Primary Care Spending in Oregon

A report to the Oregon State Legislature

Oregon Health Authority

February 2017

Department of Consumer & Business Services

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Executive summary

Senate Bill 231 (2015) and House Bill 4017 (2016) require the Oregon Health Authority (OHA) and the Department of Consumer and Business Services (DCBS) to report on the percentage of medical spending allocated to primary care each year through 2020 by the following health care payers:

- Prominent carriers, defined as health insurance carriers with annual premium income of $200 million or more. These carriers may offer commercial or Medicare Advantage plans.
- Health insurance plans contracted by the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB)
- Medicaid coordinated care organizations (CCOs)

In addition to reporting on spending allocated to primary care, SB 231 requires OHA to convene a Primary Care Payment Reform Collaborative. The Collaborative has helped OHA develop recommendations for directing optimal resources to primary care.

This document is an OHA and DCBS report to the Legislature on medical spending allocated to primary care. It presents information about primary care spending in calendar year 2015. It excludes prescription drug claims, health care payers not covered by SB 231, and health care spending by people who pay out of pocket including people without insurance. The health care payers in this report provided health coverage for 2.4 million Oregonians, 60 percent of Oregon's population in 2015.

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

This report will help policymakers and the public assess the resources allocated to primary care in Oregon and develop proposals for improving primary care. Specifically, it will inform the work of the Primary Care Payment Reform Collaborative as it develops recommendations for assisting Oregon's primary care providers and methods for optimizing investment in primary care.

CCOs and prominent carriers captured in this report spent $1.1 billion on primary care in 2015.

Prominent carriers spent $681 million, or 9 percent of their total medical spending, on primary care. CCOs spent $458 million, or 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 allocated 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 last year, the average percentage of non-claims-based spending as a share of total primary care spending increased for CCOs and prominent carriers.

Background

Primary care is the front line of Oregon's health care system. Primary care providers deliver preventive services like flu shots and cancer screenings, respond to new patient needs and undiagnosed conditions, and identify health problems before they become serious. They help patients navigate an increasingly complex health care system, coordinate care with specialists and other providers, and maintain relationships with patients over time. Primary care providers include physicians, physicians' assistants, nurse practitioners, and naturopathic health care providers. Research indicates that availability of primary care providers is associated with improved health outcomes, including reduced mortality rates, reduced rates of low birth weight and preventable hospitalizations, and increased self-rated health status (1).

The Oregon Legislature enacted Senate Bill 231 (2015) and House Bill 4017 (2016) to provide information about primary care in Oregon and strengthen Oregon's primary care infrastructure. SB 231 and HB 4017 requires the Oregon Health Authority (OHA) and the Department of Consumer and Business Services (DCBS) to report the percentage of medical spending allocated to primary care each year through 2020 by the following health care payers:

- Prominent carriers, defined as health insurance carriers with annual premium income of $200 million or more. These carriers may offer commercial or Medicare Advantage plans.
- Health insurance plans contracted by the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB).
- Medicaid coordinated care organizations (CCOs).

In addition to reporting on spending allocated to primary care, SB 231 requires OHA to convene a Primary Care Payment Reform Collaborative. The Collaborative, which includes 49 members representing a broad range of provider, payer, and other primary care stakeholder perspectives, has met eight times since April 2016. The Collaborative recently finalized recommendations that provide concrete strategies for supporting sustainable primary care payment reform within the following areas: technical assistance, measurement, data aggregation, primary care behavioral health integration, collaborative governance, and a primary care payment model. In December 2016, the Collaborative presented these recommendations to the Oregon Health Policy Board. The Primary Care Payment Reform Collaborative will continue to convene in 2017.

OHA and DCBS made a special effort to collect complete information on primary care spending and total medical spending by the health care payers covered in SB 231. This effort ensured that the report includes the following types of payments used to pay for health care services:

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

To collect information about non-claims-based payments for this report, OHA and DCBS adopted the following Oregon Administrative Rules:

- OAR 836-053-1500 through 836-053-1510, effective October 20, 2015: These rules define prominent carriers and require carriers to report non-claims-based primary care spending and total medical spending.
- OAR 409-027-0010 through 409-027-0030, effective November 5, 2015: These rules require CCOs to report non-claims-based primary care spending and total medical spending.

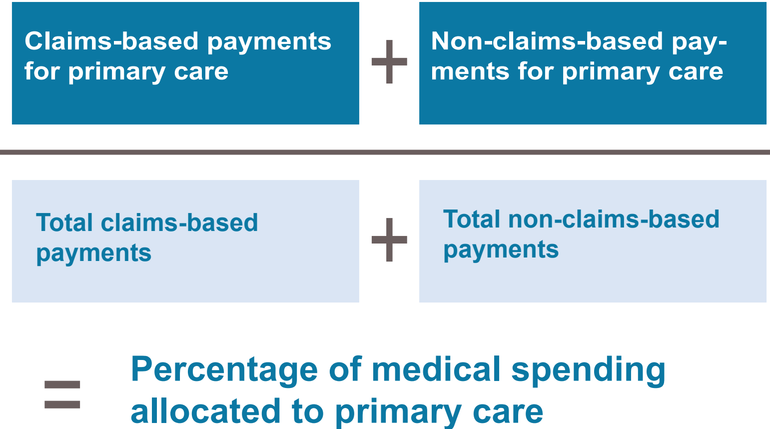
The rules define non-claims-based spending that prominent carriers and CCOs must report and include a specialized reporting template that each prominent carrier and CCO must submit to provide the information.

Primary care spending: What's included?

Consistent with the definition of primary care in SB 231, this report includes the following types of primary care spending:

1. **Claims-based payments:** Payments to primary care providers or provider organizations for primary care services rendered to health plan members. These payments are based on paid medical claims reported by health care payers. They exclude prescription drug payments.
2. **Non-claims-based payments:** 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 is divided by the sum of total claims-based and non-claims-based payments to all providers (illustrated at right). As the denominator, total payments include all payments for members including specialty care, mental health care, hospitalizations and more, but does not include prescription drugs.



Claims-based payments

Payments to primary care providers and practices:

Primary care providers

- Physicians specializing in primary care, including family medicine, general medicine, obstetrics and gynecology, pediatrics, general psychiatry, and geriatric medicine
- Naturopathic and homeopathic providers
- Physicians' assistants
- Nurse practitioners

Primary care practices

- Primary care clinics
- Federally qualified health centers (FQHCs)
- Rural health centers

For primary care services:

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

Non-claims-based payments

Payments to primary care providers and practices:

- Capitation payments and provider salaries
- Risk-based payments
- Payments for patient-centered primary care home or patient-centered medical home recognition
- Payments to reward achievement of quality or cost-savings goals
- Payments aimed at developing capacity to improve care for a defined population of patients, such as patients with chronic conditions
- Payments to help providers adopt health information technology, such as electronic health records
- Payments or expenses for supplemental staff or activities, such as practice coaches, patient educators, patient navigators or nurse care managers

Data and limitations

Health care spending information in this report was obtained from two sources:

Information about claims-based payments is from the All Payer All Claims (APAC) Database.

APAC collects information about health care claims and encounters from health insurance carriers with more than 5,000 members in Oregon, all CCOs, and all OEBB and PEBB plans. This information includes services rendered by health care providers, amounts paid to providers, and provider attributes such as specialty and practice address. APAC will begin collecting non-claims-based payments to providers in September 2017 for calendar year 2016 data.

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

Because APAC does not currently collect information about non-claims-based payments, OHA and DCBS developed a specialized reporting template to collect this information. The template requires carriers and CCOs to report non-claims-based primary care spending and total spending in six categories. In addition, it requires carriers and CCOs to report total months of enrollment for the calendar year, allowing for calculation of spending per-member per-month. Reporting requirements in the template were incorporated into Oregon Administrative Rules 836-053-1500 through 836-053-1510 and 409-027-0010 through 409-027-0030.

The following limitations should be noted when interpreting this report:

- **This report excludes primary care spending by some health care payers.** The report excludes health insurance carriers with annual premium income of less than $200 million in the calendar year, self-insured employers, Medicaid fee-for-service, Medicare fee-for-service and other federal health insurance programs. In addition, the report excludes primary care spending by people who pay out of pocket, including people without insurance.

- **Multiple factors can affect primary care spending by carriers and CCOs.** Age and health status, distance from primary care providers and other demographic factors can affect utilization of primary care and other services by health plan members. These factors, in addition to carriers' and CCOs' spending decisions, can affect spending allocated to primary care.

See page 21 for a complete list of carriers and CCOs included in this report.

See "Methodology" starting on page 24 for additional information about data collection and analysis.

Health care payers in this report

A health care payer is an organization that pays doctors, hospitals and other health care providers for care and services received by a person with health care coverage. This report provides information about primary care spending by two types of health care payers: prominent carriers and coordinated care organizations (CCOs). The report presents information separately for three types of health insurance plans offered by prominent carriers: commercial plans, Medicare Advantage plans, and PEBB and OEBB plans.

Prominent carriers

Prominent carriers are health insurance carriers that offer health plans to individuals and employers. For the purpose of reporting on spending allocated to primary care, prominent carriers were defined by temporary Oregon Administrative Rule 836-053-1505 as health insurance carriers with annual premium income of $200 million or more. According to this definition, there were ten prominent carriers in 2015.

