

**Public Law Ch. 244 Advisory Committee Meeting**

**Summary Notes**

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

# Purpose

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

# Attendees

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| **IN PERSON:** Senator Linda Sanborn, Lisa Letourneau, Neil Korsen, Lisa Harvey McPherson, Joan Orr, Andrew McLean, Joanne Rawlings-Sekunda, Darcy Shargo, Sarah Calder, and Stephen Corral.  **VIA PHONE:** Katherine Pelletreau, Renee Fay-LeBlanc, Sara Fitzgerald Jon Fanburg,  **STAFF:** Karynlee Harrington, Judy Loren, Kim Fox, Carolyn Gray, Jenny MacKenzie, Cathy McGuire, and Tom Merrill. |

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| AGENDA ITEM | Discussion Summary |
| **Welcome** |  |
| * **Introductions** (Karynlee Harrington) | Karynlee Harrington welcomed the members of the group and provided an overview of the requirements of Public Law Chapter 244 and the charge of the advisory group. Karynlee also explained that she has contracted with Muskie and Judy Loren to help her with developing the report and to provide technical expertise and guidance. |
| * **Background Behind LD 1353** (Senator Linda Sanborn and Lisa Letourneau) | Senator Linda Sanborn provided background on the legislation and why she introduced the bill to the legislature. She explained the need for increased investment in primary care to improve health outcomes, increase satisfaction and lower overall healthcare costs. As an example, she referenced that other countries with higher percentages of primary care investment, have much lower total health care costs. She also described Rhode Island’s experience, as one of the first states to measure and invest in greater primary care spending 10 years ago, and how total health care expenditures had decreased dramatically as primary care spending has increased.  Lisa Letourneau provided background on the national context and her involvement with the Patient-Centered Primary Care Collaborative (PCPCC) workgroup. The group has been discussing primary care investment and what percentage spend is sufficient. An increasing number of states have passed legislation to assess primary care spending and some have set targets for value-based purchasing efforts of a minimum percentage of primary care spending. In Maine, determining the percent spent on primary care is a starting point to increased primary care investments. |
| * **Reporting Requirements of Public Law Chapter 244** (Karynlee Harrington) | MQF is required to submit an annual report to the legislature beginning January 15, 2020. The APCD claims data will be used to calculate the percentage of primary care spending in Maine and the report will also include the insurers’ methods for reimbursing primary care. The law includes a high-level definition of primary care that explicitly excludes urgent care and emergency department visits.  Our process to date has involved two steps:   1. An environmental scan of how other states and national organizations have defined primary care to inform our claims analyses and 2. Gathering information through a survey of Maine’s largest insurers on how they define primary care using information identified in the environmental scan to inform the questionnaire. |
| * **Role of the Advisory Committee** (Karynlee Harrington) | MQF is looking for feedback from the Advisory Committee on the proposed approach and primary care definitions identified from these sources to calculate the percentage of total medical spending spent on primary care in Maine.  Karynlee proposed a schedule of two meetings of the Advisory Committee before the January report deadline. Group agreed to be flexible and do as much via e-mail as possible. |
| **Defining Primary Care** |  |
