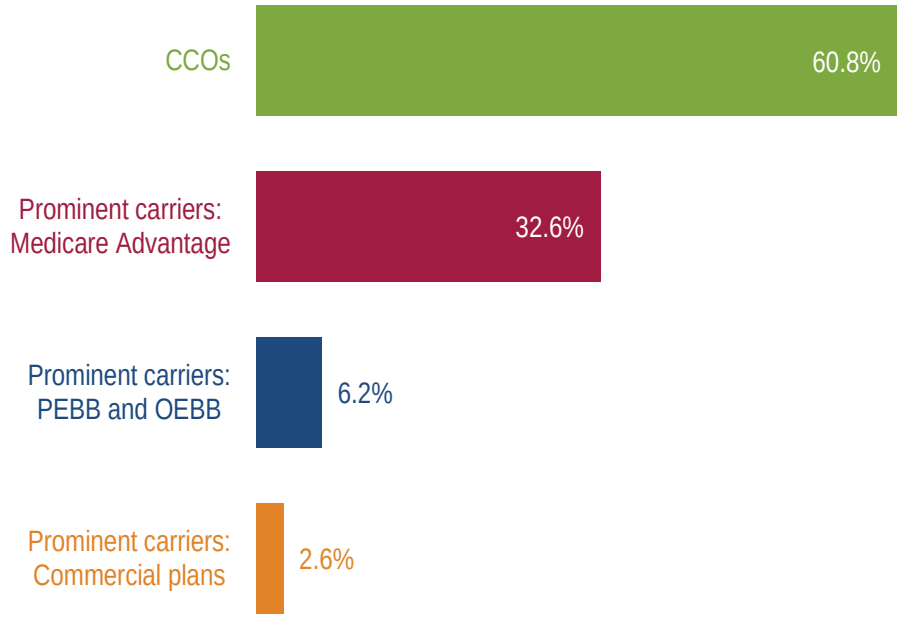
TOTAL CLAIMS-BASED AND NON-CLAIMS-BASED PRIMARY CARE SPENDING ($ MILLION): In 2014, CCOs spent $232 million on primary care through non-claims-based payments.

Commercial, Medicare Advantage, and PEBB and OEBB plans spent $34 million on primary care through non-claims-based payments.



NON-CLAIMS-BASED SPENDING AS A PERCENTAGE OF TOTAL PRIMARY CARE SPENDING: In 2014, 61% of primary care spending by CCOs was non-claims-based.

One-third of spending by Medicare Advantage plans was non-claims-based.



Excludes spending by Carrier 3 because this carrier was unable to break out claims-based and non-claims-based spending within the data collection timeframe for this report. In addition, excludes commercial spending by Carrier 2 and Medicare Advantage spending by Carrier 2 and Carrier 7 due to issues with claims-based spending data. See Page 18 for a complete list of carriers and CCOs included in this report and Methodology for data details.

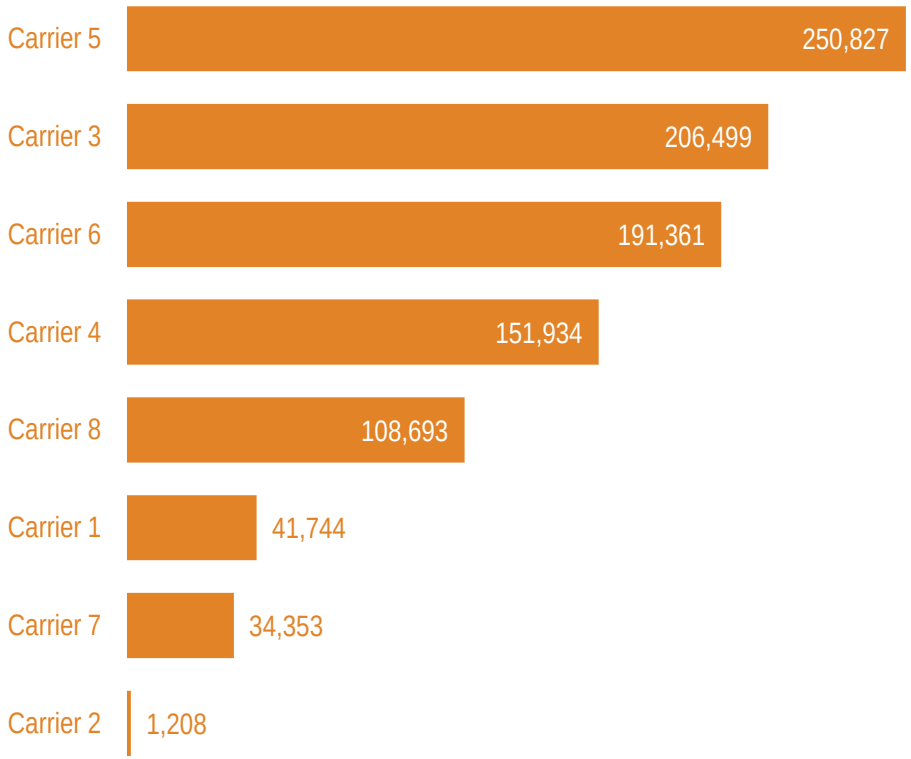
Commercial Plans: Enrollment

The graphs on this page show the number of people enrolled in commercial plans offered by prominent carriers and commercial plan enrollment with each prominent carrier as a percentage of commercial enrollment for all prominent carriers. Enrollment is reported as number of unique people enrolled in June 2014.

In addition to commercial plans, prominent carriers offer Medicare Advantage and PEBB and OEBB plans. Enrollment in Medicare Advantage and PEBB and OEBB plans is reported separately and not included on the graphs in this page.

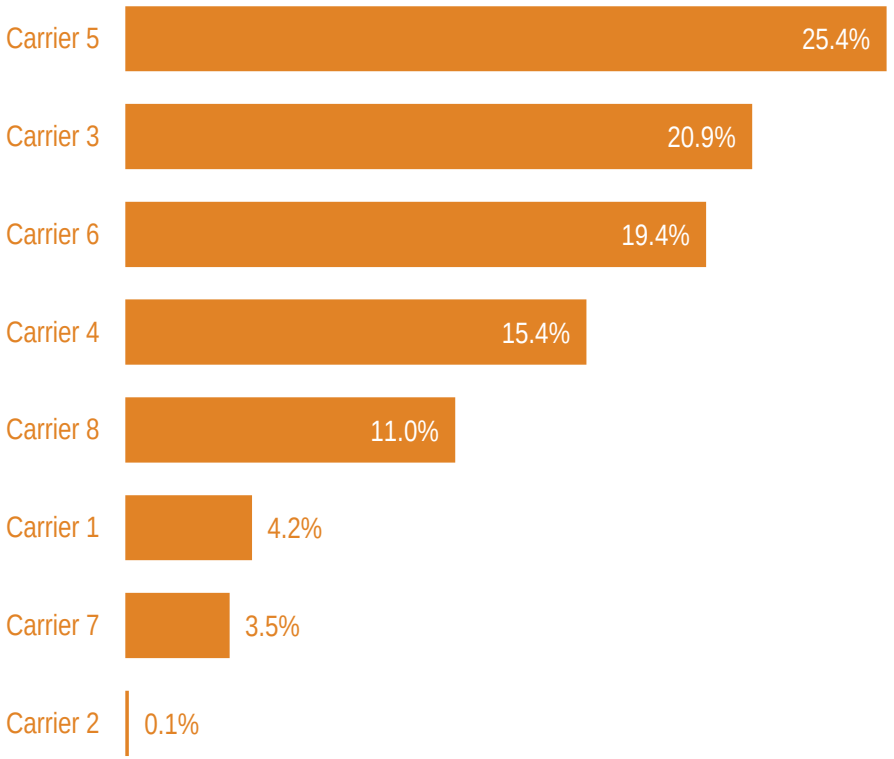
NUMBER OF PEOPLE ENROLLED: In June 2014, 986,619 people were enrolled in commercial plans offered by prominent carriers.