Prominent carriers offer the following types of health plans:

- Commercial health plans: Group plans for employers and individual plans for people without employer-sponsored health insurance.
- Medicare Advantage plans: Plans where the federal Medicare program pays part of the premium. The overwhelming majority of people covered by Medicare Advantage plans are age 65 and older.
- PEBB and OEBB plans: Health plans offered to public employees and educators. The Public Employees Benefit Board and Oregon Educators Benefit Board contract with insurance companies to offer these plans.

Because commercial, Medicare Advantage, and PEBB and OEBB plans have very different benefit structures and member demographics, this report presents enrollment and spending separately for each type of plan.

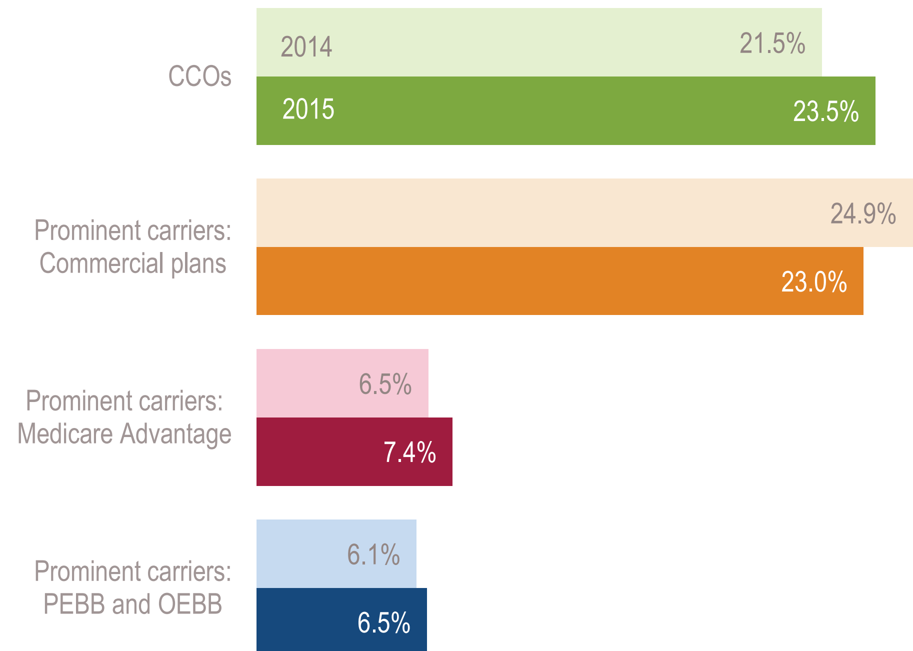
Coordinated care organizations (CCOs)

CCOs are local organizations that provide physical, mental and dental health care using global budgets that grow at a fixed rate. CCOs are accountable for the health outcomes of populations they serve. CCOs are part of Oregon's Medicaid program, which provides health coverage for Oregonians with incomes at or below 138 percent of the federal poverty level. There were 16 CCOs in 2015 (enrollment and spending for the two CCOs associated with Pacific Source Community Solutions are reported together).

See Page 21 for the complete list of carriers and CCOs included in this report.

PERCENTAGE OF OREGON'S POPULATION COVERED BY HEALTH CARE PAYERS INCLUDED IN THIS REPORT:

In 2015, prominent carriers and **CCOs** provided coverage for 2.4 million Oregonians, or 60 percent of Oregon's population.*



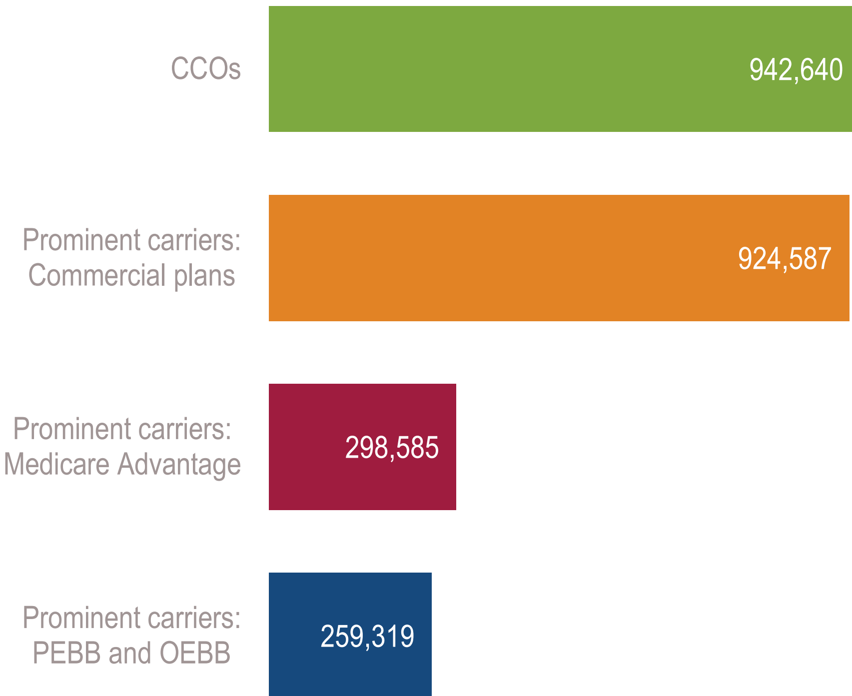
*Oregon's estimated population was 4,013,845 as of July 1, 2015. Population Research Center, Portland State University.

Enrollment and total primary care spending

The graphs on this page show enrollment and total primary care spending by prominent carriers and CCOs in calendar year 2015. Enrollment is reported as the average number of unique people enrolled in a given month. On the right are total primary care spending and total spending broken out by payer category.

MONTHLY ENROLLMENT:

In any given month of 2015, an average of 942,640 Oregonians were enrolled in **CCOs.** In the same year, 1.5 million Oregonians were enrolled in **commercial**, **Medicare Advantage**, and **PEBB and OEBB** plans offered by prominent carriers.



TOTAL PRIMARY CARE SPENDING IN 2015:

CCOs, commercial plans, Medicare Advantage plans, and PEBB and OEBB plans **spent more than $1 billion on primary care** out of $10.9 billion of total spending.

CCOs

Primary care spending:
$458 million
Total spending:
$3.7 billion

Commercial

Primary care spending:
$363 million
Total spending:
$3.6 billion

Medicare Advantage

Primary care spending:
$235 million
Total spending:
$2.6 billion

PEBB and OEBB

Primary care spending:
$82 million
Total spending:
$1.0 billion

Total primary care spending excludes commercial spending by UnitedHealthcare Insurance Company's Medicare and commercial lines of business as well as UnitedHealthcare of Oregon's commercial line of business due to lack of data reliability. Data for Kaiser Foundation Health Plan of the Northwest are based solely on non-claims-based spending and exclude claims-based data.

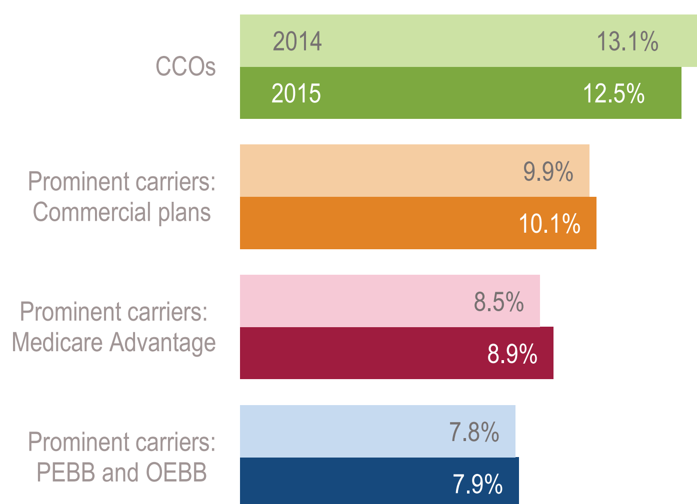
Primary care spending: Percentage of total medical spending and per-member per-month (PMPM)

The graphs on this page show two measures of medical spending allocated to primary care by prominent carriers and CCOs in calendar years 2014 and 2015, represented by ligher and darker shades of the same color:

- **Percentage of total medical spending allocated to primary care.** This measure allows for comparison of spending allocated to primary care as a share of total medical spending, regardless of total dollars spent.
- **Per-member per-month (PMPM) primary care spending compared with PMPM non-primary care spending.** This measure represents the average amount paid to health care providers in a month for each member with coverage. Total PMPM spending is defined as (primary care spending + non-primary care spending) ÷ total months of enrollment in the calendar year. It allows for comparison of dollars per person spent on primary care and other types of care. On the below graph at right, the colored part of each bar shows PMPM primary care spending and the gray part of each bar shows PMPM non-primary-care spending. The lighter colored bars and lighter gray bars reflect last year's data for comparison. The graph is sorted by highest to lowest PMPM primary care spending in 2015.