| * **Working Definition Based on Insurer Survey and Literature Review**   (Kim Fox) | Kim Fox from the University of Southern Maine described the process for arriving at the initial primary care definition used for the preliminary claims analyses as summarized in the PowerPoint slide deck.  Environmental scan:   * Six states have undertaken similar work to calculate primary care spend. While there is some overlap in what states define as primary care in terms of the provider types and specific services included, there is no standard definition. Both the numerators (i.e. what is included/counted as primary care) and the denominators (i.e. what is included in the definition of total health care spending) can vary across states. Benchmarks from these states are included in the PPT slide presentation for ballpark comparison, but Kim noted they are not directly comparable given different definitions used. * Several national studies funded by the Milbank Memorial Fund and the PCPCC have also moved toward developing a standard definition of primary care. Specifications from these studies also informed the identification of provider types and service codes for the analyses.   Insurer survey:   * Insurers were asked about what provider types, specific services and non-claims based payments they use to define primary care using general categories that have been used in other states and allowing them to indicate other codes they may use. For non-claims based payments, insurers were asked to indicate the degree to which they use and currently measure the categories of non-claims based payments that Rhode Island, Oregon and other states require insurers to report to the Dept. of Insurance. * Based on 5 out of 8 Maine insurers’ surveyed, most payers use similar definitions to those identified in other states in terms of provider type (e.g. include family medicine, pediatrics, internal medicine) and services as shown in slides. * Related to non-claims based payments, there is a lot of variability between payers, but no Maine insurer uses capitated or salary based payments. Several use some form of risk-based payments or provider incentive payments that are not counted in claims. * Karynlee stressed the importance of accounting for these non-claims based payments. Based on a recent conversation with a large insurer that provides non-claims based, per member per month payments to primary care that is paid out for about 80% of the members. These amount to millions of dollars and aren’t currently captured by MHDO. Collecting data on alternative payment models is being discussed by the National Association of Health Data Organizations. They will be discussing ways to standardize collection among the states. We need to figure out how to capture this and the MHDO Board will need to provide some direction. * Kim Fox also had recently participated in a meeting of New England States (NESCO), which is working to create a standardized definition across the New England states including non-claims based payments. In Rhode Island where they have required insurers to submit data on non-claims based payments, these account for about 50% of their primary care spend. |
| * **Summary of Claims Analysis to Date**   (Kim Fox) | From these sources, USM and consultant, Judy Loren conducted a preliminary analysis of 2017 APCD data using the definition of primary care provider types that provide specific primary care services. Findings are presented by commercial insurers, Medicaid and Medicare. Per one advisory group member question, it was clarified that Medicare Advantage is included in the analysis, but Medigap supplemental plans were excluded.  Preliminary results are shown in the slide deck separately for when primary care provider types are limited to those identified by all Maine insurers and when OB/GYNs and Psychiatrists providing primary care services are also included.  Results are based on the intersection of specific primary care provider types that provided specific services (e.g. HCPCS/CPT codes) defined as primary care.  Based on these definitions, the preliminary analyses shows a primary care spending estimate of 5.2% on average overall when OB/GYN and psychiatry are excluded, and a slightly higher percentage when primary care services billed by OB/GYN and Psychiatry are included.  The presentation slides also show other services provided by primary care providers that are not included in the specific primary care service list used for this analyses by payer and the associated percentage of total spend. The analytic team asked for input from the Advisory group on whether these services should/should not be included. *The table below summaries the issues/questions and how they will be addressed.* |
| **Next Steps and Timeline** |  |
|  | * Minutes from today’s meeting and questions for the Advisory Committee to weigh in on will be shared next week. * The Advisory Committee should provide any additional feedback to MQF by November 1. |

