Stakeholders Report Regarding
"An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health" (LD 1196) to the Maine Legislature Joint Standing Committee on Health Coverage, Insurance, and Financial Services of the 130th Maine Legislature

Maine Medical Association

January 15, 2022

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Maine Medical Association
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I. Executive Summary

Access to primary care can lower overall health care utilization, increase the use of preventive services, and lower disease and death rates.[1] Mainers (and the rest of the United States) *pay almost twice as much to be far sicker with less fairness* than peer nations that have more robust Primary Care. Visits to Primary Care clinicians here are declining, the workforce pipeline is shrinking, and access remains a concern.

Behavioral/Mental healthcare similarly is under-resourced, which increases suffering and contributes to costs in other areas of society. Maine's opioid epidemic is a vivid, longstanding, and grim illustration.

Other parts of the health system are important too. Fair and equitable access to necessary hospital care is crucial, especially in rural "critical access hospital" service areas, and especially during a pandemic.

In response to these concerns, "An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health" (LD 1196) was introduced to the 130th Maine Legislature in Spring 2021. The Health Coverage, Insurance, and Financial Services Committee recognized the importance and complexity of the issues at stake, and unanimously voted to carry over the bill to the following year. The committee chairs requested that Maine Medical Association (MMA) convene stakeholders and facilitate further discussion on LD 1196; share information; solicit input; and provide recommendations back to the committee by January 15, 2022.

II. Background

Primary care in Maine and across America has eroded to dangerous levels according to the top U.S. think tank of scientists, engineers, and health system experts. In May of 2021, the National Academies of Science, Engineering, and Medicine (NASEM) published a detailed report *Implementing High Quality Primary Care*.[2] This 425-page evidence-based document provides a plan for rebuilding Primary Care, the foundation of a high-functioning health care system. Primary Care is critical to meeting four important objectives (healthcare's "Quadruple Aim": improving population health, reducing costs, enhancing the patient experience, and improving the health care team experience to reduce burnout.

Countries and health systems with high-quality Primary Care experience better health outcomes and more health equity,[3] but Primary Care in the United States is weak and under-

[1] Robert Graham Center. The State of Primary Care in the United States. Washington DC. https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/PrimaryCareChartbook.pdf

[2] National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington DC: The National Academies Press. https://doi.org/10.17226/25983.

[3] Mirror, Mirror 2021: Reflecting Poorly. Health Care in the U.S. Compared to Other High Income Countries, Commonwealth Fund Report, August 4, 2021. Access: https://www.commonwealthfund.org/publications/fund-

resourced, accounting for 35% of health care visits while receiving only about 5% of health care expenditures. Moreover, visits to Primary Care clinicians are declining, the workforce pipeline is shrinking, and unfair access remains a concern.[4]

Findings from the NASEM report highlight the challenges we face in Maine:

1. As of the 2020 US Department of Health and Human Services Report, every county in Maine is at least partially a Health Professional Shortage Area, meaning the supply of Primary Care physicians does not meet the needs of the local population.
2. The proportion of physicians in training, nurse practitioners, and physician assistants entering Primary Care has decreased in recent years.[5]
3. The breakdown of Primary Care in Maine is a problem because "Primary Care is the only health care component where an increased supply is associated with better population health and more equitable outcomes."[6]

The *Journal of the American Medical Association* published a large research study in 2019 that quantified the connection between Primary Care and health. "Every 10 additional Primary Care physicians per 100,000 population was associated with a 51.5-day increase in life expectancy."[7]

Fair and equitable access to necessary hospital care is crucial, especially in rural "critical access hospital" service areas, and especially during a pandemic.

- Seven out of the eight Maine hospitals with at least five consecutive years of loss are rural.[8]
- Health systems face a huge array of usage and billing requirements from multiple payers, which leads to high administrative costs for billing and reimbursements. The U.S. spends about 8% of its healthcare dollars on administrative costs, compared to 1% to 3% in the 10 other countries according to a 2020 JAMA study.[9]
- The Maine Hospital Association asserts that hospital groups in Maine employ between half and two-thirds of all Primary Care providers and staff.
- Hospital employed primary care providers generate over $2 million in net revenue annually for their affiliated hospitals according to a national survey.[10]

reports/2021/aug/mirror-mirror-2021-reflecting-poorly

[4] NASEM, 2021

[5] AANP 2020; NASEM 2016; NCCPA 2020), Naylor and Kurtzman 2010; NRMP 2020)in NASEM 2021,73.

[6] NASEM 2021, 4.

[7] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2724393

[8] http://themha.org/Protect-Rural-Maine

[9] JAMA "Health Care Spending in the United States and Other High-Income Countries." Accessed December 21, 2021

[10] Merrit Hawkins, 2019 Physician Inpatient/Outpatient Revenue Survey, 2019. Available at: https://www.merritthawkins.com/uploadedFiles/MerrittHawkins_RevenueSurvey_2019.pdf

- A clearly stated intent of hospitals in our state is to significantly improve community health outcomes.[11,12] Data show that can be achieved through increased investment in Primary Care and better access to preventative clinical care for the best opportunity at improving outcomes.[13]

Overall health outcomes are poor. Mainers (and the rest of the United States) *pay two to three times more to be far sicker* than peer nations that have more robust Primary Care.[14] Average life expectancy is three to *five years shorter* here than what those other countries show is possible.

Health inequity is prevalent in the United States and is unjust.[15] In fact, early in the COVID-19 pandemic, Maine made national headlines for having the worst coronavirus racial disparities gap in the country.[16]

The NASEM report says state policy and regulations that are compatible with locally tailored care can enable Primary Care stake holders to implement needed changes."[17] Coordination of such efforts requires active support from all levels of the health service and political leadership.

III. LD 1196 Process to Date

Primary Care has been eroding to a breaking point for decades before the NASEM Report. In response, "An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health" (LD 1196) was introduced during the First Session of the 130th Maine Legislature, and public hearings were held April 15, 2021 (appendix 1). The bill sponsor, Representative Sam Zager of Portland, introduced a draft amendment during the hearing in response to feedback from interested parties (appendix 2). This version reflected input from many of these groups and was intended to achieve the following: 1) make the legislation more practical to administer; 2) delay some cost cap provisions to enable hospital systems to adjust; 3) stagger the Primary Care and Behavioral/Mental Health components; and 4) move toward value-based care and away from fee-for-service. LD 1196 Electronic Committee File can be accessed here: http://legislature.maine.gov/ctl/HCIFS/04-15-2021

During the work session on May 4, 2021, the Health Coverage, Insurance, and Financial

[11] https://www.mainehealth.org/About/Mission-Vision
[12] https://northernlighthealth.org/Our-System/Mayo-Hospital/About/Mission-and-Vision
[13] Investing in Primary Care, A State Level Analysis
https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf
[14] Organization for Economic Cooperation and Development (OECD). https://ourworldindata.org/grapher/life-expectancy-vs-health-expenditure?time=earliest..2015
[15] Smedley, Stith, Nelson et al, Unequal Treatment, Institute of Medicine (2002) was a sobering report in the field of healthcare. For up to date research, see also https://www.cdc.gov/chronicdisease/healthequity/index.htm;
[16] https://www.bostonglobe.com/2020/06/21/nation/maine-has-widest-coronavirus-racial-disparity-gap-country/
[17] NASEM 2021, 5.

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Services Committee recognized the importance and complexity of the issues at stake, and unanimously voted to carry over the bill to the following year. Upon carry over, the committee requested that Maine Medical Association (MMA) convene stakeholders and facilitate further discussion on LD 1196; share information; solicit input; and provide recommendations back to the committee by January 15, 2022. Stakeholder organizations, offices and entities were identified in the chairs' letter to the MMA (appendix 3).

The MMA convened four virtual meetings, and asked stakeholder group participants to attend at least three of the meetings.

Friday, September 24, 2021, 1:00-3:00 p.m.
Friday, October 22, 2021, 1:00 – 3:00 p.m.
Tuesday, November 16, 2021, 7:30 – 9:00 a.m.
Friday, December 3, 2021, 1:00 – 4:00 p.m.

Board Member Elisabeth Wilson, MD MPH, MS-HPEd, served as chair of the stakeholder group. Approximately 20 stakeholders regularly participated among 27 that were invited.

Representative Zager explained to the stakeholder group at the first meeting that he fully expected that further compromise would be needed among all stakeholders to "build a ship we and our loved ones and neighbors are all climbing aboard." He emphasized that we must put in an earnest effort to find as much consensus as possible. By doing so, we can improve the system for Mainers; we can orient our system more towards better preventive care, chronic disease management, health care access and equity, and treatment for Behavioral/Mental Health conditions.

Over the course of the four meetings, the stakeholder group:

- Summarized the findings presented in the Maine Quality Forums Annual Report on Primary Care Spending in Maine and examined the landscape across the country regarding these issues. Dr. Zirui Song, an Assistant Professor of Medicine and Internal Medicine physician at Massachusetts General Hospital, Assistant Professor of Health Care Policy at Harvard Medical School, and co-author of policy reviews in top healthcare journals briefed the stakeholders on health economics. The launch slide for Dr. Song's presentation was taken from Maine Quality Forum's annual report on primary care spending in Maine. Dr. Song clarified the inherent problems with fee-for-service healthcare and offered ideas for ensuring Primary Care survives.
- Looked in depth at Rhode Island because it was the first state to address these issues in 2011. Former Health Commissioner for the State of Rhode Island and President of the Millbank Fund Chris Koller attended a stakeholder meeting and described that state's work and outcomes to date. He was joined by Dr. Alan Kurose, Vice President for Primary Care and Population Health at Lifespan, a large hospital system in Rhode Island.
- Heard stakeholders' statements of position and perspective. This occurred during

virtual meetings, in subgroup meetings arranged by the MMA, and via email to the distribution list of all stakeholders.

