Primary Care Spending in Oregon

A Report to the Oregon Legislature

OREGON HEALTH AUTHORITY

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DCBS | Department of Consumer and Business Services

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Methodology

What's included in total medical spending and primary care spending?

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

Claims-based payments

These include payments to health care providers and organizations as reported in health care claims data. Total medical spending and primary care spending from claims-based payments were identified using information about the rendering or billing provider and the service rendered on the claim.

Information about claims-based payments was obtained from OHA's All Payer All Claims (APAC) Data Reporting Program. APAC collects information about health care claims and encounters from all health care payers covered by primary care reporting statutes (SB 231 and HB 4017). This includes:

- Prominent carriers
- CCOs, and
- PEBB and OEBB plans.

APAC also collects information from entities below, which are not covered by primary care reporting statutes:

- Medicaid fee-for-service, and
- Medicare fee-for-service programs.

APAC does **not** collect information from:

- Carriers with fewer than 5,000 members in Oregon
- ERISA 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. This includes people without insurance.

APAC data are refreshed quarterly so carriers and CCOs can adjust and finalize claims. All of the data in this report have been refreshed four times, which is the maximum. In other words, there has been ample time to adjust any claims data used to generate this report.

Non-claims-based payments

These payments go to health care providers and provider organizations to:

- Motivate 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. However, some types of non-claims-based payments may be based on analysis of claims data (e.g., payments to reward providers for achieving quality or cost savings based on quality measures calculated from claims data).

Methodology (continued)

Information about non-claims-based payments is collected by the OHA APAC Program. In addition to claims data, APAC collects Payment Arrangement File (PAF) data from carriers and CCOs for all contracts sitused (i.e., issued or located) in Oregon. PAF data contain primary care and total health care payments between a carrier or CCO and a health care provider or entity, including hospitals, clinics, and doctors (at the organization level). The payments in PAF are reported by contract and by line of business including Medicaid CCOs, Medicare Advantage, PEBB, OEBB, and commercial. The payments in PAF are also separated by the following payment categories based on the Health Care Payment Learning and Action Network's (HCP-LAN) Alternative Payment Methodology (APM) Framework with some modifications to better fit with Oregon's initiatives.

HCP-LAN Categories

- Fee-for-Service (FFS) & Other Payments – No Link to Quality includes
  - 1: FFS – No Link to Quality
  - 3N: Risk-Based Payments Not Linked to Quality
  - 4N: Capitated Payments Not Linked to Quality
- FFS – Link to Quality includes
  - 1A: FFS – Link to APM payments
  - 2A: Foundational Payments including Patient-Centered Primary Care Home
  - 2B: Pay for Reporting
  - 2C: Pay for Performance
- Shared Savings and/or Risk includes
  - 3A: Shared Savings
  - 3B: Shared Savings and Risk
- Population-Based Capitation includes
  - 4A: Condition-Specific Population-Based Payment
  - 4B: Comprehensive Population-Based Payment
  - 4C: Integrated Finance & Delivery System

http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

Methodology (continued)

The PAF data are submitted annually in September by carriers and CCOs for services implemented or incurred during the previous calendar year. This report analyzes payments for services provided in calendar year 2023, and payments for dental services are excluded.

All the payments in PAF are processed for proration value. For example, a contract from July 2022-June 2023 totaling $100 million would be prorated as $50 million for 2023, because only the half of the contract was in the reporting year. Some carriers or CCOs may have negative payments for certain payment categories, which means the health care provider paid the carrier or CCO this amount.

Carriers and CCOs are also required to report the total months of enrollment for the reporting year in the PAF. This allows for calculation of per-member per-month non-claims-based spending.

Limitations

Prominent carriers and CCOs vary in organizational size, composition of network providers and unique arrangements. Moreover, CCOs are required to provide services, such as non-emergent medical transportation, that commercial carriers do not commonly provide. These differences may affect the results presented in this report.