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| SUMMARY OF ISSUES RAISED AND NEXT STEPS | | |
| ISSUE | Action to Address | OUTCOMES/NEXT STEPS |
| **Provider types -** Lisa Harvey McPherson and Jonathan Fanburg recommended that geriatricians and adolescent medicine be included in provider types. Judy Loren noted that both were included. Adolescent medicine does not have separate taxonomy codes but are included under pediatrics. | No additional action required | Clarify adolescent medicine and geriatrics are included in the final report. |
| **Inclusion of NPs/PAs working with specialists** - Lisa Letourneau asked whether the estimates included all NPs and PAs as some of them can be providing specialty services. Judy Loren indicated a cross section was used to identify the claims with the taxonomy codes for the providers but PAs do not have a separate taxonomy code so some specialty could be included. | No additional action required | Explain in the final report that some PAs working with specialists may be included in primary care spend estimate because they could not be separately identified in claims. |
| **Psychiatry –** Lisa L raised concerns that inclusion of psychiatry may overstate primary care spend as they use the office visit code for specialty visits, but should not be considered a primary care service. | No additional action required | Psychiatry will be excluded from the definition of primary care. |
| **Family planning and other primary care services not in current definition.**  Judy Loren clarified that family planning clinics providing primary care services are included in our definition.  Kim Fox indicated that CPT codes change frequently so limiting to a specific set of service codes can miss newer codes (e.g. for this analyses insurer identified many immunizations and injection codes not identified in other studies). This analysis excluded other primary care services provided by primary care providers (e.g. those associated with an emergency department or inpatient setting) but also excludes other services the Committee may want to count as primary care (e.g. family planning, labs). Neil Korsen said it’s important to align the definition with what was done in other states.   * Should family planning services (procedure codes for IUDs) be included? * Should labs be included? | The Muskie School will investigate how/if other states have included these non-primary care services and if they only include administration costs or the cost both of administration and the equipment. Judy Loren indicated it is not always clear if the claim is for the procedure or the equipment so may be difficult to distinguish.  Judy Loren will run additional analyses of other primary care services not in current definition by primary care providers and OB/GYN to assess frequency of family planning in primary care settings or OB/GYn  Muskie will also investigate how other states have included labs in their estimates. | Recommend excluding family planning services and labs for this initial report to Advisory Group because:   1. It is in alignment with most of other states as confirmed by Muskie additional investigation. 2. Most family planning services (i.e. contraception such as IUD) are being performed by Ob/Gyns and our current definition already includes primary care services delivered at family planning clinics. 3. While there may be some specific labs or family planning services that should be included with primary care, the research required to identify them individually does not align with the timing of when the report is due to the Legislature. As such we recommend including in the methodological notes in the final report that these services were excluded. |
| **OB/GYN** services are only for those services considered primary care. Staff confirmed OB/GYN costs only include primary care services provided by OB/Gyn | . No additional action required | Clarify in the final report. |
| ISSUE | Action to Address | OUTCOMES/NEXT STEPS |
| **Rural Hospitals**: Was cost-based reimbursement captured for rural hospitals? Smaller hospitals are hiring providers in order to get reimbursed indirectly for primary care. This is a way they fund primary care. David Winslow could help sort out the issue around provider based reimbursement. | Determine if CAHs need to be treated/counted differently due to cost-based reimbursement and/or explained in report.  Staff will reach out to David Winslow and Lisa Harvey McPherson to get more information on cost-based reimbursement of CAHs to inform how primary care services provided in these settings are captured. | David Winslow confirmed that there is a cost adjustment at the end of the year from the public payers to the critical access hospitals. However, since the settlement amount doesn’t account for primary versus specialty care, it should not change the percentage spent on primary care. Showing percentages instead of total dollar will cancel out this issue.  Staff recommends addressing this by clearly explaining in the final report that the distribution to primary care will be the same regardless inclusion/non-inclusion of the cost settlement. |
| **LTC facilities**: Group agreed that services by primary care providers provided in LTC facilities should be included. | Include the Medicaid in residential non-SNF locations, as long as the services are primary care. | LT residential non-SNF codes where primary care providers were providing primary care services will be added into the definition in the final report. |
| **Hospice:** Is there a separate code for hospice if there is a PCP billing for the service? Judy confirmed that hospice was not included in the analysis, but may be captured under home visits. | Lisa Harvey McPherson offered to look into this question further and will provide hospice codes if they are not included under home visits. | Staff confirmed that hospice services provided by PCPs identified by Lisa Harvey McPherson had been included in the code list and will clarify in the final report. |
| **Facility Fees**: Are the facility fees for the provider based reimbursement captured? Is cost based reimbursement the same as for the FQHCs and critical access hospitals? What about enhanced payments that come in through Medicaid for the medical homes? Judy confirmed that facility fees are captured but not alternative payment models. | Lisa Letourneau suggested breaking out the facility fees. Karynlee confirmed that we can differentiate facility versus professional fees in the claims data.  A revised analysis will be run by professional/facility to assess whether to report these separately. | An analysis of primary care costs by facility and professional fees shows that most of the facility fees are going to FQHCs and RHCs for Medicare and Medicaid, but is not a significant percentage for Commercial.  Staff recommends including these fees as primary care and explaining the decision in the final report. |
| **Duals**: Do other states look at the data set for the dually eligible population? | Kim Fox did not recall any states or other reports separating out the dual population, but will confirm. | Staff recommends not separating out the dual population, which is in alignment with other states. |
| **Occupational Health**: Is occupational health included without the worker’s comp? Some of these codes are billed through primary care and might appear in the commercial insurance. Karynlee confirmed that there are no worker’s comp claims in the APCD. | No additional action required |  |
| **Charity/free care:** Is charity or free care included? Is there a way to capture the value of that? Karynlee said that this analysis is just capturing what was spent, so that wouldn’t be included. | No additional action required |  |