- Discussed possible adjustments to specific provisions of LD 1196, with the aim of making consensus recommendations to the HCIFS committee for the Second Regular Session.

IV. Findings

Findings include general observations and opinions; evidence from Maine data; the experience of another New England state that made similarly changes a decade ago; conclusions from the peer-reviewed scientific literature; and stakeholder comments as the group sought consensus about as many provisions as possible.

- Stakeholders cited the need for a common definition of Primary Care. Several stakeholders endorsed the NASEM 2021 definition.[18]
- Primary care infrastructure, in part, includes having a sufficient workforce, but "the high rates of burnout reported among U.S. clinicians and learners is a strong signal that the nation's health care system is failing."[19] This is a crucial concern in light of the "demographic bubble" in which baby boomer providers are retiring as the care of baby boomer patients gets increasingly demanding. The problem compounds for Maine's future as trainees are entering the Primary Care workforce in smaller and smaller numbers.
- Primary care infrastructure also means that the workforce has necessary tools to serve patients optimally. Some of this infrastructure is in place in Maine's federally qualified health centers, for example, which are required to include practice enhancements such as: counselors/therapists embedded in the primary care practice; expanded opioid and other substance use disorder care; enhanced care management and social supports; expanded secure telehealth including video, phone, and asynchronous messages; enhanced evening/weekend availability. Other primary care practices could learn from the FQHC model and across the spectrum primary care practices of all stripes could consider meaningful ways of engaging and collaborating.
- Excluding non-claims-based payments, the Maine Quality Forum (MQF) has been required by statute to publish data every January since 2020.[20] The data reveal Maine is typical in the United States: approximately 5-9% of our health dollars go towards Primary Care, depending on how Primary Care is defined.
- Behavioral/Mental Health is in crisis, but we do not yet have a system-wide

[18] "High-quality Primary Care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities." NASEM 2021.

[19] National Academies of Science. *Taking Action Against Clinician Burnout: A Systems Approach to Supporting Professional Well-Being* (2019) https://nam.edu/systems-approaches-to-improve-patient-care-by-supporting-clinician-well-being/

[20] 24-A M.R.S. §6951(12) https://legislature.maine.gov/legis/statutes/24-A/title24-Asec6951.html

understanding about how much we are investing in various components and levels of Behavioral/Mental Health in the state. An environmental scan of what other states are doing can be used to calibrate any future system-wide changes for the Behavioral/Mental Health system in Maine. The MQF reported to stakeholders that it has a "really good starting point" to collect on behavioral/mental investment health similarly.

- There is much overlap among Behavioral/Mental Health and Primary Care, but they exist on different axes; one model is the Behavioral Health Pyramid of Care. (M. Shaughnessy 12/3/21 presentation in appendix.)
- Healthcare purchasers are willing to support increased primary care investment, but only to the extent that is does not increase healthcare costs. Absent cost containment strategies that are implemented at the same time as the increase in primary care spending, purchasers do not support the increased spend. They aim to lower the cost of healthcare and ensure any investments in the Primary Care system are tied to identifiable value (e.g., clinical outcomes; access to care) and that the impact of such measurement is measured and reported on.
- The Maine Academy of Family Physicians referenced discussions focused on accountability measures for primary care investment. While the organization understands the goals, the concern was that extensive reporting will create more administrative work on primary care practices already stressed for adequate time caring for patients, especially for smaller independent practices.
- The Maine Hospital Association is concerned about capping absolute costs (i.e., hospital revenue) or growth-of-costs, especially during the pandemic when high need, rising costs; staffing shortages, and nursing home closures threaten their sustainability.
- Nevertheless, Maine hospitals could support "broader payment reform". A senior executive of one of Maine's largest hospital groups said, "We need to improve investment in Primary Care" but insurers need to bear risk along with the hospitals.
- Commercial insurers have concerns about increased primary care spending raising health care costs and urged stakeholders to consider where the additional funds will come from.
- MaineCare offered a clarifying statement that "cost caps" were generally a cap on percentage growth, not a cap on absolute costs.
- Guest health policy expert Dr. Song noted that market forces have left Primary Care and Behavioral/Mental Health chronically underfunded and in disrepair. He suggested Maine think about investments through separate prospective payments or a global budget (e.g., a Primary Care trust, or patient-centered Primary Care accounts).
- Dr. Song also made the point that increased spending on primary care will increase total health care spending absent cost controls.
- Commercial insurers also raised the question of how to ensure that increased primary care payments go to primary care providers as intended and that resulting savings are passed back to purchasers.
- The general trend across the country is a movement from fee-for-service (FFS) to

value-based (or alternative) payments. The Office of MaineCare is moving in this direction. MaineCare Director Michelle Probert reported that Maine Care is working toward a goal of having 40% of MaineCare's total expenditures paid out via Alternative Payment Models (APMs) by the end of CY 2022. So far, they have increased from about 20% spending on APMs in CY 2018 to 36% in CY 2020.

- Increasing Primary Care spending alone would not necessarily save money in the short run, but it can help slow the growth of health spending while maintaining quality, as occurred in Rhode Island.[21] This would allow the growth of wages and Gross Domestic Product to catch up, instead of being further outpaced by the outsized growth of health costs ("To bend the cost curve").
- Dr. Al Kurose, a Rhode Island health system executive with a background in Primary Care, said that since the 2011 changes, "Primary Care is more secure than it would have been...more services for patients, more value-based care. The big hospital systems have started to pivot toward Primary Care and Population health."
- Chris Koller, former Insurance Commissioner of Rhode Island, and President of the Millbank Fund said that the concentration of PCPs in RI increased and "access to specialists and hospital services remains robust."

[21] Baum A, Song Z, Landon BE, Phillips RS, Bitton A, Basu S. Health Affairs. 2019.; Song Z and Gondi S. Will Increasing Primary Care Spending Alone Save Money? JAMA 2019

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V. Behavioral Health Subgroup

Behavioral Health meetings were held for more in-depth depth discussions on various aspects of primary care and behavioral health investment.

Stakeholders from behavioral health leadership of Tri-County Behavioral Health, National Association of Social Workers, Maine Chapter, and the Alliance of Addiction and Mental Health Services met separately to assess policy implications that would:

1) Address the workforce shortage of behavioral health providers in Maine,
2) Reduce value-free administrative costs & barriers to behavioral healthcare
3) Broaden access to behavioral health services, especially in primary care, and
4) Improve overall medical (including behavioral health) costs, outcomes and experience of patients, providers and teams.

The LD 1196 Stakeholder Behavioral Health Committee Collaborative Statement is attached to this report. It includes, among other suggestions, recommendations for a definition of behavioral health providers and a definition of integrated behavioral health in primary care.

Behavioral Health Subgroup Policy Recommendations:

1) Complete the behavioral health service rate analysis and recommendations of the Department of Health and Human Service 2020 MaineCare Rate Evaluation Study by December 31, 2022. Currently most behavioral health outpatient reimbursement comparisons are minimal or lacking compared to the typical five- state medical service comparison rates. This is key information to adequately reimburse for behavioral health services in Maine.
2) Eliminate the need for outpatient medical practices to apply for a behavioral health license to get the higher reimbursement rate given to licensed behavioral health organizations.
3) Eliminate the review/authorization/rationing of behavioral health services through MaineCare's Administrative Services Organization (ASO, currently KEPRO). The rationing/authorization step requires extra administrative staffing for licensed organization, rarely effects the treatment, and is not required for the provision of medical care. We believe it is not needed for behavioral health care.
4) Eliminate commercial insurance carve-outs for behavioral health billing and credentialing purposes. This creates the need for additional personnel, processes and relationships that are cost prohibitive for behavioral health and medical integrated services in primary care and behavioral health homes.

The recommendations of the Behavioral Health Subgroup were received after the last stakeholder meeting and not presented to the larger stakeholder group.

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VI. Recommendations

A draft report with recommendations gleaned from meeting notes was circulated to all stakeholders for review and input. Separate meetings were offered to stakeholder groups to discuss the draft report and recommendation. Ultimately, to ensure input from all groups, a survey was conducted to assess the level of agreement on each draft recommendation. Stakeholders were asked to rate the following recommendations on a scale of 1 to 5.
1-Strongly Disagree, 2-Disagree, 3-Neutral, 4-Agree, 5-Strongly Agree.
Nine stakeholders responded.

