Primary Care Spending in Oregon

A report to the Oregon State Legislature

Oregon Health Authority

February 2018

DCBS | Consumer and Business Services

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Executive summary

Senate Bill 231 (2015) and House Bill 4017 (2016) require 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 health premium income of $200 million or more. These carriers may offer commercial or Medicare Advantage plans.
- 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 has helped OHA develop recommendations for directing optimal resources to primary care.

This document is an OHA and DCBS report to the Legislature on medical spending allocated to primary care. It presents information about primary care spending in calendar year 2016. 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 2.5 million Oregonians, 62 percent of Oregon's population in 2016.

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

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 the Primary Care Payment Reform Collaborative as it develops recommendations for optimizing investment in primary care.

This year's report uses an updated methodology
See section titled "What's new in this report."

CCOs and prominent carriers captured in this report spent $1.5 billion on primary care in 2016. On average, CCOs allocated a greater percentage of total medical spending to primary care than any other type of health care payer.
Prominent carriers spent $981 million on primary care. Commercial carriers' primary care spending averaged 13.6 percent of total medical spending. Medicare Advantage and PEBB and OEBB plans' primary care spending averaged 11.7 percent and 12.3 percent, respectively. CCOs spent $518 million on primary care, representing 15.7 percent of total medical spending.

The percentage of total medical spending allocated to primary care varied substantially.
Commercial carriers allocated from 6.9 to 17.1 percent of medical spending to primary care. Medicare Advantage plans allocated from 4.1 to 25.9 percent to primary care and PEBB and OEBB plans allocated from 10.4 to 17.0 percent to primary care. CCOs allocated from 8.9 to 34.6 percent to primary care.

On average, non-claims-based payments comprised a greater percentage of primary care spending by Medicare Advantage plans than by other payer types.
Non-claims-based payments are payments to a health care provider intended to motivate efficient care delivery, reward achievement of quality or cost-savings goals, and build health care infrastructure and capacity. In total, more than 64 percent of primary care spending by Medicare Advantage plans was non-claims-based and more than 56 percent of primary care spending by CCOs was non-claims-based. By contrast, non-claims-based payments comprised 44 and 33 percent of primary care spending for commercial carriers and PEBB and OEBB plans, respectively.

Of non-claims-based primary care spending, most carriers and CCOs use provider incentives and capitated payments.
Most prominent carriers and CCOs reported some primary care spending in the form of provider incentives and many reported capitated or salaried payments to providers. The other non-claims-based categories were less common.

Background

Primary care is the front line of Oregon's health care system. Primary care providers deliver preventive services such as 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, physicians' 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.

The Oregon Legislature enacted Senate Bill 231 (2015) and House Bill 4017 (2016) to provide information about primary care in Oregon and strengthen Oregon's primary care infrastructure. SB 231 and HB 4017 require the OHA and 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 health premium income of $200 million or more that may offer commercial or Medicare Advantage plans
- 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, these bills require OHA to convene a Primary Care Payment Reform Collaborative (collaborative) comprised of more than 40 members representing a broad range of provider, payer and other primary care stakeholder perspectives. The collaborative advises and assists OHA in the implementation of the Primary Care Transformation Initiative (initiative). The purpose of the Initiative is to develop and share best practices in technical assistance and methods of reimbursement that direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care. Senate Bill 934 (2017) extends the collaborative through 2027, and requires the collaborative to submit an annual report on the initiative's progress to the Oregon Health Policy Board and the Oregon Legislature.

Further, SB 934 requires health insurance carriers and coordinated care organizations to allocate at least 12 percent of their health care expenditures to primary care by 2023. Commercial carriers including PEBB and OEBB plans, as well as CCOs that do not meet the 12 percent target, will be required to submit to OHA and DCBS a plan to increase the carrier's primary care spending by 1 percentage point each year.

OHA and DCBS made a significant 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. As reflected in statute, OHA uses claims based on specific provider types and for specific services related to primary care. Information about claims-based payments made by Oregon's major health care payers is available from OHA's All Payer All Claims (APAC) Reporting Program.
- Non-claims-based payments: Payments to health care providers intended to motivate efficient care delivery, reward achievement of quality or cost-savings goals, and build primary care infrastructure and capacity.

To collect information about non-claims-based payments for this report, OHA and DCBS aligned with the following administrative rules (OARs):

- OAR 836-053-1500 through 836-053-1510: 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: 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.

Primary care spending: What's included?

The Primary Care Spending Report defines primary care based on the **health care provider** and **what service is given**. In other words, primary care in this report is defined by specific types of health care professionals who provide a specific set of services to patients. The definition of primary care also includes certain provider organizations and excludes specific health care settings.

Who are primary care providers?

For this report, primary care providers are defined as:

- Physicians specializing in primary care, including family medicine, general medicine, obstetrics and gynecology, pediatrics, general psychiatry, and geriatric medicine
- Naturopathic and homeopathic providers
- Physicians' assistants
- Nurse practitioners
- Primary care clinics
- Federally qualified health centers (FQHCs)
- Rural health centers.

The costs associated with services provided in hospitals and ambulatory surgical centers do not count toward primary care spending.

What services are considered primary care?

For this report, primary care services are defined as:

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

For a complete list of procedure codes, please contact PC.ServicesReport@dhsoha.state.or.us.

For example, the paid claims associated with a family physician who administered a vaccine to a patient in a clinic would be considered primary care spending. However, if a physician performs a primary care service such as a general medical exam in an emergency department, it would not be considered primary care spending because emergency department visits are excluded from the definition of primary care spending.

Primary care data:

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 the carriers and CCOs. Prescription drug payments are not included in the analysis. These data come from the All Payer All Claims Reporting Program and include the criteria outlined above.

2. Non-claims-based payments: Payments to primary care providers or provider organizations intended to motivate efficient care delivery, reward achievement of quality or cost-savings goals, and build primary care infrastructure and capacity. These data come from a data template that carriers and CCOs complete.

Primary care spending: What's included?

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 below). As the denominator, total payments include all payments for members including specialty care, mental health care, hospitalizations and more, but does not include prescription drugs.

$$\frac{\text{Claims-based payments for primary care} + \text{Non-claims-based payments for primary care}}{\text{Total claims-based payments} + \text{Total non-claims-based payments}} = \text{Percentage of medical spending allocated to primary care}$$

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
- Physicians' 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
- Immunizations
- Preventive medicine evaluation or counseling
- Health risk assessments
- Routine obstetric care, including delivery
- 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 (APAC) Reporting Program.

APAC collects information about health care claims and encounters from health insurance carriers with more than 5,000 Oregon members, 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 began collecting non-claims-based payments to providers in September 2017 and OHA continues to analyze these data for use in future reports.

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

Because non-claims-based payments were recently collected in APAC for the first time, OHA and DCBS continue to rely on a reporting template to collect this information. The template requires carriers and CCOs to report non-claims-based primary care spending and total spending in six categories. In addition, it requires carriers and CCOs to report total months of enrollment for the calendar year, allowing for calculation of spending per-member per-month. Reporting requirements in the template were incorporated into Oregon Administrative Rules 836-053-1500 through 836-053-1510 and 409-027-0010 through 409-027-0030.

