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GOVERNOR

Maine Quality Forum
MEASURING TO IMPROVE

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04333-0102

Date: February 16, 2023

Submitted to: Senator Bailey, Representative Perry, and members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services
Commissioner Lambrew, Department of Health and Human Services

CC: Colleen McCarthy Reid, Principal Analyst
Bethany Beausang, Senior Policy Advisor, Office of Governor Mills
MQF Primary Care Spending Advisory Committee

Submitted by: Karynlee Harrington, Director Maine Quality Forum

RE: **Annual Primary Care Spending Report**

Public Law 2019, Chapter 244, requires the Maine Quality Forum to develop an annual report on primary care spending using claims data from the Maine Health Data Organization. Please find attached a copy of our fourth annual report.

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Executive Summary

Public Law 2019, Chapter 244, *An Act to Establish Transparency in Primary Care Health Care Spending*, requires the Maine Quality Forum (MQF) to submit an annual report on primary care spending in Maine to the Joint Standing Committee on Health Coverage, Insurance and Financial Services and the Commissioner of the Department of Health and Human Services.[1]

The Maine Quality Forum (MQF) contracts with the University of Southern Maine, Muskie School of Public Service with consultation from Judy Loren, for the technical support in the preparation of this report.

Primary Care Spending estimates reported in the first three MQF annual reports were based on analyses of claims payment data submitted by payors to the Maine Health Data Organization (MHDO) as defined in 90-590 Chapter 243, *Uniform Reporting System for Health Care Claims Data* Sets. MQF's definition of primary care is found in *Attachment C.*[2-4]

A limitation of the earlier estimates, as noted in previous reports, was that they did not include non-claims-based payments made by payors to providers (e.g., capitation payments, pay-for-performance payments, care management/care coordination/population health payments, or other prospective provider-based payments)[i] as these data were not available to MHDO. Prior estimates also did not include claims data related to substance use disorder (SUD) per the payors' interpretation of the federal requirements defined in 42 CFR Part 2 to redact SUD claims prior to submitting data to the MHDO.

In an effort to support a more comprehensive reporting of primary care spending in the State of Maine, the MHDO's Board of Directors adopted a rule that governs the submission of non-claims-based payments, 90-590 CMR Chapter 247, *Uniform Reporting System for Non-Claims Based Payments and Other Supplemental Health Care Data Sets*, which requires both non-claims and aggregated SUD claims data to be reported to MHDO annually effective October 2022.[5]

MQF's fourth annual report includes both claims-based payments and non-claims-based payments and other supplemental SUD data, which allows MQF to establish a new baseline representing a more comprehensive estimate of primary care payments in Maine. Due to differences in the granularity of claims data versus the non-claims and SUD data submitted to MHDO, we are reporting the percentage of primary care spending based on all the data available as a range.

MQF's prior annual reports presented primary care spending estimates based on a broad definition (all services provided by primary care providers) and a narrow definition (specific services provided by primary care providers) (*Attachment C*). However, because non-claims-based payments and supplemental SUD payments are largely made at the provider-level and not limited to specific services delivered by those providers, MQF's baseline estimates for our year four annual report reflect the broad definition as defined in *Attachment C*.

Key Findings:

- There is no standard definition of primary care used across states for claims and non-claims-based spending reporting.
- Using similar narrow and broad definitions as in previous MQF reports (claims-based only), the percentage that primary care payments represent of a payors' total medical payments, reported in claims for calendar year 2021, for Commercial payors is 5.8% (narrow) and 11.9% (broad), for MaineCare is 8.4% (narrow) and 12.0% (broad), and 4.9% (narrow) and 8.1% (broad) for Medicare. (*See Attachment E*, Table 6.)
- Based on calendar year 2021 claims, non-claims and supplemental SUD payment data, the percentage that primary care payments represent of a payors' total medical payments applying the broad definition

is estimated to be 12.4% for commercial payors, between 10.3-11.5% for MaineCare, and 8.1% for Medicare (claims only)*. For more details on how estimates were calculated, see *Attachment C.*

- Including non-claims-based payments and supplemental SUD data in 2021 resulted in an increase in the total dollars paid for primary care services.
- Including non-claims-based payments and supplemental SUD data in the calculation does not substantially change the percentage of primary care spending applying the broad definition for commercial payors when compared to the estimate of primary care spending when applying the same definition for claims payments only. For MaineCare, including non-claims-based payments slightly lowered the primary care spending estimates because approximately 7-8% of the non-claims-based payments reported were paid to primary care. As a result, adding non-claims and SUD to claims (in both the numerator and denominators) lowers the overall primary care % spending from 12% in claims to 10.3-11.5%. *See Attachment E*, Table 6

- Based on claims analyses for the period 2019-2021, the percent of primary care claim payments for services delivered via telehealth fell to half of what it had been in 2020 for commercial payors and Medicare but remained comparable for MaineCare.
- The percentage of primary care paid by consumers (or supplemental insurance plans) has declined as a percent of the total paid from 19.1% in 2019 to 15.7% in 2021.[3]

Requirement and Overview of Process

Public Law Chapter 244

In 2019, the Maine legislature passed Public Law 2019, Chapter 244, *An Act to Establish Transparency in Primary Care Health Care Spending* requiring the Maine Quality Forum (MQF) to submit an annual report on primary care spending to the Department of Health and Human Services and the Joint Committee of Health Coverage, Insurance and Financial Services of the Maine State legislature and the Commissioner of the Department of Health and Human Services.[1] (*Attachment A*)

Primary Care Spending in Maine: New Baseline

Part I: Total Primary Care Spending, Claims, Non-Claims and Supplemental Data

The Primary Care Spending estimates for calendar year 2021 shown in Table 1 and Chart 1 of this report reflect the percent of total payments including both claims, non-claims, and supplemental data. The estimates are based on MQF's broad definition of Primary Care (all services provided by a defined list of providers-see *Attachment D*) and an analysis of both claims data submitted by payors per the requirements in 90-590 Chapter 243, *Uniform Reporting System for Health Care Claims Data Sets*, and non-claims-based payments and supplemental data as defined in Chapter 247, *Uniform Reporting System for Non-Claims Based Payments, and Other Supplemental Health Care Data Sets.*

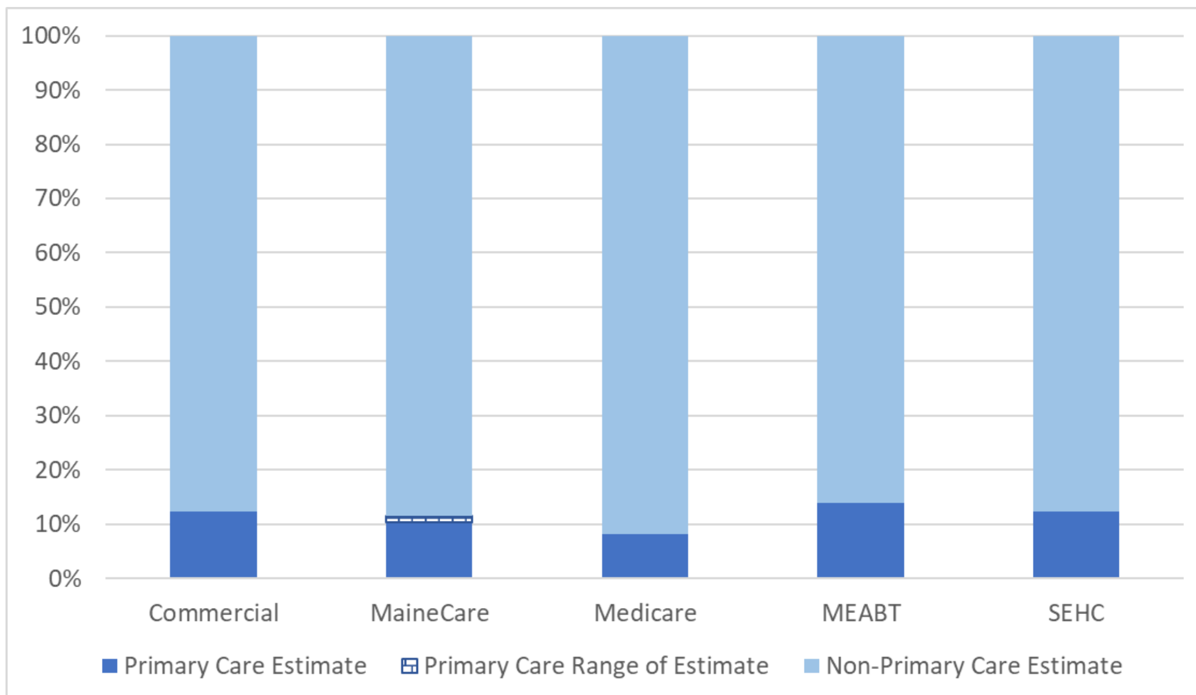
In reviewing estimates in Chart 1 and Table 1, note the following:

- Commercial/ SEHB/MEA Total SUD data reported by commercial payors per the requirements in Chapter 247 do not differentiate the portion paid to primary care and non-primary care. As such, we estimated the portion of SUD paid to primary care based on a limited claims sample and show as a range.

*Medicare includes both traditional Medicare and Medicare Advantage claims payments. Traditional Medicare is not subject to requirements in Chapter 247, thus MHDO does not have traditional Medicare non-claims and Medicare estimates are based on claims only.