1. Recommend a shared definition of Primary Care be developed and defined.
   Strongly Agree-5, Strongly Disagree-3, Neutral-1
2. Recommend a shared definition of Behavioral Health Care.
   Strongly Agree-4, Agree-2, Strongly Disagree-2, Disagree-1
3. Recommendation to remove the absolute cost cap.
   Strongly Agree-3, Strongly Disagree-3, Neutral-2
4. Recommendation to task the newly created Office of Affordability in Health Care to evaluate and make recommendations to the 131st and subsequent legislatures on "bending the cost curve" with legislative vehicles to implement recommendations.
   Strongly Agree-3, Strongly Disagree-4, Neutral-1
5. Recommendation for the proposed legislation to retain a Behavioral/Mental Health spending provision while data is gathered to appropriately calibrate the spectrum of services and determine a Behavioral/Mental Health spending baseline.
   Strongly Agree-2, Strongly Disagree-4, Neutral-2, Agree-1

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Stakeholder Invitations

Alliance for Addiction and Mental Health Services

Malory Shaughnessy, Executive Director

American Academy of Pediatrics (ME)

Dee Kerry, Executive Director

Bureau of Insurance

Eric Cioppa, Superintendent of Insurance

Joanne Rawlings-Sekunda, Policy Development Specialist

Benjamin Yardley, Senior Staff Attorney

Greater Portland Health

Renee Fay-LeBlanc, MD, Chief Medical Officer

Consumers for Affordable Healthcare

Ann Woloson, Executive Director

Healthcare Purchasers Alliance of Maine

Peter Hayes, President & CEO

Maine Academy of Family Physicians

Deborah Halbach, Executive Director

Frank Bellino, Board member

Marco Cornelio, Board member

Maine Association of Health Plans

Katherine D. Pelletreau, Executive Director

Maine Association of Physician Assistants

Angela M. Leclerc, President

Maine DHHS / Office of MaineCare

Michelle Probert, Director of MaineCare

Maine Hospital Association

Jeff Austin, VP, Government Affairs & Communications

Maine Osteopathic Association

Amanda Richards, Executive Director

Maine Primary Care Association

Darcy Shargo, Chief Executive Officer

Maine Quality Forum / Maine Health Data Organization

Karynlee Harrington, Executive Director

Maine Street Solutions

(law firm representing InterMed & Harvard Pilgrim)

Sara Vanderwood, Government Affairs

Kate Healy, JD, Health Care Practice Attorney

MaineHealth

Rob Chamberlain, MD, CMO, MaineHealth ACO

Katie Fullam Harris, SVP, Government Relations

Martin's Point

Dan McCormack, COO, Delivery System

Northern Light Health

Gavin Ducker, MD, Co-President, NL Health Medical Group

Lisa Harvey-McPherson, VP, Government Relations

Spectrum Healthcare Partners

Ann Robinson, JD, Pierce Atwood LLP

130th MAINE LEGISLATURE

FIRST REGULAR SESSION-2021

Legislative Document **No. 1196**

H.P. 874 House of Representatives, March 22, 2021

An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health

Received by the Clerk of the House on March 18, 2021. Referred to the Committee on Health Coverage, Insurance and Financial Services pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

ROBERT B. HUNT
Clerk

Presented by Representative ZAGER of Portland.
Cosponsored by Senator CLAXTON of Androscoggin and
Representatives: CONNOR of Lewiston, Speaker FECTEAU of Biddeford, MEYER of Eliot, TEPLER of Topsham, Senators: President JACKSON of Aroostook, MOORE of Washington, SANBORN of Cumberland.

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

Sec. 1. 5 MRSA §285, sub-§17 is enacted to read:

17. Targets for investment in primary care and behavioral health care. Beginning in plan year 2023, the State shall meet the following requirements related to targets for investment and spending in primary care and behavioral health care in the group health plan.

A. As used in this subsection, unless the context otherwise indicates, the following terms have the following meanings.

(1) "Behavioral health care" means mental health services, including community-based or peer support treatments for substance use disorder provided by licensed health care practitioners providing services within their scope of practice, regardless of practice setting.

"Behavioral health care" also includes provider loan repayments and services such as health information technology services, recruitment services and practice transformation services that support the practitioners described in this subparagraph in the delivery of behavioral health care services.

(2) "Primary care" means care provided by:

(a) Primary care practitioners, including family physicians, internists, pediatricians and geriatricians, except when practicing inpatient care or when practicing in an emergency department or stand-alone urgent care clinic;

(b) Obstetrician-gynecologists who assume responsibility for a patient's general primary care according to the gynecologic and nongynecologic standards of the United States Preventive Services Task Force or its successor organization except when practicing inpatient care or in an emergency department or stand-alone urgent care clinic;

(c) Physicians or surgeons of any specialty when providing general or reproductive care to special populations or in special circumstances, including, but not limited to, in clinics for persons who are homeless or indigent, federally qualified health centers, home-based palliative care, school-based health centers and general clinics focusing on traditionally marginalized populations such as indigenous or other people of color, immigrants, asylum-seekers, migrant workers, persons who are marginalized on the basis of gender identity or sexual orientation, victims of human trafficking, incarcerated individuals and victims of declared natural or human-caused disasters; and

(d) Advanced practice clinicians providing the services described in divisions (a) to (c).

"Primary care" also includes provider loan repayments and services such as health information technology services, recruitment services and practice transformation services that support the practitioners described in this subparagraph in the delivery of primary care services.

B. Targets for investment and spending by the State in the group health plan for primary care and behavioral health care are established as follows.

(1) For plan year 2023, the group health plan shall determine its baseline percentage of combined spending on primary care and behavioral health care based on claims data reported for plan year 2019 and report that percentage to the Superintendent of Insurance by January 1, 2022. The superintendent shall establish the median percentage for all health insurance carriers for plan year 2023. In subsequent plan years, the superintendent shall recalculate the median so that plan year 2024 is based on claims data reported for calendar year 2023, plan year 2025 is based on claims data reported for calendar year 2024 and plan year 2026 is based on claims data reported for calendar year 2025.

(2) Beginning in plan year 2023 and through plan year 2026, if the group health plan spends less than or equal to the median described in subparagraph (1) on primary care and behavioral health care, the group health plan shall increase its percentage spent on primary care and behavioral health care combined by at least 2% the following plan year over the plan year referenced in subparagraph (1) plus an increase equal to the rate of increase each year in the Consumer Price Index for medical care services as reported by the United States Department of Labor, Bureau of Labor Statistics.

(3) Beginning in plan year 2023 and through plan year 2026, if the group health plan spends above the median described in subparagraph (1) on primary care and behavioral health care, the group health plan shall increase its percentage spent on primary care and behavioral health care combined by at least 1% the following plan year over the plan year referenced in subparagraph (1) plus an increase equal to the rate of increase each year in the Consumer Price Index for medical care services as reported by the United States Department of Labor, Bureau of Labor Statistics.

(4) The Superintendent of Insurance shall recalculate the median for each plan year based on the reference plan year described in subparagraph (1). The requirements of subparagraphs (2) and (3) must be adjusted each plan year based on the group health plan's updated percentage spent on primary care and behavioral health care combined.

(5) The group health plan may demonstrate that the targets required by this subsection are met by averaging its increases in spending on primary care and behavioral health care combined over more than one plan year as long as the total increases required pursuant to this subsection through plan year 2026 are met each year.

(6) For plan year 2027 and each plan year thereafter, the group health plan shall maintain, at a minimum, the total combined spending on primary care and behavioral health care required pursuant to this section for plan year 2026.

The group health plan shall meet the targets required in this paragraph without increasing spending on total health expenditures. The group health plan may also meet the targets required in this paragraph by making supplemental payments focused on primary care and behavioral health care.

Sec. 2. 22 MRSA §3173-J is enacted to read:

§3173-J. Targets for investment in primary care and behavioral health care

Beginning in fiscal year 2023, the department shall meet the following requirements related to targets for investment and spending in primary care and behavioral health care in the MaineCare program.

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Behavioral health care" means mental health services, including community-based or peer support treatments for substance use disorder provided by licensed health care practitioners providing services within their scope of practice, regardless of practice setting.

"Behavioral health care" also includes provider loan repayments and services such as health information technology services, recruitment services and practice transformation services that support the practitioners described in this paragraph in the delivery of behavioral health care services.

B. "Primary care" means care provided by:

(1) Primary care practitioners, including family physicians, internists, pediatricians and geriatricians, except when practicing inpatient care or when practicing in an emergency department or stand-alone urgent care clinic;

(2) Obstetrician-gynecologists who assume responsibility for a patient's general primary care according to the gynecologic and nongynecologic standards of the United States Preventive Services Task Force or its successor organization except when practicing inpatient care or in an emergency department or stand-alone urgent care clinic;

(3) Physicians or surgeons of any specialty when providing general or reproductive care to special populations or in special circumstances, including, but not limited to, in clinics for persons who are homeless or indigent, federally qualified health centers, home-based palliative care, school-based health centers and general clinics focusing on traditionally marginalized populations such as indigenous or other people of color, immigrants, asylum-seekers, migrant workers, persons who are marginalized on the basis of gender identity or sexual orientation, victims of human trafficking, incarcerated individuals and victims of declared natural or human-caused disasters; and

(4) Advanced practice clinicians providing the services described in subparagraphs (1) to (3).

"Primary care" also includes provider loan repayments and services such as health information technology services, recruitment services and practice transformation services that support the practitioners described in this paragraph in the delivery of primary care services.

2. Targets. Targets for investment and spending by the department in primary care and behavioral health care are established as follows.

