AMERICAN ACADEMY OF FAMILY PHYSICIANS

Primary Care Spend Toolkit

Oregon's Legislative Work on Primary Care Spend

Establishing the Primary Care Collaborative and Reporting Requirements

Oregon began its work on Primary Care Spend when the Legislature passed SB 231, which was signed into law by Governor John A. Kitzhaber, MD on June 26, 2015. The bill was filed at the request of Governor on behalf of the Oregon Health Authority. The bill passed the Senate 24-6 and the House passed an amended bill 47-4. The Senate concurred with the House amendments and passed it 22-8.

The bill defined the following:

- Carrier: an insurer that offers a health benefit plan.
- Prominent carrier: a carrier with annual premium income at a threshold established by the Department of Consumer and Business Services by rule, the Public Employees' Benefit Board (PEBB), and the Oregon Educators Benefit Board (OEBB).
- Primary care: family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.
- Primary care provider: a physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in the state, whose clinical practice is in the area of primary care. A PC provider also includes a health care team or clinic that has been certified by the Oregon Health Authority as a patient centered primary care home.

The bill required the following:
All prominent carriers were to report to the Department of Consumer and Business Services (DCBS), no by December 31, 2015, the proportion of the carrier's total medical expenses allocated to primary care. The DCBS was to share the information with the Oregon Health Authority (OHA) so that they could prepare and evaluate the report. DCBS and OHA were to adopt rules prescribing the primary care services for which costs must be reported. OHA and DCBS were to report to the Legislative Assembly the percentage of the medical expenses of carriers, coordinated care organizations, the Public Employees' Benefit Board and the Oregon Educators Benefit Board allocated to primary care and how carriers, coordinated care organizations, the Public Employees' Benefit Board and the Oregon Educators Benefit Board paid for primary care.

OHA was required to convene a Primary Care Payment Reform Collaborative to advise and assist the authority in creating a Primary Care Transformation Initiative 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. OHA was required to invite the following representatives to participate in the Primary Care Payment Reform Collaborative: primary care providers, health care consumers, experts in primary care contracting and reimbursement, independent practice associations, behavioral health treatment providers, third party administrators, employers that offer self-insured health benefit plans, the Department of Consumer and Business Services, carriers, a statewide organization for mental health professionals who provide primary care, a statewide organization for mental health professionals who provide primary care, a statewide organization representing federally qualified health centers, a statewide organization representing hospitals and health systems, a statewide professional association for family physicians, a statewide professional association for physicians, a statewide professional association for nurses, and the Centers for Medicare and Medicaid Services.

The bill also specifies the intent to exempt the Primary Care Payment Reform Collaborative participants from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine[1], for the activities essential to the calculation that might otherwise be constrained by such laws.

Primary Care Spending in Oregon: A Report to the Oregon State Legislature

In February 2016 the Oregon Health Authority and Department of Consumer Business and Services published their report Primary Care Spending in Oregon: A report to the Oregon State Legislature. It was then updated in February 2017.

The report included claims-based payments and non-claims-based payments for primary care spending.

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

To calculate percentage of total medical spending allocated to primary care, the sum of claims-based and non-claims-based payments to primary care providers was divided by the sum of total claims-based and non-claims-based payments to all providers. As the denominator, total payments include all payments for members including specialty care, mental health care hospitalizations and more, but not prescription drugs.

The report found four key takeaways:
Oregon Medicaid coordinated care organizations (CCOs) and prominent carriers spent $1.1 billion on primary care in 2015. Prominent carriers spent 9 percent of their total medical spending on primary care. Medicaid coordinated care organizations spent nearly 13 percent of their total medical spending on primary care.

On average, CCOs allocated a greater percentage of total medical spending to primary care than any other type of health care payer. On average, CCOs allocated 12.5 percent of total medical spending to primary care. By contrast, other types of payers spent an average of 10 percent or less of total medical spending to primary care. The 12.5 percent CCOs spent on primary care in 2015 is a slightly smaller percentage as compared to 13.1 percent in 2014. Prominent carriers spent slightly more on primary care, as a percent of total medical spending, in 2015 compared to 2014.