- MaineCare Total non-claims and SUD data reported by MaineCare per the requirements in Chapter 247 include payments for long term services and supports (LTSS). To have comparable estimates to other payors, we removed an estimated portion of MaineCare total non-claims and SUD reported payments that may have been for LTSS, which were estimated as a range. Similar to commercial payors, we estimated the portion of SUD paid to primary care based on a limited MaineCare claims sample and show as a range. For a listing of what falls under LTSS see Attachment F Table 5.
- Medicare estimates include both traditional Medicare and Medicare Advantage payments. Traditional Medicare is not subject to Chapter 247 requirements; reported non-claims and SUD payments only reflect those reported by Medicare Advantage plans. As traditional Medicare accounts for 60% of total Medicare claims payments, Medicare estimates are based on claims only.
- Absolute $s All payments shown in Table 1 are presented in millions (M). For example, $2,500 million equals $2,500,000,000 or $2.5 billion dollars.
- Based on claims, non-claims and supplemental SUD data for calendar year 2021, the percentage that primary care payments represent of payors' total medical payments is estimated to be **12.4% for Commercial payors, 10.3-11.5% for MaineCare, and 8.1% for Medicare.**
- Total non-claims-based payments reported to MHDO for CY 2021 were $613-$689 M ($573-$649M for MaineCare, and $40M for commercial payors). We estimate that of the total non-claims-based payments, the primary care-related payments represented $22M or 55% of total non-claims payments for commercial payors and $48M or 7-8% of MaineCare's total non-claims payments. The estimate for MaineCare excludes payments for LTSS that are not generally covered by commercial payors.
- The total claims payments for substance use disorder (SUD) reported to MHDO for CY 2021 was $64M by commercial payors and $165-$186M by MaineCare (excludes estimated LTSS payments). (*Attachment C*)

Chart 1. Estimated Primary Care Percentage of Total Payments by Payor, 2021 (Broad definition)



Data Source: MHDO APCD claims data, SUD redacted data, non-claims-based payments. Claims medical spending reflects plan paid amounts.
SEHC = State Employee Health Commission
MEABT = Maine Education Association Benefits Trust
* SEHC and MEABT are reported separately as required by PL Chapter 244 and are a subset of commercially insured.

Table 1. Payor Paid Medical and Primary Care Payments and Percent Primary Care Spending (Claims, Non-Claims, SUD payments), MQF Broad Definition, CY 2021

Calendar Year 2021	Total Dollars (millions)	Primary Care (millions)	% Primary Care
Commercial			
Claims	$2,098	$249	11.9%
Non-claims	$40	$22	55.0%
SUD	$64	$1.6 - $3.2*	2.5% - 5.0%*
Total	$2,202	$273 - $274	12.4%
MaineCare			
Claims	$1,270	$153	12.0%
Non-claims	$573 - $649^	$48	7% - 8%^
SUD	$165 - $186^	$16.5 - $30*	10% - 16%^*
Total	$2,008 - $2,105	$218 - $230	10.3% - 11.5%
Medicare (Traditional and Medicare Advantage)**			
Claims	$2,942	$239	8.1%
Non-claims***	$1	$1	100.0%
SUD^^	$19	$0.1 - $0.9	2.5% - 7.5%
Total	$2,962	$240	8.1%
SEHC			
Claims	$162	$19	11.9%
Non-claims	$1	$1	98.5%
SUD	$5	$0.12 - $0.36*	2.5% - 7.5%*
Total	$168	$21	12.4%
MEABT			
Claims	$318	$42	13.3%
Non-claims	$3	$3	98.5%
SUD	$9	$0.22 - $0.64*	2.5% - 7.5%*
Total	$330	$46	14.0%

Data Source: MHDO APCD claims data, SUD redacted data, non-claims-based payments. Claims medical spending reflects plan paid amounts.

* Total SUD data reported by commercial payors and MaineCare per current Chapter 247 requirements did not include the portion paid to primary care and non-primary care. The estimated portion of SUD paid to primary care was derived based on a limited claims sample and shown as a range.

^ The total non-claims and SUD data reported by MaineCare per current Chapter 247 requirements include payments for long term services and supports (LTSS). To have estimates comparable to other payors, we removed an estimated portion of MaineCare total non-claims and SUD reported payments that may have been for LTSS. Both were estimated as a range.

**Medicare includes both traditional and Medicare Advantage claims payments. Traditional Medicare is not subject to requirements in Chapter 247, thus MHDO does not have non-claims-based payments for traditional Medicare, only for Medicare Advantage plans. As traditional Medicare accounts for 60% of total Medicare claims, Medicare total primary care estimates are based on claims only.

*** Medicare non-claims estimated ranges are based on Medicare Advantage Plan data reported to MHDO.

^^Traditional Medicare does not redact SUD, so SUD payments are included in claims total. SUD redacted claims shown are for Medicare Advantage Plans that reported to MHDO.

Standardized Definition of Primary Care

To inform modifications or improvements to Maine's definition of primary care and to align Maine's definitions with 'best practice' as per requirements in the statute, MQF annually reviews other state and national reports measuring primary care spending to compare with our methodology.

There is still no standardized definition of primary care. A 2022 report developed by Freedman Healthcare for the California Health Care Foundation to summarize state-based efforts to measure and invest in primary care in 12 states and two regional reports, revealed considerable variability in:

- Which provider specialties were defined as providing primary care (e.g., inclusion of behavioral health or OB/GYN for all or a portion of the services they provide),
- Whether other states use both a broad and narrow definition and how each of these were defined,
- When definitions are limited to specific procedures performed by primary care provider specialties, which procedures were included,
- The data sources and methods used (e.g., aggregate insurer reporting versus aggregated claims databases), and
- What was included/excluded from the total expenditure denominator (e.g. pharmacy) to measure primary care investment.[6]

This variability in definitions across states limits the ability to compare and benchmark with one another. A detailed summary table from the Freedman Healthcare report can be found in *Attachment B*.

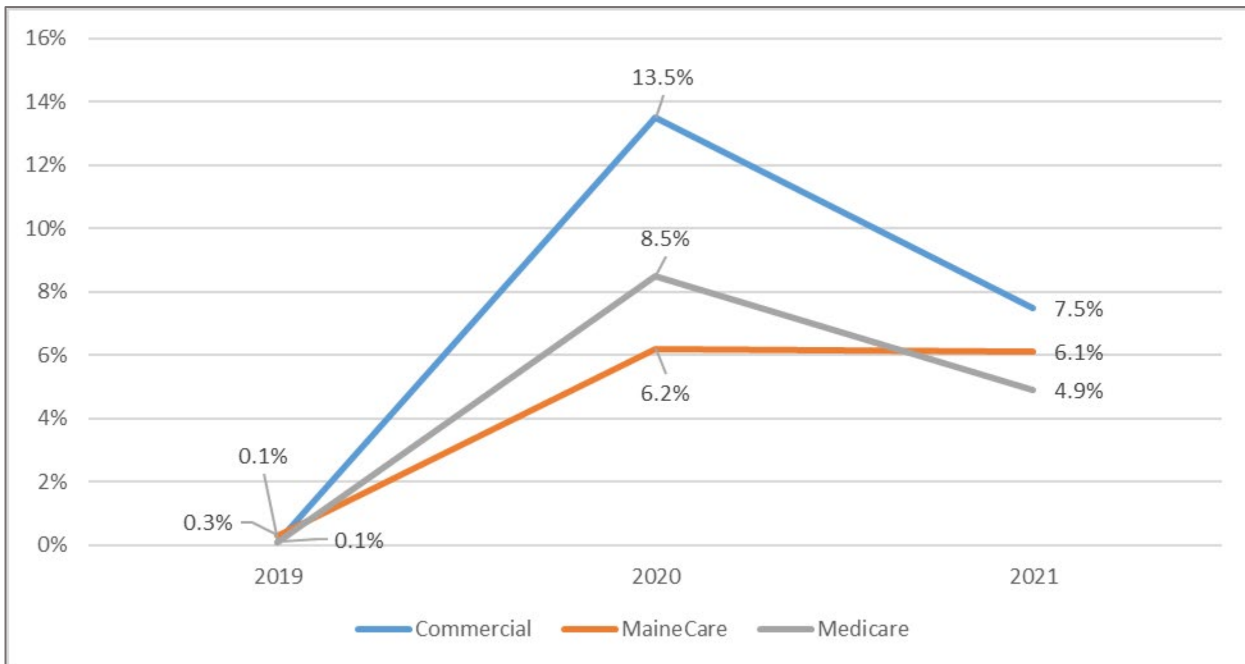
Part II: 2019-2021 Telehealth and Consumer Cost Share

Telehealth Analysis

As shown in Chart 2, prior to 2020, telehealth accounted for less than 1% of primary care payments for all payors but increased in 2020, accounting for 6.2% to 13.5% of primary care payments across payors, with commercial insurers seeing the largest increase in primary care provided via telehealth. As noted in last year's report, the increased use of telehealth was likely due to COVID-19.ii

In the claims data for calendar year 2021, the percent of primary care payments for services delivered via telehealth fell to half of what it had been in 2020 for commercial payors and Medicare but was comparable for MaineCare.