A. For fiscal year 2023, the department shall determine its baseline percentage of combined spending on primary care and behavioral health care based on claims data reported for fiscal year 2019 and report that percentage to the Superintendent of Insurance by January 1, 2022. The superintendent shall establish the median

percentage for all health insurance carriers for plan year 2023. In subsequent plan years, the superintendent shall recalculate the median so that plan year 2024 is based on claims data reported for calendar year 2023, plan year 2025 is based on claims data reported for calendar year 2024 and plan year 2026 is based on claims data reported for calendar year 2025.

B. Beginning in fiscal year 2023 and through fiscal year 2026, if the MaineCare program spends less than or equal to the median for all health insurance carriers described in paragraph A on primary care and behavioral health care, the department shall increase its percentage spent on primary health care and behavioral health care combined by at least 2% the following fiscal year over the fiscal year referenced in paragraph B plus an increase equal to the rate of increase each year in the Consumer Price Index for medical care services as reported by the United States Department of Labor, Bureau of Labor Statistics.

C. Beginning in fiscal year 2023 and through fiscal year 2026, if the MaineCare program spends above the median described in paragraph A on primary care and behavioral health care, the department shall increase its percentage spent on primary health care and behavioral health care combined by at least 1% the following fiscal year over the fiscal year referenced in paragraph B plus an increase equal to the rate of increase each year in the Consumer Price Index for medical care services as reported by the United States Department of Labor, Bureau of Labor Statistics.

D. The Superintendent of Insurance shall recalculate the median for each fiscal year based on the reference fiscal year described in paragraph A. The requirements of paragraphs B and C must be adjusted each fiscal year based on the MaineCare program's updated percentage spent on primary care and behavioral health care combined.

E. The department may demonstrate that the targets required by this subsection are met by averaging its increases in spending on primary care and behavioral health care combined over more than one fiscal year as long as the total increases required pursuant to this subsection through fiscal year 2027 are met.

F. For fiscal year 2027 and each fiscal year thereafter, the department shall maintain, at a minimum, the total combined spending on primary care and behavioral health care required pursuant to this section for fiscal year 2026.

The department shall meet the targets required in this subsection without increasing spending on total health expenditures. The department may also meet the targets required in this subsection by making supplemental payments focused on primary care and behavioral health care.

Sec. 3. 24-A MRSA §2303, sub-§1, ¶B, as enacted by PL 1969, c. 132, §1, is amended to read:

B. Rates ~~shall~~ may not be excessive, inadequate or unfairly discriminatory and, in the case of health insurance rates beginning for plan year 2023, must comply with the requirements of section 4319-B.

Sec. 4. 24-A MRSA §4319-B is enacted to read:

§4319-B. Targets for investment in primary care and behavioral health

Beginning in plan year 2023, carriers in the large group, small group and individual markets shall meet the following requirements related to targets for investment and spending in primary care and behavioral health care.

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Behavioral health care" means mental health services, including community-based or peer support treatments for substance use disorder provided by licensed healthcare practitioners providing services within their scope of practice, regardless of practice setting.

"Behavioral health care" also includes provider loan repayments and services such as health information technology services, recruitment services and practice transformation services that support the practitioners described in this paragraph in the delivery of behavioral health care services.

B. "Primary care" means care provided by:

(1) Primary care practitioners, including family physicians, internists, pediatricians and geriatricians, except when practicing inpatient care, or when practicing in an emergency department or stand-alone urgent care clinic;

(2) Obstetrician-gynecologists who assume responsibility for a patient's general primary care according to the gynecologic and nongynecologic standards of the United States Preventive Services Task Force or its successor organization except when practicing inpatient care or in an emergency department or stand-alone urgent care clinic;

(3) Physicians or surgeons of any specialty when providing general or reproductive care to special populations or in special circumstances, including, but not limited to, in clinics for persons who are homeless or indigent, federally qualified health centers, home-based palliative care, school-based health centers and general clinics focusing on traditionally marginalized populations such as indigenous or other people of color, immigrants, asylum-seekers, migrant workers, persons who are marginalized on the basis of gender identity or sexual orientation, victims of human trafficking, incarcerated individuals and victims of declared natural or human-caused disasters; and

(4) Advanced practice clinicians providing the services described in subparagraphs (1) to (3).

"Primary care" also includes provider loan repayments and services such as health information technology services, recruitment services and practice transformation services that support the practitioners described in this paragraph in the delivery of primary care services.

2. Targets. Targets for investment and spending by a carrier in primary care and behavioral health care are established as follows.

A. For plan year 2023, each carrier shall determine its baseline percentage of combined spending on primary care and behavioral health care based on claims data reported for plan year 2019 and report that percentage to the superintendent. The superintendent shall establish the median percentage for all carriers for plan year 2023. In subsequent

plan years, the superintendent shall recalculate the median so that plan year 2024 is based on claims data reported for calendar year 2023, plan year 2025 is based on claims data reported for calendar year 2024 and plan year 2026 is based on claims data reported for calendar year 2025.

B. Beginning in plan year 2023 and through plan year 2026, if a carrier spends less than or equal to the median described in paragraph A on primary care and behavioral health care, the carrier shall increase its percentage spent on primary care and behavioral health care combined by at least 2% the following plan year over the plan year referenced in paragraph A plus an increase equal to the rate of increase each year in the Consumer Price Index for medical care services as reported by the United States Department of Labor, Bureau of Labor Statistics.

C. Beginning in plan year 2023 and through plan year 2026, if the carrier spends at or above the median described in paragraph A on primary care and behavioral health care, the carrier shall increase its percentage spent on primary care and behavioral health care combined by at least 1% the following plan year over the plan year referenced in paragraph A plus an increase equal to the rate of increase each year in the Consumer Price Index for medical care services as reported by the United States Department of Labor, Bureau of Labor Statistics.

D. The superintendent shall recalculate the median for each plan year based on the reference plan year described in paragraph A. The requirements of paragraphs B and C must be adjusted each year based on the carrier's updated percentage spent on primary care and behavioral health care combined.

E. A carrier may demonstrate that the targets required by the subsection are met by averaging its increases in spending on primary care and behavioral health care combined over more than one plan year as long as the total increases required pursuant to this subsection through plan year 2026 are met.

F. For plan year 2027 and each fiscal year thereafter, the carrier shall maintain, at a minimum, the total combined spending on primary care and behavioral health care required pursuant to this section for plan year 2026.

A carrier shall meet the targets required in this subsection by reducing avoidable health care spending without increasing spending on total health expenditures. A carrier may also meet the targets required in this subsection by making supplemental payments to providers focused on primary care and behavioral health care.

3. Rate approval. Beginning in plan year 2023, the superintendent may not approve any rate filed by a carrier unless the carrier demonstrates that the targets required by this section have been met. The superintendent may approve rates provisionally for one year, if the superintendent is satisfied with an action plan submitted by a carrier to meet the targets described in this section. As part of any rate filing, the superintendent may require a carrier to provide such additional information as necessary to determine compliance with this section.

SUMMARY

This bill requires health carriers to meet certain targets for investment and spending in primary care and behavioral health care beginning in plan year 2023 and through plan year

2026. Overall spending may not increase to meet the targets. The bill establishes a benchmark for combined spending in primary care and behavioral health care as a percentage of overall health spending. The benchmark is indexed to the median amount spent by carriers on primary care and behavioral health care for plan year 2019. The bill requires carriers to increase relative spending in these areas by at least 2% per year if spending is less than or equal to the median and at least 1% per year if spending is above the median. Beginning in plan year 2027, carriers are required to maintain, at a minimum, the total combined spending on primary care and behavioral health care achieved in plan year 2026. The bill prohibits the Superintendent of Insurance from approving health insurance rates filed by a carrier unless the carrier demonstrates that the targets have been met. The bill also authorizes a carrier to meet the spending targets by supplemental payments focused on primary care and behavioral health care.

The bill also requires the MaineCare program and the state employee health plan to meet the same targets beginning in 2023.

LD 1196
Proposed by Rep. Zager
For review by HCIFS Committee at 4/15 Hearing

PROPOSED DRAFT COMMITTEE AMENDMENT:
An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health

Amend the bill by making the following changes:

- Increase the interval from one year to two years. There would still be four iterations.

- Cost containment would not immediately go into effect "overnight," but be delayed for 4 years to enable time for some up-front investments for moving from fee-for-service to value-based care. It also would allow for implementation of mechanism(s) to ensure the money goes where intended.

- Create a two-phase "staggered" implementation:

    - Phase 1 would implement the printed bill's provisions for Primary Care, while calling for Maine Quality Forum to measure Behavioral Health spending like it's been doing for Primary Care since 2019.
    - Phase 2 would involve implementing the provisions for Behavioral Health, calibrated by the data the Maine Quality Forum would be reporting.

STATE OF MAINE
ONE HUNDRED AND THIRTIETH LEGISLATURE
COMMITTEE ON HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

June 30, 2021

Dan Morin
Maine Medical Association
P.O. Box 190
Manchester, Maine 04351

Dear Mr. Morin:

As you know, the Joint Standing Committee on Health Coverage, Insurance and Financial Services has carried over LD 1196, An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health, to the Second Regular Session. We believe carrying the bill over will allow time for additional discussion and consideration of the complex issues raised in the bill.