CCOs vary in organizational size, populations and geographic regions served, demographics, available providers, types of providers, plan type and other factors that may influence primary care and total medical spending. In some cases, spending amounts for certain services may be outside the control of the CCO. The dataset used by OHA to determine primary care spending may exclude some primary care spending due to how hospital-affiliated primary care providers bill for services.

PAF data include both claims and non-claims related payments for each contract. Claims-based data for Kaiser Foundation Health Plan of the Northwest are collected from PAF.

Methodology (continued)

What's not included in this report?

This report includes total health care spending and primary care spending of plans offered by prominent carriers and by CCOs:

- Commercial
- Medicare Advantage, and
- PEBB and OEBB.

The report excludes spending by the following health care payers:

- Health insurance carriers with annual health premium income of less than $200 million in 2023
- ERISA self-insured employers
- Medicare fee-for-service
- Medicaid fee-for-service
- TRICARE
- Veterans Health Administration, and
- Indian Health Service.

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

Identifying total medical spending and primary care spending from claims-based payments

Total medical spending: Claims that met the following criteria were used to calculate total medical spending:

- Claims for medical services rendered in calendar year 2023. Medical claims for provider-administered prescription drugs, sometimes referred to as "medical pharmacy" or "J-codes," and retail pharmacy claims were both excluded.
- Services rendered by health care providers or provider organizations with a practice address in Oregon or one of the following border areas:
    - In Washington
        - Longview
        - Vancouver
        - Battle Ground, or
        - Walla Walla
    - In Idaho
        - Emmett
        - Fruitland
        - Payette
        - New Plymouth, or
        - Weiser
- Claims not denied by health care payers.

Spending was calculated as the sum of dollars paid to health care providers by carriers or CCOs. Dollars paid to providers by patients in the forms of a copay, coinsurance or deductible were excluded.

Methodology (continued)

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

- Providers or provider organizations that rendered services as primary care providers. 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
    - Providers identified as PCPs in OHA's Health Care Work Force data.

The complete list of taxonomy codes is on page 13 of this report.

The following types of individual providers are included:

- Physicians specializing in:
    - Child and adolescent psychiatry
    - Family medicine
    - General medicine
    - General psychiatry
    - Geriatric medicine
    - Obstetrics and gynecology
    - Pediatrics
    - Preventive medicine
- Nurses
    - Nurse practitioners
    - Nurse non-practitioners
    - Certified clinical nurse specialists
- Physicians' assistants
- 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.

- Claims for primary care services were included. 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
    - 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 on page 12 of this report.

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), and
- Other preventive medicine.

Methodology (continued)

Claims were grouped by carrier and CCO to report primary care spending as a percentage of total medical spending for each. For carriers, claims were further grouped to report results separately for each type of coverage by:

- Commercial
- Medicare Advantage, and
- PEBB and OEBB.

Calculating total medical spending and primary care spending by payer type and payer

To calculate total medical and primary care spending by prominent carriers and CCOs, the following were summed from the Payment Arrangement File (PAF) data:

- Claims-based payments from APAC, and
- Non-claims-based payments.

For prominent carriers, payments by the following plans were summed to report results separately for each type of coverage:

- Commercial
- Medicare Advantage, and
- PEBB and OEBB.

Calculating per-member per-month (PMPM) spending

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

- For claims-based payments, spending by carriers and CCOs were divided by total member months for each payer type from APAC.
- For non-claims-based payments, spending by carriers and CCOs from the PAF data were divided by member months from PAF data.
- 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 CCOs and prominent carriers offering:

- Commercial
- Medicare Advantage, and
- PEBB and OEBB plans.

These steps were also used to calculate PMPM spending for each carrier and CCO.

Enrollment

Enrollment is reported as number of unique people with health care coverage in 2023 as reported in APAC. Enrollment is calculated by taking the total member months and dividing by 12. This number is used as the annual enrollment number. A person may be enrolled with more than one health plan at the same time. This means the number of people enrolled with all carriers in this report may sum to more than the total number of actual people enrolled.