Chart 2. Telehealth as a Percent of Primary Care Paid Amount, 2019-2021



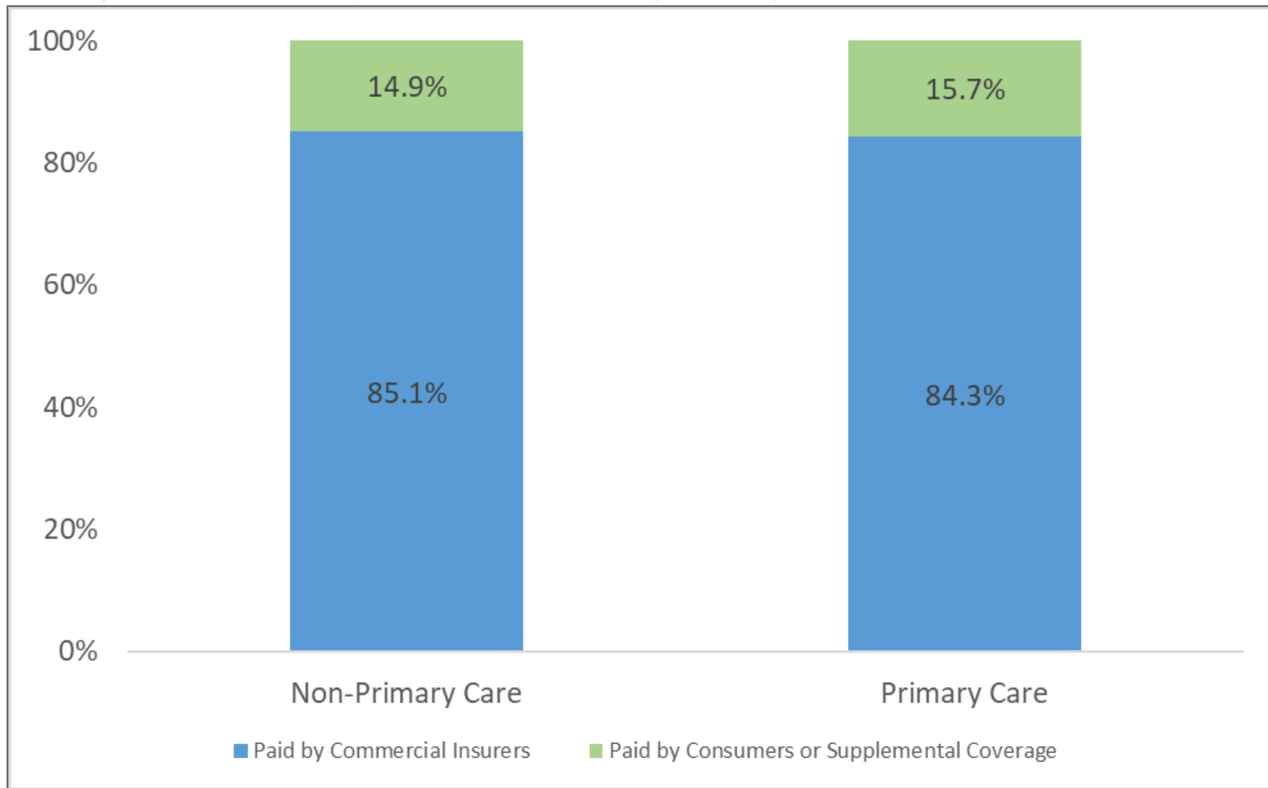
Data Source: MHDO APCD claims data; Reported medical spending reflects plan paid amounts

Commercial Payors Share and Consumer Payments for Primary Care and All Other Medical Expenditures

Chart 3 shows how payments for primary and non-primary care medical expenditures are shared between commercial plans and the consumer or the consumer's secondary coverage.

- In 2021, commercial insurance plans covered approximately 84% of the cost of primary care, with approximately 16% to be paid out-of-pocket by consumers (or their supplemental coverage).
- For all other non-primary care medical care payments, commercial payors paid approximately 85% of costs, while consumers (or their supplemental coverage) paid for the remaining 15%.
- The percentage of commercial primary care payments by consumers (or supplemental coverage plans) has declined as a percent of the total payments from 19.1% in 2019[3] to 15.7% in 2021.

Chart 3. Percentage of Total Payments Paid by Commercial Insurers and Consumers or Supplemental Coverage Plans for Primary Care and Non-Primary Care Expenditures



Data Source: MHDO APCD claims data; Reported medical spending reflects plan paid amounts

Conclusion and Future Considerations

With the adoption of 90-590 Chapter 247, *Uniform Reporting System for Non-Claims Based Payments and Other Supplemental Health Care Data Sets,* MQF has access to additional payment data from MHDO which allowed for a more comprehensive reporting of spending on primary care in Maine; and for the establishment of a new baseline estimate on primary care spending in Maine. While the absolute dollars increased for both primary care and total payments for calendar year 2021 based on the additional data from the payors, the primary care spending estimates as a percentage of total spending (the new baseline), are largely consistent with primary care estimates as a percentage of total claims spending using the broad definition reported in prior years.

As there is no standard definition of primary care nationally, for this and prior reports, MQF's definition of primary care, is based on best practice and input from our Advisory Committee. However, as noted in this report the new baseline reflects only the broad definition.

We commend MHDO on the adoption of Chapter 247 and suggest a few modifications to the rule to improve the use of this data, specifically, breaking down the total non-claims-based payments and supplemental SUD payments by primary care and behavioral health care. This additional level of granularity will eliminate the need for MQF to calculate ranges as reported above.

Lastly, to streamline this reporting process, MQF plans to explore the feasibility of developing future annual reports in an interactive Tableau report that we would post on both the MQF and MHDO's publicly accessible websites.

Attachments: Supporting Documentation

A. **Public Law Chapter 244**

B. **Overview of Primary Care Definitions Used in Other States**

C. **Methodology for Estimating Primary Care Spending**

D. **Primary Care Provider Taxonomy Codes (Broad and Narrow), Primary Care Specific Procedure Codes (Narrow), and Telehealth Codes in Primary Care Spending Analyses**

E. **Claims-Based Primary Care Spending, 2019 - 2021**

F. **Glossary**

G. **Endnotes**

Attachment A – Public Law Chapter 244

APPROVED	CHAPTER
JUNE 7, 2019	244
BY GOVERNOR	PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND NINETEEN

S.P. 421 - L.D. 1353

An Act To Establish Transparency in Primary Health Care Spending

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §6903, sub-§13-B is enacted to read:

13-B. Primary care. "Primary care" means regular check-ups, wellness and general health care provided by a provider with whom a patient has initial contact for a health issue, not including an urgent care or emergency health issue, and by whom the patient may be referred to a specialist.

Sec. 2. 24-A MRSA §6951, sub-§12 is enacted to read:

12. Primary care reporting. Beginning January 15, 2020 and annually thereafter, the forum shall submit to the Department of Health and Human Services and the joint standing committee of the Legislature having jurisdiction over health coverage and health insurance matters a report on primary care spending using claims data from the Maine Health Data Organization and information on the methods used to reimburse primary care providers requested annually from payors, as defined in Title 22, section 8702, subsection 8. The report must include:

A. Of their respective total medical expenditures, the percentage paid for primary care by commercial insurers, the MaineCare program, Medicare, the organization that administers health insurance for state employees and the Maine Education Association benefits trust and the average percentage of total medical expenditures paid for primary care across all payors; and

B. The methods used by commercial insurers, the MaineCare program, Medicare, the organization that administers health insurance for state employees and the Maine Education Association benefits trust to pay for primary care.

Sec. 3. Maine Quality Forum to conduct health spending reporting study. The Maine Quality Forum, established in the Maine Revised Statutes, Title 24-A, section 6951, shall consult with other state and national agencies and organizations to determine the best practices for reporting spending on primary care services by insurers. For

purposes of this section, "primary care" means regular check-ups, wellness and general health care provided by a health care provider with whom a patient has initial contact for a health issue, not including an urgent care or emergency health issue, and by whom the patient may be referred to a specialist.

Attachment B – Overview of Primary Care Definitions used in Other States

Overview of Primary Care Investment Definitions Sourced from California Health Care Foundation Report[6]

Appendix E. Overview of Primary Care Investment Definitions

PRIMARY CARE DEFINITION	PRACTICING		IN PROCESS							GETTING STARTED			MULTI-STATE REPORTS	
	OR	RI	CO	CT	DE	MA	MD	VT	WA	ME	UT	CA/IHA	MILBANK	NESCSO
Narrow (N), Broad (B), or No Distinction (ND)	ND	ND	ND	N, B	ND	ND	ND	ND	N, B	N, B	N, B	N, B	N, B	N, B
Most Common Provider Specialties														
➤ Family/general practice	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
➤ Internal medicine (no subspecialty)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
➤ Pediatrics (no subspecialty)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
➤ Nurse practitioner/physician assistant	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Expanded Provider Specialties														
➤ Certified clinical nurse specialist	✔		✔			✔					✔			
➤ Nurse, nonpractitioner	✔		✔			✔	✔		✔	✔	✔			
➤ Internal medicine (geriatric specialty)	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔
➤ Adolescent medicine	✔	✔	✔	✔		✔			✔	✔	✔	✔	✔	✔
➤ Obstetrician/gynecologist	✔		✔	✔		✔*		✔		✔†	✔		✔	✔
➤ Behavioral health practitioner	✔		✔			✔‡								
➤ Homeopath/naturopath	✔					✔	✔	✔	✔	✔	✔			
➤ FQHC/primary care clinic/rural health clinic practitioner	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔
➤ Other			✔	✔		✔		✔	✔			✔		✔

* In Massachusetts, services delivered by ob/gyn practitioners may be reported only for procedure codes listed in the Office Type, Preventive, and Obstetric measure categories.

† Maine only included specific primary care services/procedures provided by ob/gyn providers for both broad and narrow definitions.

‡ Massachusetts technical specifications allow for stand-alone calculations of behavioral health spend.

PRIMARY CARE DEFINITION	PRACTICING		IN PROCESS							GETTING STARTED			MULTI-STATE REPORTS	
	OR	RI	CO	CT	DE	MA	MD	VT	WA	ME	UT	CA/IHA	MILBANK	NESCSO
Services and Expenses														
➤ Office visits/preventive visits/vaccine administration	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
➤ Behavioral health	✔		✔			✔	✔	✔						
➤ Care coordination and/or management	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔
➤ Health information exchange/other infrastructure	✔	✔	✔	✔		✔		✔						✔
➤ Maternity	✔[§]		✔[§]					✔						
➤ Primary care incentive payments		✔	✔	✔	✔	✔		✔						✔
Data Source														
➤ All-payer claims database (APCD)	✔		✔	✔	✔		✔	✔	✔	✔	✔	✔		
➤ Payer submits Excel template to state	✔	✔	✔	✔	✔	✔		✔				✔	✔	✔
➤ Non-claims-based payments included	✔	✔	✔	✔	✔	✔		✔				✔		✔
Definition of Total Spending Includes														
➤ Non-claims payments	✔	✔	✔	✔	✔	✔		✔				✔		✔
➤ Prescriptions (Rx)		✔		✔		✔	✔		✔			✔	✔	

[§] Colorado and Oregon include some delivery services at 60% of payment.