We are writing on behalf of the committee to request that the Maine Medical Association convene a stakeholder group to facilitate further discussion of LD 1196 and the issues associated with the bill. We are supportive of improving health outcomes and lowering health care costs. While LD 1196 focuses on accomplishing that through spending targets for primary care and behavioral health care, we want to ensure that improving utilization of primary care and behavioral health care is also considered by the group.

When convening the stakeholder group, we ask that you invite participation from the sponsors and cosponsors of LD 1196 and HCIFS Committee members and staff. In addition, we believe representatives of these organizations should also be included:

- Maine Quality Forum and Maine Health Data Organization;
- Department of Health and Human Services, including the Commissioner or the Commissioner's designee; the Director of the Office of MaineCare Services or the director's designee; and the Director of the Office of Behavioral Health or the director's designee;
- State Employee Health Plan;
- Bureau of Insurance;
- Maine Medical Association, including specialty associations;
- MAFP, ACP, AAP
- Maine Hospital Association, including representatives of Maine Health and Northern Light Health;
- Maine Osteopathic Association;
- Maine Nurse Practitioners Association;
- Maine Association of Physician Assistants;
- Maine Primary Care Association;
- InterMed;
- Martin's Point;
- Independent healthcare providers in solo or small practices;

- Healthcare Purchasers Alliance of Maine;
- Consumers for Affordable Healthcare;
- Maine Association of Health Plans and their carrier members;
- Alliance for Addiction and Mental Health Services;
- Behavioral Health Community Collaborative; and
- Law firms providing services to health care providers.

To assist in its efforts, we also encourage the stakeholder group to engage assistance from health policy experts knowledgeable about efforts in Rhode Island and other states.

We ask that you report back to the committee on the activities of the stakeholder group, along with any recommendations, to the committee no later than January 15, 2022 so the committee can take final action on LD 1196 before the end of the Second Regular Session. If you have any questions, please do not hesitate to contact us or our legislative analyst, Colleen McCarthy Reid. Thank you for your consideration.

Sincerely,

Sen. Heather B. Sanborn
Senate Chair

Rep. Denise A. Tepler
House Chair

Maine Medical Association

Karen Saylor, MD, President | Jeffrey S. Barkin, MD, President-Elect | Erik N. Steele, DO, FAAFP, Chair, Board of Directors
Andrew B. MacLean, JD, CEO | Dan Morin, Director of Communications & Government Affairs

Stakeholder Invitation

You are cordially invited to participate in the following stakeholder meetings to discuss potential amendments to LD 1196, An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health (Representative Samuel Zager).

The Joint Committee On Health Coverage, Insurance and Financial Services has requested the Maine Medical Association to convene this stakeholder process to facilitate further discussion on the bill, share information, and solicit input with a directive to report potential recommendations back to the committee in January 2022 (HCIFS letter attached).

Representative Zager has suggested the following to assist the committee with improving LD 1196:

- A call for that group to produce a consensus proposal to the committee, to improve health outcomes and lower costs in the long run. The proposal must realistically orient our system more towards (1) prevention, (2) chronic disease management, (3) access and equity, and (4) treatment for behavioral/mental health conditions such as substance use disorder.
- A plan to move further away from the fee-for-service structure, towards value-based care.
- A request that participants bring to the first meeting suggestions to move towards better health outcomes at lower costs over the long run. It can be acknowledged that in the short run, spending might need to be increased overall, for the sake of systems change towards a better "end state."
- A timeline for getting there.

The stakeholder process will consist of several meetings of invited participants. We will be hosting stakeholder meetings to allow both in-person attendance (following appropriate COVID-19 protocols) at our centrally located site just outside of Augusta and a virtual access platform to allow maximum availability for all.

The first meeting on **Friday, September 24, 2021**, will be held at the Maine Medical Association, 30 Association Drive in Manchester, ME 04351, from **1:00 PM to 3:00 PM**. This meeting will be conducted in two parts. Part 1 will be a plenary session with background and introduction of the issue by Representative Zager and discussion to determine the stakeholder process, present the issues under consideration, identify potential work group participants, and outside policy and analytical resources. Part 2 will attempt to launch the process. Virtual invitations and a first meeting agenda will be forthcoming.

Additional meeting dates are as follows:

- Friday, October 22, 2021, 1:00 – 3:00 p.m.
- Tuesday, November 16, 2021, 7:30 – 9:00 a.m.
- Friday, December 3, 2021, 1:00 – 3:00 p.m.

While we are certainly aware of the many competing obligations for such a large group, we are hoping each entity can participate in a minimum of three of the above-mentioned dates and times. The committee was clear that we should encourage broad participation. It would ideally be the same person(s) from each entity. The goal is to potentially build the best bill we can at this stage.

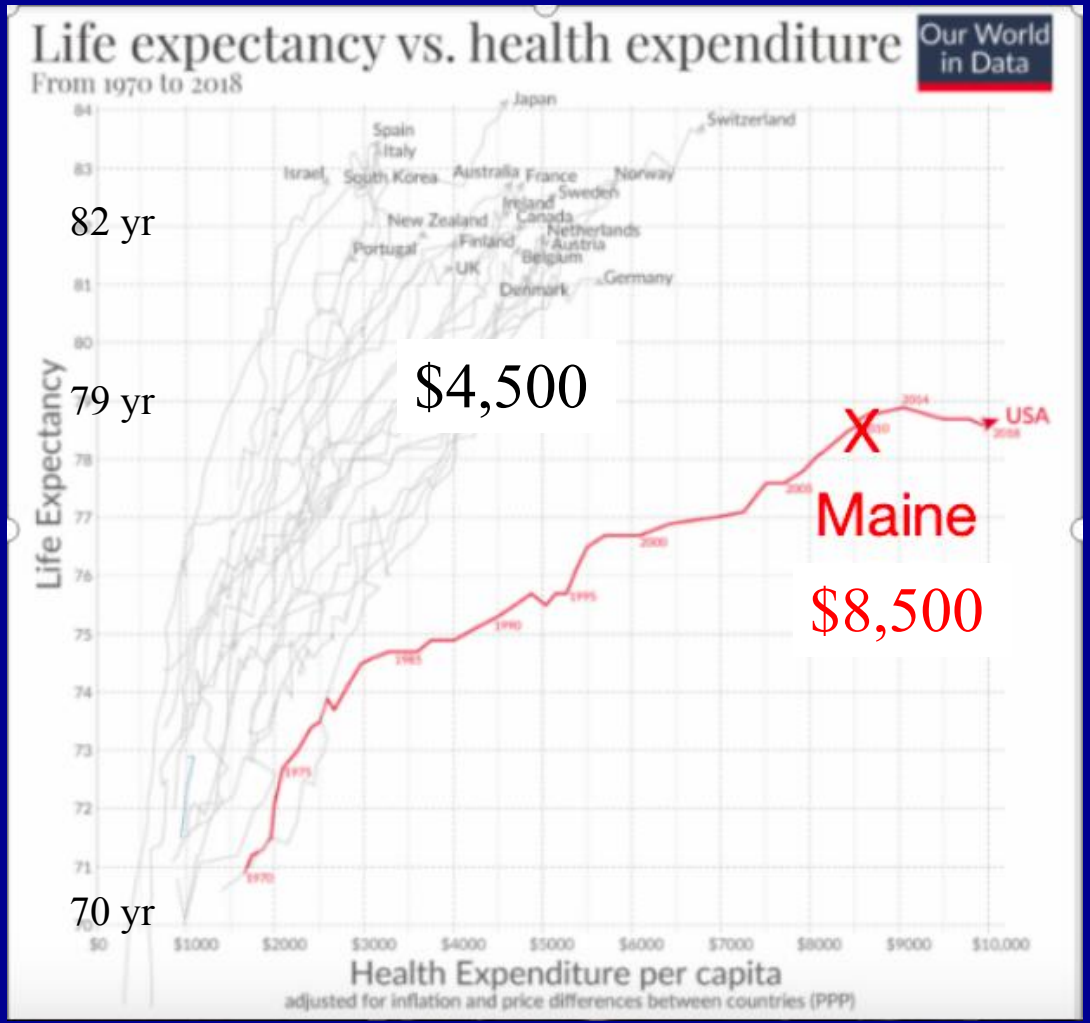
Participation in this first stakeholder meeting will be by invitation only, however, feel free to reach out with additional suggestions of inclusion prior to the meeting. Please RSVP by April 1st to attend the September 24 meeting, or to coordinate attendance by a designee, by contacting me at dmorin@mainemed.com & (207) 838-8613 or Sarah Lepoff at MMA slepoff@mainemed.com (207) 480-4191

LD 1196:
Setting the Stage

Stakeholders Kickoff Meeting

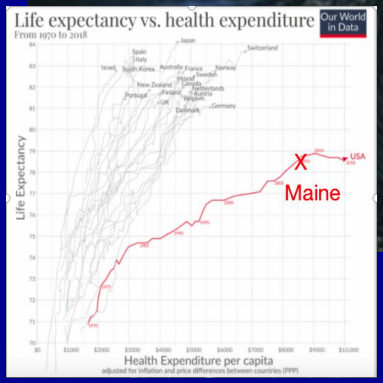
Representative Sam Zager, MD, M.Phil
District 41 (Portland)
Sept 24, 2021