The following limitations should be noted when interpreting this report:

This report excludes primary care spending by some health care payers.

The report excludes health insurance carriers with annual health premium income of less than $200 million in the calendar year, self-insured employers, Medicaid fee-for-service, Medicare fee-for-service and other federal health insurance programs. 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 use of primary care and other services by health plan members. These factors, in addition to carriers' and CCOs' spending decisions, provider networks and other policy decisions can affect spending allocated to primary care.

See page 20 for a complete list of carriers and CCOs included in this report.

See "Methodology" starting on page 21 for additional information about data collection and analysis.

What's new in this report?

This 2018 Primary Care Spending Report differs from the 2017 report. The methodology has been updated to more accurately reflect primary care spending. Because of the methodological changes, this report does not show comparisons to the 2016 or 2017 reports. Future reports can include year-to-year comparisons using the definition outlined in this report to track trends in primary care spending.

Change #1: Adding procedure codes for primary care

When preparing the first Primary Care Spending Report in 2016, OHA and DCBS developed the list of procedure codes to define primary care. For the 2018 report, additional codes were added. These include flu and shingles vaccine codes, care management services, depression screenings, smoking and tobacco use cessation counseling, and others that, when delivered by a primary care provider in a primary care setting, align with the activities that were included in the previous definition of primary care.

Change #2: Referencing other data fields when identifying primary care providers

Previous reports relied on a field in the claims data called "billing provider" to identify if the provider was primary care. However, some carriers and CCOs do not include sufficient distinguishing information in that data field. Sometimes the relevant information can only be found in a data field called "rendering provider." The 2018 report methodology uses both fields to determine if a primary care provider delivered a procedure or service .

Change #3: Removing J-codes from total medical expenditures

J-codes are a category of health care claims used for drugs that generally cannot be self-administered. For example, a chemotherapy drug administered by a health care professional would be coded as a J-code.

Senate Bill 934 (2017) specifies that prescription drugs should be excluded from the primary care analysis. Although J-codes are not technically prescriptions – there is no script and the patient does not obtain the drug from a pharmacy – they are nonetheless pharmaceuticals, and some are quite expensive. As more very expensive drugs come to market, some of those drugs are captured in the J-code category. The 2018 report methodology excludes J-codes.

Change #4: Removing CCO members who are only covered for mental health and/or dental services

Approximately 4% of CCO members are only covered for mental health services and/or dental services. These individuals access physical health services outside of their CCO and these individuals' physical health services are not paid for by their CCO. The 2018 report methodology excludes these CCO members.

Additional changes

In addition to the methodological changes outlined here, several carriers took a critical look at the claims data they had reported to APAC and resolved data quality issues in the next data submission cycle.

Moving forward

Trending primary care spending over time is important to this analysis. If there are no significant methodological changes to this report, future reports will show year-to-year trends in primary care spending.

For more information about the specific codes included in the definition of primary care or any other information about the methodology, please email PC.ServicesReport@dhsoha.state.or.us.

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

For the purpose of reporting on spending allocated to primary care, prominent carriers were defined by OAR 836-053-1505 as health insurance carriers with annual health premium income of $200 million or more. According to this definition, there were 12 prominent carriers in 2016. 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.

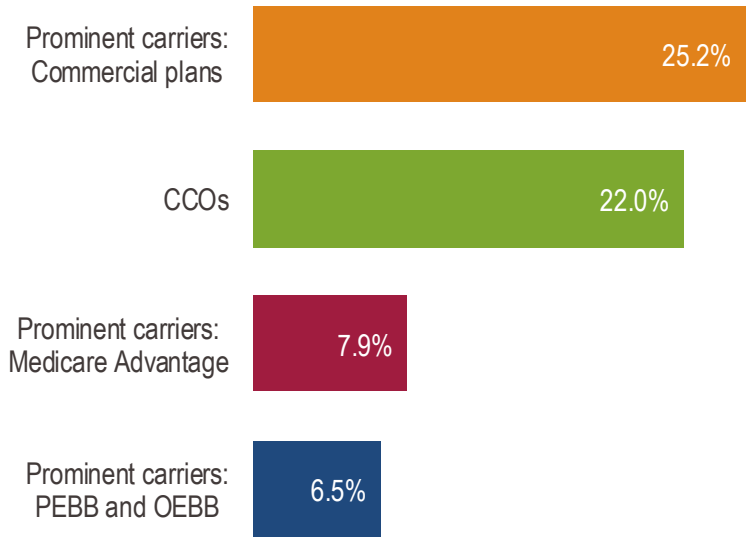
Coordinated care organizations (CCOs)

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 2016 (enrollment and spending for the two CCOs associated with Pacific Source Community Solutions are reported together).

See Page 20 for the complete list of carriers and CCOs included in this report.

Percentage of Oregon's population covered by heath care payers included in this report:

In 2016, prominent carriers and CCOs provided coverage for nearly 2.5 million Oregonians, or nearly 62 percent of Oregon's population.*



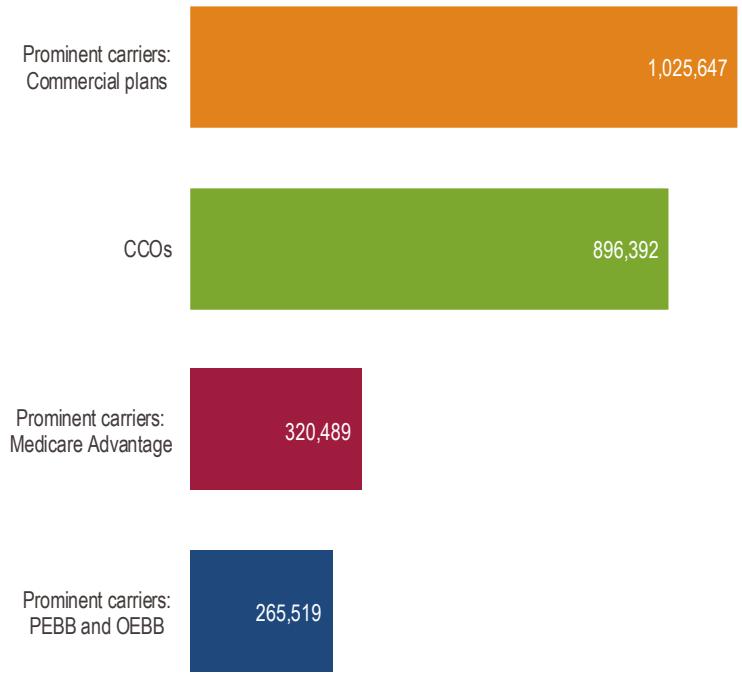
*Oregon's estimated population was 4,076,350 as of July 1, 2016. Population Research Center, Portland State University.