648,687 people were enrolled in commercial plans offered by the top three prominent carriers.



PERCENTAGE OF TOTAL ENROLLMENT: In June 2014, the top three prominent carriers accounted for two-thirds of commercial enrollment among all prominent carriers.

Carrier 5 accounted for one-quarter of commercial enrollment among all prominent carriers.



See Page 18 for a complete list of carriers included in this report and Methodology for data details.

Commercial Plans: Primary Care Spending

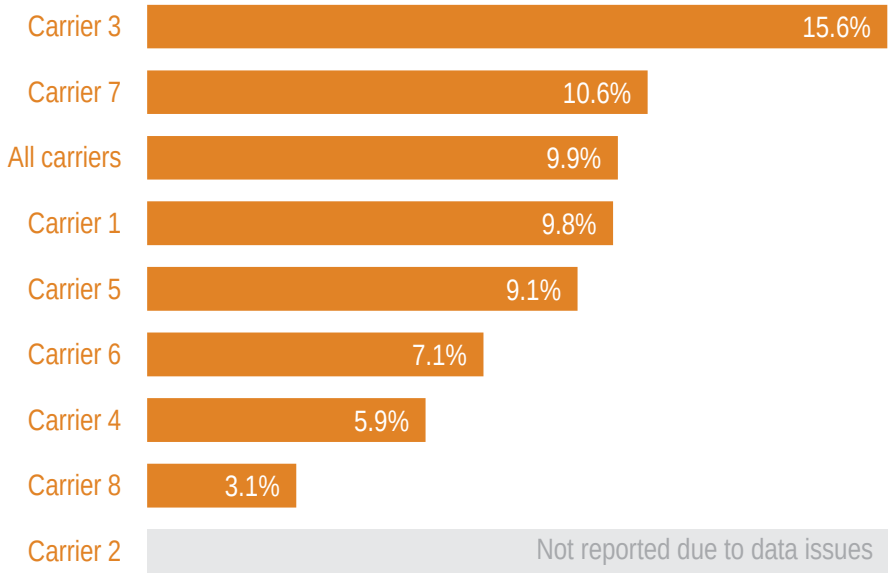
The graphs on this page show two measures of medical spending allocated to primary care by commercial plans offered by prominent carriers in calendar year 2014:

- **Percentage of total medical spending allocated to primary care.** This measure allows for comparison of spending allocated to primary care as a share of total medical spending, regardless of total dollars spent.
- **Per-member, per-month (PMPM) primary care spending and non-primary care spending.** This measure represents the average amount paid to health care providers in a month for each member with coverage. It allows for comparison of dollars per person spent on primary care and other types of care. On the graph, the dark part of each bar shows primary care spending PMPM and the light part of each bar shows non-primary-care spending PMPM.

In addition to commercial plans, prominent carriers offer Medicare Advantage and PEBB and OEBB plans. Spending by Medicare Advantage and PEBB and OEBB plans is reported separately and not included in the graphs on this page.

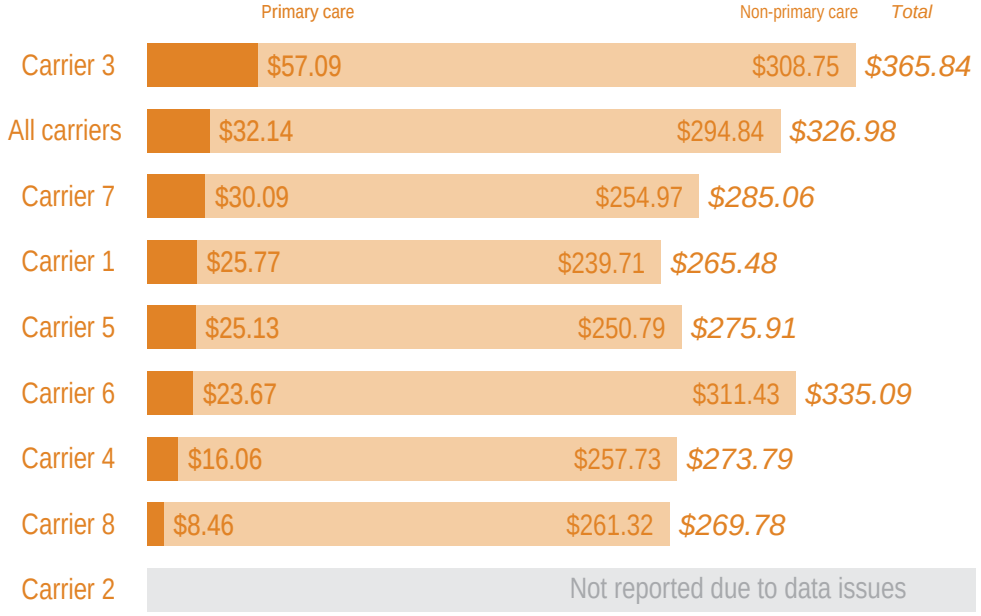
PERCENTAGE OF TOTAL MEDICAL SPENDING ALLOCATED TO PRIMARY CARE: In 2014, share of spending allocated to primary care ranged from 3% to 16% among commercial plans.

Commercial plans offered by 5 of 7 prominent carriers allocated less than 10% of total medical spending to primary care.



PER-MEMBER, PER-MONTH (PMPM) PRIMARY CARE SPENDING: In 2014, primary care spending ranged from $8 PMPM to $57 PMPM among commercial plans.

PMPM primary care spending by Carrier 3's commercial plans was nearly twice that of the next highest prominent carrier.



Excludes spending by Carrier 2 due to issues with claims-based data. See Page 18 for a complete list of carriers included in this report and Methodology for data details.