Notes: For states or reports that include narrow and broad service definitions, the narrow service definition is reflected in the table. As several definitions include multiple configurations of providers, the table includes all provider specialties. Table does not include New Mexico and Pennsylvania (no primary care investment measurements). Definitions in the table were taken from the state's report, which may differ from the New England States Consortium Systems Organization (NESCSO) report. *FQHC* is Federally Qualified Health Center; *IHA* is Integrated Healthcare Association. **Vermont** stakeholders requested that the data be shown with obstetrics and mental health services included and excluded. Vermont uses a set of homegrown non-claims payment categories that support primary care in the ways identified under "Services and Expenses." **Maine** excludes dental claims and applies a factor to Medicaid medical expenditure to exclude long-term services and support (LTSS). Maine also counts insurer paid amounts, not total paid amount. Non-claims payments voluntarily reported by insurers will be included in the February 2022 Maine Quality Forum (MQF) third annual spending report. **California/IHA**: Voluntary multi-payer claims database used for fee-for-service (FFS) amounts; the only non-claims payment included in the calculation is capitation. The **Milbank Memorial Fund** offered four definitions of primary care provider, including any specialty designated by an insurer as a PCP. See Michael H. Bailit, Mark W. Friedberg, and Margaret L. Houy, ***Standardizing the Measurement of Commercial Health Plan Primary Care Spending***, Milbank Memorial Fund, July 25, 2017. **NESCSO**: ***The New England States' All-Payer Report on Primary Care Payments*** (PDF), NESCSO, December 22, 2020.

Attachment C – Methodology for Estimating Primary Care Spending

To determine the percentage of total healthcare payor payments that are for primary care in Maine, we used the Maine Health Data Organization's (MHDO) all payer claims data (APCD) for claims-based payments, and (**new this year**) Chapter 247 information collected from payors about payments made outside of claims (non-claims-based payments) as well as information about claims that were redacted before submission to the MHDO due to SUD-related codes (SUD redacted). The following describes the methods used to estimate primary care spending for these two data sources.

Primary Care Definitions: Broad (claims, non-claims, and supplemental data) and Narrow (claims based only)

As in prior MQF reports, primary care definitions are based on:

- Language in P.L. Chapter 244, Sec. 2. 24-A MRSA §6903, sub-§13-B,
- Methods and definitions used in the prior annual reports and recommendations for future reporting,
- Consultation with the MQF Primary Care Spending Advisory Committee on proposed changes to Maine's definitions.

For the first annual report, MQF sent a questionnaire to Maine's six largest insurers asking how they define primary care, whether they offer non-claims payments or incentives for primary care and whether they track these payments to inform potential future non-claims reporting to the state. We vetted other national and state definitions and those reported by Maine insurers with the MQF Primary Care Spending Advisory Committee.

Given the lack of a standard primary care definition, MQF reported a range of primary care spending estimates using narrow and broad definitions, using taxonomy codes for primary care providers and specific procedure codes for primary care services identified from the environmental scan and/or where at least one insurer identified them in its definition on the Maine insurer survey.

The provider specialties identified as primary care are the same in both definitions, excluding those delivered in an inpatient or emergency department setting as required by Chapter 244. The full list of primary care provider taxonomies can be found in *Attachment D*. For OB/GYN providers in both broad and narrow definition, the narrow definition, and for OB/GYN providers only a specific set of services provided by these provider specialties are included; whereas the broad definition includes all services provided by the provider specialties.

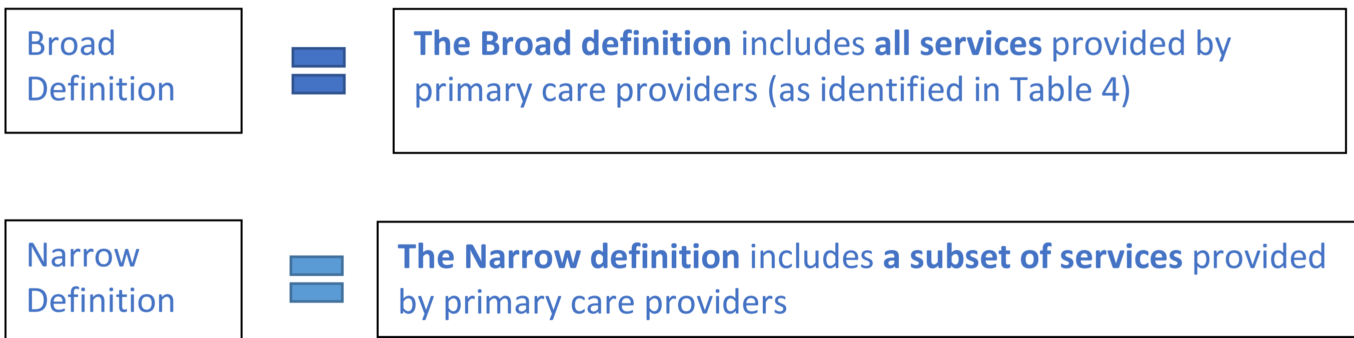


Table 4. Primary Care Providers in Both Broad and Narrow Definitions of Primary Care

Family medicine (including subspecialties of Geriatric, Adult, and Adolescent)	Physician assistants†
Internal medicine	Nurse practitioners (family, pediatrics, primary care, general medicine, adult health, gerontology)
General medicine	Federally Qualified Health Centers (FQHCs)‡
Pediatrics (including adolescent medicine)	Rural health centers
Geriatric medicine	Preventive medicine
Naturopathic/homeopathic medicine	Obstetrics and gynecology (includes NP) – **only for selected primary care services**

The list of procedure codes included in the narrow definition of primary care is essentially the same as prior years, with the addition of new COVID-19 immunization and telehealth. The complete list of primary care specific service procedure codes used to identify primary care payments using the narrow definition can be found in *Attachment D*. Generally, they include:

- Office visits (includes Medicare/Medicaid clinic visits)
- Home visits
- Preventive Visits
- Immunizations and injections
- Transitional Care Management
- Chronic Care Management
- Telehealth Services

For this report and based on the lack of a national standard definition, we used the same definitions as in the 3rd annual report for claims analyses. However, because 2021 reported non-claims-based payments and supplemental SUD payments are reported in aggregate based on payments made to primary care providers and not limited to specific services delivered by those providers, the 2021 new baseline primary care spending estimates are based on the broad definition.

For claims analyses, as in previous reports, we also separately analyzed primary care services delivered via telehealth, the percentage of consumer or supplemental payor cost share and insurer paid amount relative to total primary care and medical care claim payments, and services provided by primary care providers included in

† Some physician assistants working with specialists may be included in the primary care estimate because they could not be separately identified in claims.

‡ While other states have included behavioral health and psychiatry within their list of primary care providers, based on the guidance of the MQF Advisory Committee, behavioral health providers are not included in MQF's definition of primary care providers for the purposes of estimating primary care spending. However, due to the lack of rendering or servicing provider identification on FQHCs' claims, FQHC estimates may also include behavioral health providers integrated in the FQHC primary care practice model. Given differences in FQHC billing for MaineCare and commercial payors, we were unable to consistently separate/exclude FQHC behavioral health services from primary care services in claims.

the broad but not narrow definition. Specific codes used to identify services delivered via telehealth are included in *Attachment D*.

Understanding consumer cost-sharing is relevant in reporting total payments for primary care services. The challenge in measuring consumer cost sharing in all payer claims data is that the amount that the primary claims processor assigns to the consumer may be paid by additional benefits the consumer has, such as a supplemental plan or membership in two primary plans. This kind of overlap is likely to be particularly large for the population covered by both Medicare and MaineCare, also known as the dually eligible, where MaineCare covers most or all the members' Medicare out of pocket expenses. As entered in the APCD, the primary claim shows any amount owed to the provider that the plan does not cover as a consumer expense. Secondary processing may show those same amounts paid by another plan on a separate claim making it difficult to isolate what payments are actually paid by consumers. Since Medicare and MaineCare eligible beneficiaries are more likely to have supplemental policies, we focused our consumer cost-sharing analysis on commercial claims only.

Since the third annual primary care spending report, legislation was passed to report on Behavioral Health Spending in Maine (Public Law 2021, Ch 603).[5] The primary care spending and the behavioral health spending reports will be separate reports. Note that some services provided by a primary care provider as defined by our list of taxonomy codes and/or service codes also have a primary diagnosis of Behavioral Health and therefore will be part of both calculations. Under the broad definition of primary care, less than 5% of commercial and Medicare primary care payments had a behavioral health primary diagnosis. The overlap between primary care and behavioral health is higher for MaineCare where 13% of MaineCare primary care payments were for a behavioral health primary diagnosis.

Claims Data Source and Method

Information for calendar years 2019-2021 from Maine's APCD maintained by the MHDO was used to calculate the claims-based portion of overall Primary Care spending and for telehealth and consumer cost-share analyses.

The Maine APCD contains claims and enrollment information for commercial insurance carriers, third party administrators, pharmacy benefit managers, dental benefit administrators, MaineCare, and Medicare.[§] Only medical claims (not dental or pharmacy) were included in the total for this study.

The submission of claims data to the MHDO is governed under the terms and conditions defined in 90-590 CMR Chapter 243, Uniform Reporting System for Health Care Claims Data Sets.

As defined in 90-590 CMR Chapter 243, MHDO's APCD does not include claims information from:

- Claims processors with less than $2 million per calendar year of Maine adjusted premiums or claims processed[**];
- Claims for health care policies issued for specific diseases, accident, injury, hospital indemnity, disability, long-term care, vision [††], coverage of durable medical equipment;
- Claims related to Medicare supplemental [‡‡], and Tricare supplemental; and

[§] Medicare Advantage plans and regular fee-for-service Medicare are included.

[**] With the exception of self-funded ERISA plans which are not required to report but may voluntarily submit their data. *Gobeille v. Liberty Mutual Insurance Company*, US Supreme Court Decision that Employee Retirement Income Security Act (ERISA) standards preempt state reporting requirements.