Enrollment and total primary care spending

The graphs on this page show enrollment and total primary care spending by prominent carriers and CCOs in calendar year 2016. Enrollment is reported as the average number of unique people enrolled in a given month. On the right are total primary care spending and total spending broken out by payer category.

Monthly enrollment

In any given month of 2016, an average of 896,392 Oregonians were enrolled in CCOs. In the same year, 1.6 million Oregonians were enrolled in commercial, Medicare Advantage, and PEBB and OEBB plans offered by prominent carriers.



Total primary care spending in 2016

CCOs, commercial plans, Medicare Advantage plans, and PEBB and OEBB plans spent $1.5 billion on primary care out of $11.0 billion of total spending.

CCOs

Primary care spending
$518 million
Total spending
$3.3 billion
Percent primary care
15.7%

Commercial

Primary care spending
$528 million
Total spending
$3.9 billion
Percent primary care
13.6%

Medicare Advantage

Primary care spending
$321 million
Total spending
$2.7 billion
Percent primary care
11.7%

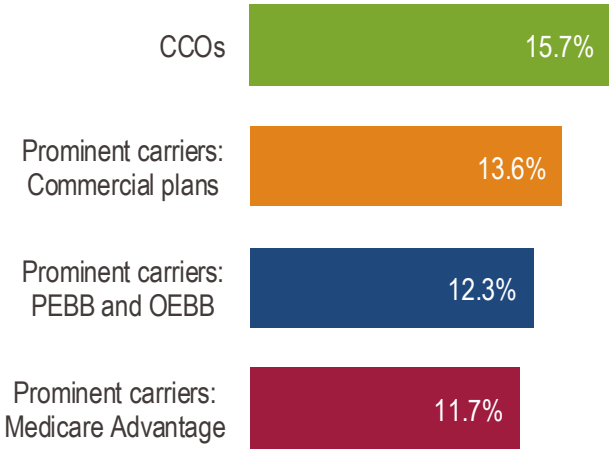
PEBB and OEBB

Primary care spending
$132 million
Total spending
$1.1 billion
Percent primary care
12.3%

Primary care spending: Percentage of total medical spending and per-member per-month (PMPM)

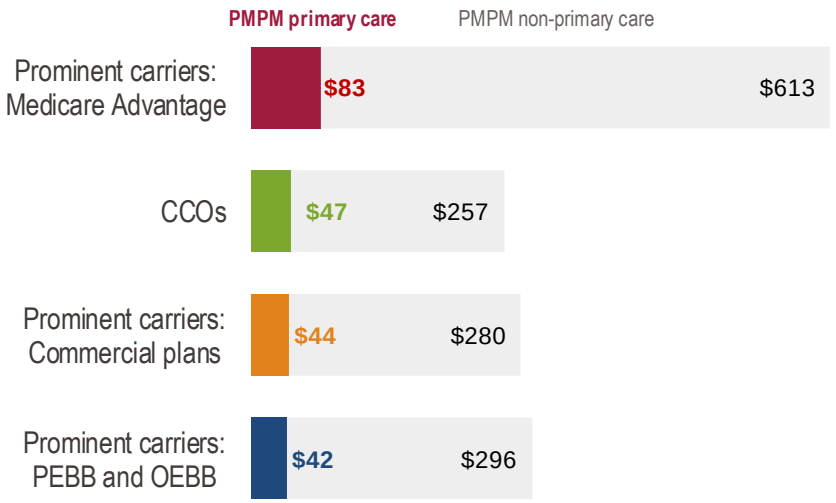
Percentage of total medical spending allocated to primary care

In 2016, CCOs allocated an average of 15.7 percent of total medical spending to primary care. Commercial, Medicare Advantage, and PEBB and OEBB plans allocated an average of 13.6 percent or less of total medical spending to primary care.



Per-member per-month (PMPM) primary care spending

In 2016, PMPM primary care spending ranged from $42 for PEBB and OEBB plans to $83 for Medicare Advantage plans on average. Non-primary care spending ranged from $257 PMPM for CCOs to $613 PMPM for Medicare Advantage plans on average.



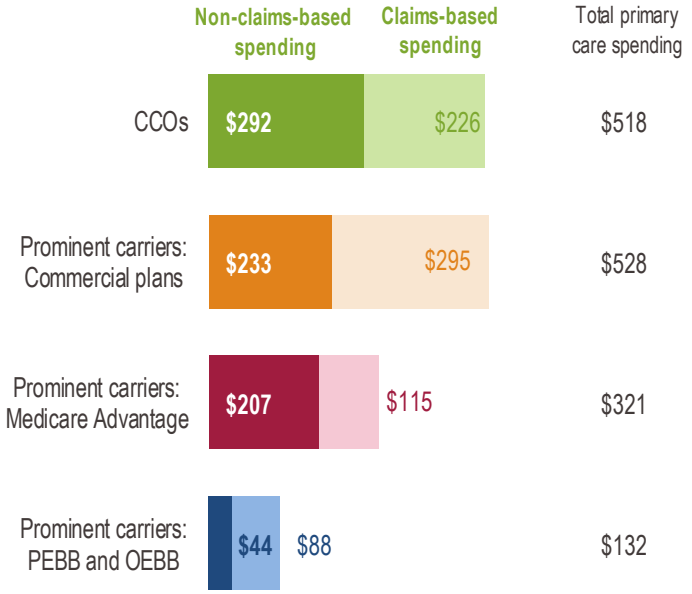
The graphs on this page show two measures of medical spending allocated to primary care by prominent carriers and CCOs in 2016:

- 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. Total PMPM spending 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 colored part of each bar shows PMPM primary care spending and the gray part of each bar shows PMPM non-primary-care spending. The graph is sorted by highest to lowest PMPM primary care spending in 2016.

Primary care spending: Claims-based and non-claims-based spending

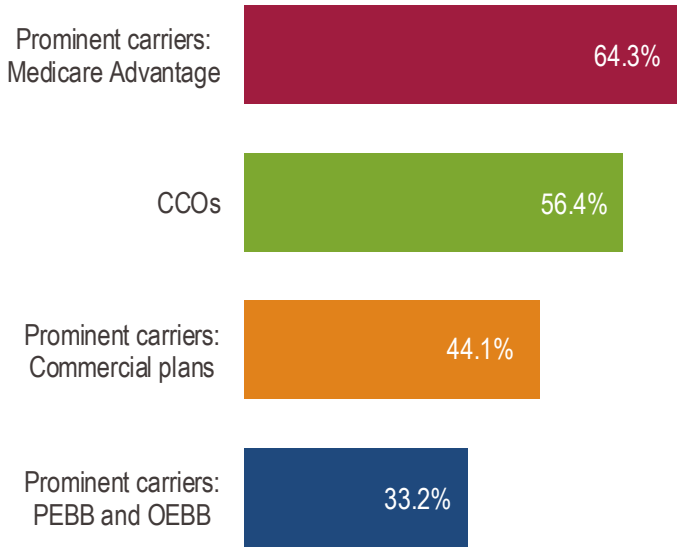
Total claims-based and non-claims-based primary care spending ($ Million)

In 2016, CCOs spent $292 million on primary care through non-claims-based payments. Commercial, Medicare Advantage, and PEBB and OEBB plans spent $233, $207 and $44 million respectively on primary care through non-claims-based payments.