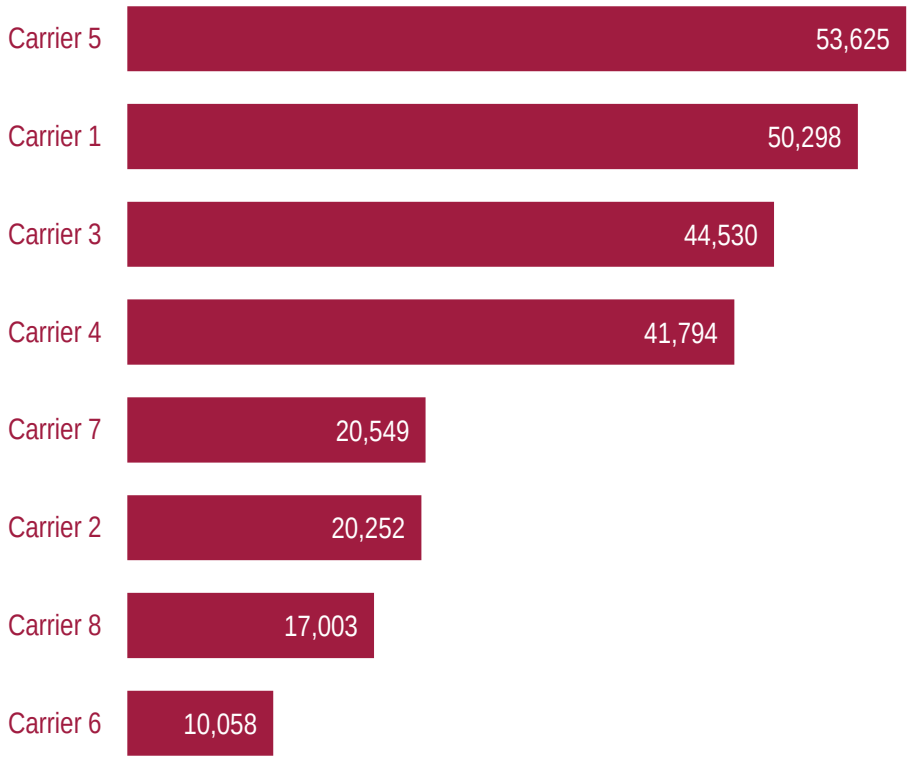
Medicare Advantage Plans: Enrollment

The graphs on this page show the number of people enrolled in Medicare Advantage plans offered by prominent carriers and Medicare Advantage enrollment with each prominent carrier as a percentage of Medicare Advantage enrollment for all prominent carriers. Enrollment is reported as number of unique people enrolled in June 2014.

In addition to Medicare Advantage plans, prominent carriers offer commercial and PEBB and OEBB plans. Enrollment in commercial and PEBB and OEBB plans offered by prominent carriers is reported separately and not included in the graphs on this page.

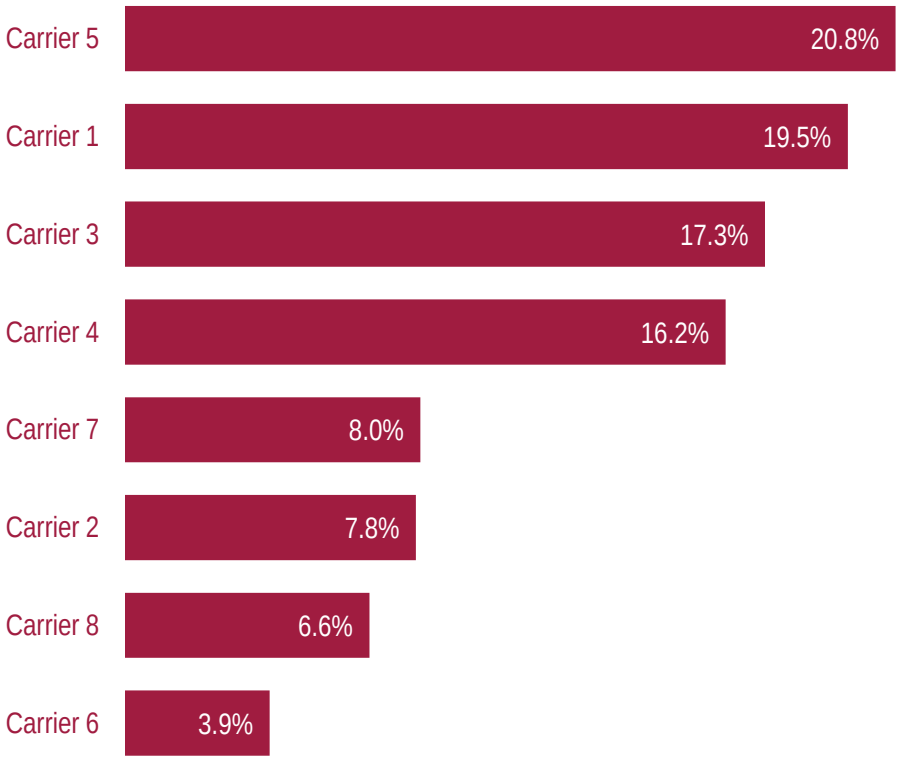
NUMBER OF PEOPLE ENROLLED: In June 2014, 258,109 people were enrolled in Medicare Advantage plans offered by prominent carriers.

148,453 people were enrolled in Medicare Advantage plans offered by the top three prominent carriers.



PERCENTAGE OF TOTAL ENROLLMENT: In June 2014, the top three prominent carriers accounted for 58% of Medicare Advantage enrollment among all prominent carriers.

Carrier 5 accounted for one-fifth of Medicare Advantage enrollment among all prominent carriers.



See Page 18 for a complete list of carriers included in this report and Methodology for data details.

Medicare Advantage Plans: Primary Care Spending

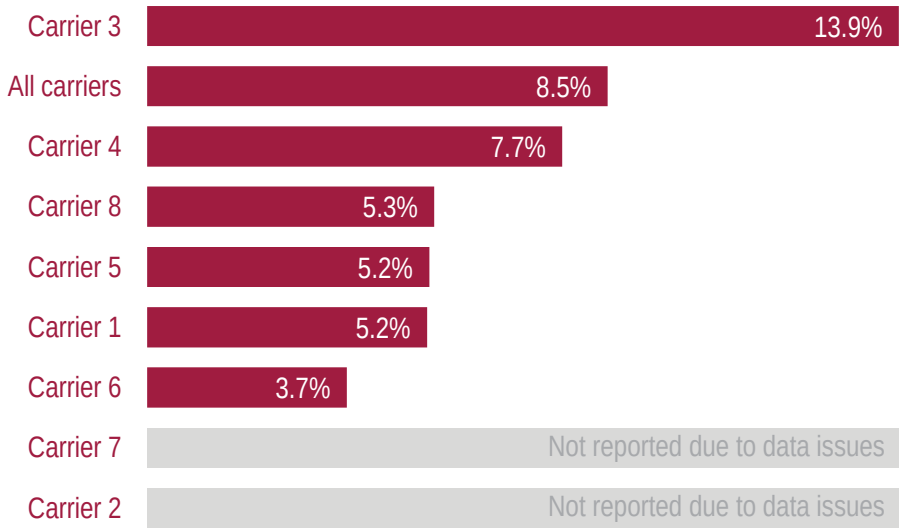
The graphs on this page show two measures of medical spending allocated to primary care by Medicare Advantage plans offered by prominent carriers in calendar year 2014:

- **Percentage of total medical spending allocated to primary care.** This measure allows for comparison of spending allocated to primary care as a share of total medical spending, regardless of total dollars spent.
- **Per-member, per-month (PMPM) primary care spending and non-primary care spending.** This measure represents the average amount paid to health care providers in a month for each member with coverage. It allows for comparison of dollars per person spent on primary care and other types of care. On the graph, the dark part of each bar shows primary care spending PMPM and the light part of each bar shows non-primary-care spending PMPM.

In addition to Medicare Advantage plans, prominent carriers offer commercial and PEBB and OEBB plans. Spending by commercial and PEBB and OEBB plans is reported separately and not included in the graphs on this page.