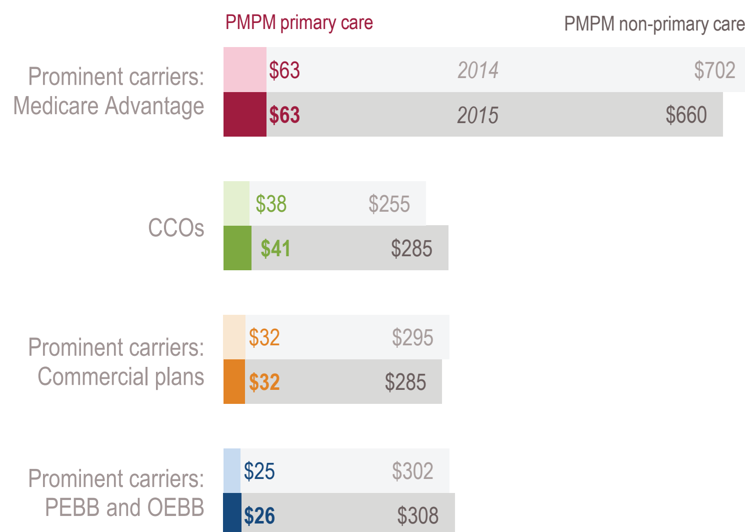
PERCENTAGE OF TOTAL MEDICAL SPENDING ALLOCATED TO PRIMARY CARE:

In 2015, **CCOs** allocated an average of nearly 13 percent of total medical spending to primary care, which is slightly less than last year. **Commercial, Medicare Advantage,** and **PEBB and OEBB** plans allocated an average of 10 percent or less of total medical spending to primary care, a slight increase from last year.



PER-MEMBER PER-MONTH (PMPM) PRIMARY CARE SPENDING:

In 2015, PMPM primary care spending ranged from $26 for **PEBB and OEBB** plans to $63 for **Medicare Advantage** plans on average. Non-primary care spending ranged from $285 PMPM for **commercial** and **CCOs** to $660 PMPM for Medicare Advantage plans on average.



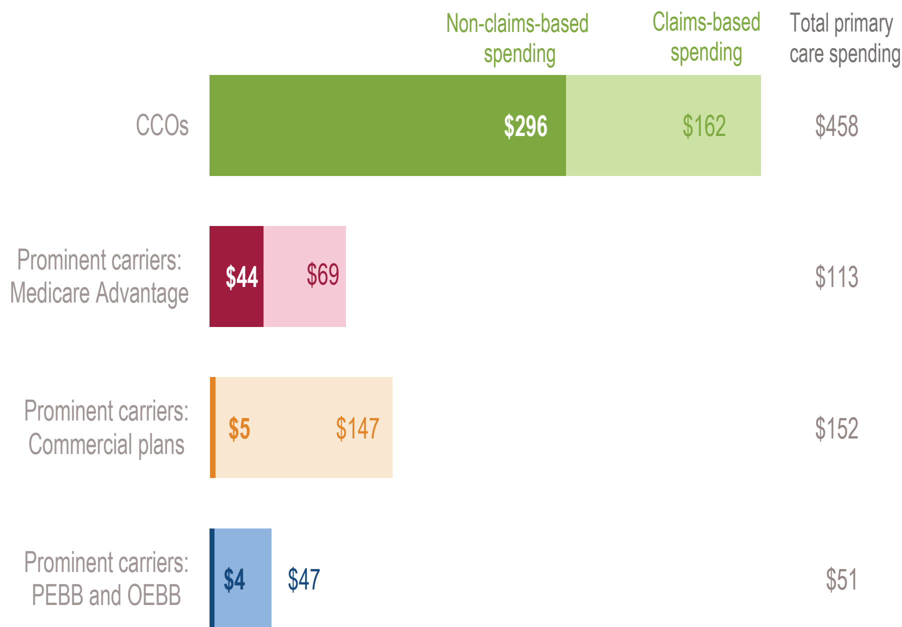
Total primary care spending excludes commercial spending by UnitedHealthcare Insurance Company's Medicare and commercial lines of business as well as UnitedHealthcare of Oregon's commercial line of business due to lack of data reliability. Data for Kaiser Foundation Health Plan of the Northwest are based solely on non-claims-based spending and exclude claims-based data.

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

The graphs on this page show claims-based and non-claims-based primary care spending in dollars and percentages of total primary care spending. Non-claims-based payments are payments to health care providers intended to incentivize efficient care delivery, reward achievement of quality or cost-savings goals, and build primary care infrastructure and capacity. In the graph at left, the dark part of each bar shows non-claims-based primary care spending and the light part of each bar shows total claims-based primary care spending. The graph at right shows non-claims-based primary care spending as a proportion of total primary care spending for both 2014 and 2015.

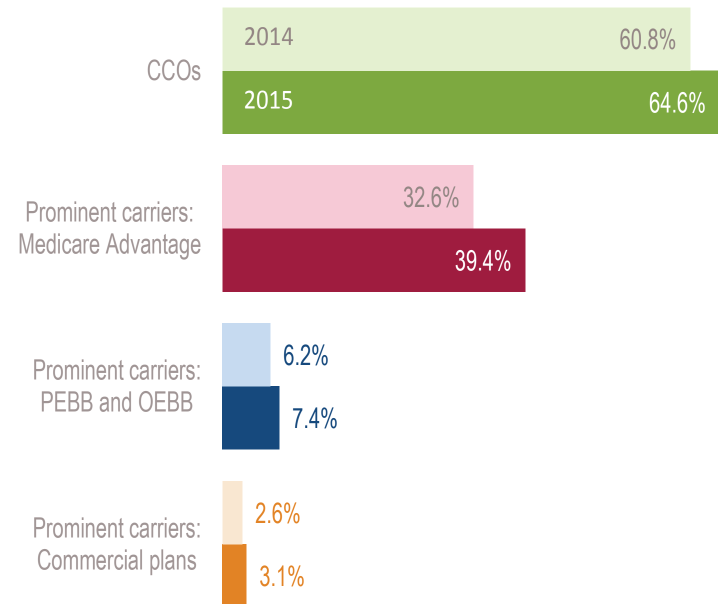
TOTAL CLAIMS-BASED AND NON-CLAIMS-BASED PRIMARY CARE SPENDING ($ MILLION):

In 2015, **CCOs** spent $296 million on primary care through non-claims-based payments. **Commercial**, **Medicare Advantage**, and **PEBB and OEBB** plans spent $53 million on primary care through non-claims-based payments.



NON-CLAIMS-BASED SPENDING AS A PERCENTAGE OF TOTAL PRIMARY CARE SPENDING:

In 2015, nearly 65 percent of primary care spending by **CCOs** was non-claims-based, up from 61 percent last year. More than 39 percent of spending by **Medicare Advantage** plans was non-claims-based.



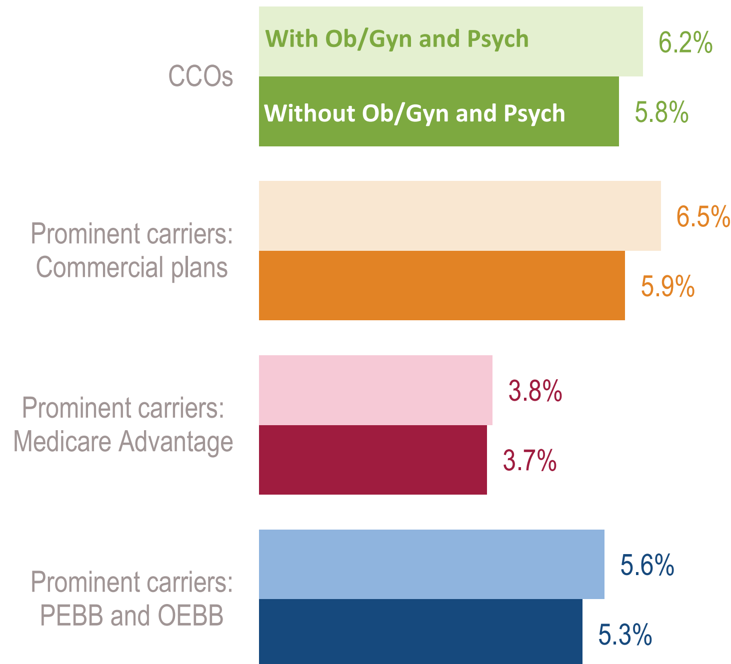
Total primary care spending excludes commercial spending by UnitedHealthcare Insurance Company's Medicare and commercial lines of business as well as UnitedHealthcare of Oregon's commercial line of business due to lack of data reliability. Data for Kaiser Foundation Health Plan of the Northwest are excluded from these graphs because all spending is non-claims-based.

Primary care spending: Excluding obstetric, gynecologic and psychiatric care

As mandated by SB 231, the definition of primary care used in this report includes obstetric, gynecologic and general psychiatric care related to primary care. The data below show how much claims-based primary care spending is associated with these services. Payers were not required to submit non-claims-based spending by provider type for this report; therefore non-claims-based data are not included.

CLAIMS-BASED PRIMARY CARE WITH AND WITHOUT CERTAIN SERVICES:

In 2015, expenditures for obstetric, gynecologic, and general psychiatric care ranged from 0.1 to 0.6 percentage points of primary care. **Commercial** plans had the biggest share of these services and **Medicare Advantage** plans had the smallest share.