Mainers (and rest of USA) pay almost twice as much to be far sicker than peer nations that have more robust primary care



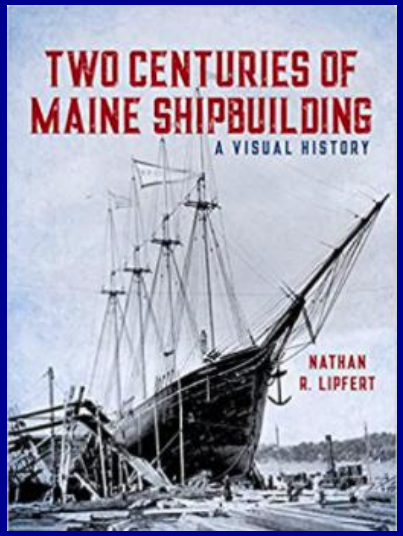
Data source: OECD
https://ourworldindata.org/grapher/life-expectancy-vs-health-expenditure?time=earliest..2015

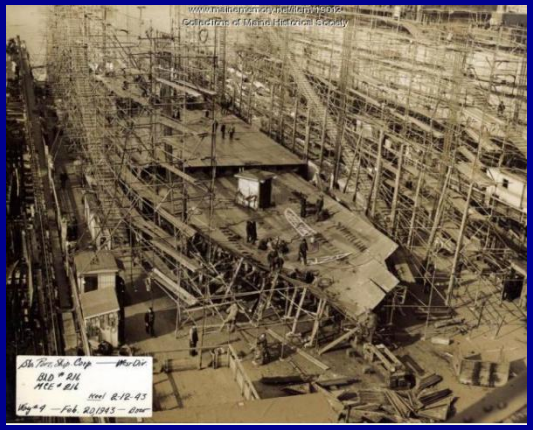
US Navy Photo



We need a "sea-worthy" health system

(more oriented toward Primary Care and Behavioral/Mental Health)





South Portland in WWII

Bath Iron Works Today

Maine can do this!

Credits: Maine Historical Society, Bath Iron Works; Amazon

Maine Hospitals are Crucial

LOCAL & STATE > Posted Yesterday at 8:48 AM | Updated September 23

Maine schools now have 72 outbreaks and 2,080 cases as COVID surge continues

BY KEVIN MILLER STAFF WRITER

Share

LOCAL & STATE > Posted September 9 | Updated September 10

Maine hospitals treating record number of ICU patients as new COVID-19 cases climb

More than 90% of patients in intensive care are unvaccinated, say state officials, who have added staffing to handle a backlog of positive tests.

pressherald.com

Mental/Behavioral Health Crisis

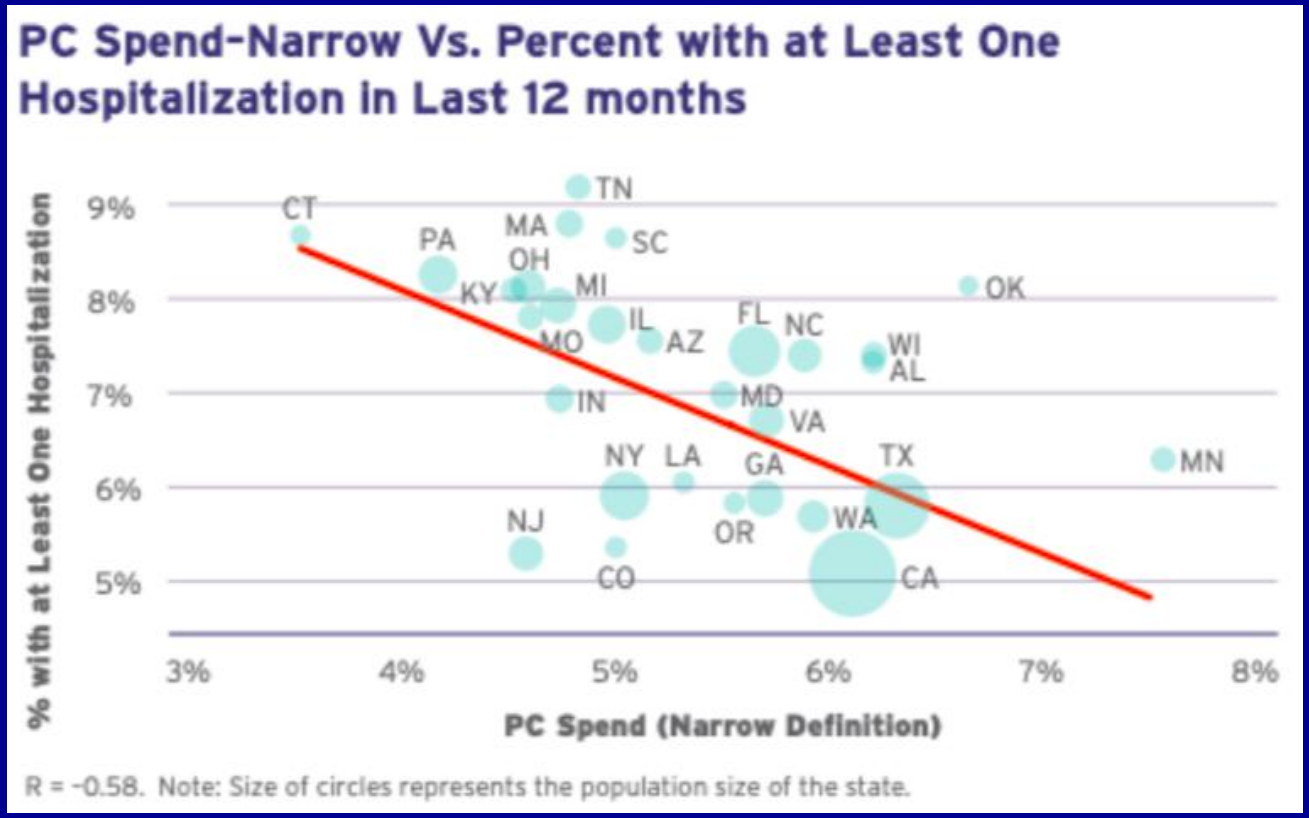
Drug Deaths in Maine by Quarter, 2013 - Q1 2021

BY BARBARA A. WALSH | MAY 9, 2021

Source: Office of the Maine Attorney General, Maine Drug Death Report, 2020. For more on this metric see Leadership data on the hub.

OPTIONS SAVE LIVES

States emphasizing primary care tend to be healthier



https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf

LD 1196 in a nutshell

Percent to PriCare of total spent in Maine (PC%)	Commercial Payer A	Commercial Payer B	ME Commercial Median (A,B,C...)
Baseline (pre-COVID)	4.5%	9.0%	7.0%
+ 2 yr	Required: 6.5% (1) Actual: 7.0%	Required: 10.0% (1) Actual: 10.0%	Actual: 8.6%
+4 yr	Required: 9.0% Actual: 11.8%	Required: 11.0% Actual: 11.0%	Actual: 11.0%
+6 yr	Required: 12.8% Actual: 13.0%	Required: 13% Actual: 13.0%	Actual: 12.8%
+8 yr (endpoint)	Required: 14.0% Actual: 14.5%	Required: 14.0% Actual: 14.3%	Actual 14.0%

1 Adjusted for inflation (Consumer Price Index)

Other Provisions of LD 1196

- Supt of Insur may not approve rates unless requirements met; 2-yr provisional approval if action plan in place.
- Wide discretion for how investments can be made (e.g. embedded Beh Health in PriCare programs; IT investments; staff recruitment and retention)
- Foster value-based care (Practice transformation; ensure utilization
- MaineCare and State Employee Health Plan same requirements as commercial payers, but separate pool

Sponsor's Amendments Proposed at initial hearing, Apr 2021

- Interval 2 yr (not 1 yr)
- Total expenditures limit (exceptions: pandemic? game-changer treatment e.g. Sofosbuvir "Sovaldi"?). Not immediate, but delayed for 4 years
- Staggered implementation
  - Phase 1: Primary Care implementatio; Beh/Mental health data collection, as done for PriCare since 2019 (Maine Qual Forum)
  - Phase 2: Implement Beh/Mental health provisions

We can figure this out together!