Methodology (continued)

Calculating primary care non-claims-based spending as a percent of total primary care spending

Primary care spending by most prominent carriers and CCOs consists of both claims-based and non-claims-based spending. The proportion of primary care spending that a prominent carrier or CCO allocates to non-claims-based spending is calculated by dividing primary care non-claims-based spending by total primary care spending.

Vendor change impacts processing and data results

Beginning in 2020, APAC contracted with a new vendor, Human Services Research Institute (HSRI), for the collection, processing and management of APAC data. Since each vendor has different methodologies for data management, such as identifying duplicate claims or application of validation rules, slight variations in reported data will occur. Differences due to vendor processes appear insignificant. However, OHA recommends caution in comparing reports published in 2020 and earlier with reports published in 2021 and later.

Glossary

Capitation payment: Single payment to a health care provider to provide health care services to 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. Conversely, they may be narrow, such as primary care or mental health only. Capitation payments are a type of non-claims-based payment. They provide financial incentives for providers to manage care efficiently. They also avoid costly complications or expensive services such as emergency department or inpatient admissions.

Claims: Communications from health care providers to health care payers requesting payments for services rendered by providers. Claims include information about patient diagnoses, procedures performed by providers, amount payers and patients will pay for services under health insurance plans, and — in cases of paid claims — amounts paid by payers.

Claims-based payment: Payments to health care providers for specific services or sets of services rendered by providers and documented on health care claims. This is also known as fee-for-service. Claims-based payment systems may motivate providers to bill health care payers for a high volume of services rather than providing efficient care.

Commercial health plans: Group or individual health insurance plans offered by health insurance carriers.

Coordinated care organizations (CCOs): 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 low-income Oregonians.

Health care payers: Health insurance plans or health coverage programs that pay doctors, hospitals and other health care providers for care and services received by people with health care coverage. Health care payers include:

- Commercial health insurance plans
- Medicare Advantage plans
- 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.

Glossary (continued)

Medicaid: Health coverage for low-income Oregonians. Medicaid coverage includes:

- CCOs
- Other Medicaid managed care, and
- Medicaid fee-for-service (FFS).

Medicaid is funded by a mix of state and federal funds. Since 2014, Oregonians with incomes at or below 138 percent of the federal poverty level have been Medicaid-eligible. The waiting list for the Medicaid program has been eliminated.

Medicaid fee-for-service: A payment methodology by which the state directly pays health care providers for services delivered to individuals with Medicaid coverage. Payments are based on claims. 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. This is also known as Medicare Part C. The overwhelming majority of people in Medicare Advantage are age 65 and older.

Medicare fee-for-service: A payment methodology by which the federal Medicare program directly pays health care providers for services to individuals with Medicare coverage. Payments are based on claims. Primary care spending by Medicare fee-for-service is not included in this report.

Member months: Total number of months in a given calendar year that the enrolled health insurance plan members have coverage. For example, if one member was enrolled in a plan for all 12 months of 2022 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 per-member per-month (PMPM) spending.

Non-claims-based payment: Payments to health care providers 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 providers and reported on health care claims. However, they may be awarded based on information reported on claims. 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). See page 4 for a list of the categories.

Glossary (continued)

Patient-centered medical homes (PCMHs): Health care clinics that:

- Are accountable for the large majority of each patient's physical and mental health care needs
- Are patient-centered and oriented toward the whole person, and
- Coordinate 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 homes (PCPCHs): Health care clinics recognized by the Oregon Health Authority for the clinics' 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 and HB 4017, primary care is defined as a specific set of health care services delivered by specific types of health care providers and practices (see the "Methodology" section for details).

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

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: Payments received by health care providers that may be reduced if costs exceed defined targets. In a risk-based payment system, providers may pay a penalty or share in costs that exceed the target.

Self-insured employers: Employers that set aside funds to pay for health care expenses of employees, rather than buy a group health insurance plan offered by a private insurance company. Primary care spending by ERISA self-insured employers is not included in this report.