Excludes Kaiser Foundation Health Plan of the Northwest because its primary care spending is based on non-claims reports, not claims-based data. The "with Ob/Gyn and Psych" percentages reflect only claims-based primary care spending and thus do not match other data presented in this report that reflect primary care spending as a combination of both claims-based and non-claims-based spending.

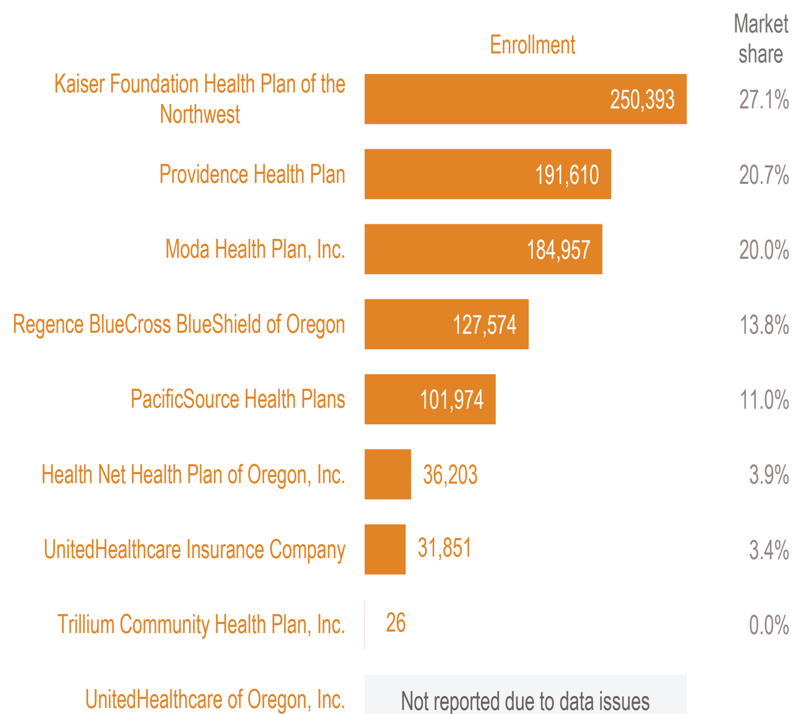
Commercial plans: Enrollment and primary care spending

The graph on the left shows the number of people enrolled in commercial plans offered by prominent carriers. Enrollment is reported as the number of total member months in 2015 divided by 12. The graph on the right shows per-member per-month primary care spending for each commercial plan offered by prominent carriers.

In addition to commercial plans, prominent carriers offer Medicare Advantage and PEBB and OEBB plans. Enrollment in Medicare Advantage and PEBB and OEBB plans is reported separately and not included in the graphs on this page.

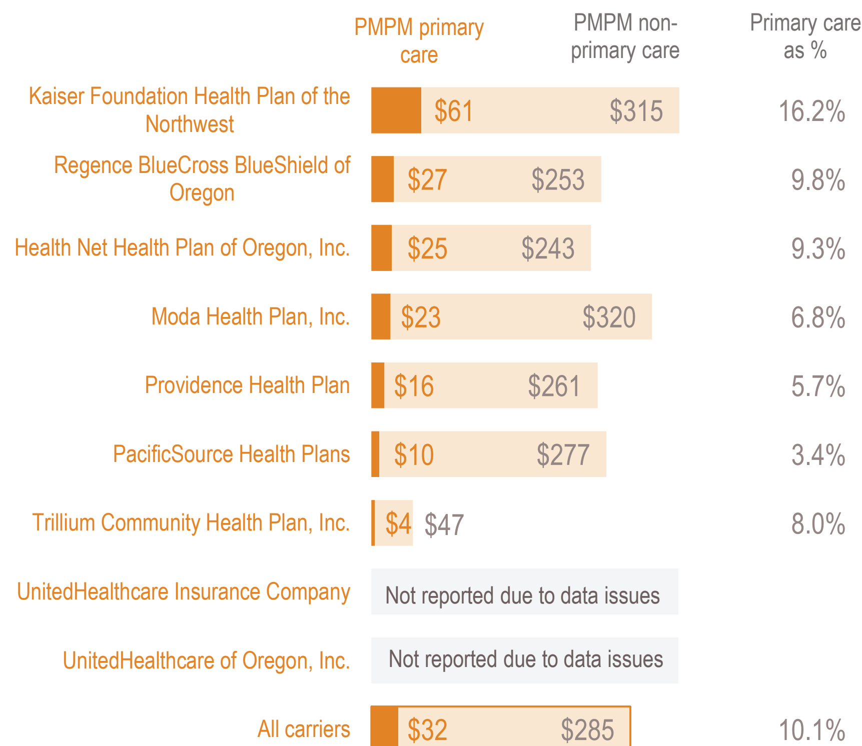
NUMBER OF PEOPLE ENROLLED:

In 2015, an average of 924,587 people per month were enrolled in **commercial** plans offered by prominent carriers. More than two-thirds of these individuals were enrolled in commercial plans offered by the three largest prominent carriers.



PER-MEMBER PER-MONTH (PMPM) PRIMARY CARE SPENDING:

In 2015, the average PMPM primary care spending for **commercial** plans was $32. The plans' spending ranged from $4 PMPM to $61 PMPM.



These data exclude commercial spending by UnitedHealthcare Insurance Company's commercial line of business as well as UnitedHealthcare of Oregon's commercial line of business due to lack of data reliability. Data for Kaiser Foundation Health Plan of the Northwest are based solely on non-claims-based spending and exclude claims-based data.

Medicare Advantage plans: Enrollment and primary care spending

The below graph on the left shows the number of people enrolled in Medicare Advantage plans offered by prominent carriers. Enrollment is reported as the number of total member months in 2015 divided by 12. The graph on the right shows per-member per-month primary care spending for each Medicare Advantage plan offered by prominent carriers. In addition to Medicare Advantage plans, prominent carriers offer commercial and PEBB and OEBB plans. Enrollment in commercial and PEBB and OEBB plans offered by prominent carriers is reported separately and not included in the graphs on this page.

NUMBER OF PEOPLE ENROLLED:

In 2015, an average of 298,585 people per month were enrolled in **Medicare Advantage** plans offered by prominent carriers. The three largest prominent carriers enrolled more than half of all Medicare Advantage enrollees reflected in this report.

	Enrollment	Market share
Health Net Health Plan of Oregon, Inc.	58,890	19.7%
Kaiser Foundation Health Plan of the Northwest	57,510	19.3%
Regence BlueCross BlueShield of Oregon	55,807	18.7%
Providence Health Plan	44,567	14.9%
UnitedHealthcare of Oregon, Inc.	24,732	8.3%
PacificSource Health Plans	15,867	5.3%
UnitedHealthcare Insurance Company	12,825	4.3%
Moda Health Plan, Inc.	12,639	4.2%
Health Plan of Care Oregon, Inc.	11,561	3.9%
Trillium Community Health Plan, Inc.	4,187	1.4%

PER-MEMBER PER-MONTH (PMPM) PRIMARY CARE SPENDING:

In 2015, the average PMPM primary care spending for **Medicare Advantage** plans was $63. The plans' spending ranged from $10 to $180.

	PMPM primary care	PMPM non-primary care	Primary care as %
Kaiser Foundation Health Plan of the Northwest	$180	$938	16.1%
UnitedHealthcare of Oregon, Inc.	$119	$524	18.5%
Providence Health Plan	$35	$723	4.7%
Regence BlueCross BlueShield of Oregon	$33	$666	4.7%
Health Net Health Plan of Oregon, Inc.	$32	$579	5.3%
PacificSource Health Plans	$29	$609	4.6%
Health Plan of Care Oregon, Inc.	$29	$889	3.1%
Moda Health Plan, Inc.	$22	$601	3.5%
Trillium Community Health Plan, Inc.	$10	$886	1.1%
UnitedHealthcare Insurance Company	Not reported due to data issues		
All carriers	$63	$660	8.9%

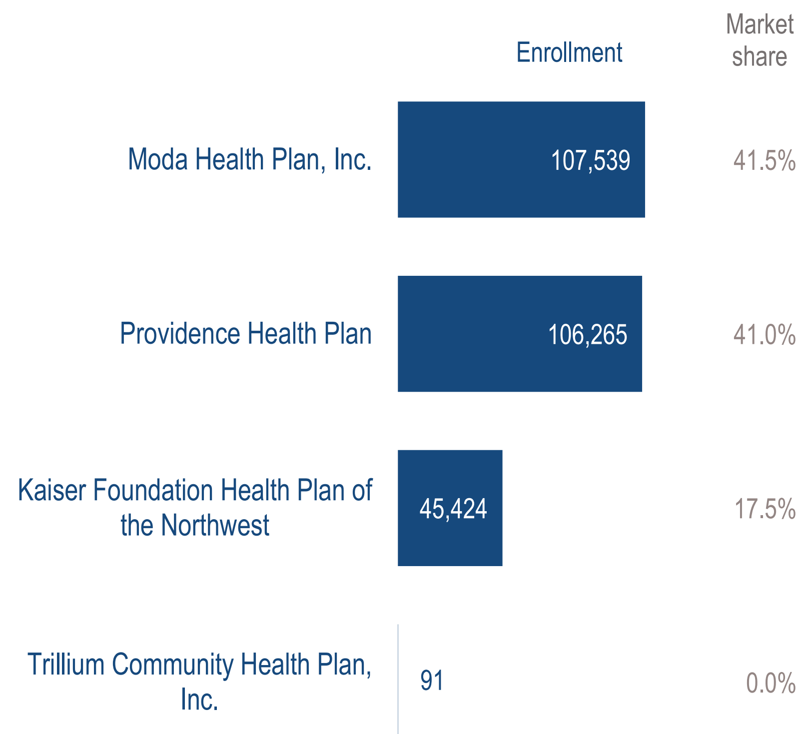
See page 21 for a complete list of carriers included in this report and page 24 for the methodology.

