Primary Care Expenditure Guidance for SB 231

Background: Senate Bill 231 (SB231) requires prominent insurance carriers, Coordinated Care Organizations (CCOs), the Public Employees' Benefit Board (PEBB), and the Oregon Educators Benefit Board (OEBB) to report the proportion of the organization's total medical expenses that are allocated to primary care. Data must be reported no later than December 31, 2015. The Department of Consumer and Business Services (DCBS) and the Oregon Health Authority (OHA) must work collaboratively together to collect and synthesize this data which will be reported to the Legislature no later than February 1, 2016.

SB231 directs DCBS to define prominent carrier through Oregon Administrative Rule (OAR). It also direct DCBS and the OHA to define by OAR the specific primary care services to be included in the data reported by carriers, CCOs, PEBB, and OEBB. This memo provides guidance on what services DCBS and the OHA intend to include in those OARs.

Proposed Primary Care Definition and Guidance:

Claims-based expenditures

As defined in SB231, primary care means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry. For purposes of reporting fee-for-service (FFS) primary care expenditures that can be captured through claims data, the OHA will use data already available through the All-Payer All-Claims (APAC) Database. Spending is currently reported by six service categories called Health Cost Guidelines (HCGs). HCGs are based on diagnosis codes, procedure codes, and other claims information. HCGs do not overlap; each dollar is reported in only one category. HCGs include:

- *Ancillary*: Includes private duty nursing, ambulance and non-emergency transportation, dental care, durable medical equipment, and supplies
- *Emergency*: Visits to the hospital emergency department
- Inpatient: Care provided at a hospital or other inpatient facility where the patient stays overnight
- *Outpatient*: Care provided at a hospital, clinic, or other facility where the patient does not stay overnight
- *Pharmacy*: Prescription drugs where at least part of the cost is paid by a payer
- *Primary Care*: Services provided during visits to a primary care provider, including preventive physical exams and well-baby exams

A modified version of the HCGs will be used for purposes of this report to ensure that all primary care services and provider types included in the legislation are accounted for. The total amount of expenditures accounted for in the modified primary care HCG will be reported as a percent of the insurance carrier's/CCO's total expenditures. Since the OHA already has access to this data, insurance carriers, CCOs, PEBB, and OEBB will not be required to report additional data on FFS expenditures that are captured in APAC.

Non claims-based primary care expenditures

The intent of SB231 is to include all investments directed toward primary care at the clinic level, even those outside of the traditional FFS system. Neither DCBS nor the OHA has access to consistent non claims-based expenditures that could be compared and reported across carriers and CCOs. Therefore, entities will need to report on expenditures in the following primary care categories for Calendar Year (CY) 2014 by December 31, 2015:

Comment [WH*O1]: What is the definition of entities? Are these the CCO's and prominent carriers?

1. Capitation and/or salaried arrangements with primary care providers not billed or captured through claims
2. Risk-based arrangements with primary care providers not billed or captured through claims
3. Patient-Centered Primary Care Homes/Medical Homes (PCPCH/PCMH)
    a. Patient-Centered Primary Care Homes
    b. Proprietary PCMH initiatives
    c. Other Multi-payer PCMH initiatives (i.e. Comprehensive Primary Care Initiative)
4. Provider Incentives

    a. Retrospective performance-based incentive payments to primary care providers aimed at lowering costs and increasing quality by attaining mutually agreed-to and clearly documented performance levels based on nationally-accepted or state-based measures

    b. Retrospective performance-based payments to primary care providers and entities working in partnership with primary care providers to improve the value of the full or partial continuum of care for a defined population of patients

    c. Prospective per capita payments to primary care providers and entities working in partnership with primary care providers to help specific primary care providers develop the capacity to improve the value of the full or partial continuum of care for a defined population of patients. The payments should be designated for capacity-building in a specific functional area, as determined or part of a contract that offers meaningful incentives to the specified primary care providers to improve the value of the full or partial continuum of care for a defined population of patients.