Non-claims-based spending as a percentage of total primary care spending

In 2016, more than 64 percent of primary care spending by Medicare Advantage was non-claims-based. The averages presented below for commercial, Medicare Advantage and PEBB and OEBB plans are heavily influenced by one or two carriers that allocate nearly all primary care spending to non-claims-based. See pages 13 to 16 for more detail.

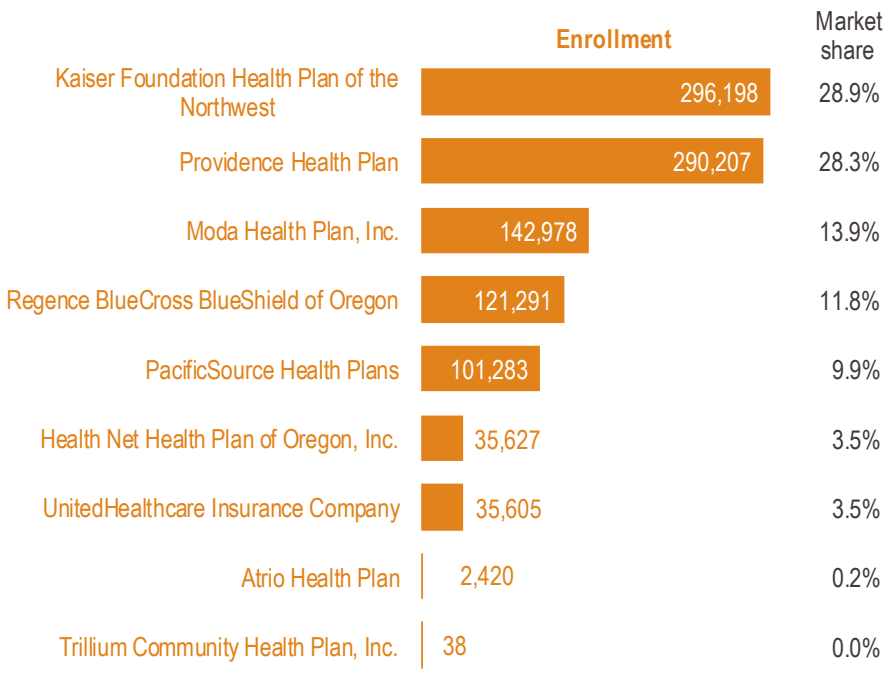


The graphs on this page show claims-based and non-claims-based primary care spending in dollars and percentages of total primary care spending for 2016. Non-claims-based payments are payments to health care providers intended to motivate efficient care delivery, reward achievement of quality or cost-savings goals, and build primary care infrastructure and capacity. In the graph at left, the dark part of each bar shows non-claims-based primary care spending and the light part of each bar shows total claims-based primary care spending. The graph at right shows non-claims-based primary care spending as a proportion of total primary care spending for 2016.

Commercial plans: Enrollment and primary care spending

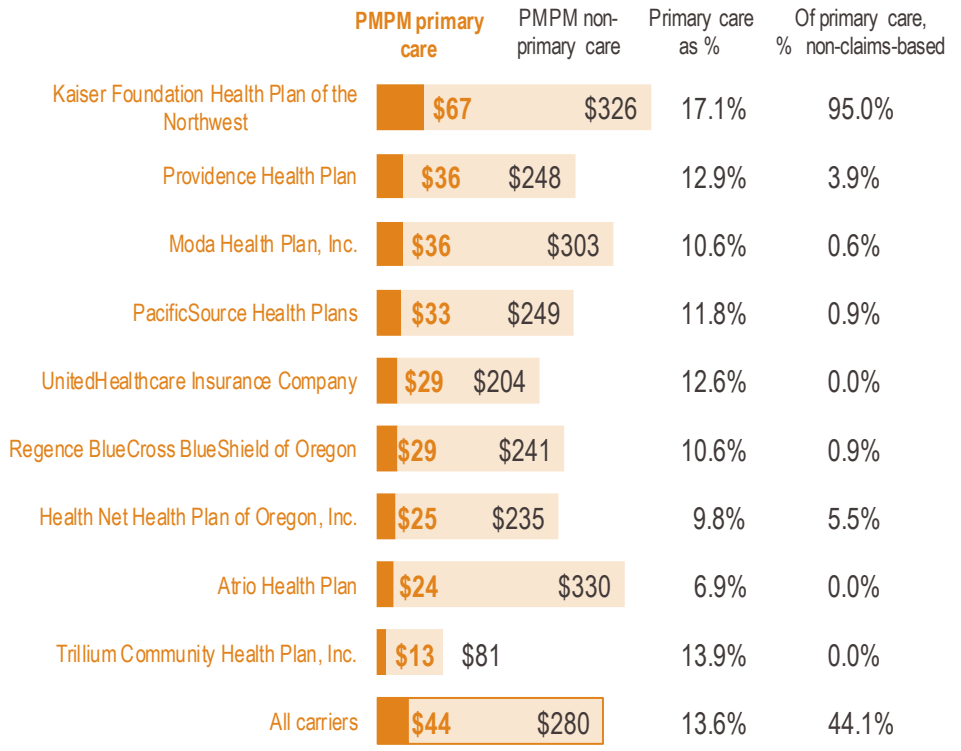
Number of people enrolled

In 2016, an average of 1,025,647 people per month were enrolled in commercial plans offered by prominent carriers. More than two-thirds of these individuals were enrolled in commercial plans offered by the three largest prominent carriers



Per-member per-month (PMPM) primary care spending

In 2016, the average PMPM primary care spending for commercial plans was $44. The carriers' spending ranged from $13 PMPM to $67 PMPM. Among most carriers, the proportion of total primary care that is non-claims-based is less than 1 percent



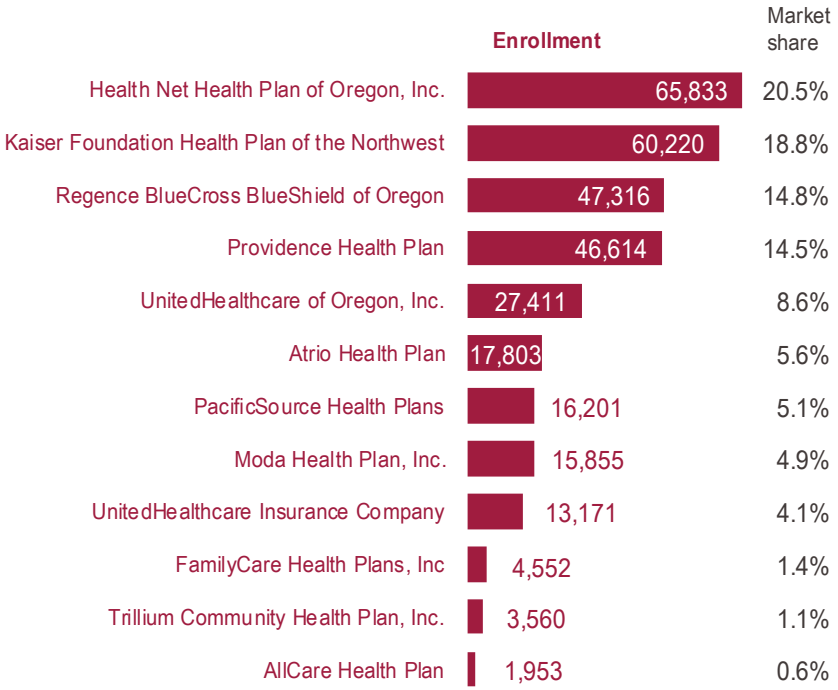
The graph on the left shows the number of people enrolled in commercial plans offered by prominent carriers. Enrollment is reported as the number of total member months in 2016 divided by 12. The graph on the right shows per-member per-month primary care spending and non-primary care spending for each prominent commercial carrier. The graph on the right also includes primary care spending as a percent of total medical spending as well as the percent of primary care spending that was non-claims-based.