Codes used to define primary care

CPT Code	Description
59400	Routine obstetric care including vaginal delivery (global code) - 60 percent of payment for CCOs
59510	Routine obstetric care including cesarean delivery (global code) - 60 percent of payment for CCOs
59610	Routine obstetric care including vaginal birth after C-section (VBAC) delivery (global code) - 60 percent of payment for CCOs
59618	Routine obstetric care including attempted VBAC delivery (global code) - 60 percent of payment for CCOs
90460-90461	Immunization through age 18, including provider consult
90471-90472	Immunization by injection
90473-90474	Immunization by oral or intranasal route
96160-96161	Administration of health risk assessment
96372	Therapeutic, prophylactic or diagnostic injection
98966-98968	Non-physician telephone services
98000-98003	Telehealth visit, new patient
98004-98007	Telehealth visit, established patient
98972-98974	Online assessment, management services by non-physician
99202-99205	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
99341-99345	Home visit for a new patient
99347-99350	Home visit for an established patient
99381-99387	Well-baby visits for infants < 1 year old
99391-99397	Preventive medicine periodic reevaluation
99401-99404	Preventive medicine counseling or risk reduction intervention

CPT Code	Description
99406-99407	Smoking and tobacco use cessation counseling visit
99408-99409	Alcohol or substance abuse screening and brief intervention
99411-99412	Group preventive medicine counseling or risk reduction intervention
99421-99423	Online medical evaluation by a physician or other qualified health professional
99429	Unlisted preventive medicine service
99441-99443	Telephone calls for patient management
99483	Cognition and functional assessment
99484	Care management services for behavioral health conditions
99492	Initial psychiatric collaborative care management
99493	Subsequent psychiatric collaborative care management
99494	Initial or subsequent psychiatric collaborative care management
99495-99496	Transitional care management services
G0008-G0010	Administration of influenza virus, pneumococcal, hepatitis B vaccine
G0396-G0397	Alcohol or substance abuse assessment
G0438-G0439	Medicare annual wellness visit
G0442	Annual alcohol screening
G0443	Brief behavioral counseling for alcohol misuse
G0444	Annual depression screening
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services
G0513-G0514	Prolonged preventive service

Codes used to define primary care (continued)

Specialty taxonomy code and description

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
2084P0800X	Physician, general psychiatry
2084P0804X	Physician, child and adolescent psychiatry
207V00000X	Physician, obstetrics and gynecology
207VG0400X	Physician, gynecology
208D00000X	Physician, general practice
363L00000X	Nurse practitioner
363LA2200X	Nurse practitioner, adult health
363LF0000X	Nurse practitioner, family
363LP0200X	Nurse practitioner, pediatric
363LP0808X	Nurse practitioner, psychiatric
363LP2300X	Nurse practitioner, primary care
363LW0102X	Nurse practitioner, women's health
363LX0001X	Nurse practitioner, obstetrics and gynecology
363A00000X	Physician's assistant
363AM0700X	Physician's assistant, medical
207RG0300X	Physician, geriatric medicine
175L00000X	Homeopathic medicine
2083P0500X	Physician, preventive medicine
364S00000X	Certified clinical nurse specialist
163W00000X	Nurse, non-practitioner

Codes used to define primary care (continued)

ICD-10 codes and description

Z00	Encounter for general exam without complaint
Z000	Encounter for general adult medical examination
Z0000	Encounter for general adult medical exam without abnormal findings
Z0001	Encounter for general adult medical exam with abnormal findings
Z001	Encounter for newborn, infant and child health examinations
Z0011	Newborn health examination
Z00110	Health examination for newborn under 8 days old
Z00111	Health examination for newborn 8 to 28 days old
Z0012	Encounter for routine child health examination
Z00121	Encounter for routine child health exam with abnormal findings
Z00129	Encounter for routine child health exam without abnormal findings
Z008	Encounter for other general examination
Z014	Encounter for gynecological examination
Z0141	Encounter for routine gynecological examination
Z01411	Encounter for gynecological exam, general, routine with abnormal findings
Z01419	Encounter for gynecological exam, general, routine without abnormal findings

Endnotes

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