LD 1196 will be changed and I look forward to robust, fruitful stakeholder conversation this Fall

Thank you in advance!

sam.zager@legislature.maine.gov

(207) 400-6846

Next: Maine in Context of Health Systems Policy
Zirui Song, MD, PhD

Zirui Song, MD, PhD

Assistant Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School; Assistant Professor of Medicine and Internal Medicine Physician, Department of Medicine, Massachusetts General Hospital

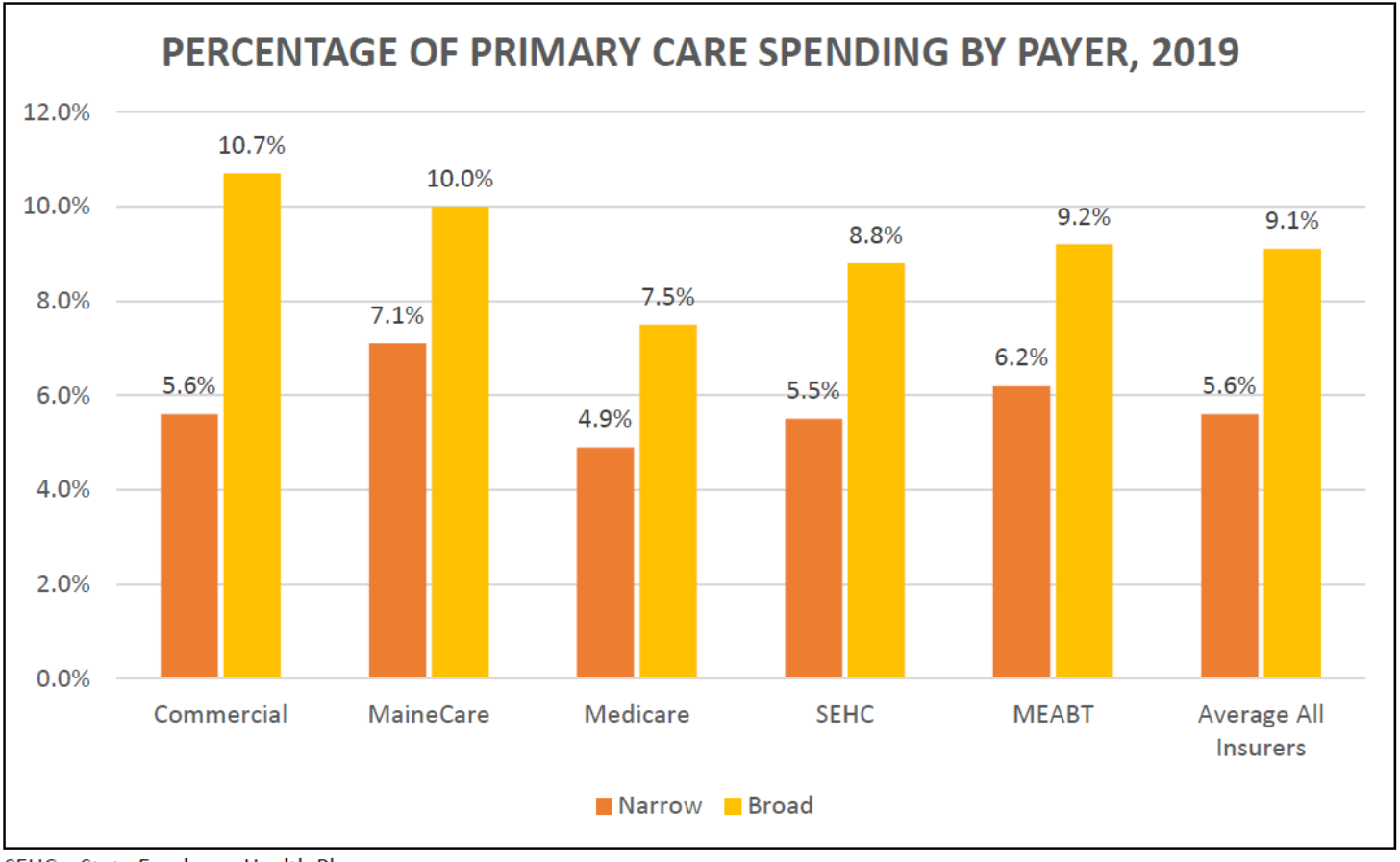
Primary Care and Behavioral Health Investment for Maine

LD 1196 Stakeholder Meeting

September 24, 2021

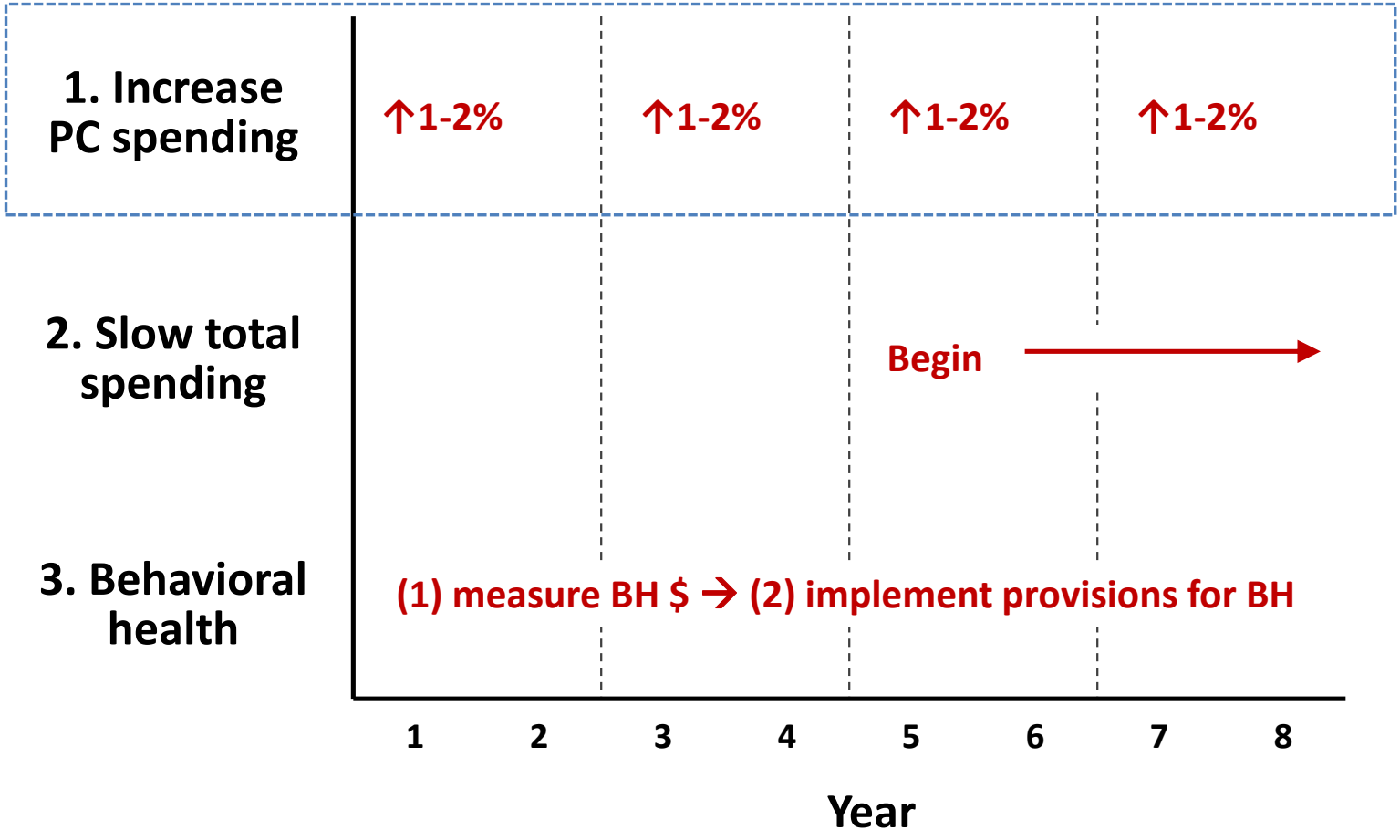
Zirui Song, MD, PhD
Harvard Medical School
Massachusetts General Hospital

Primary Care Spending in Maine



SEHC = State Employee Health Plan
MEABT = Maine Education Association Benefits Trust