PEBB and OEBB plans: Enrollment and primary care spending

The below graph on the left shows the number of people enrolled in PEBB and OEBB plans offered by prominent carriers. Enrollment is reported as number of total member months in 2015 divided by 12. The graph on the right shows per-member per-month primary care spending for each PEBB and OEBB plan offered by prominent carriers.
In addition to PEBB and OEBB plans, prominent carriers offer commercial and Medicare Advantage plans. Enrollment in commercial and Medicare Advantage plans offered by prominent carriers is reported separately and not included in the graphs on this page.

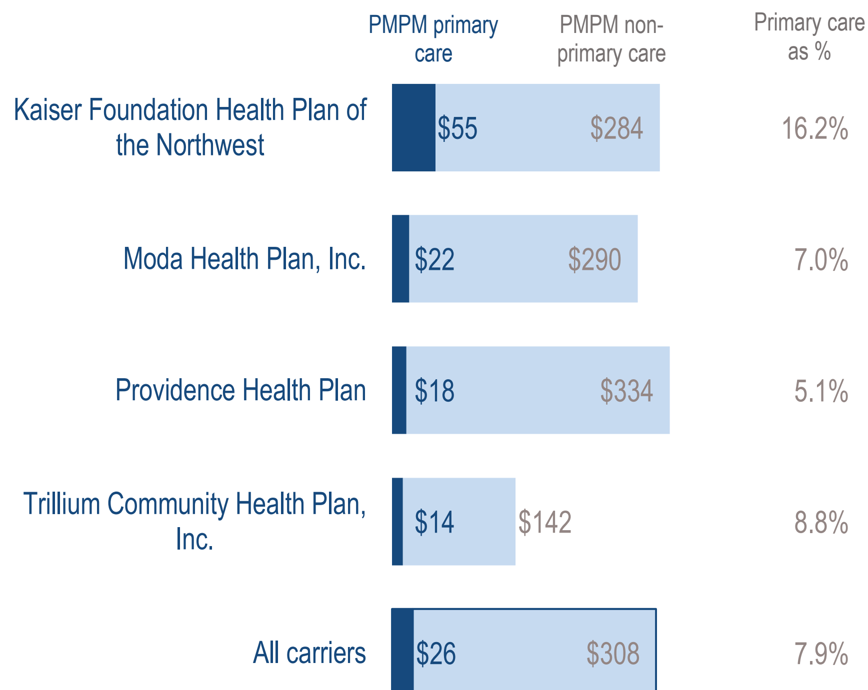
NUMBER OF PEOPLE ENROLLED:

In 2015, an average of 259,319 people per month were enrolled in **PEBB and OEBB** plans offered by prominent carriers. More than 82 percent of PEBB and OEBB enrollees are enrolled in Moda Health Plan, Inc. and Providence Health Plan.



PER-MEMBER PER-MONTH (PMPM) PRIMARY CARE SPENDING:

In 2015, the average PMPM primary care spending for **PEBB and OEBB** plans was $26. The plans' spending ranged from $14 to $55.



See page 21 for a complete list of carriers included in this report and page 24 for the methodology.

Coordinated care organizations: Enrollment and primary care spending

The below graph on the left shows the number of people enrolled in CCOs. Enrollment is reported as the number of total member months in 2015 divided by 12. The graph on the right shows per-member per-month primary care spending for each CCO.

NUMBER OF PEOPLE ENROLLED:

In 2015, an average of 942,640 people per month were enrolled in **CCOs**. The three largest CCOs cover nearly half of all enrollees.

	Enrollment	Market share
Health Share of Oregon	241,551	25.6%
FamilyCare Health Plans, Inc	125,996	13.4%
Willamette Valley Community Health, LLC	101,343	10.8%
Trillium Community Health Plan, Inc.	92,841	9.8%
PacificSource Health Plans	66,678	7.1%
IHN-CCO	57,242	6.1%
AllCare CCO, Inc.	50,533	5.4%
Eastern Oregon CCO	48,178	5.1%
Jackson County Care Connect	30,709	3.3%
Columbia Pacific CCO, LLC	27,165	2.9%
Umpqua Health Alliance	26,633	2.8%
Yamhill Community Care Organization	23,775	2.5%
Western Oregon Advanced Health	20,879	2.2%
Cascade Health Alliance, LLC	17,398	1.8%
PrimaryHealth of Josephine County	11,720	1.2%

PER-MEMBER PER-MONTH (PMPM) PRIMARY CARE SPENDING:

In 2015, the average PMPM primary care spending for **CCOs** was $41. CCO spending ranged from $19 to $111.

	PMPM primary care	PMPM non-primary care	Primary care as %
PrimaryHealth of Josephine County	$111	$258	30.0%
Willamette Valley Community Health, LLC	$64	$272	18.8%
Western Oregon Advanced Health	$58	$250	18.4%
FamilyCare Health Plans, Inc	$57	$188	22.8%
Cascade Health Alliance, LLC	$56	$252	17.6%
Umpqua Health Alliance	$44	$262	14.2%
Jackson County Care Connect	$42	$257	13.7%
Trillium Community Health Plan, Inc.	$38	$283	11.9%
IHN-CCO	$37	$332	9.9%
PacificSource Health Plans	$35	$216	14.0%
Yamhill Community Care Organization	$34	$276	10.7%
AllCare CCO, Inc.	$33	$233	12.3%
Eastern Oregon CCO	$32	$307	9.3%
Health Share of Oregon	$28	$363	7.1%
Columbia Pacific CCO, LLC	$19	$323	5.4%
All CCOs	$41	$285	12.5%

There are 16 CCOs, two of which are operated by PacificSource Health Plans: PacificSource Community Solutions in Central Oregon and in the Columbia Gorge. These two CCOs are combined for this report. See page 21 for a complete list of carriers included in this report and page 24 for the methodology.

Primary care spending: A closer look at non-claims-based spending

Overview

This section provides detailed information about non-claims-based payments for primary care in 2015. It reports the number of carriers and CCOs that made any of seven types of non-claims-based payments and shows each type of non-claims-based primary care payment as a percentage of carriers' and CCOs' total non-claims-based primary care spending. Findings are reported separately for commercial health plans, Medicare Advantage plans, PEBB and OEBB plans, and CCOs.

Key findings

All CCOs reported non-claims-based primary care spending, whereas five commercial carriers reported non-claims-based primary care spending.*

Additionally, nine Medicare Advantage plans and two PEBB and OEBB plans reported non-claims-based primary care spending.*

Of the CCOs and prominent carriers that reported non-claims-based primary care spending, the most prevalent payment types were:

- Among CCOs, capitation and retrospective incentives
- Among commercial plans, patient-centered medical home payments and retrospective incentives
- Among Medicare Advantage plans, retrospective incentives, capitation and supplemental workforce payments
- Among PEBB or OEBB plans, retrospective incentives, supplemental workforce payments and patient-centered medical home payments

*Excluding Kaiser Foundation Health Plan of the Northwest because all of Kaiser's spending is considered non-claims-based.

Of the CCOs and prominent carriers that reported non-claims-based primary care spending:

Nearly all CCOs and prominent carriers offering commercial and PEBB and OEBB plans made retrospective incentive payments.

Fourteen CCOs, four commercial plans, and both PEBB and OEBB plans made retrospective incentive payments to reward primary care providers for achieving quality or cost savings. Additionally, 14 CCOs and half of the prominent carriers offering Medicare Advantage plans made capitation and provider salary payments.

The majority of CCOs and prominent carriers offering commercial and PEBB and OEBB plans made payments to clinics for recognition as patient-centered medical homes (PCMHs).

Ten CCOs, four commercial plans, and both PEBB and OEBB plans made non-claims-based payments to primary care clinics for recognition as PCMHs. Three prominent carriers offering Medicare Advantage plans made payments for PCMHs.

Some CCOs and prominent carriers made non-claims-based payments to improve primary care infrastructure or capacity.

Seven CCOs made supplemental workforce payments and prospective incentive payments, but only two CCOs made payments to help providers adopt health information technology (HIT). Only two prominent carriers offering commercial plans and two prominent carriers offering PEBB and OEBB plans made supplemental workforce payments.

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

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

The adopted administrative rules (836-053-1500 to 836-053-1510) can be viewed here: http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_836/836_053.html.