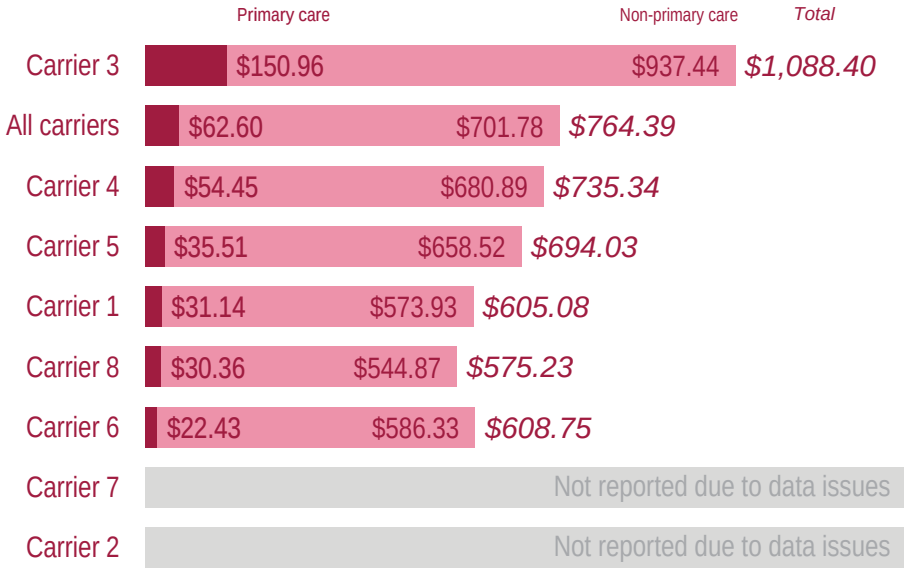
PERCENTAGE OF TOTAL MEDICAL SPENDING ALLOCATED TO PRIMARY CARE: In 2014, share of spending allocated to primary care ranged from 4% to 14% among Medicare Advantage plans.

Medicare Advantage plans offered by 5 of 6 prominent carriers allocated less than 10% of medical spending to primary care.



PER-MEMBER, PER-MONTH (PMPM) PRIMARY CARE SPENDING: In 2014, primary care spending ranged from $22 PMPM to $151 PMPM among Medicare Advantage plans offered by prominent carriers.

PMPM primary care spending by Carrier 3's Medicare Advantage plans was nearly three times that of the next highest prominent carrier.



Excludes spending by Carrier 2 and Carrier 7 due to issues with claims-based data. See Page 18 for a complete list of carriers included in this report and Methodology for data details.

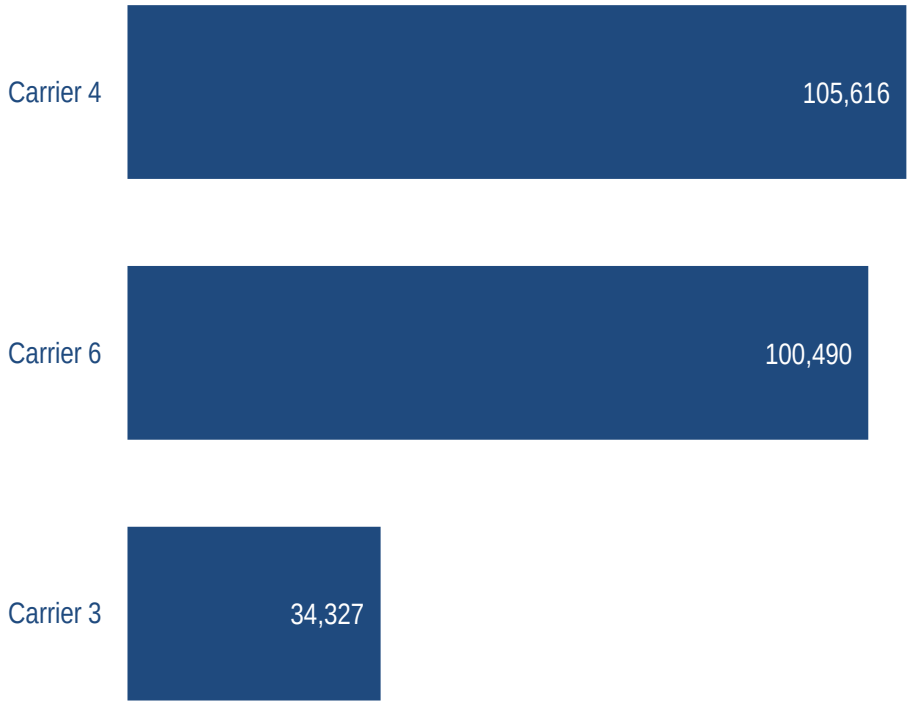
PEBB and OEBB Plans: Enrollment

The graphs on this page show the number of people enrolled in PEBB and OEBB plans offered by prominent carriers and PEBB and OEBB enrollment with each prominent carrier as a percentage of PEBB and OEBB enrollment for all prominent carriers. Enrollment is reported as number of unique people enrolled in June 2014.

In addition to PEBB and OEBB plans, prominent carriers offer commercial and Medicare Advantage plans. Enrollment in commercial and Medicare Advantage plans offered by prominent carriers is reported separately and not included in the graphs on this page.

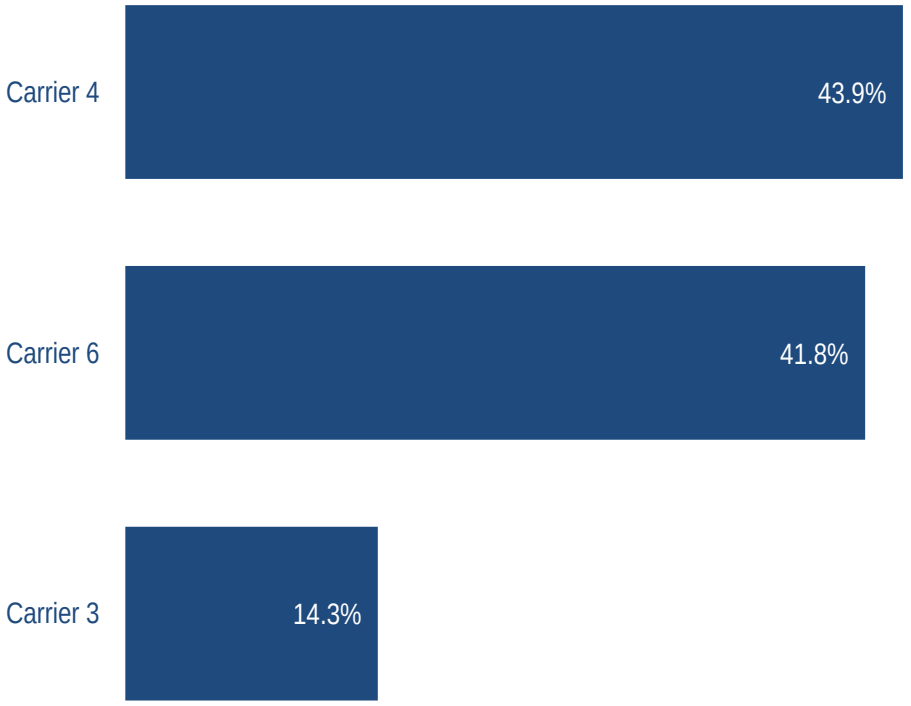
NUMBER OF PEOPLE ENROLLED: In June 2014, 240,433 people were enrolled in PEBB and OEBB plans offered by prominent carriers.

206,106 people were enrolled in PEBB and OEBB plans offered by Carrier 4 and Carrier 6.



PERCENTAGE OF TOTAL ENROLLMENT: In June 2014, Carrier 4 and Carrier 6 accounted for 86% of OEBB and PEBB enrollment among prominent carriers.

Carrier 4 and Carrier 6 accounted for 44% and 42% of PEBB and OEBB enrollment among prominent carriers, respectively.



See Page 18 for a complete list of carriers included in this report and Methodology for data details.