Note: See page 20 for a complete list of carriers included in this report and page 21 for the methodology.

Medicare Advantage plans: Enrollment and primary care spending

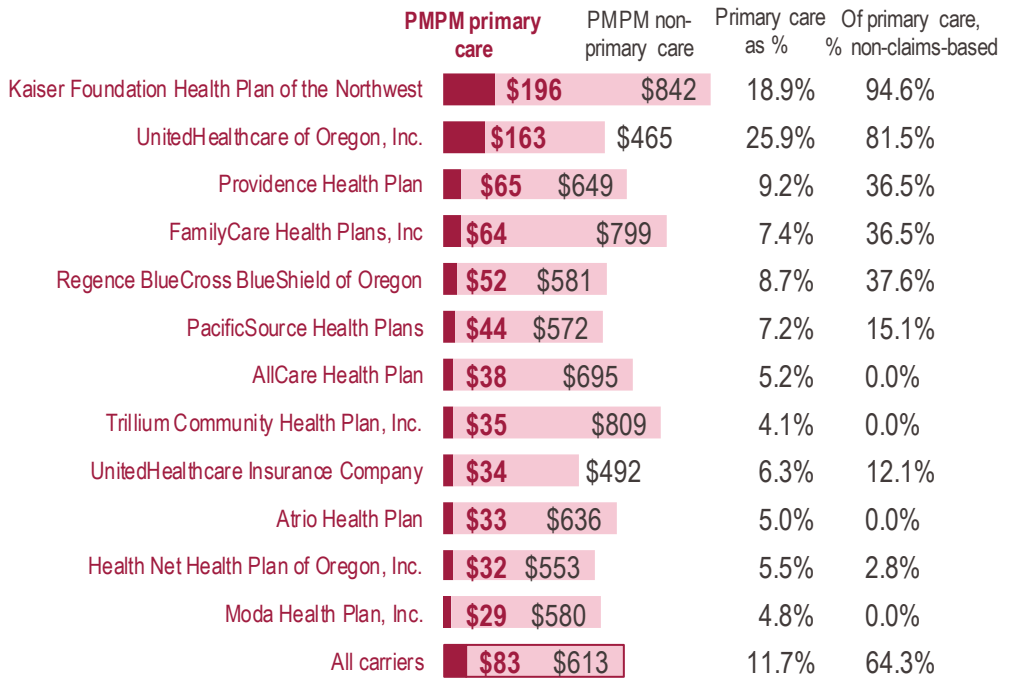
Number of people enrolled

In 2016, an average of 320,489 people per month were enrolled in Medicare Advantage plans offered by prominent carriers. The three largest prominent carriers, those at the top of the graph, enrolled more than half of all Medicare Advantage enrollees reflected in this report.



Per-member per-month (PMPM) primary care spending

In 2016, the average PMPM primary care spending for Medicare Advantage plans was $83. The plans' spending ranged from $29 to $196. Many carriers allocated more than a third of total primary care spending to non-claims-based spending, while some had less than 3 percent.



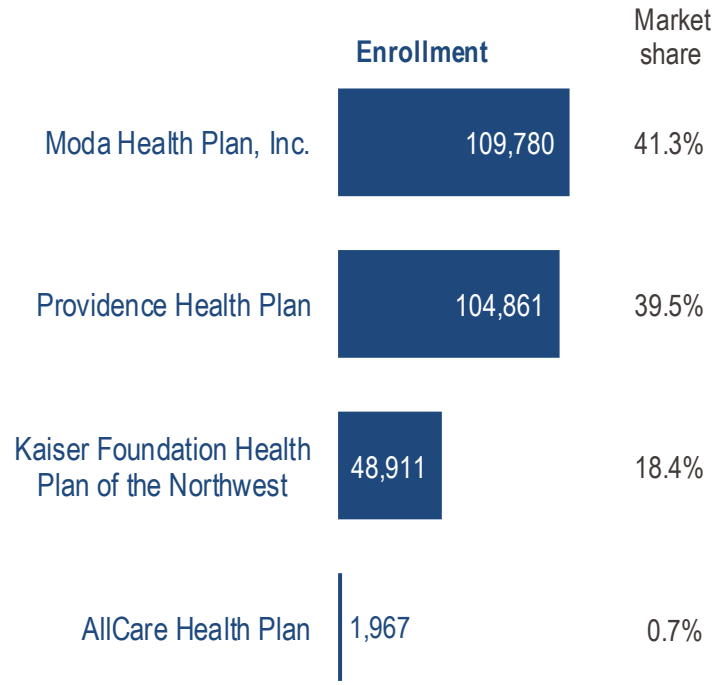
The graph on the left shows the number of people enrolled in Medicare Advantage plans offered by prominent carriers. Enrollment is reported as the number of total member months in 2016 divided by 12. The graph on the right shows per-member per-month primary care spending and non-primary care spending for each prominent Medicare Advantage carrier. The graph on the right also includes primary care spending as a percent of total medical spending as well as the percent of primary care spending that was non-claims-based.

Note: See page 20 for a complete list of carriers included in this report and page 21 for the methodology.