5. Health Information Technology (HIT)
    a. Payments for structural changes at the practice such as electronic records and data reporting capacity from those records.
    b. Expenses by insurers spent to make clinical and utilization information available to primary care physicians are included as long as those expenses:
        i. Are for data reporting projects including a representative consortium of primary care physicians organized for the purposes of practice improvement;
        ii. Are directed to any effort to aggregate clinical, claims or enrollment information possessed by health plans and to analyze and transmit this information to groups of primary care providers;

iii. Result in aggregated data that are used primarily for the purposes of quality improvement, care coordination and practice management, not private negotiation;
iv. Result in analyses that are publicly available under disclosure methods agreed to by all parties; and
v. Are those directly incurred by the insurer or a contractor for these projects - not for allocated insurer administrative costs – and there is sufficient documentation of the expenses by the insurer.

6. Workforce
    a. Payments for supplemental staff or supplemental activities integrated into the primary care setting (i.e. patient educators, patient navigators, etc.)
    b. Expenses for services provided by a third party integrated into the primary care setting – to either patients or the practice itself (i.e. practice coaching, nurse care managers, behavioral health and pharmacy co-location)
    c. Expenses to build primary care workforce capacity, including support for loan forgiveness programs targeting new Oregon physicians, nurse practitioners, physician assistants, and clinical social workers

The above categories are intended to be mutually exclusive; therefore, expenditures should only be accounted for in one category.

The following item is NOT considered primary care for the purposes of this report:

1. Expenses to non-primary care providers for services or activities outside the primary care setting, regardless of a primary care capacity building intent

Non claims-based total health care expenditures

With the same intent as described previously but accounting for all health care expenditures, not only those directed toward primary care, entities will need to report on expenditures in the following categories for Calendar Year (CY) 2014 by December 31, 2015:

Comment [WH*O2]: Need to define

1. Capitation and/or salaried arrangements with all providers not billed or captured through claims
2. Risk-based arrangements with all providers not billed or captured through claims
3. Patient-Centered Primary Care Homes/Medical Homes/Specialty Homes (PCPCH/PCMH)
    a. Patient-Centered Primary Care Homes
    b. Proprietary PCMH initiatives
    c. Other Multi-payer PCMH initiatives (i.e. Comprehensive Primary Care Initiative)
    d. Specialty Care Homes
4. Provider Incentives
    a. Retrospective performance-based incentive payments to all providers aimed at lowering costs and increasing quality by attaining mutually agreed-to and clearly documented performance levels based on nationally-accepted or state-based measures

b. Retrospective performance-based payments to all providers and entities working in partnership with primary care providers to improve the value of the full or partial continuum of care for a defined population of patients
c. Prospective per capita payments to all providers and entities working to develop the capacity to improve the value of the full or partial continuum of care for a defined population of patients. The payments should be designated for capacity-building in a specific functional area, as determined or part of a contract that offers meaningful incentives to the specified providers to improve the value of the full or partial continuum of care for a defined population of patients.

5. Health Information Technology (HIT)
    a. Payments for structural changes at the practice such as electronic records and data reporting capacity from those records.
    b. Expenses by insurers spent to make clinical and utilization information available to physicians are included as long as those expenses:
        i. Are for data reporting projects including a representative consortium of physicians organized for the purposes of improvement;
        ii. Are directed to any effort to aggregate clinical, claims or enrollment information possessed by health plans and to analyze and transmit this information to groups of providers;
        iii. Result in aggregated data that are used primarily for the purposes of quality improvement, care coordination and practice management, not private negotiation;
        iv. Result in analyses that are publicly available under disclosure methods agreed to by all parties; and
        v. Are those directly incurred by the insurer or a contractor for these projects - not for allocated insurer administrative costs – and there is sufficient documentation of the expenses by the insurer.
6. Workforce
    a. Payments for supplemental staff or supplemental activities integrated into the care setting (i.e. patient educators, patient navigators, etc.)
    b. Expenses for services provided by a third party integrated into the care setting – to either patients or the practice itself (i.e. practice coaching, nurse care managers, behavioral health and pharmacy co-location)
    c. Expenses to build workforce capacity, including support for loan forgiveness programs targeting new Oregon physicians, nurse practitioners, physician assistants, and clinical social workers

The above categories are intended to be mutually exclusive; therefore, expenditures should only be accounted for in one category.