PEBB and OEBB Plans: Primary Care Spending

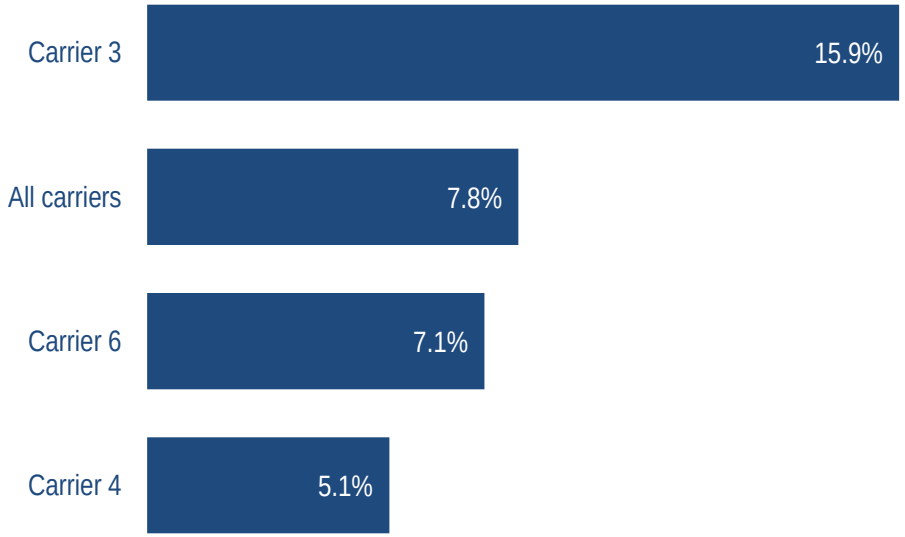
The graphs on this page show two measures of medical spending allocated to primary care by PEBB and OEBB plans offered by prominent carriers in calendar year 2014:

- **Percentage of total medical spending allocated to primary care.** This measure allows for comparison of spending allocated to primary care as a share of total medical spending, regardless of total dollars spent.
- **Per-member, per-month (PMPM) primary care spending and non-primary care spending.** This measure represents the average amount paid to health care providers in a month for each member with coverage. It allows for comparison of dollars per person spent on primary care and other types of care. On the graph, the dark part of each bar shows primary care spending PMPM and the light part of each bar shows non-primary-care spending PMPM.

In addition to PEBB and OEBB plans, prominent carriers offer commercial and Medicare Advantage plans. Spending by commercial and Medicare Advantage plans is reported separately and not included in the graphs on this page.

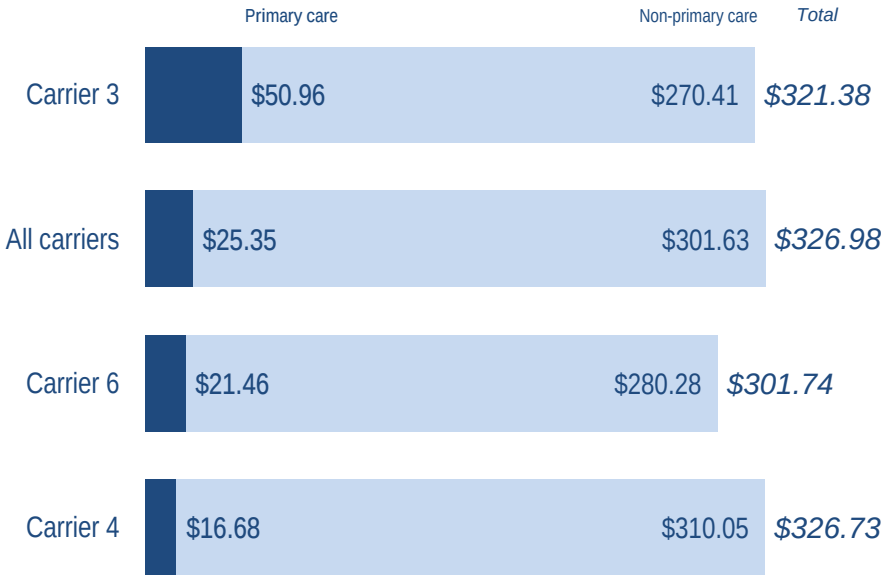
PERCENTAGE OF TOTAL MEDICAL SPENDING ALLOCATED TO PRIMARY CARE: In 2014, share of spending allocated to primary care ranged from 5% to 16% among PEBB and OEBB plans.

The share of medical spending allocated to primary care by Carrier 3 was more than twice that of the next highest prominent carrier.



PER-MEMBER, PER-MONTH (PMPM) PRIMARY CARE SPENDING: In 2014, primary care spending ranged from $17 PMPM to $51 PMPM among PEBB and OEBB plans offered by prominent carriers.

PMPM primary care spending by Carrier 3's PEBB and OEBB plans was more than twice that of the next highest carrier.



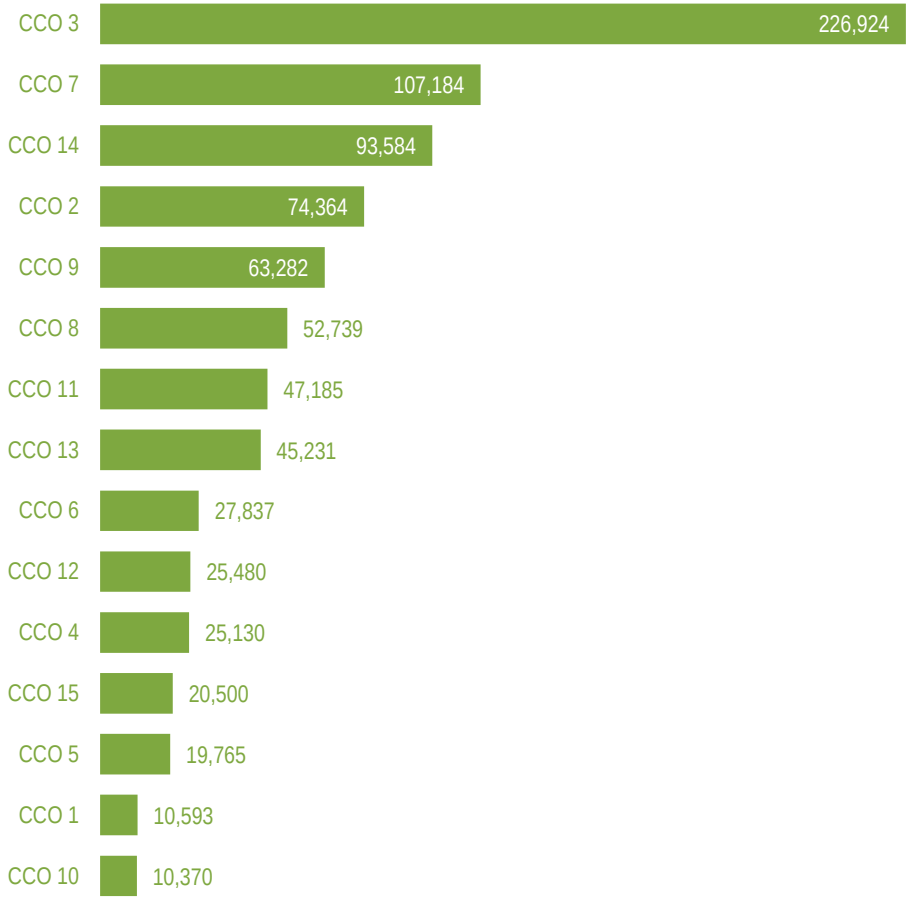
See Page 18 for a complete list of carriers included in this report and Methodology for data details.

Coordinated Care Organizations: Enrollment

The graphs on this page show the number of people enrolled in CCOs and enrollment with each CCO as a percentage of enrollment for all CCOs. Enrollment is reported as number of unique people enrolled in June 2014.