[††] Quality review of the data has identified the submission of some of these types of plans. We have deleted these from this analysis

[‡‡] Quality review of the data has identified the submission of some of these types of plans. We have deleted these from this analysis

- Claims for workplace injuries covered by worker's compensation insurance.

The self-funded ERISA plans in Maine are exempt from the state mandate to submit information to the MHDO due to a Supreme Court ruling[§§], but many of the largest self-funded ERISA plans in the State voluntarily submit claims data to the MHDO.

Additionally, the APCD does not include information about Mainers who are uninsured or any health care that is not covered by insurance.

Maine's APCD is a large representative sample of data as it includes claims data for approximately 90% of Maine's insured population including 100% of Medicare and MaineCare claims for Maine members and approximately 70% of the commercially insured population in Maine.

This study used medical claims (CY 2019-2021), excluding dental and pharmacy claims. Additionally, for MaineCare total payments, long-term services and support (LTSS) are excluded based on an estimate of the percentage of total costs these services represent in each year. The MaineCare LTSS estimate used for this report has been modified from prior years to align with the Office of MaineCare Services (OMS) definition of long-term services and supports used in their alternative payment methodology (APM). LTSS estimates were based on payments made associated with the policy sections from the MaineCare Benefits Manual (MBM) noted in Table 5.[6]

Table 5. MaineCare LTSS Policy Sections

Section	Title
2	Adult Family Care Services
12	Consumer Directed Attendant Services
18	Home and Community-Based Services (HCBS) for Adults with Brain Injury
19	Home and Community Benefits (HCBS) for the Elderly and Adults with Disabilities
20	Home and Community Based Services (HCBS) for Adults with Other Related Conditions
21	Home and Community Benefits (HCBS) for Members with Intellectual Disabilities or Autism Spectrum Disorder
26	Day Health Services
29	Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder
40	Home Health Services
50	ICF-MR Services
67	Nursing Facility Services
96	Private Duty Nursing and Personal Care Services
97	Private Non-Medical Institution Services (PNMI) Appendix C and F
102	Rehabilitative Services

[§§] *Gobeille v. Liberty Mutual Insurance Company*, US Supreme Court Decision that Employee Retirement Income Security Act (ERISA) standards preempt state reporting requirements.

The MHDO's APCD contains information about the payor for the health care service. This information was used to categorize claims paid for the following populations: commercial (excluding Medicare Advantage); MaineCare; Medicare (including both Medicare Advantage and Fee-for-service plans). Additionally, as required by the legislation, claims for two plan sponsors were tabulated: the Maine Education Association Benefit Trust (MEABT) and the State Employee Health Commission (SEHC).

Primary Provider Identification on Claims

Medical claims contain identifiers (National Provider Identifiers (NPI)) for multiple levels of providers. To determine whether the provider of a claim met the definition of a Primary Care Provider, the billing and servicing provider NPIs s were examined to find the Individual provider and their primary taxonomy code. If both billing and servicing providers were organizations, the servicing provider was used. Once a single provider was identified for each claim, the taxonomy code (medical specialty of the provider) was determined using a copy of the National Plan and Provider Enumeration System (NPPES) database maintained in the MHDO Enclave data management system (updated 11/2021).

Primary Care provider identification relies on associating a claim with a taxonomy code from the provider taxonomy list in *Attachment D* for the rendering/servicing provider or organization on a claim. In the claims submitted to the APCD, hospital affiliated providers and FQHC/RHCs that bill on a facility claim type (UB-04) often do not provide an individual rendering/servicing provider and bill for services with only the NPI of the hospital or FQHC/RHC. While we decided to include all claims (except dental) billed by an FQHC/RHC[***], we were not able to establish a reliable mechanism for identification of primary care services for claims that specified only a hospital as the provider. Thus hospital-based primary care providers who bill under the hospital NPI with no individual rendering/servicing information provided are not included in our primary care estimates. As a result of some of these anomalies in provider billing practices on claims, primary care spending estimates may be understated.

Identification of Primary Care Services on Claims

Both professional (1500 claim form) and facility (Uniform Billing Form (UB-04)) claim types were examined to find procedure codes included in the narrow definition of primary care services.[†††] The lists of primary care taxonomy and procedure codes were identified from other state, regional and national studies, as well as the results from the state insurer questionnaires collected in prior years by MQF. Primary care services provided in hospice, nursing and custodial care facilities were also included based on the guidance of the Advisory Committee.

While some states use ICD-10 diagnosis codes to identify primary care, the lack of methodological clarity on how these are incorporated led to their <u>not</u> being included as part of the definition of Primary Care in this study.

Health care services provided in hospital inpatient, emergency departments and urgent care facilities were <u>excluded</u> from Primary Care as mandated by the legislation.

[***] All medical care provided by FQHCs, excluding dental services, was included as primary care. Therefore, Behavioral Health (BH) services provided by FQHCs are included in primary care. While we can identify the BH services from the MaineCare claims, we could not reliably identify them in the Commercial claims. For consistency, all FQHC care is included in the narrow definition of primary care.

[†††] Inclusion of facility claims allowed for the identification of facility fees associated with primary care including hospital associated providers, who use both professional and facility claims, as well as federally qualified (FQHC) and rural (RHC) health care facilities, who use only facility claims.

Identification of Telehealth Delivered Services

Claim lines associated with delivery of services via telehealth were identified using specific procedure code modifiers (GT, 95), place of service (POS) code (02) or procedure codes provided in *Attachment D*. Codes were updated from the prior report as indicated in *Attachment D*. The costs on these claim lines were attributed to telehealth delivery.

Identification of Costs

As mandated by the legislation, medical and primary care costs identified in this study include payments by insurers for claims incurred during the measurement year that meet the inclusion criteria identified above. For the insurers that provided the information, non-claims-based payments were added to their estimates.[‡‡‡] The denominator, or base for the calculation of Primary Care percentage, was the sum of plan paid amounts for all medical (not pharmacy or dental) claims used in this study (see *Data Source*, above) plus non-claims based and SUD redacted amounts.

The Primary Care amount (the numerator of the percentage calculation) is the sum of the plan paid amounts on claim lines that met the definition criteria for broad (i.e., ***all services provided by primary care providers*** *based on taxonomy codes*) and narrow (i.e., ***selected services identified as primary care*** *provided by these primary care providers*) plus the portions of non-claims (provided by the Commercial payors, estimated by us for MaineCare) and SUD redacted claims (estimated by us) that would fall into the definition of Primary Care.

We included insurer payments made for services that occurred any time during the calendar year and paid up to at least six months after the service was provided. No consideration was given to the length of time a member was covered by health insurance during the measurement year.

Non-Claims Data Source and Method

As required by Chapter 247, *Uniform Reporting System for Non-Claims Based Payments and Other Supplemental Health Care Data Sets*, payors are to report annually to MHDO the amounts paid to healthcare providers that are not included in claims submissions to the MHDO. Non-claims payments are submitted in total and by payments specific to primary care and behavioral health care providers for 2021 going forward by commercial payors and MaineCare.

For 2021 PC spending estimates we added non-claims 2021 data, which was submitted by the majority of payors (those that account for 95% of the claims-reported dollars), to claims-based primary care and total dollars to estimate total primary care spending.

Estimating primary care percent in SUD: As reported aggregated SUD redacted payments were not required to be reported separately for primary care and non-primary care in 2021, we estimated the percentage of SUD redacted claims that would also qualify as primary care based on observation of non-redacted SUD claims submitted to MHDO by commercial payors. As the percent of primary care of non-redacted SUD varied between different commercial insurers, we present a range of the lowest and highest estimates applied to total commercial aggregate redacted SUD payments. MaineCare primary care percent of SUD was based on analyses of estimates observed in a limited non-redacted claims sample.

MaineCare LTSS exclusion method: Total non-claims aggregate payments and SUD aggregated redacted claims payments reported by MaineCare include payments for LTSS (long-term services and supports), which are excluded from the denominator in the claims-based analyses. To be comparable to the claims analyses and with

[‡‡‡] MaineCare non-claims-based payments included Prospective Interim and Supplemental Payments to critical access and select general acute care hospitals. These facilities are paid on a cost settlement basis and are not reflected in the APCD claims data.

commercial PC estimates that do not include LTSS, for MaineCare we calculated Primary Care as a percent of total medical (non-LTSS) payments, excluding the estimated range of non-claims payments provided by the Office of MaineCare Services that were for LTSS. We were also able to estimate the portion of SUD-redacted payments that were LTSS based on information available in other data sources. These estimates resulted in some uncertainty in the overall percent primary care for MaineCare and thus are shown as a range.

Medicare estimates: Traditional Medicare is not subject to Chapter 247 requirements so reported non-claims and SUD payments only reflect those reported by Medicare Advantage plans, which are operated by commercial insurers and are subject to Chapter 247. Traditional Medicare does not redact SUD payments, which are included in claims. As traditional Medicare accounts for 60% of total Medicare claims, total Medicare estimates are based on claims only.

Attachment D – Primary Care Provider Taxonomy Codes (Broad and Narrow), Primary Care Specific Procedure Codes (Narrow), and Telehealth Codes in Primary Care Spending Analyses

Primary Care Provider Type Taxonomy Codes and Description Included in Broad and Narrow Definitions

Primary Care	
261QF0400X	Federally Qualified Health Center
261QP2300X	Primary Care Clinic
261QR1300X	Rural Health Clinic
261Q00000X	Clinic/Center when POS or bill type of FQHC
207Q00000X	Physician, Family Medicine
207R00000X	Physician, General Internal Medicine
175F00000X	Naturopathic Medicine
208000000X	Physician, Pediatrics
208D00000X	Physician, General Practice
363L00000X	Nurse Practitioner
363LA2200X	Nurse Practitioner, Adult Health
363LF0000X	Nurse Practitioner, Family
363LG0600X	Nurse Practitioner, Gerontology
363LP0200X	Nurse Practitioner, Pediatrics
363LP2300X	Nurse Practitioner, Primary Care
363A00000X	Physician Assistants
363AM0700X	Physician Assistants, Medical
207RG0300X	Physician, Geriatric Medicine
207QG0300X	Family Practice Geriatrics
207QA0505X	Family Practice Adult
207QA0000X	Family Practice Adolescent
175L00000X	Homeopathic Medicine
2083P0500X	Physician, Preventive Medicine
364S00000X	Certified Clinical Nurse Specialist
163W00000X	Registered Nurse, Non-Practitioner
163WG0000X	General Practice Registered Nurse
OB/GYN Codes[§§§]	
207V00000X	Physician, Obstetrics and Gynecology
207VG0400X	Physician, Gynecology
363LW0102X	Nurse Practitioner, Women's Health
363LX0001X	Nurse Practitioner, Obstetrics and Gynecology

[§§§] For OB/GYN taxonomy codes, we only included payments for primary care services listed in narrow definition.