The percentage of total medical spending allocated to primary care varied substantially among payers. Spending allocated to primary care ranged from 5 percent to 30 percent among CCOs, 3 percent to 16 percent among commercial plans, 5 percent to 16 percent among PEBB and OEBB plans, and 1 percent to 19 percent among Medicare Advantage plans.

On average, non-claims-based payments comprised a greater percentage of primary care spending by CCOs than by other payer types. Non-claims-based payments are payments to a health care provider intended to incentivize efficient care delivery, reward achievement of quality or cost-savings goals, and build health care infrastructure and capacity. On average, 65 percent of primary care spending by CCOs was non-claims-based. By contrast, 39 percent of primary care spending by Medicare Advantage plans was non-claims-based. For PEBB and OEBB plans and commercial plans, non-claims-based payments comprised 7 percent and 3 percent of primary care spending, respectively. Notably, compared to 2016, the average percentage of non-claims-based spending as a share of total primary care spending increased for CCOs and prominent carriers.

Mandating Primary Care Spend

Oregon's Legislature passed SB 934 which was signed into law June 27, 2017. The bill passed in the Senate 29-0 and the House 55-0. The Senate concurred in the House amendments and repassed the bill 29-0. The bill went into effect on January 1, 2018.

[1]The state action doctrine is a legal principle that the Fourteenth Amendment applies only to state and local governments, not to private entities. Under state action doctrine, private parties outside of government do not have to comply with procedural or substantive due process under the Fourteenth Amendment.

The bill defined the following:

- Primary care: family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.
- Total medical expenditures: payments to reimburse the cost of physical and mental health care provided to enrollees, excluding prescription drugs, vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment mechanism.

The bill required the following:
The bill mandates that by January 1, 2023, spending on primary care be at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

The Department of Consumer and Business Services must establish requirements for carriers offering health benefit plans that spend less than 12 percent of total medical expenditures on payments for primary care to submit with each rate filing a plan to increase spending on payments for primary care as a percentage of total medical expenditures by at least one percent each plan year.

An insurer offering a health benefit plan that reimburses the costs of services provided by a national primary care medical home payment model, conducted by the Center for Medicare and Medicaid Innovation, that includes performance-based incentive payments for primary care, must offer similar alternative payment methodologies to reimburse the costs of services provided by patient centered primary care homes that serve beneficiaries of the health benefit plan.

The Public Employee's Benefit Board and Oregon Educators Benefit Board must spend at least 12 percent of its total medical expenditures on self-insured health benefit plans on payments for primary care. These boards must report to the Legislative Assembly on the boards' progress every year by February 1. If these boards spend less than 12 percent of total medical expenditures in self-insured health benefit plans on payments for primary care, the boards must implement a plan for increasing the percentage of total medical expenditures spend on payment for primary care by at least one percent each year.

Oregon and Primary Care Spend: What's Next

Oregon SB 934 also requires the Primary Care Transformation Initiative to do the following:

- Use value-based payment methods that are not paid on a per claim basis to:
    - Increase the investment in primary care;
    - Align primary care reimbursement by all purchasers of care; and
    - Continue to improve reimbursement methods, including by investing in the social determinants of health;
- Increase investment in primary care without increasing costs to consumers or increasing the total cost of health care;
- Provide technical assistance to clinics and payers in implementing the initiative;
- Aggregate the data from and align the metrics used in the initiative with the work of the Health Plan Quality Metrics Committee;
- Facilitate the integration of primary care behavioral and physical health care; and
- Ensure the goals of the initiative are met by December 31, 2027.

Each year the primary care payment reform collaborative must annually report to the Oregon Health Policy Board and to the Legislative Assembly on the achievement of the primary care spending targets and the implementation of the Primary Care Transformation Initiative.