PEBB and OEBB plans: Enrollment and primary care spending

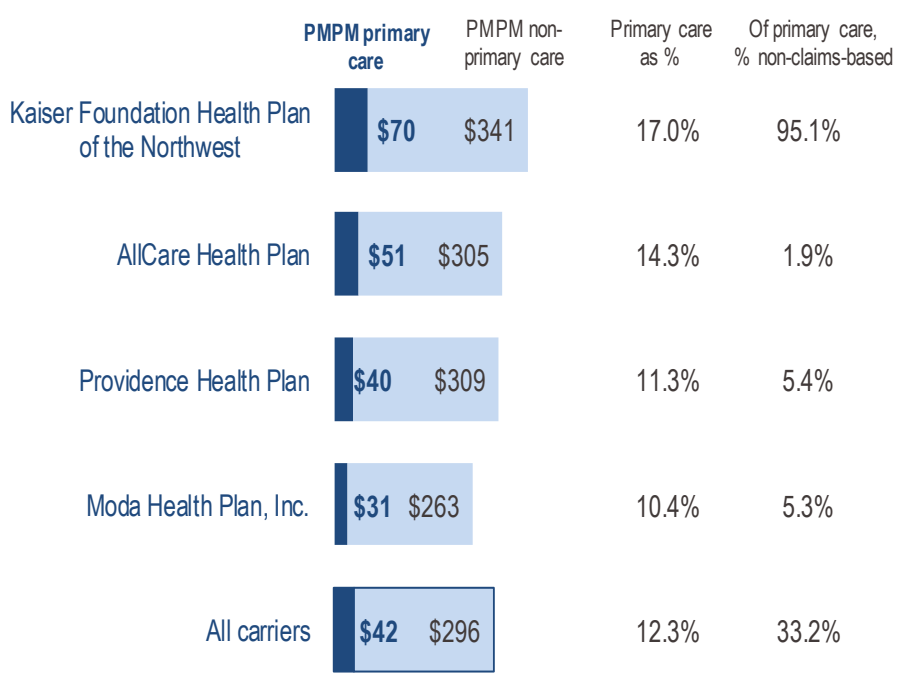
Number of people enrolled

In 2016, an average of 265,519 people per month were enrolled in PEBB and OEBB plans offered by prominent carriers. More than 81 percent of PEBB and OEBB enrollees are enrolled in Moda Health Plan, Inc. and Providence Health Plan.



Per-member per-month (PMPM) primary care spending

In 2016, the average PMPM primary care spending for PEBB and OEBB plans was $42. The plans' spending ranged from $31 to $70. All but one carrier allocated less then 6 percent of primary care spending to non-claims-based spending.



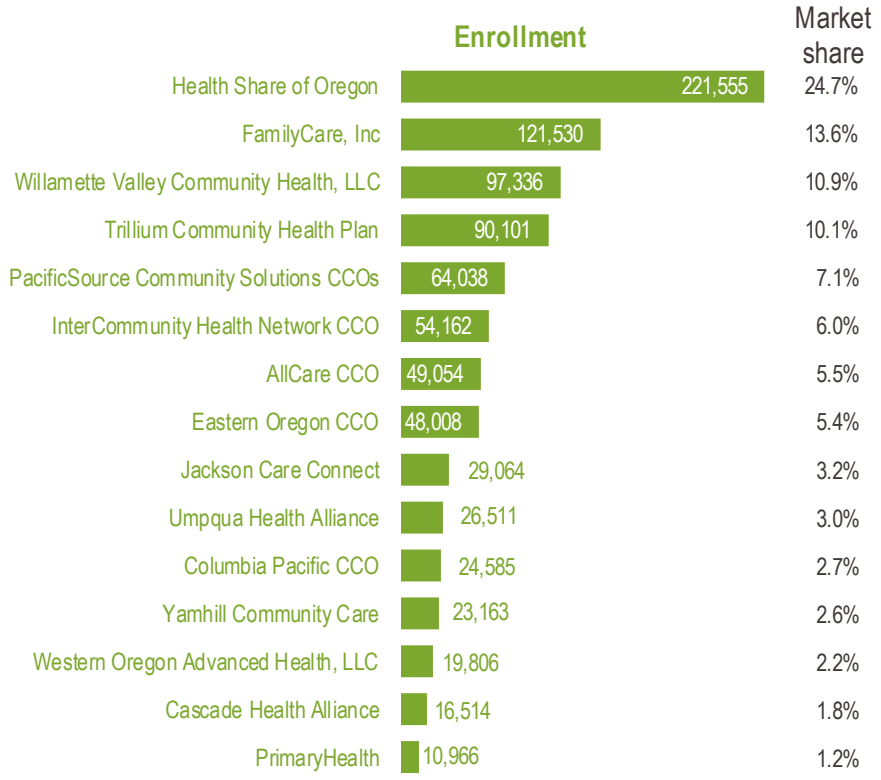
The graph on the left shows the number of people enrolled in PEBB and OEBB plans offered by prominent carriers. Enrollment is reported as number of total member months in 2016 divided by 12. The graph on the right shows per-member per-month primary care spending and non-primary care spending for each prominent PEBB and OEBBB carrier. The graph on the right also includes primary care spending as a percent of total medical spending as well as the percent of primary care spending that was non-claims-based.

Note: See page 20 for a complete list of carriers included in this report and page 21 for the methodology.

Coordinated care organizations: Enrollment and primary care spending

Number of people enrolled

In 2016, an average of 896,392 people per month were enrolled in CCOs. The three largest CCOs cover nearly half of all enrollees.



Per-member per-month (PMPM) primary care spending

In 2016, the average PMPM primary care spending for CCOs was $47. CCO spending ranged from $32 to $96. All CCOs allocated at least 31 percent of primary care spending to non-claims-based payments.

	PMPM primary care	PMPM non-primary care	Primary care as %	Of PC, % non-claims-based
PrimaryHealth	$96	$178	34.6%	90.8%
Willamette Valley Community Health, LLC	$75	$250	22.9%	71.2%
Western Oregon Advanced Health, LLC	$59	$282	17.4%	78.2%
FamilyCare, Inc	$59	$200	22.9%	50.9%
InterCommunity Health Network CCO	$57	$294	16.2%	58.9%
Eastern Oregon CCO	$53	$294	15.1%	73.0%
Cascade Health Alliance	$49	$250	16.2%	84.0%
Umpqua Health Alliance	$49	$265	15.5%	55.1%
Jackson Care Connect	$46	$272	14.3%	44.3%
PacificSource Community Solutions CCOs	$44	$223	16.5%	75.9%
Yamhill Community Care	$43	$264	13.9%	37.7%
Trillium Community Health Plan	$41	$271	13.2%	49.9%
AllCare CCO	$39	$228	14.7%	57.9%
Health Share of Oregon	$33	$284	10.4%	31.7%
Columbia Pacific CCO	$32	$321	8.9%	33.5%
All CCOs	$47	$257	15.7%	56.4%

Note: CCOs vary in organizational size, populations they serve, demographics, geographic regions served, available providers, types of providers, plan type and other factors that may influence primary care and/or total medical spending. In some cases, spending amounts for certain services may be outside the control of the CCO. The dataset used by the OHA to determine primary care spending may exclude some primary care spending due to how hospital-affiliated primary care providers bill for their services. There are 16 CCOs, two of which are operated by PacificSource Health Plans: PacificSource Community Solutions in Central Oregon and in the Columbia Gorge. These two CCOs are combined for this report. See page 20 for a complete list of carriers included in this report and page 21 for the methodology.

Non-claims-based spending: What's included?