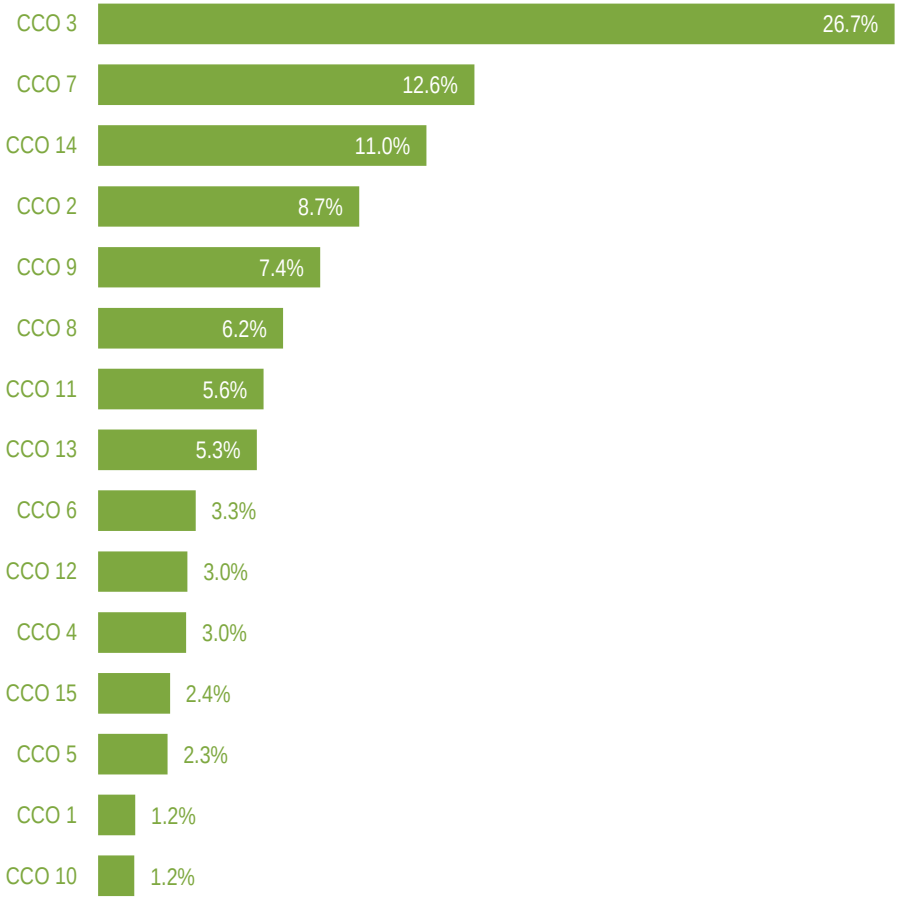
NUMBER OF PEOPLE ENROLLED: In June 2014, 850,168 people were enrolled in CCOs.

427,692 people were enrolled in the three largest CCOs.



PERCENTAGE OF TOTAL ENROLLMENT: In June 2014, the three largest CCOs accounted for half of all CCO enrollment.

CCO 3 accounted for one-quarter of all CCO enrollment.



See Page 18 for a complete list of CCOs included in this report and Methodology for data details.

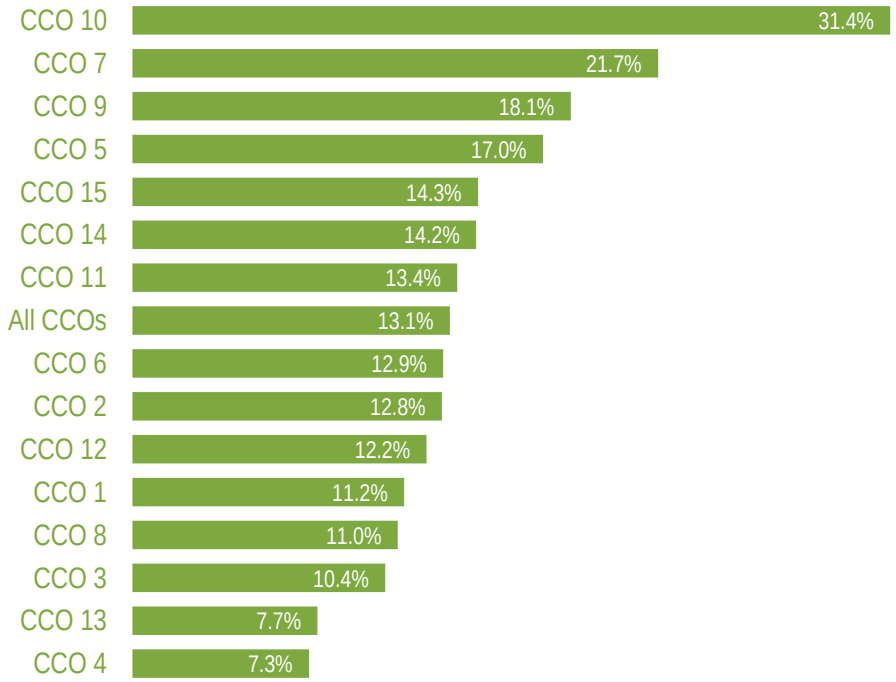
Coordinated Care Organizations: Primary Care Spending

The graphs on this page show two measures of medical spending allocated to primary care across CCOs in calendar year 2014:

- **Percentage of total medical spending allocated to primary care.** This measure allows for comparison of spending allocated to primary care as a share of total medical spending, regardless of total dollars spent.
- **Per-member, per-month (PMPM) primary care spending and non-primary care spending.** This measure represents the average amount paid to health care providers in a month for each member with coverage. It allows for comparison of dollars per person spent on primary care and other types of care. On the graph, the dark part of each bar shows primary care spending PMPM and the light part of each bar shows non-primary-care spending PMPM.

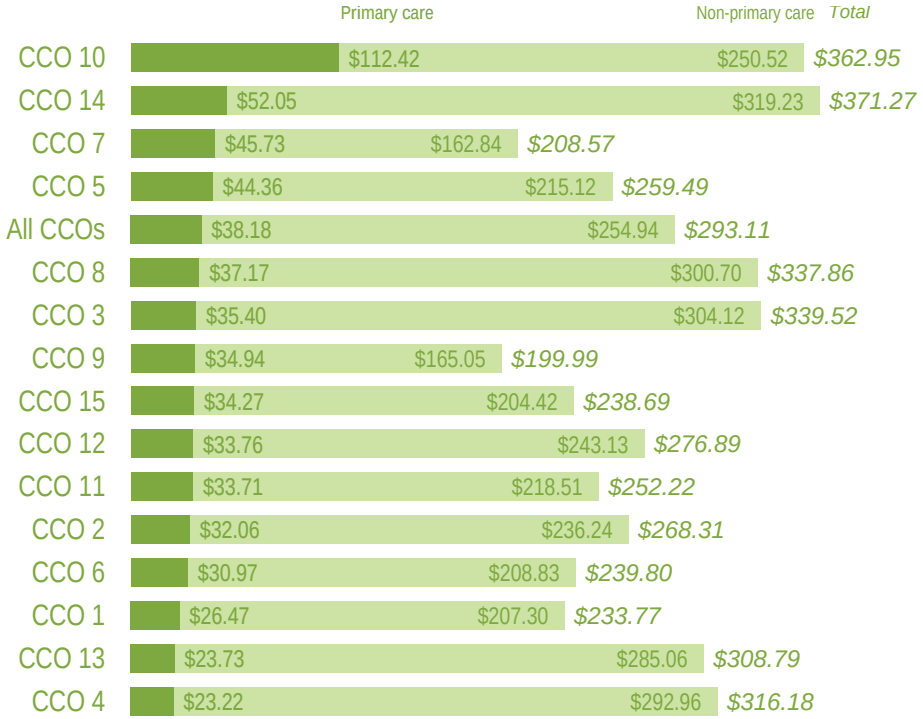
PERCENTAGE OF TOTAL MEDICAL SPENDING ALLOCATED TO PRIMARY CARE: In 2014, share of spending allocated to primary care ranged from 7% to 31% among CCOs.