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

Non-claims-based spending: Payments to incentivize efficiency or quality

This page shows, out of those that submitted non-claims-based data, the number of CCOs and prominent carriers that made capitation or provider salary payments, risk-based payments and retrospective incentive payments for primary care in calendar year 2015. In addition, it shows each type of payment as a percentage of total non-claims-based primary care spending by CCOs and prominent carriers that made each type of payment. Payers are ordered by number of Oregonians with coverage in 2015.

Capitation or provider salary payments

Number of payers with this type of payment for primary care in 2015:

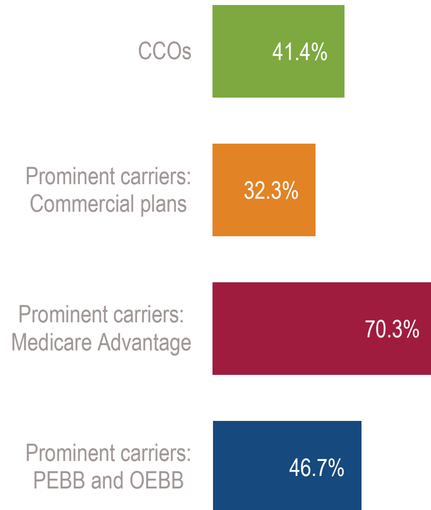
14 of 15 CCOs

1 of 5 prominent carriers with commercial plans

4 of 9 prominent carriers with Medicare Advantage plans

1 of 2 prominent carriers with PEBB or OEBB plans

Percentage of total non-claims-based primary care spending in 2015:



Risk-based payments

Number of payers with this type of payment for primary care in 2015:

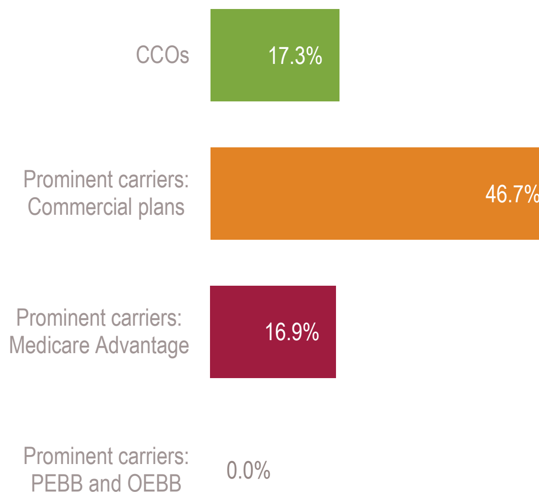
9 of 15 CCOs

2 of 5 prominent carriers with commercial plans

2 of 9 prominent carriers with Medicare Advantage plans

0 of 2 prominent carriers with PEBB or OEBB plans

Percentage of total non-claims-based primary care spending in 2015:



Retrospective incentive payments

Number of payers with this type of payment for primary care in 2015:

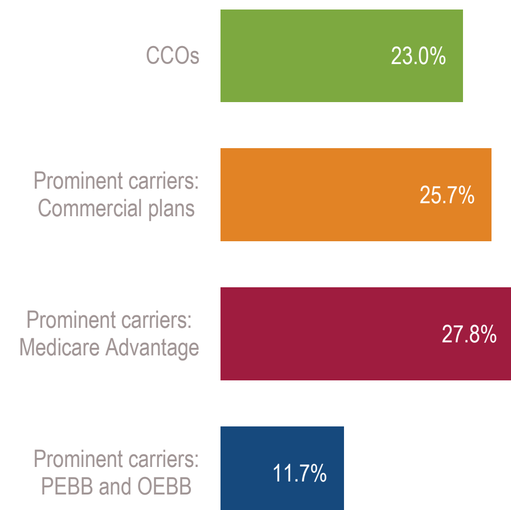
14 of 15 CCOs

4 of 5 prominent carriers with commercial plans

5 of 9 prominent carriers with Medicare Advantage plans

2 of 2 prominent carriers with PEBB or OEBB plans

Percentage of total non-claims-based primary care spending in 2015:



Data from Kaiser Foundation Health Plan of the Northwest are excluded from the non-claims-based spending charts because all of Kaiser's spending is considered non-claims-based. There are 16 CCOs, two of which are operated by PacificSource Health Plans: PacificSource Community Solutions in Central Oregon and in the Columbia Gorge. These two CCOs are combined for this report.

Non-claims-based spending: Payments for patient-centered medical home recognition

A patient-centered medical home (PCMH) is a primary care clinic that is recognized by an outside entity for providing good primary care. PCMHs include patient-centered primary care homes (PCPCHs) recognized by OHA's PCPCH Program and PCMHs recognized by other medical home programs.

This page shows the number of CCOs and prominent carriers that made any PCMH recognition payments, PCPCH recognition payments and other PCMH recognition payment in calendar year 2015. In addition, it shows PCMH recognition payments as a percentage of non-claims-based primary care spending by CCOs and prominent carriers that made a PCMH recognition payment. A payer may make both types of PCMH recognition payments, meaning that the sum of payers that made PCPCH payments and other PCMH payments may be larger than the number that made any kind of PCMH payment. Payers are ordered by number of Oregonians with coverage in 2015.

Any PCMH recognition payment

Number of payers with this type of payment for primary care in 2015:

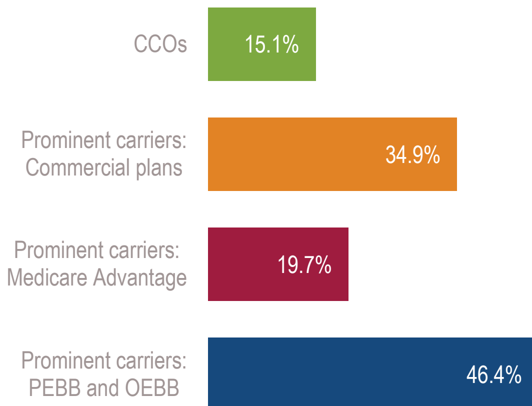
10 of 15 CCOs

4 of 5 prominent carriers with commercial plans

3 of 9 prominent carriers with Medicare Advantage plans

2 of 2 prominent carriers with PEBB or OEBB plans

Percentage of total non-claims-based primary care spending in 2015:



PCPCH recognition payments

Number of payers with this type of payment for primary care in 2015:

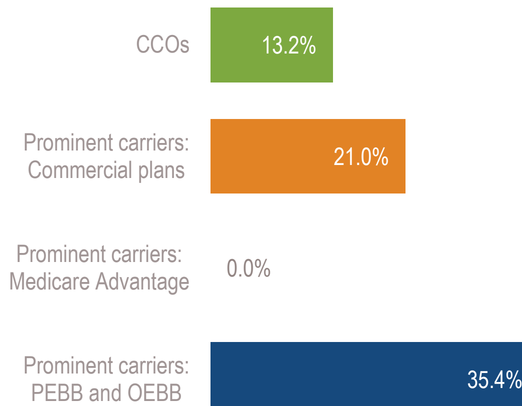
9 of 15 CCOs

1 of 5 prominent carriers with commercial plans

0 of 9 prominent carriers with Medicare Advantage plans

2 of 2 prominent carriers with PEBB or OEBB plans

Percentage of total non-claims-based primary care spending in 2015:



Other PCMH recognition payments

Number of payers with this type of payment for primary care in 2015:

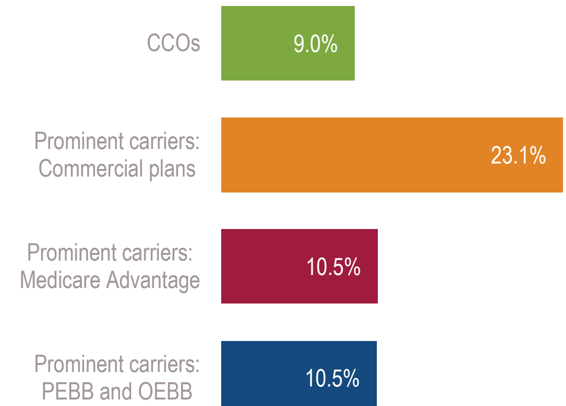
2 of 15 CCOs

3 of 5 prominent carriers with commercial plans

3 of 9 prominent carriers with Medicare Advantage plans

1 of 2 prominent carriers with PEBB or OEBB plans

Percentage of total non-claims-based primary care spending in 2015:



Data from Kaiser Foundation Health Plan of the Northwest are excluded from the non-claims-based spending charts because all of Kaiser's spending is considered non-claims-based. There are 16 CCOs, two of which are operated by PacificSource Health Plans: PacificSource Community Solutions in Central Oregon and in the Columbia Gorge. These two CCOs are combined for this report.

Non-claims-based spending: Payments to improve provider infrastructure and capacity

This page shows the number of CCOs and prominent carriers that made prospective incentive payments to improve care for a defined population of patients; payments to help providers adopt health information technology (HIT); and payments for supplemental staff and activities. In addition, it shows each type of payment as a percentage of total primary care spending by CCOs and prominent carriers that made each type of payment. Payers are ordered by number of Oregonians with coverage in 2015.