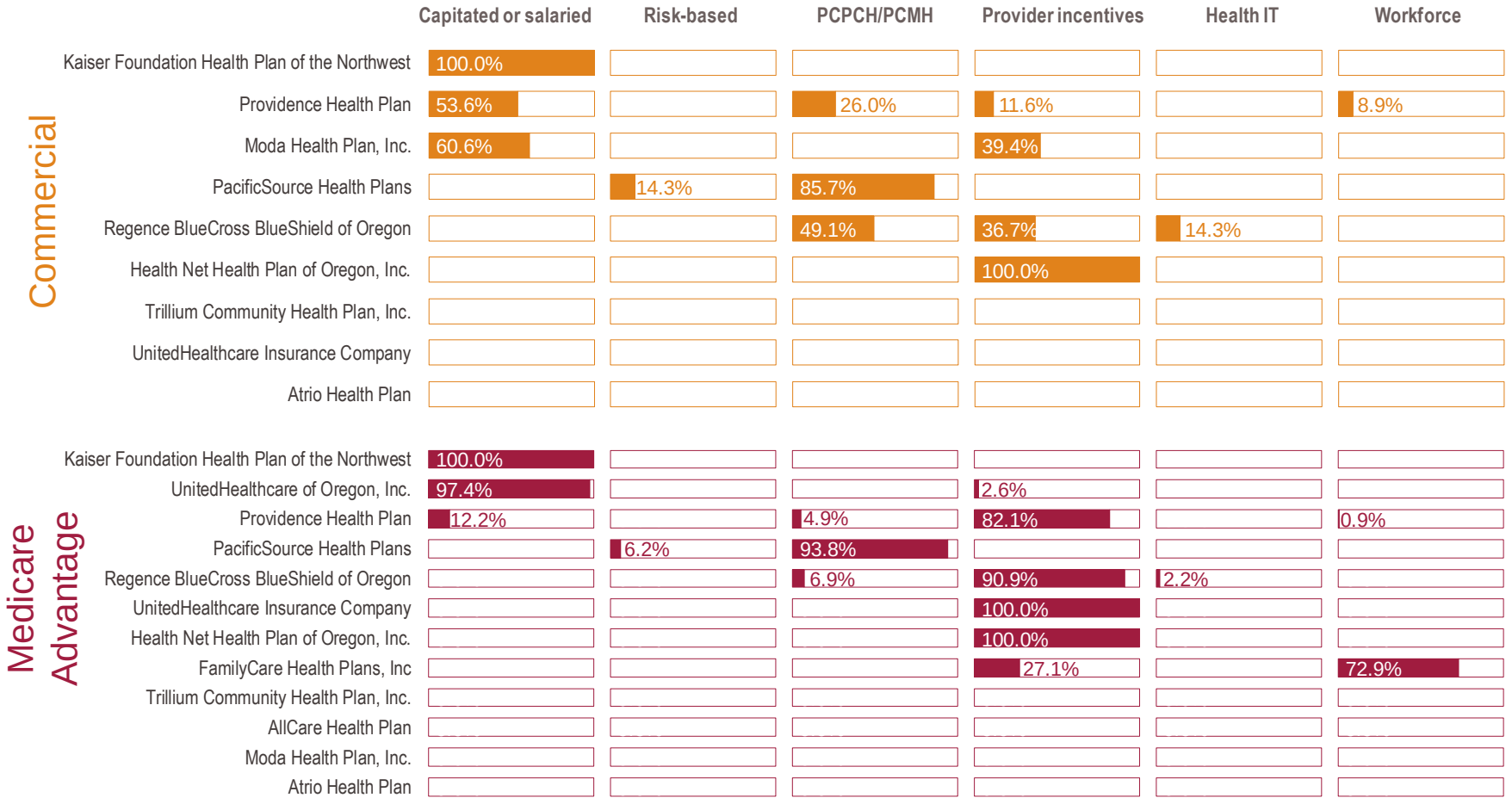
To report on primary care spending in Oregon, OHA and DCBS collected information about non-claims-based spending from prominent carriers and CCOs. OHA and DCBS adopted administrative rules defining non-claims-based spending. The rules define seven types of non-claims-based payments to primary care providers that carriers and CCOs were required to report. This section organizes the seven types of non-claims-based payments into three overall categories, shown in the table below (payments for recognition as a patient-centered medical home are broken out into payments for recognition by OHA's Patient-Centered Primary Care Home Program and recognition by other patient-centered medical home programs).

The adopted administrative rules 836-053-1500 to 836-053-1510 and 409-027-0010 through 409-027-0030 can be viewed here: http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_836/836_053.html and http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_409/409_027.html .

Non-claims-based payments	
Payments to motivate efficiency or quality	**Capitation or provider salary payments** • 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. Capitation payments can motivate providers to manage care efficiently and avoid costly complications or expensive services. • Salary payment: Payment for salaries of providers who provide the member's care. Like capitation payments, salary payments can motivate providers to manage care efficiently and avoid costly complications or expensive services.
	Risk-based payments: Payments received by providers that may be reduced if costs exceed a defined target. Risk-based payments can encourage providers to work on controlling costs.
	Retrospective incentive payments: Payments to reward providers for achieving quality or cost-savings goals. Retrospective incentive payments can encourage providers to work on improving quality and controlling costs.
Payments for patient-centered medical home recognition	**Patient-centered primary care home (PCPCH) recognition payments:** Payments to clinics recognized by OHA's PCPCH Program as providing good primary care.
	Other patient-centered medical home (PCMH) recognition payments: Payment to clinics recognized by other medical-home programs as providing good primary care.
Payments to improve provider infrastructure and capacity	**Prospective incentive payments:** Payments aimed at developing provider capacity to improve care for a defined population of patients, such as patients with chronic conditions.
	Health information technology payments: Payments to help providers adopt health information technology, such as electronic medical records. Health information technology can help providers coordinate care, improve quality and control costs.
	Supplemental workforce payments: Payments for supplemental staff or activities, such as practice coaches, patient educators, patient navigators or nurse care managers. Supplemental staff can help doctors and other health care providers organize clinics to function better, and help patients take charge of their health.