The share of medical spending allocated to primary care by CCO 10 was almost 10 percentage points higher that of the next highest CCO.



PER-MEMBER, PER-MONTH (PMPM) PRIMARY CARE SPENDING: In 2014, primary care spending ranged from $23 PMPM to $112 PMPM among CCOs.

PMPM primary care spending by CCO 10 was twice that of the next highest CCO.



See Page 18 for a complete list of CCOs included in this report and Methodology for data details.

Prominent Carriers and CCOs in this Report

Prominent Carriers

- Health Net Health Plan of Oregon, Inc.
- Kaiser Foundation Plan of the Northwest
- Moda Health Plan, Inc.
- PacificSource Health Plan
- Providence Health Plan
- Regence BlueCross BlueShield of Oregon
- UnitedHealthcare Insurance Company
- UnitedHealthcare of Oregon, Inc.

Commercial plan spending by one carrier and Medicare Advantage plan spending by two carriers were excluded due to issues with claims-based data. See Methodology for additional information about data collection and analysis.

CCOs

- AllCare Health Plan
- Cascade Health Alliance
- Columbia Pacific CCO
- Eastern Oregon CCO
- FamilyCare
- HealthShare
- Intercommunity Health Network
- Jackson Care Connect
- Pacific Source Community Solutions
- PrimaryHealth of Josephine County
- Trillium Community Health Plan
- Umpqua Health Alliance
- Western Oregon Advanced Health
- Willamette Valley Community Health
- Yamhill Community Care Organization

Glossary

Capitation payment: Single payment to a health care provider to provide health care services needed by a health plan member over a defined period of time. Services covered by capitation payments may be broad, such as all outpatient and inpatient services, or narrow, such as primary care or mental health only. Capitation payments are a type of non-claims-based payment. They provide financial incentivize for providers to manage care efficiently and avoid costly complications or expensive services such as emergency department or inpatient admissions.[3]

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.

Claims-based payment: Payment to a health care provider for a specific service or set of services rendered by the provider and documented on a health care claim. Also known as fee-for-service. Claims-based payment systems may incentivize providers to bill health care payers for a high volume of services rather than providing efficient care.

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

Coordinated Care Organization (CCO): Local organization that provides physical, mental, and dental health care using a global budget that grows at a fixed rate. CCOs are accountable for the health outcomes of populations they serve. CCOs are part of Oregon's Medicaid program, which provides health coverage for low-income Oregonians. As of June 15, 2014, 85 percent of people with physical health care coverage through Medicaid were enrolled in a CCO.

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. Health care payers include commercial health insurance plans, Medicare Advantage plans, and PEBB and OEBB plans offered by health insurance carriers; CCOs that provide and pay for care for Medicaid members; and public programs such as Medicaid fee-for-service, Medicare fee-for-service, and other state and federal programs that pay claims for members.

Medicaid: Health coverage for low-income Oregonians. Medicaid coverage includes coordinated care organizations (CCOs), other Medicaid managed care, and Medicaid fee for service (FFS). Medicaid is funded by a mix of state and federal resources. Since 2014, Oregonians with incomes at or below 138 percent of the federal poverty level have been Medicaid eligible, and the waiting list for the Medicaid has been eliminated.

Medicaid fee-for-service: Health care payer that pays claims for Medicaid members not enrolled in CCOs or other Medicaid managed care. Under Medicaid fee for service, the state Medicaid program pays health care providers directly. As of June 15, 2014, 14 percent of people with physical health care coverage through Medicaid were enrolled in Medicaid FFS. Primary care spending by Medicaid fee-for-service is not included in this report.

Medicare Advantage: Health insurance plans offered by health insurance carriers where the federal Medicare program pays part of the premium. Also known as Medicare Part C. The overwhelming majority of people in Medicare Advantage are age 65 and older.

Medicare fee-for-service: Health care payer that pays claims for Medicare members not enrolled in Medicare Advantage. Under Medicare fee-for-service, the federal Medicare program pays health care providers directly. Primary care spending by Medicare fee-for-service is not included in this report.

Member months: Total number of months within a given calendar year that the enrolled members of a health insurance plan have health coverage. For example, if one member was enrolled in a plan for all 12 months of 2013 and another member was enrolled for only 10 months, total member months equal 22. To provide a standard measure of spending across types of coverage or insurance plans, total spending is often divided by member months in order to report spending per-member, per-month (PMPM).

Non-claims-based payment: Payment to a health care provider intended to incentivize 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

[3] Center for Evidence-Based Policy, Oregon Health & Science University. 2014. *Alternative Payment Methodologies in Oregon: The State of Reform.*

Glossary

information reported on claims. Temporary Oregon Administrative Rules 836-053-1500 through 836-053-1510 and 409-027-0010 through 409-027-0030 define seven types of non-claims-based payments for purposes of reporting on medical spending allocated to primary care under Senate Bill 231 (2015).

Patient-centered medical home (PCMH): Health care clinic that is accountable for the large majority of each patient's physical and mental health care needs, patient-centered and oriented toward the whole person, and that coordinates care with specialists, hospitals, and other elements of the broader health care system. PCMHs include patient-centered primary care homes and clinics recognized by other primary care initiatives.

Patient-centered primary care home (PCPCH): Health care clinic recognized by the Oregon Health Authority for its commitment to providing high quality, patient-centered care. A PCPCH must meet quality measures in six core attributes to receive recognition.

Per-member, per-month (PMPM): Spending on care for members of a health plan divided by member months. Dividing spending by member months provides a comparable measure of spending across health plans and payers, regardless of the number of members enrolled.

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 SB 231, primary care is defined as a specific set of health care services delivered by specific types of health care providers and practices (see Methodology for details).

Prominent carrier: Health insurance carrier with annual premium income of $200 million or more. Prominent carriers were defined by temporary Oregon Administrative Rules 836-053-1500 through 836-053-1510 for purposes of reporting on medical spending allocated to primary care under SB 231. There were eight prominent carriers in 2014.

Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB): Boards that contract with private health insurance companies to provide health insurance plans for educators and public employees, and contribute the employer share of premiums for covered employees. OEBB and PEBB became part of OHA in 2009.

Risk-based payments: A payment received by a health care provider that may be reduced if costs exceed a defined target. In a risk-based payment system, providers may pay a penalty or share in the costs exceeding the target.[4]

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 is not included in this report.

[4] Center for Evidence-Based Policy, Oregon Health & Science University. 2014. *Alternative Payment Methodologies in Oregon: The State of Reform.*

Total Medical Spending and Primary Care Spending: What's Included?

Total medical spending and primary care spending in this report are calculated from claims-based payments and non-claims-based payments to health care providers and provider organizations.

Claims-based payments

Payments to health care providers and provider organizations reported on health care claims. Total medical spending and primary care spending from claims-based payments were identified using information about the rendering provider and the service rendered on the claim (see below for details).