Narrow Definition Primary Care Service Procedural Terminology (HCPCS) Codes and Description

Procedure Codes included in the Narrow Primary Care Definition	
Procedure Codes	**Description**
Immunizations and Injections	
90281	Immune Globulin
90287	Botulinum antitoxin, equine, any route
90288	Botulism immune globulin, human, for intravenous use
90291	Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use
90296	Diphtheria antitoxin, equine, any route
90371	Hepatitis B immune globulin
90375 - 90376	Rabies immune globulin
90384 - 90386	Rho(D) immune globulin
90389	Tetanus immune globulin
90393	Vaccinia immune globulin
90396	Varicella-zoster immune globulin
90399	Unlisted immune globulin
90460 - 90461	Immunization through age 18, including provider consult
90465 - 90466	Immunization administration younger than 8 years of age
90467 - 90468	Immunization administration younger than age 8 years
90471 - 90472	Immunization by injection/oral/intranasal route
90473 - 90474	Immunization administration by intranasal or oral route
90476 - 90477	Adenovirus vaccine
90581	Anthrax vaccine
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer,
90587	Dengue vaccine
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine
90621	Meningococcal recombinant lipoprotein vaccine
90625	Cholera vaccine
90630	Influenza virus vaccine
90632 - 90633	Hepatitis A vaccine, pediatric/adolescent dosage-2
90634	Hepatitis A vaccine, pediatric/adolescent dosage
90636	Hepatitis A and hepatitis B vaccine
90644	Meningococcal conjugate vaccine
90645 - 90648	Hemophilus influenza b vaccine
90649 - 90650	Human Papilloma virus (HPV) vaccine
90651	Human Papilloma virus vaccine
90653 - 90661	Influenza virus vaccine
90662	Flu
90663 - 90664	Influenza virus vaccine
90665	Lyme disease vaccine

Procedure Codes included in the Narrow Primary Care Definition	
Procedure Codes	**Description**
90666 - 90668	Influenza virus vaccine
90669 - 90670	Pneumococcal conjugate vaccine
90672 - 90674	Influenza virus vaccine
90675 - 90676	Rabies vaccine
90680 - 90681	Rotavirus vaccine
90682	Influenza virus vaccine
90685 - 90689	Influenza virus vaccine
90691	Typhoid vaccine
90696	DtaP-IPV
90697	DTaP-IPV-Hib-HepB
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine,
90700	DTaP
90701	DTP
90702	Diphtheria and tetanus toxoids (DT)
90703	Tetanus toxoid adsorbed
90704	Mumps virus vaccine
90705	Measles virus vaccine
90706	Rubella virus vaccine
90707	Measles, mumps and rubella virus vaccine (MMR)
90708	Measles and rubella virus vaccine
90710	Measles, mumps, rubella, and varicella vaccine (MMRV)
90712 - 90713	Poliovirus vaccine
90714 - 90715	Tetanus, diphtheria toxoids adsorbed
90716	Varicella virus vaccine
90717	Yellow fever vaccine
90718	Tetanus and diphtheria toxoids (Td) adsorbed
90719	Diphtheria toxoid,
90720	Diphtheria, tetanus toxoids
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib)
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV)
90725	Cholera vaccine
90727	Plague vaccine,
90732	Pneumococcal polysaccharide vaccine
90733	Meningococcal polysaccharide vaccine
90734	Meningococcal conjugate vaccine
90735	Japanese encephalitis virus vaccine
90736	Zoster (shingles) vaccine
90738	Japanese encephalitis virus vaccine,

Procedure Codes included in the Narrow Primary Care Definition	
Procedure Codes	**Description**
90739 - 90740	Hepatitis B vaccine (HepB)
90743 - 90744	Hepatitis B vaccine
90746 - 90747	Hepatitis B vaccine
90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib)
90749	Unlisted vaccine/toxoid
90750	Zoster (shingles) vaccine
90756	Influenza virus vaccine
90785	add-on code specific for psychiatric service
91300 - 91316	COVID immunization
0001A – 0004A	COVID immunization
0011A – 0013A	COVID immunization
0021A – 0022A	COVID immunization
0031A	COVID immunization
0034A	COVID immunization
0041A - 0042A	COVID immunization
0044A	COVID immunization
0051A – 0054A	COVID immunization
0064A	COVID immunization
0071A – 0074A	COVID immunization
0081A – 0083A	COVID immunization
0091A – 0094A	COVID immunization
0104A	COVID immunization
0111A – 0113A	COVID immunization
0124A	COVID immunization
0134A	COVID immunization
0144A	COVID immunization
0154A	COVID immunization
0164A	COVID immunization
Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes chemotherapy and other highly complex drug or highly complex biologic agent administration)	
96160 - 96161	Administration of health risk assessment (replaces 99420 as of 1/1/2017)
96372 - 96374	Therapeutic, prophylactic, or diagnostic injection
Non-face-to-Face Non-Physician Services	
98966 - 98968	Non-physician telephone services
98969	Online assessment, mgmt. services by non-physician
Evaluation and Management Services	
Office Visits	
99201 - 99205	Office or outpatient visit for a new patient
99211 - 99215	Office or outpatient visit for an established patient
99241 - 99245	Office or other outpatient consultations

Procedure Codes included in the Narrow Primary Care Definition	
Procedure Codes	**Description**
Home/NH Visits	
99304 - 99310	Nursing Facility Care
99315 - 99316	Nursing Facility Care
99318	Nursing Facility Care
99324 - 99328	Domiciliary or rest home Custodial Care
99334 - 99337	Domiciliary or rest home Custodial Care
99339 - 99340	Domiciliary or rest home multidisciplinary care planning
99341 - 99346	Home visit for a new patient
99347 - 99350	Home visit for an established patient
99354 - 99359	Prolonged Service Office Visit
99360	Standby service
99367	Medical team conference
G0181 – G0182	Physician or allowed practitioner supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician or allowed practitioner development and/or revision of care plans
S9110	Telemonitoring of patient in their home, including all necessary equipment, patient education and support
Preventive Visits	
96110	Developmental screen
99381 - 99385	Preventive medicine initial evaluation
99386 - 99387	Initial preventive medicine evaluation
99391 - 99397	Preventive medicine periodic reevaluation
99401 - 99404	Preventive medicine counseling and/or risk reduction intervention
99406 - 99409	Smoking and tobacco use cessation counseling visit (Alcohol/Substance Abuse Screening)
99411 - 99412	Group preventive medicine counseling and/or risk reduction intervention
99420	Administration and interpretation of health risk assessments
99429	Unlisted preventive medicine service
99441 - 99443	Telephone calls for patient mgmt.
99444	Non-face-to-face on-line Medical Evaluation
99446 - 99452	Interpersonal telephone/internet/EHR consultation
99487	Chronic Care Management
99490 - 99491	Chronic Care Management
99495 - 99496	Transitional care management service
99497 - 99498	Advance Care Planning
G0102	Prostate cancer screening; digital rectal examination
G0108 – G0109	Diabetes outpatient self-management training services
G2025	Payment for telehealth distant site service at RHC or FQHC only
G0406	Follow up inpatient consultation, 15 minutes with patient via telehealth
G0407	Follow up inpatient consultation, 25 minutes with patient via telehealth
G0408	Follow up inpatient consultation, 35 minutes with patient via telehealth

Procedure Codes included in the Narrow Primary Care Definition	
Procedure Codes	**Description**
G0472	Hepatitis C antibody screening
G0475	HIV antigen/antibody, combination assay, screening
G0476	Pap test add-on
G8420	BMI is documented within normal parameters
G8427	Med review
G8482	Influenza immunization administered or previously received
G8709	Patient prescribed antibiotic
G8711	Patient prescribed antibiotic for documented medical reason
G8730 – G8731	Pain assessment documented
G8950	BP reading documented
G9903	Patient screened for tobacco use and identified as a non-user
G9964	Patient received at least one well-child visit with a pcp during the performance period
G9965	Patient did not receive at least one well-child visit with a pcp during the performance period
G9966	Children who were screened for risk of developmental, behavioral and social delays
G9967	Children who were NOT screened for risk of developmental, behavioral and social delays
Q3014	Telehealth originating site facility fee
S0610	Annual gynecological exam, established patient
S0612	Annual gynecological exam, new patient
S0613	Annual gynecological exam; clinical breast exam without pelvic
T1014	Telehealth transmission per minute, professional services billed separately
Other Primary Care HCPCS Codes (Medicare/Medicaid)	
G0008	Administration of influenza virus vaccine
G0009	Administration of influenza virus vaccine
G0103	PSA screening
G0101	CA screen;pelvic/breast exam
G0123	Screen cerv/vag thin layer
G0145	Scr c/v cyto, thinlayer, rescr
G0151	Hhcp-serv of pt, ea 15 min
G0166	Extrnl counterpulse, per tx
G0202	Screening mammography digital
G0249	Provide inr test mater/equip
G0279	Tomosynthesis, mammo
G0283	Elec stim other than wound
G0299	Hhs/hospice of rn ea 15 min
G0399	Home sleep test/type 3 porta
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit
G0424	Pulmonary rehab w exer