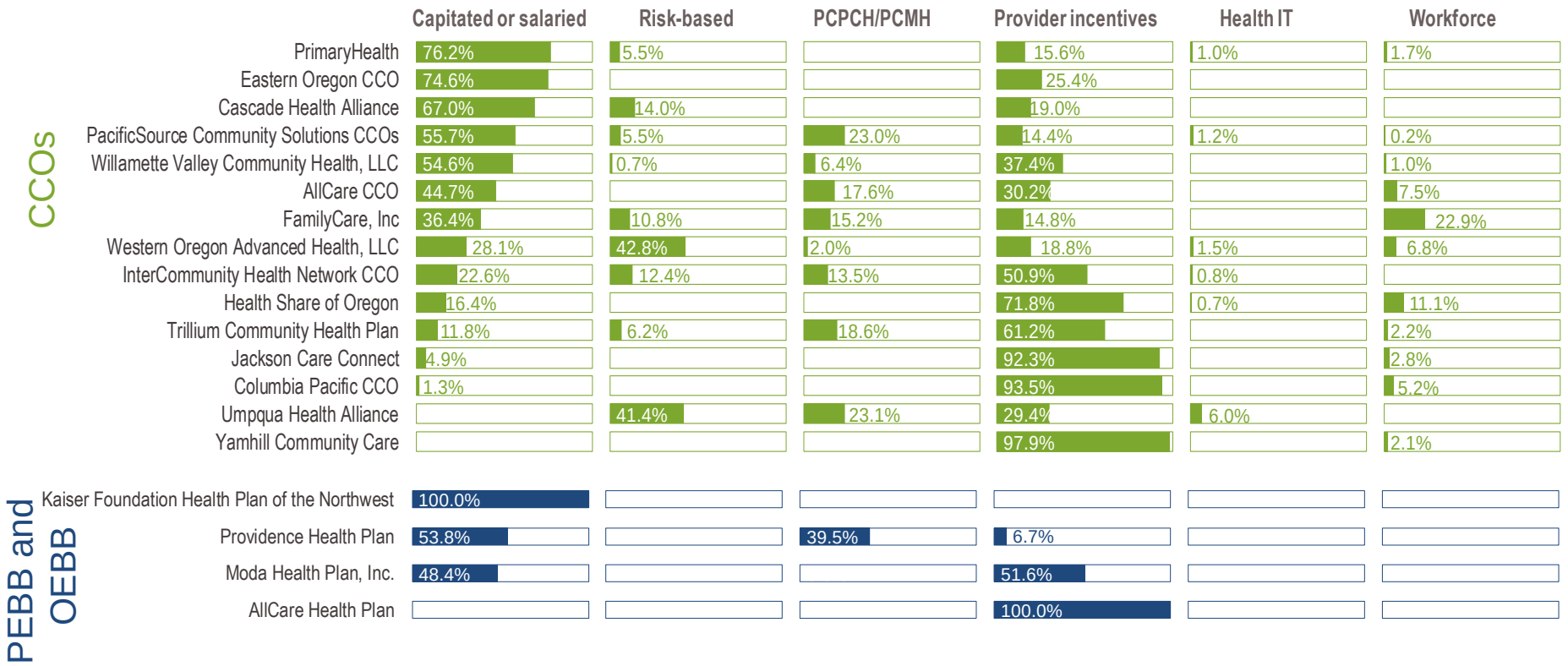
Non-claims-based spending

Primary care spending can be either claims-based or non-claims-based. The graphs below show only the non-claims-based primary care spending by each commercial and Medicare Advantage carrier. As the graphs below show, some carriers focus on one or two categories of non-claims-based spending such as capitated payments or PCPCH, while other carriers spend in multiple categories. A minority of commercial and Medicare Advantage carriers have no non-claims-based primary care spending. All rows below may not sum to 100.0% due to rounding.



Non-claims-based spending (continued)

Primary care spending can be either claims-based or non-claims-based. The graphs below show only the non-claims-based primary care spending by each CCO and PEBB and OEBB carrier. As the graphs below show, some carriers focus on one or two categories of non-claims-based spending such as capitated payments or PCPCH, while other carriers spend in multiple categories. Every CCO and PEBB and OEBB carrier has non-claims-based primary care spending. All rows below may not sum to 100.0% due to rounding.



Prominent carriers and CCOs in this report

Prominent carriers

AllCare Health Plan

Atrio Health Plan

FamilyCare Health Plans

Health Net Health Plan of Oregon, Inc.

Kaiser Foundation Health Plan of the Northwest

Moda Health Plan, Inc.

PacificSource Health Plan

Providence Health Plan

Regence BlueCross BlueShield of Oregon

Trillium Community Health Plan, Inc.

UnitedHealthcare Insurance Company

UnitedHealthcare of Oregon, Inc.

CCOs

AllCare CCO

Cascade Health Alliance

Columbia Pacific CCO

Eastern Oregon CCO

FamilyCare, Inc.

Health Share or Oregon

InterCommunity Health Network CCO

Jackson Care Connect

PacificSource Community Solutions CCOs

PrimaryHealth

Trillium Community Health Plan, Inc.

Umpqua Health Alliance

Western Oregon Advanced Health, LLC

Willamette Valley Community Health, LLC

Yamhill Community Care

Methodology

Total medical spending and primary care spending: What's included?

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 reported by health care claims. 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) Reporting Program. APAC collects information about health care claims and encounters from all health care payers covered by SB 231 and HB 4017, 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. APAC data are refreshed quarterly so that carriers and CCOs can adjust and finalize claims. The first three quarters of the annual data in this report have been refreshed four times, which is the maximum, and the last quarter has been refreshed three times. In other words, there has been ample time to adjust any of the claims data that were 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, although 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).

Information about non-claims-based payments is from a 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 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
- Payments for workforce expenditures, such as practice coaches, patient educators, patient navigators or nurse care managers.

Carriers and CCOs were instructed to report spending on the template for services implemented or incurred in calendar year 2016. 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 2016, allowing for calculation of non-claims-based spending per-member per-month. Carriers were also instructed to report non-claims-based spending and enrollment separately for commercial, Medicare Advantage, and PEBB and OEBB plans.

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 are not commonly provided by commercial carriers. These differences may affect the results presented in this report.

Claims-based data for Kaiser Foundation Health Plan of the Northwest are self-reported expenditures and not from the APAC.

Methodology (continued)

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 2016, these entities provided coverage for 2.5 million Oregonians, 62 percent of Oregon's population. The report excludes spending by the following health care payers:

- Health insurance carriers with annual health premium income of less than $200 million in 2016
- 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.

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 2016. 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, Battle Ground or Walla Walla, Washington and Emmett, Fruitland, Payette, New Plymouth or Weiser, Idaho.
- 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; physicians' 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.

Methodology (continued)

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 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 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 2016 as reported in APAC. Enrollment is calculated by taking the total member months and dividing by 12 to obtain an annual enrollment number. 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.

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.

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 incentives for providers to manage care efficiently and avoid costly complications or expensive services such as emergency department or inpatient admissions.

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 motivate 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.

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 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. 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 delivered to individuals with Medicare coverage. Payments are based on claims. Primary care spending by Medicare fee-for-service is not included in this report.

Glossary (continued)

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 2016 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: Payment to a health care provider 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 a provider and reported on a health care claim, although 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).

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, is patient-centered and oriented toward the whole person, and 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 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 "Methodology" for details).

Prominent carrier: Health insurance carrier with annual premium income 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. There were 12 prominent carriers in 2016.

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.

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.

Endnotes

1. Rhode Island Department of Health. Impact of primary care on healthcare cost and population health: A literature review. 2012 Feb. 23 [cited 2017 Jan 23] Available from: http://health.ri.gov/publications/literaturereviews/ ImpactOfPrimaryCareOnHealthcareCostAndPopulationHealth.pdf.

2. Center for Evidence-Based Policy, Oregon Health & Science University. Alternative payment methodologies in Oregon: The state of reform. 2014 [cited 2017 Jan 23] Available from: https://www.ohsu.edu/xd/research/centers- institutes/evidence-based-policy-center/upload/APM-Report-123014.pdf.

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