Prospective incentive payments

Number of payers with this type of payment for primary care in 2015:

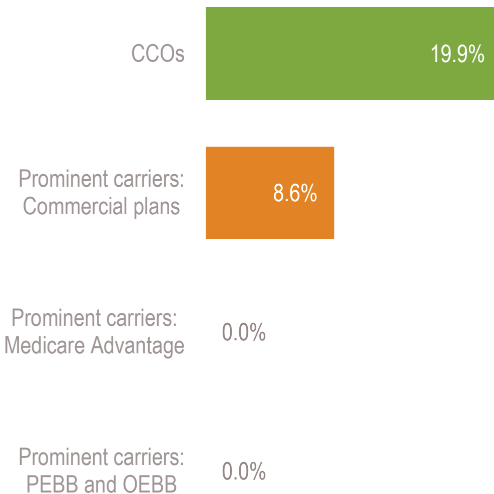
7 of 15 CCOs

1 of 5 prominent carriers with commercial plans

0 of 5 prominent carriers with Medicare Advantage plans

0 of 2 prominent carriers with PEBB or OEBB plans

Percentage of total non-claims-based primary care spending in 2015:



HIT payments

Number of payers with this type of payment for primary care in 2015:

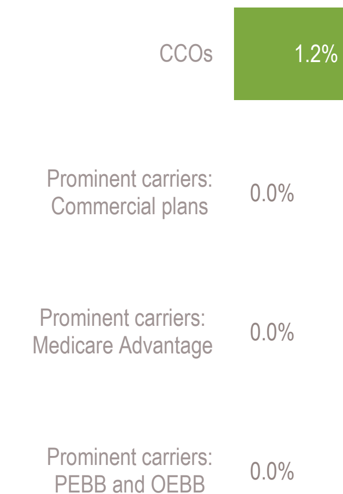
2 of 15 CCOs

0 of 5 prominent carriers with commercial plans

0 of 5 prominent carriers with Medicare Advantage plans

0 of 2 prominent carriers with PEBB or OEBB plans

Percentage of total non-claims-based primary care spending in 2015:



Supplemental workforce payments

Number of payers with this type of payment for primary care in 2015:

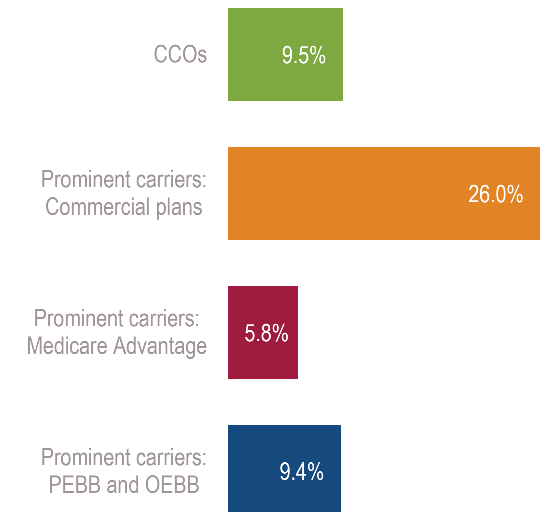
7 of 15 CCOs

2 of 5 prominent carriers with commercial plans

4 of 5 prominent carriers with Medicare Advantage plans

2 of 2 prominent carriers with PEBB or OEBB plans

Percentage of total non-claims-based primary care spending in 2015:



Data from Kaiser Foundation Health Plan of the Northwest are excluded from the non-claims-based spending charts because all of Kaiser's spending is considered non-claims-based. There are 16 CCOs, two of which are operated by PacificSource Health Plans: PacificSource Community Solutions in Central Oregon and in the Columbia Gorge. These two CCOs are combined for this report.

Prominent carriers and CCOs in this report

Prominent carriers

- Health Net Health Plan of Oregon, Inc.
- Kaiser Foundation Health Plan of the Northwest
- Moda Health Plan, Inc.
- PacificSource Health Plan
- Providence Health Plan
- Regence BlueCross BlueShield of Oregon
- Trillium Community Health Plan, Inc.
- UnitedHealthcare Insurance Company
- UnitedHealthcare of Oregon, Inc.

See “Methodology” (pages 24-26) for additional information about data collection and analysis.

CCOs

- AllCare Health Plan
- Cascade Health Alliance
- Columbia Pacific CCO
- Eastern Oregon CCO
- FamilyCare
- HealthShare
- Intercommunity Health Network
- Jackson Care Connect
- Pacific Source Community Solutions
- PrimaryHealth of Josephine County
- Trillium Community Health Plan
- Umpqua Health Alliance
- Western Oregon Advanced Health
- Willamette Valley Community Health
- Yamhill Community Care Organization

Glossary

Capitation payment: Single payment to a health care provider to provide health care services needed by a health plan member over a defined period of time. Services covered by capitation payments may be broad, such as all outpatient and inpatient services, or narrow, such as primary care or mental health only. Capitation payments are a type of non-claims-based payment. They provide financial incentives for providers to manage care efficiently and avoid costly complications or expensive services such as emergency department or inpatient admissions (2).

Claim: Communication from a health care provider to a health care payer requesting payment for services rendered by the provider. A claim includes information about the patient's diagnoses, the procedures performed by the provider, the amount the payer and patient will pay for the service under a health insurance plan, and in the case of a paid claim, the amount paid by the payer.

Claims-based payment: Payment to a health care provider for a specific service or set of services rendered by the provider and documented on a health care claim. Also known as fee-for-service. Claims-based payment systems may incentivize providers to bill health care payers for a high volume of services rather than providing efficient care.

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

Coordinated care organization (CCO): Local organization that provides physical, mental and dental health care using a global budget that grows at a fixed rate. CCOs are accountable for the health outcomes of populations they serve. CCOs are part of Oregon's Medicaid program, which provides health coverage for low-income Oregonians.

Health care payer: Health insurance plan or health coverage program that pays doctors, hospitals and other health care providers for care and services received by a person with health care coverage. Health care payers include commercial health insurance plans, Medicare Advantage plans, and PEBB and OEBB plans offered by health insurance carriers; CCOs that provide and pay for care for Medicaid members; and public programs such as Medicaid fee-for-service, Medicare fee-for-service, and other state and federal programs that pay claims for members.

Medicaid: Health coverage for low-income Oregonians. Medicaid coverage includes coordinated care organizations (CCOs), other Medicaid managed care, and Medicaid fee for service (FFS). Medicaid is funded by a mix of state and federal resources. Since 2014, Oregonians with incomes at or below 138 percent of the federal poverty level have been Medicaid-eligible, and the waiting list for the Medicaid program has been eliminated.

Medicaid fee-for-service: Health care payer that pays claims for Medicaid members not enrolled in CCOs or other Medicaid managed care. Under Medicaid fee-for-service, the state Medicaid program pays health care providers directly. Primary care spending by Medicaid fee-for-service is not included in this report.

Medicare Advantage: Health insurance plans offered by health insurance carriers where the federal Medicare program pays part of the premium. Also known as Medicare Part C. The overwhelming majority of people in Medicare Advantage are age 65 and older.

Medicare fee-for-service: Health care payer that pays claims for Medicare members not enrolled in Medicare Advantage. Under Medicare fee-for-service, the federal Medicare program pays health care providers directly. Primary care spending by Medicare fee-for-service is not included in this report.

Member months: Total number of months within a given calendar year that the enrolled members of a health insurance plan have health coverage. For example, if one member was enrolled in a plan for all 12 months of 2015 and another member was enrolled for only 10 months, total member months equal 22. To provide a standard measure of spending across types of coverage or insurance plans, total spending is often divided by member months in order to report per-member per-month (PMPM) spending.

Non-claims-based payment: Payment to a health care provider intended to incentivize efficient care delivery, reward achievement of quality or cost-savings goals, and build health care infrastructure and capacity. Non-claims-based payments are not payments for specific services rendered by a provider and reported on a health care claim, although they may be awarded based on information reported on claims. Oregon Administrative Rules 836-053-1500 through 836-053-1510 and 409-027-0010 through 409-027-0030 define seven types of non-claims-based payments for purposes of reporting on medical spending allocated to primary care under Senate Bill 231 (2015).

Glossary

Patient-centered medical home (PCMH): Health care clinic that is accountable for the large majority of each patient's physical and mental health care needs, is patient-centered and oriented toward the whole person, and that coordinates care with specialists, hospitals and other elements of the broader health care system. PCMHs include patient-centered primary care homes and clinics recognized by other primary care initiatives.

Patient-centered primary care home (PCPCH): Health care clinic recognized by the Oregon Health Authority for its commitment to providing high quality, patient-centered care. A PCPCH must meet quality measures in six core attributes to receive recognition.

Per-member per-month (PMPM): Spending on care for members of a health plan divided by member months. Dividing spending by member months provides a comparable measure of spending across health plans and payers, regardless of the number of members enrolled.

Primary care: Health care that includes general exams and assessments, preventive care, and care coordination. Primary care providers respond to new patient needs and undiagnosed conditions, help patients navigate the health system, and maintain relationships over time. For purposes of reporting on medical spending allocated to primary care under SB 231 and HB 4017, primary care is defined as a specific set of health care services delivered by specific types of health care providers and practices (see "Methodology" for details).

Prominent carrier: Health insurance carrier with annual premium income of $200 million or more. Prominent carriers were defined by Oregon Administrative Rules 836-053-1500 through 836-053-1510 for purposes of reporting on medical spending allocated to primary care under SB 231. There were nine prominent carriers in 2015.

Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB): Boards that contract with private health insurance companies to provide health insurance plans for educators and public employees, and contribute the employer share of premiums for covered employees. OEBB and PEBB became part of OHA in 2009.

Risk-based payments: A payment received by a health care provider that may be reduced if costs exceed a defined target. In a risk-based payment system, providers may pay a penalty or share in the costs exceeding the target (2).

Self-insured employer: Employer that sets aside funds to pay for health care expenses of employees rather than buying a group health insurance plan offered by a private insurance company. Primary care spending by self-insured employers is not included in this report.

Methodology

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

Medical and primary care spending in this report are calculated from claims-based and non-claims-based payments to health care providers and provider organizations.

Claims-based payments

This includes payments to health care providers and provider organizations reported on health care claims. Total medical spending and primary care spending from claims-based payments were identified using information about the rendering provider and the service rendered on the claim (see below for details).

Information about claims-based payments was obtained from OHA's All Payer All Claims Reporting Program (APAC). APAC collects information about health care claims and encounters from all health care payers covered by SB 231 and HB 4017, including prominent carriers, CCOs, and PEBB and OEBB plans. In addition to this information, APAC collects information from Medicaid fee-for-service and Medicare fee-for-service programs, which are not covered by SB 231. APAC does not collect information from carriers with fewer than 5,000 members in Oregon, self-insured employers, some types of commercial health plans, and some types of public health care coverage. In addition, APAC does not collect information about health care received by people who pay out of pocket, including people without insurance.

Non-claims-based payments

These payments go to health care providers and provider organizations to incentivize efficient care delivery, reward achievement of quality or cost-savings goals and build health care capacity. Non-claims-based payments are separate from payments made using claims, although some types of non-claims-based payments may be based on analysis of claims data (for example, payments to reward providers for achieving quality or cost-savings based on quality measures calculated from claims data).

Information about non-claims-based payments are from a specialized reporting template completed by carriers and CCOs. The template instructed carriers and CCOs to report total health care spending and primary care spending in the following categories as defined by Oregon Administrative Rules 836-053-1500 through 836-053-1510 and 409-027-0010 through 409-027-0030:

- Capitation payments and provider salaries
- Risk-based payments
- Payments to patient-centered primary care homes or other patient-centered medical homes
- Payments to reward achievement of performance goals, such as quality or cost-savings goals
- Payments to help providers adopt health information technology
- Payments for workforce expenditures, such as practice coaches, patient educators, patient navigators or nurse care managers

Carriers and CCOs were instructed to report spending on the template for services implemented or incurred in calendar year 2015. Consistent with criteria used to identify total medical spending and primary care spending from claims-based payments, the template instructed carriers and CCOs to include behavioral health expenditures provided at the primary care clinic level and exclude dental spending.

In addition to non-claims-based spending, carriers and CCOs were required to report total months of enrollment in 2015, allowing for calculation of non-claims-based spending per-member per-month. Carriers were also instructed to report non-claims-based spending and enrollment separately for commercial, Medicare Advantage, and PEBB and OEBB plans.

Limitations

Prominent carriers and CCOs vary in organizational size, composition of network providers, and unique arrangements. These differences may impact the results presented in this report.

At the request of Kaiser Foundation Health Plan of the Northwest, this report excludes Kaiser's claims-based data because the non-claims-based data capture all spending.

Data from UnitedHealthcare Insurance Company's commercial and Medicare Advantage plans were unreliable and not used in this report.

Data from UnitedHealthcare of Oregon's commercial plan was unreliable and not used in this report.

What's not included in this report?

This report includes total health care spending and primary care spending by commercial, Medicare Advantage, and PEBB and OEBB plans offered by prominent carriers and by CCOs. As of 2015, these entities provided coverage for 2.4 million Oregonians, 60 percent of Oregon's population. The report excludes spending by the following health care payers:

- Health insurance carriers with annual premium income of less than $200 million in 2015
- Self-insured employers
- Medicare fee-for-service
- Medicaid fee-for-service
- TRICARE
- Veterans Administration
- Indian Health Service

In addition, the report excludes information about health care received by people who pay out of pocket, including people without insurance.

Identifying total medical spending and primary care spending from claims-based payments

Total medical spending: Claims meeting the following criteria were used to calculate total medical spending.

- The claim was for medical services rendered in calendar year 2015. Prescription drug claims were excluded.
- The service was rendered by a health care provider or provider organization with a practice address in Oregon or one of the following border areas: Longview, Vancouver or Walla Walla, Washington.
- The claim was not denied by a health care payer.

Spending was calculated as the sum of dollars paid to the health care provider by the carrier or CCO. Dollars paid to the provider by the patient in the form of a copay, coinsurance or deductible were excluded.

Primary care spending: Primary care spending is a subset of total medical spending. To calculate primary care spending, claims meeting the following criteria were selected from claims used to calculate total medical spending:

- The provider or provider organization that rendered the service was a primary care provider. A list of provider taxonomy codes used to identify primary care providers was established through review of SB 231, the National Uniform Claim Committee's Health Care Provider Taxonomy code set, and the Health Cost Guidelines code set, which is used to identify primary care claims in APAC. The complete list of taxonomy codes is available from OHA upon request.

  The following types of individual providers were included in the code list: physicians specializing in child and adolescent psychiatry, family medicine, general medicine, general psychiatry, geriatric medicine, obstetrics and gynecology, pediatrics, or preventive medicine; nurse practitioners, nurse non-practitioners, certified clinical nurse specialists, physicians' assistants, and homeopathic and naturopathic medicine providers.

  The following types of provider organizations were included in the code list: primary care clinics, federally qualified health centers (FQHCs) and rural health centers.

- The claim was for a primary care service. A list of Current Procedural Terminology (CPT) codes used to identify primary care providers was established through review of CPT codes and the National Committee on Quality Assurance's Healthcare Effectiveness Data and Information Set, and through consultation with OHA's Actuarial Services Unit and Oregon Health & Science University's Center for Health Systems Effectiveness. The complete list of CPT codes is available from OHA upon request.

  The following types of services were included: office or home visits, general medical exams, routine medical and child health exams, preventive medicine evaluation or counseling, administration and interpretation of health risk assessments, routine obstetric care excluding delivery (60 percent of payment amount reported on claims is included to represent non-delivery services), immunization, and other preventive medicine.

Claims were grouped by carrier and CCO to report each carrier's and CCO's

primary care spending as a percentage of total medical spending. For carriers, claims were further grouped by commercial, Medicare Advantage, and PEBB and OEBB to report results separately for each type of coverage.

Calculating total medical spending and primary care spending by payer type and payer

To calculate total medical spending and primary care spending by prominent carriers and CCOs, claims-based payments from APAC and non-claims-based payments from the specialized reporting template were summed. For prominent carriers, payments by commercial plans, Medicare Advantage plans, and PEBB and OEBB plans were summed to report results separately for each type of coverage.

Calculating per-member per-month (PMPM) spending

PMPM spending is defined as total paid by payer ÷ member months. To calculate PMPM primary care spending and non-primary-care spending, PMPM primary care spending and non-primary-care spending were calculated separately for claims-based and non-claims-based payments and summed:

- For claims-based payments, spending by carriers and CCOs was divided by total member months for each payer type from APAC.
- For non-claims-based payments, spending by carriers and CCOs from the specialized reporting template was divided by member months from the template.
- Results from the above steps were summed to calculate PMPM total medical spending and PMPM primary care spending. PMPM primary care spending was subtracted from PMPM total medical spending to calculate PMPM non-primary-care spending.

These steps were used to calculate PMPM spending by all CCOs and prominent carriers offering commercial, Medicare Advantage, and PEBB and OEBB plans These steps were also used to calculate PMPM spending for each carrier and CCO.

Enrollment

Enrollment is reported as number of unique people with health care coverage in 2015 as reported in APAC. Enrollment is calculated by taking the total member months and dividing by 12 to obtain an annual enrollment number. A person may be enrolled with more than one health plan at the same time. This means that the number of people enrolled with all carriers in this report may sum to more than the total number of unique people enrolled.

Calculating the number of prominent carriers and CCOs with each type of non-claims-based payment

A prominent carrier or CCO was counted as making a specific type of non-claims-based payment if it reported paying at least one dollar using that type of payment in 2015. For example, a carrier offering Medicare Advantage plans was counted as having made a risk-based payment if it reported paying at least one dollar using risk-based payment for a Medicare Advantage member's primary care.

Calculating non-claims-based payments as a percentage of total primary care spending

For each type of non-claims-based payment, non-claims-based spending as a percentage of total non-claims-based primary care spending is defined as:

(Dollars paid for primary care using a specific type of non-claims-based payment, by all payers that used this type of payment)

Divided by

(Dollars paid for primary care using all non-claims-based payments, by all payers that used the specific type of non-claims-based payment)

For example, risk-based payments as a percentage of primary care spending for carriers with Medicare Advantage plans equals total dollars paid using risk-based payments for Medicare Advantage members divided by total dollars paid for primary care using all non-claims-based payments for Medicare Advantage members. The denominator includes only those plans that made risk-based payments for Medicare Advantage members.

Endnotes

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

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