Procedure Codes included in the Narrow Primary Care Definition	
Procedure Codes	**Description**
G0442	Annual alcohol screening
G0443	Brief alcohol misuse counsel
G0444	Annual depression screening
G0447	Face to face Behavioral Counseling for Obesity
G0454	Md document visit by npp
G0463	Hospital Outpatient Clinic Visit (Medicare)
G0466	FQHC Visit, new patient
G0467	FQHC Visit, established patient
G0468	FQHC Preventive visit
G0480	Drug test def 1-7 classes
G0481	Drug test def 8-14 classes
G0483	Drug test def 22+ classes
G0498	Chemo extend iv infus w/pump
G0500	Mod sedat endo service >5yrs
G8400	Pt w/dxa no results doc
G8978	Mobility current status
G8979	Mobility goal status
G9162	Lang express current status
G9163	Lang express goal status
G9197	Order for ceph
G9551	Abd imag no les, kid/livr/adr
G9557	Ct/cta/mri/a no thyr <1.0cm
G9655	Toc tool incl key elem
G9656	Pt trans from anest to pacu
G9771	Anes end, 1 temp >35.5(95.9)
G9775	Recd 2 anti-emet pre/intraop
G9968	Pt refrd 2 pvdr/spclst in pp
G9969	Pvdr rfrd pt rprt rcvd
G9970	Pvdr rfrd pt no rprt rcvd
T1015	Clinic visit, all-inclusive(FQHC)

Telehealth Codes Included in Telehealth Analysis

Procedure Codes Used in Telehealth Analysis*	Description
2 (Place of Service)	Health services are received through Telecommunications technology
FR (Modifier)	Procedure modifier
FQ (Modifier)	Procedure modifier
GT (Modifier)	Via interactive audio and video telecommunication systems
G0 (Modifier)	Procedure modifier
GQ (Modifier)	Procedure modifier
93 (Modifier)	Procedure modifier
95 (Modifier)	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
99446-99449	Interprofessional Telephone/Internet/Electronic Health Record Consultations
99451-99452	Interprofessional Telephone/Internet/Electronic Health Record Consultations
99457	QHP service; 20 minutes of Non F2F and F2F time spent in analysis and via synchronous communication with patient the findings or care plan
99458	Add-on code; full additional 20 minutes for services described in 99457
0188T-O1189T	Remote Real-Time Interactive Video-conferenced Critical Care Services
G0181	Physician or allowed practitioner supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician or allowed practitioner development and/or revision of care plans
G0182	Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more
G0406-G0408	Follow-up inpatient consultation, limited, physicians typically spend [15, 25, 35] minutes communicating with the patient via telehealth
G0425-G0427	Telehealth consultation, emergency department or initial inpatient, typically [30, 50, 70] minutes communicating with the patient via telehealth
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
G0508-G0509	Telehealth consultation, critical care
Q3014	Telehealth originating site facility fee
T1014	Telehealth transmission, per minute, professional services bill separately
G2025	Payment for a telehealth distant site service furnished by a rural health clinic (rhc) or federally qualified health center (fqhc) only
S9110	Telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month
G2010	Remote evaluation of recorded video and/or images submitted by an established patient, including interpretation with follow-up with the patient within 24 business

Procedure Codes Used in Telehealth Analysis*	Description
	hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report e/m services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
G2061-G2063	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; [5-10, 11-20, 21+] minutes
G2252	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 11–20 minutes of medical discussion
G0071	Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (rhc) or federally qualified health center (fqhc) practitioner and rhc or fqhc patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an rhc or fqhc practitioner, occurring in lieu of an office visit; rhc or fqhc only
98966-98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment
99421-99423	Online Digital Evaluation and Management Services
98970 - 98972	Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days
98980	Remote monitoring PLUS interacting with patient
98981	Addl time
99441-99443	Telephone E/M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment

*Most codes used a Modifier.

Attachment E – Claims-Based Primary Care Spending, 2019 - 2021

While non-claims and SUD aggregate payment data were only available for 2021, for claims analyses we use MHDO's All-Payer Claims Data (APCD) for calendar years 2019 through 2021.

Table 6 shows the Primary Care Spending Percent of Total by Broad and Narrow Definitions for the time-period CY 2019-2021 using definitions and methods described in *Attachment C*.

Key Findings:

On average, in 2021, Maine insurers paid approximately 5.9% of total medical payments to primary care using the narrow definition; and 10.2% of total medical payments to primary care using the broad definition, which was an increase from prior years.[****]

- As reported previously, the primary care percentage of total claims-based payments on average for all insurers remained relatively constant between 2019 and 2020 for both broad and narrow definitions of primary care, but increased in 2021, particularly for the broad definition, compared to the prior years (by 1 percentage point from 9.1-10.2%).
- For the broad definition, the 2021 increase in primary care spending rate was relatively consistent across payors but varied in the level of increase.
- Across all three years, MaineCare's primary care spending as a percent of total medical payments was consistently higher than other payors based on both narrow (7.4%-8.4%) and broad definitions (10.5-12.0%). Commercial payors had the next highest rates of primary care spending, which increased in 2021 for both narrow (5.6% to 5.8%) and broad (10.6% to 11.9%) definitions. Medicare consistently had lower primary care spending rates, potentially due to the differences in the populations they serve.

[****] Differences in primary care spending estimates between payors or over time were not tested for statistical significance for this report but will be included in future reports.

Table 6. Total Plan Paid Medical and Primary Care Payments and Percent Primary Spending by Broad and Narrow Definitions, 2019-2021

Payor		2019		2020		2021	
		Total $ (millions)	% of Total	Total $ (millions)	% of Total	Total $ (millions)	% of Total
Commercial							
TOTAL PAYMENTS		$1,925		$1,844		$2,098	
PRIMARY CARE PAYMENTS	*Broad*	$204	10.6%	$195	10.6%	$249	11.9%
	Narrow	$106	5.6%	$101	5.5%	$121	5.8%
MaineCare							
TOTAL PAYMENTS		$1,169		$1,158		$1,270	
PRIMARY CARE PAYMENTS	*Broad*	$123	10.5%	$126	10.9%	$153	12.0%
	Narrow	$86	7.4%	$87	7.5%	$107	8.4%
Medicare							
TOTAL PAYMENTS		$2,798		$2,622		$2,942	
PRIMARY CARE PAYMENTS	*Broad*	$206	7.3%	$190	7.2%	$239	8.1%
	Narrow	$133	4.8%	$116	4.4%	$146	4.9%
SEHC*							
TOTAL PAYMENTS		$161		$146		$162	
PRIMARY CARE PAYMENTS	*Broad*	$14	8.9%	$12	8.6%	$19	11.9%
	Narrow	$9	5.4%	$8	5.3%	$8	5.3%
MEABT*							
TOTAL PAYMENTS		$314		$284		$318	
PRIMARY CARE PAYMENTS	*Broad*	$29	9.2%	$26	9.1%	$42	13.3%
	Narrow	$19	6.2%	$17	6.0%	$19	5.9%
Average All Insurers							
TOTAL PAYMENTS		$5,892		$5,623		$6,310	
PRIMARY CARE PAYMENTS	*Broad*	$532	9.0%	$511	9.1%	$641	10.2%
	Narrow	$326	5.5%	$305	5.4%	$373	5.9%

Data Source: MHDO APCD claims data; Reported medical spending reflects plan paid amounts
SEHC = State Employee Health Commission
MEABT = Maine Education Association Benefits Trust
* SEHC and MEABT are reported separately as required by PL Chapter 244, but are a subset of commercially insured.

Differences between Broad and Narrow Definitions and Impact of Including OB/GYN

At the request of the MQF Advisory Committee, we assessed how including OB/GYN providers **selected primary care procedures codes** affected primary care spending estimates overall in both the broad and narrow definitions in 2019-2021. As found in prior reports, inclusion of OB/GYN providers' primary care services only accounted for a small percentage of Maine's overall estimate of primary care spending in both broad and narrow definitions and had minimal impact (>.5%) on Maine's total primary care spending estimates (Table 7)

Table 7. Primary Care as Percentage of Total Spending if OB/GYN Providers for Selected Services are Omitted vs Included, Broad and Narrow Definitions, 2021

	Commercial		MaineCare		Medicare	
Definition	**OB/GYN for selected services OMITTED**	**OB/GYN for selected services INCLUDED (Current Definitions)**	**OB/GYN for selected services OMITTED**	**OB/GYN for selected services INCLUDED (Current Definitions)**	**OB/GYN for selected services OMITTED**	**OB/GYN for selected services INCLUDED (Current Definitions)**
Broad Definition	11.5%	11.9%	12.2%	12.3%	8.1%	8.1%
Narrow Definition	5.4%	5.8%	8.6%	8.7%	4.9%	4.9%

Data Source: MHDO APCD claims data; Reported medical spending reflects plan paid amounts

Table 8 shows the top categories of procedures representing the largest portion of claims and paid amounts included in our broad definition that are not included in the narrow definition in 2021. Like prior reports:

- Injectable drugs supplied by primary care providers, not included in the narrow definition, account for 26% of the difference in the primary care paid amounts between the broad and narrow definitions.[††††]
- Other procedures delivered by and paid to primary care providers under the broad definition that were not included in the narrow definition include diagnostic procedures (17%), radiology (13%), and labs (7%).
- Laboratory tests (including venipuncture) constituted the largest proportion of primary care claim lines (48%) not included in the narrow definition.

[††††] While costs of medications dispensed by a pharmacy and paid by a prescription drug plan are excluded from our APCD claims analyses, injectable drugs and other medications administered directly by providers, often referred to as "J-codes", are paid by a medical plan and therefore are included in medical claims and costs. As noted in table 8, these costs can be substantial, both for Primary Care and for Non-Primary Care providers and may merit further discussion whether to exclude from both primary care and non-primary care medical expenditures for future analyses.