Information about claims-based payments was obtained from OHA's All-Payer, All-Claims Reporting Program (APAC). APAC collects information about health care claims and encounters from all health care payers covered by SB 231, including prominent carriers, CCOs, and PEBB and OEBB plans. In addition to this information, APAC collects information from Medicaid fee-for-service and Medicare fee-for-service programs, which are not covered by SB 231. APAC does not collect information from carriers with fewer than 5,000 members in Oregon, self-insured employers, some types of commercial health plans, and some types of public health care coverage. In addition, APAC does not collect information about health care received by people who pay out of pocket, including people without insurance.

Non-claims-based payments

Payments to health care providers and provider organizations to incentivize efficient care delivery, reward achievement of quality or cost-savings goals, and build health care capacity. Non-claims-based payments are separate from payments made using claims, although some types of non-claims-based payments may be based on analysis of claims data (for example, payments to reward providers for achieving quality or cost-savings based on quality measures calculated from claims data).

Information about non-claims-based payments are from a specialized reporting template completed by carriers and CCOs. The template instructed carriers and CCOs to report total health care spending and primary care spending in the following categories as defined by temporary Oregon Administrative Rules 836-053-1500 through 836-053-1510 and 409-027-0010 through 409-027-0030:

- Capitation payments and provider salaries
- Risk-based payments
- Payments to patient-centered primary care homes or other patient-centered medical homes
- Payments to reward achievement of performance goals, such as quality or cost-savings goals
- Payments to help providers adopt health information technology, such as electronic health records
- Payments for workforce expenditures, such as practice coaches, patient educators, patient navigators, or nurse care managers

Carriers and CCOs were instructed to report spending for services implemented or incurred in calendar year 2014 on the template. Consistent with criteria used to identify total medical spending and primary care spending from claims-based payments, the template instructed carriers and CCOs to include behavioral health expenditures provided at the primary care clinic level and exclude dental spending.

In addition to non-claims-based spending, carriers and CCOs were required to report total months of enrollment in 2014, allowing for calculation of non-claims-based spending per member, per month.

Carriers were instructed to report non-claims-based spending and enrollment separately for commercial, Medicare Advantage, and PEBB and OEBB plans.

Limitations

Carrier 3 reported total medical spending and total primary care spending, including claims-based and non-claims-based payments, on the specialized reporting template. All spending information for Carrier 3 in this report is from Carrier 3's reporting template (information from APAC was not used to report spending by Carrier 3). Carrier 3 was unable to break out claims-based and non-claims-based spending within the data collection timeframe for this report. Because Carrier 3 was unable to break out claims-based and non-claims-based spending, its spending information was excluded from graphs showing claims-based and non-claims-based spending on primary care (Carrier 3's spending information is included in all other graphs).

What's Not Included in this Report?

This report includes total health care spending and primary care spending by commercial, Medicare Advantage, and PEBB and OEBB plans offered by prominent carriers, and by CCOs. As of June 2014, these entities provided coverage for 2.3 million Oregonians, 59 percent of Oregon's population. The report excludes spending by the following health care payers:

- Health insurance carriers with annual premium income of less than $200 million in 2014.
- Self-insured employers
- Medicare fee-for-service
- Medicaid fee-for-service
- TRICARE
- Veterans Administration
- Indian Health Service

In addition, the report excludes information about health care received by people who pay out of pocket, including people without insurance.

The report also excludes commercial plan spending by Carrier 2 and Medicare Advantage spending by Carrier 2 and Carrier 7 due to issues with claims-based data. At the time of this writing, information in APAC about claims-based payments by these carriers appeared to be incomplete.

Identifying Total Medical Spending and Primary Care Spending from Claims-Based Payments

Total medical spending: Claims meeting the following criteria were used to calculate total medical spending.

- The claim was for medical services rendered in calendar year 2014. Prescription drug claims were excluded.
- The service was rendered by a health care provider or provider organization with a practice address in Oregon or one of the following border areas: Longview, Vancouver, or Walla Walla, Washington.
- The claim was not denied by a health care payer.

Spending was calculated as the sum of dollars paid to the health care provider by the carrier or CCO. Dollars paid to the provider by the patient in the form of a copay, coinsurance, or deductible were excluded.

Primary care spending: Primary care spending is a subset of total medical spending. To calculate primary care spending, claims meeting the following criteria were selected from claims used to calculate total medical spending:

- The provider or provider organization that rendered the service was a primary care provider. A list of provider taxonomy codes used to identify primary care providers was established through review of SB 231, the National Uniform Claim Committee's Health Care Provider Taxonomy code set, and the Health Cost Guidelines code set, which is used to identify primary care claims in APAC. The complete list of taxonomy codes is available from OHA upon request.

  The following types of individual providers were included in the code list: physicians specializing in child and adolescent psychiatry, family medicine, general medicine, general psychiatry, geriatric medicine, obstetrics and gynecology, pediatrics, or preventive medicine; nurse practitioners, nurse non-practitioners, certified clinical nurse specialists, physician's assistants, and homeopathic and naturopathic medicine providers.

  The following types of provider organizations were included in the code list: primary care clinics, Federally Qualified Health Centers (FQHCs), and rural health centers.
- The claim was for a primary care service. A list of Current Procedural Terminology (CPT) codes used to identify primary care providers was established through review of CPT codes and the National Committee on Quality Assurance's Healthcare Effectiveness Data and Information Set, and through consultation with OHA's Actuarial Services Unit and Oregon Health & Science University's Center for Health Systems Effectiveness. The complete list of CPT codes is available from OHA upon request.

  The following types of services were included: office or home visits, general medical exams, routine medical and child health exams, preventive medicine evaluation or counseling, administration and interpretation of health risk

assessments, routine obstetric care excluding delivery (60 percent of payment amount reported on claims is included to represent non-delivery services), immunization, and other preventive medicine.

Claims were grouped by carrier and CCO to report each carrier's and CCO's primary care spending as a percentage of total medical spending. For carriers, claims were further grouped by commercial, Medicare Advantage, and PEBB and OEBB to report results separately for each type of coverage.

Calculating Total Medical Spending and Primary Care Spending by Payer Type and Payer

To calculate total medical spending and primary care spending by prominent carriers and CCOs, claims-based payments from APAC and non-claims-based payments from the specialized reporting template were summed. For prominent carriers, payments by commercial plans, Medicare Advantage plans, and PEBB and OEBB plans were summed to report results separately for each type of coverage.

Calculating Per-Member, Per-Month (PMPM) Spending

PMPM spending is defined as: total paid by payer ÷ member months. To calculate PMPM primary care spending and non-primary-care spending, PMPM primary care spending and non-primary-care spending were calculated separately for claims-based and non-claims based payments and summed:

- For claims-based payments, spending by carriers and CCOs was divided by total member months for each payer type from APAC.
- For non-claims-based payments, spending by carriers and CCOs from the specialized reporting template was divided by member months from the template.
- Results from the above steps were summed to calculate PMPM total medical spending and PMPM primary care spending. PMPM primary care spending was subtracted from PMPM total medical spending to calculate PMPM non-primary-care spending.

These steps were used to calculate PMPM spending by all commercial, Medicare Advantage, and PEBB and OEBB plans offered by prominent carriers, all CCOs, and each carrier and CCO separately. For Carrier 3, only spending and member months from the reporting template were used (see above).

Enrollment

Enrollment is reported as number of unique people with health care coverage in June 2014 as reported in APAC. A person may be enrolled with more than one health plan at the same time. This means that the number of people enrolled with all carriers in this report may sum to more than the total number of unique people enrolled.