Table 8. Services Provided by Primary Care Providers Not included in Narrow Definition, 2021

Service*	% of Claims	% of the Difference in the Paid Amount	Example
Injectable drugs	9%	26%	Pembrolizumab, infusion services
Diagnostic procedures	2%	17%	Colonoscopy, endoscopy, arthroscopy
Radiology	7%	13%	Diagnostic mammography, CT abdomen
Labs, including venipuncture	48%	7%	Venipuncture, Lipid panel, comprehensive metabolic panel
DME	7%	5%	CPAP, oxygen delivery
Insertion, removal	1%	4%	Venous access device, Cardiac rhythm monitor
Cardiac evaluation	4%	3%	ECG, Echocardiography
Minor surgery	3%	4%	Destruction of benign lesion
Patient management	3%	2%	Advance care planning
Eye and ear procedures	1%	2%	Remove ear wax
PT, OT, assessment	3%	1%	Therapeutic exercises
All other procedures	14%	15%	New procedures, temporary codes
TOTAL	**100%**	**100%**	

* The categories shown reflect groupings of generally similar procedure codes. "All other" procedures reflect an aggregated total of all other procedures and associated categories representing less than 1-2% of either broadly defined primary care claims or paid amounts.
**A list of procedures included is available upon request.
Note: Some claims that are linked to Primary Care Providers include only Revenue codes, no procedure codes. They account for about 5% of the additional services.

Data Source: MHDO APCD claims data; Reported medical spending reflects plan paid amounts

Attachment F – Glossary [‡‡‡‡]

Claim: Communication from a health care provider to a health care payor 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 payor 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 payor.

Commercial health plan: Group or individual health insurance plan offered by a health insurance carrier.

Federally Qualified Health Center (FQHC): Safety net providers that primarily provide services furnished in an outpatient clinic. FQHCs include community health centers, migrant health centers, health care for the homeless, health centers, public housing primary care centers, and health center program "lookalikes." They also include outpatient health programs or facilities operated by a tribe or tribal organization or by an urban Indian organization. FQHCs are paid based on the FQHC Prospective Payment System (PPS) for medically necessary primary health services and qualified preventive health services furnished by a FQHC practitioner.

Fee for Service (FFS): A method of paying providers for covered services rendered to members. Under Maine's fee-for-service system, the provider is paid for each discrete service provided to a patient.

Healthcare Common Procedure Coding System (HCPCS): A uniform set of codes that represent health care procedures, service, supplies and products which may be provided to Medicare and Medicaid beneficiaries and to individuals enrolled in private health insurance programs. HCPCS includes two levels of codes: Level I codes consist of the AMA's CPT® codes. Level II codes are maintained by CMS and primarily include non-physician products, supplies, and procedures.

Health care payor: 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. A health care payor includes commercial and public plans such as Medicaid and Medicare.

International Statistical Classification of Diseases and Related Health Problems (ICD) 10 Codes: A uniform set of codes used to describe a disease and identify the diagnosis of a particular medical condition, so that the patient, health care provider as well as the insurance payor can better comprehend the medical condition under treatment.

Maine Education Association Benefits Trust (MEABT): A benefit plan that provides health insurance to Maine public school employees and their families.

Maine State Employee Health Commission (SEHC): Maine State Employee Health Commission ("SEHC") is a self-insured health benefit plan that covers State of Maine and University of Maine System employees and non-Medicare retirees, and their families.

MaineCare: Maine's Medicaid and Children's Health Insurance (CHIP) program. Medicaid provides low-income children, pregnant women, and parents with health insurance coverage for little or no cost. The program also covers low-income elderly and people with disabilities. Adults without children may be eligible through the non-categorical waiver, but the Maine expansion program was implemented in July 2018.

Non-claims-based payment: Non-claims-based payments are defined as payments that are for something other than a fee-for-service claim. These payments include but are not limited to Capitation Payments, Care Management/Care Coordination/ Population Health Payments, Electronic Health Records/Health Information Technology Infrastructure/Other Data Analytics Payments, Global Budget Payments, Patient-centered Medical Home Payments, Pay-for-performance Payments, Pay-for-reporting Payments, Primary Care and Behavioral

[‡‡‡‡] Definitions partially sourced from: Oregon Health Authority. Primary Care Spending in Oregon: A Report to the Oregon State Legislature. February 2019.

Health Integration Payments, Prospective Case Rate Payments, Prospective Episode-based Payments, Provider Salary Payments, Retrospective/Prospective Incentive Payments, Risk-based Payments, Shared-risk Recoupments, Shared-savings Distributions.

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 P.L. Chapter 244, we used the broad definition of all services provided by primary care providers and the narrow definition of a specific set of health care services delivered by specific types of primary care providers (see *Attachment C – Methodology for Estimating Primary Care Spending* for details).

Rural Health Clinics (RHCs): The Rural Health Clinic (RHC) program is intended to increase access to primary care services for patients in rural communities. RHCs can be public, nonprofit, or for-profit healthcare facilities. To receive certification, they must be located in rural, underserved areas. They are required to use a team approach of physicians working with non-physician providers such as nurse practitioners (NP), physician assistants (PA), and certified nurse midwives (CNM) to provide services. The clinic must be staffed at least 50% of the time with a NP, PA, or CNM. RHCs are required to provide outpatient primary care services and basic laboratory services.

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 that voluntarily submit data to the APCD are included in this report. The Maine State Employee Health Commission and Maine Education Association Benefits Trust are the two largest self-insured employers in Maine.

Supplemental plan: An additional health insurance plan that helps pay for healthcare costs that are not covered by a person's regular health insurance plan. These costs include copayments, coinsurance, and deductibles. There are many different types of supplemental health insurance, including vision, dental, hospital, accident, disability, long-term care, and Medicare supplemental plans. There are also supplemental health insurance plans for specific conditions, such as cancer, stroke, or kidney failure. Some types of supplemental health insurance may also be used to help pay for food, medicine, transportation, and other expenses related to an illness or injury.

Taxonomy Code: The Healthcare Provider Taxonomy Code Set is a hierarchical code set that consists of codes, descriptions, and definitions designed to categorize the type, classification, and/or specialization of health care providers. The Code Set consists of two sections: Individuals and Groups of Individuals, and Non-Individuals. The Code Set is a Health Insurance Portability and Accountability (HIPAA) standard code set. As such, it is the only code set that may be used in HIPAA standard transactions to report the type/classification/specialization of a health care provider when such reporting is required. Each taxonomy code is a unique alphanumeric code that enables providers to identify their specialty at the claim level.

Total Medical Payments: The total dollars paid by health care purchasers for health care services, claims-based medical payments excluding pharmacy, long-term care services and supports, and dental.

Attachment G – Endnotes

1. An Act To Establish Transparency in Primary Health Care Spending, P.L 2019, ch. 244, Sec. 1 - 3, 24-A MRSA §6903, §6951.
2. Maine Quality Forum. *Public Law Chapter 244 2020 Annual Report: Primary Care Spending in State of Maine.* Augusta, ME January 15, 2020. https://mhdo.maine.gov/_mqfdocs/MQF%20Primary%20Care%20Spending%20Report__Jan%202020.pdf.
3. Maine Quality Forum. *Public Law Chapter 244 2021 Annual Report: Primary Care Spending in State of Maine.* Augusta, ME February 26, 2021. https://mhdo.maine.gov/_mqfdocs/MQF%20Primary%20Care%20Spending%20Report_Feb%202021.pdf.
4. Maine Quality Forum. *Public Law Chapter 244 2022 Annual Report: Primary Care Spending.* Augusta, ME February 15, 2022. https://mhdo.maine.gov/_pdf/Year%203%20MQF%20Annual%20Primary%20Care%20Spending%20Report%20220215_final.pdf.
5. Maine Health Data Organization. Rule Chapter 247: Uniform Reporting System for Non-Claims-Based Payments. Adopted December 12, 2021. https://mhdo.maine.gov/_finalStatutesRules/Chapter%20247%20Non-Claims%20Data_211212.pdf.
6. Condon MJ, Koonce E, Sinha V, et al. *Investing in Primary Care: Lessons from State-Based Efforts.* Sacramento, CA: California Health Care Foundation; April 2022. https://www.chcf.org/wp-content/uploads/2022/03/InvestingPCLessonsStateBasedEfforts.pdf.
7. An Act Regarding Reporting on Spending for Behavioral Health Care Services and To Clarify Requirements for Credentialing by Health Insurance Carriers, P.L 2022, ch. 603, H.P. 874 - L.D. 1196.
8. Maine Department of Health and Human Services. Chapter 101: MaineCare Benefits Manual. Accessed December 14, 2022. https://www.maine.gov/sos/cec/rules/10/ch101.htm.

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[i] As defined in Chapter 247, Uniform Reporting System for Non-Claims-Based Payments, payments include but are not limited to Capitation Payments, Care Management/Care Coordination/ Population Health Payments, Electronic Health Records/Health Information Technology Infrastructure/Other Data Analytics Payments, Global Budget Payments, Patient-centered Medical Home Payments, Pay-for-performance Payments, Pay-for-reporting Payments, Primary Care and Behavioral Health Integration Payments, Prospective Case Rate Payments, Prospective Episode-based Payments, Provider Salary Payments, Retrospective/Prospective Incentive Payments, Risk-based Payments, Shared-risk Recoupments, Shared-savings Distributions. Substance Use Disorder (SUD) redacted payments include all payments in which an entire claim or some portion of a claim that would normally be part of the payor's medical or pharmacy claims submission to the MHDO was removed or altered prior to submission to conform to the requirements of 42 CFR Part 2.

[ii] Prior to COVID-19, Medicare and most insurers did not cover telehealth modality except in rural areas and for specific services and providers under certain conditions. MaineCare had much more comprehensive telehealth coverage but still had restrictions (e.g., in-person visit first, and audio only limits). At the start of the pandemic, Medicare and MaineCare basically extended telehealth coverage for all services, all providers, waiver consents/HIPAA requirements. Insurance rules in Maine were also modified to require commercial insurers to cover telehealth and reimburse at the same rate as in-person.