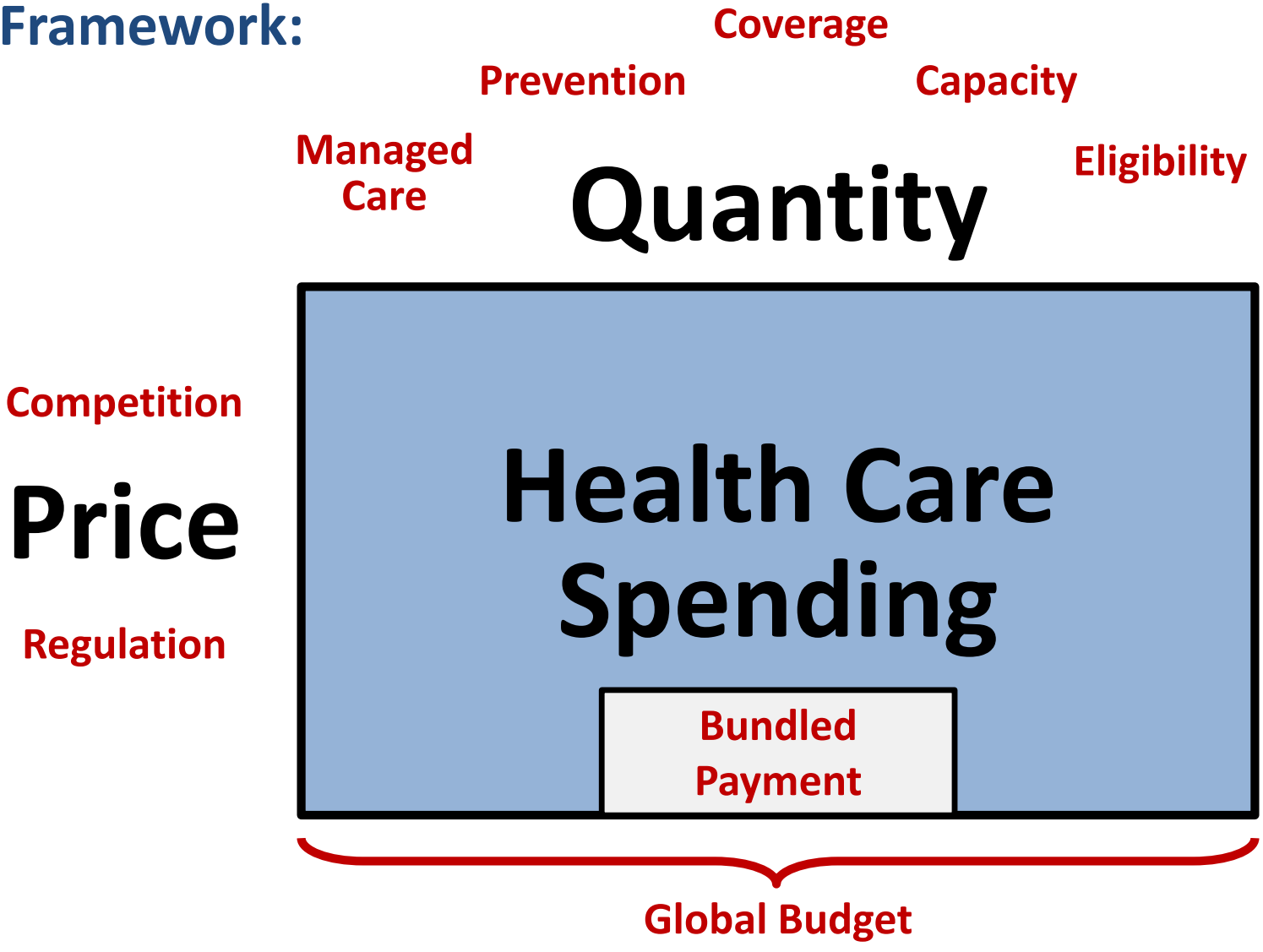
LD 1196


1. Increase PC spending
↑1-2%
↑1-2%
↑1-2%
↑1-2%
2. Slow total spending
Begin
3. Behavioral health
(1) measure BH $ → (2) implement provisions for BH
1
2
3
4
5
6
7
8
Year

4 Major Goals in Maine

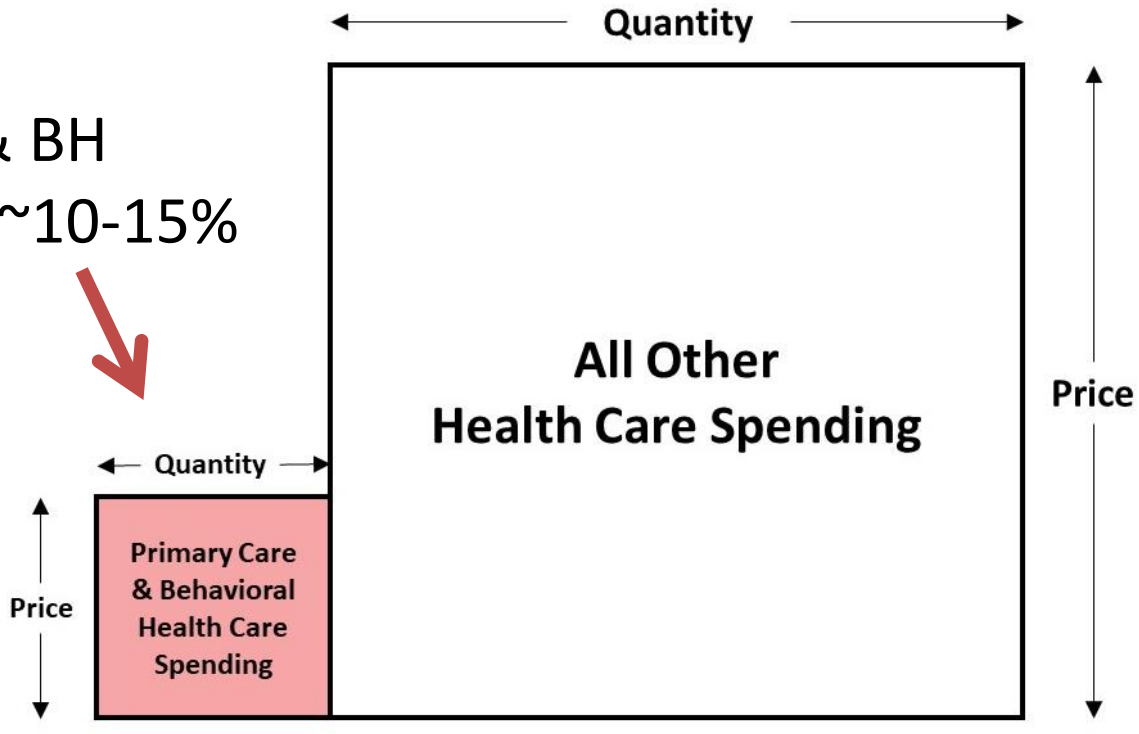
1. **Expand Access**
2. **Reduce Disparities**
3. **Improve Quality**
4. **Slow Total Spending**

Framework:

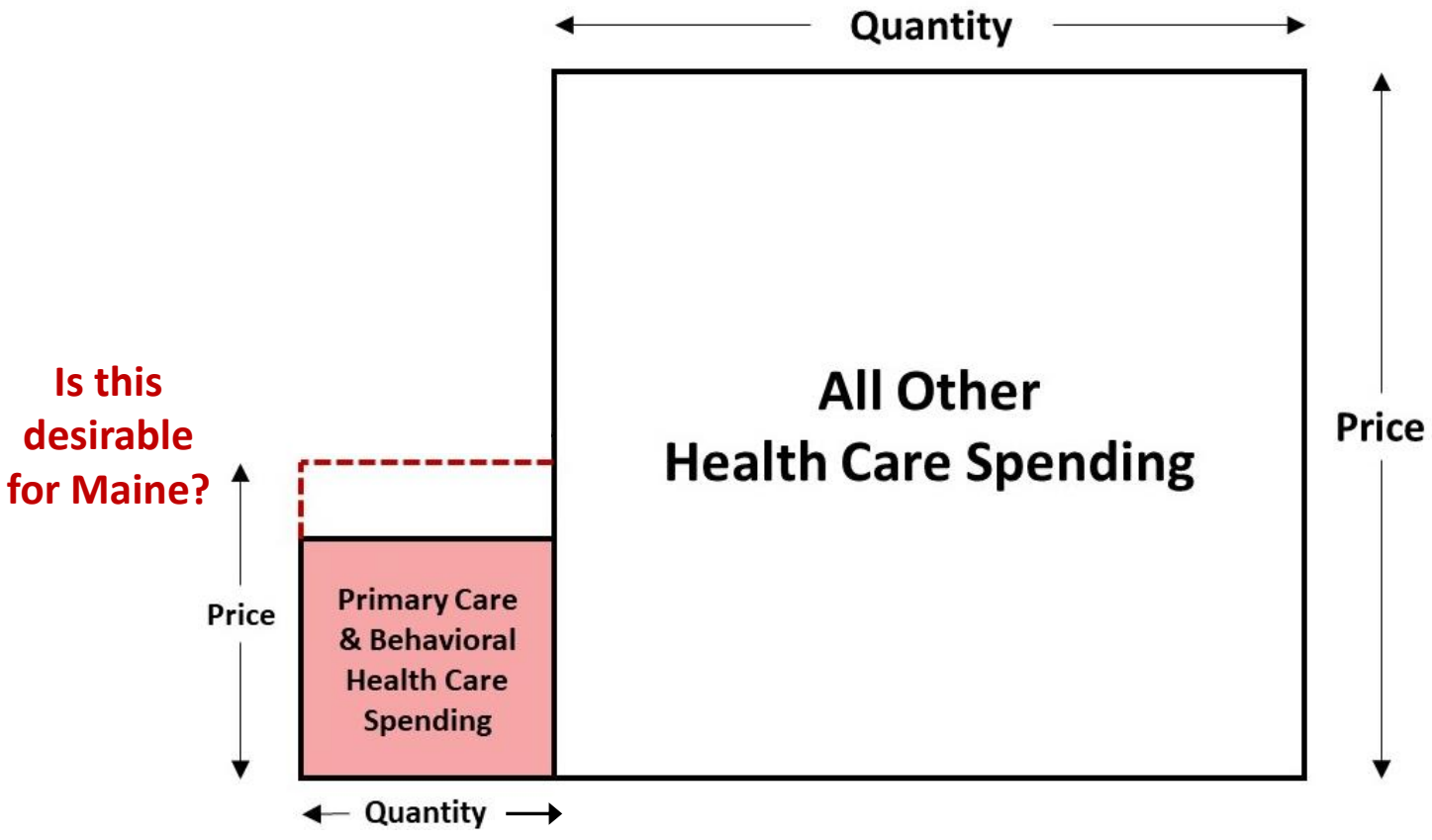

Coverage
Prevention
Capacity
Managed Care
Eligibility
Quantity
Competition
Price
Regulation
Health Care Spending
Bundled Payment
Global Budget

Fact 1: Spending = Price x Quantity

Fact 2: PC & BH spending = ~10-15%

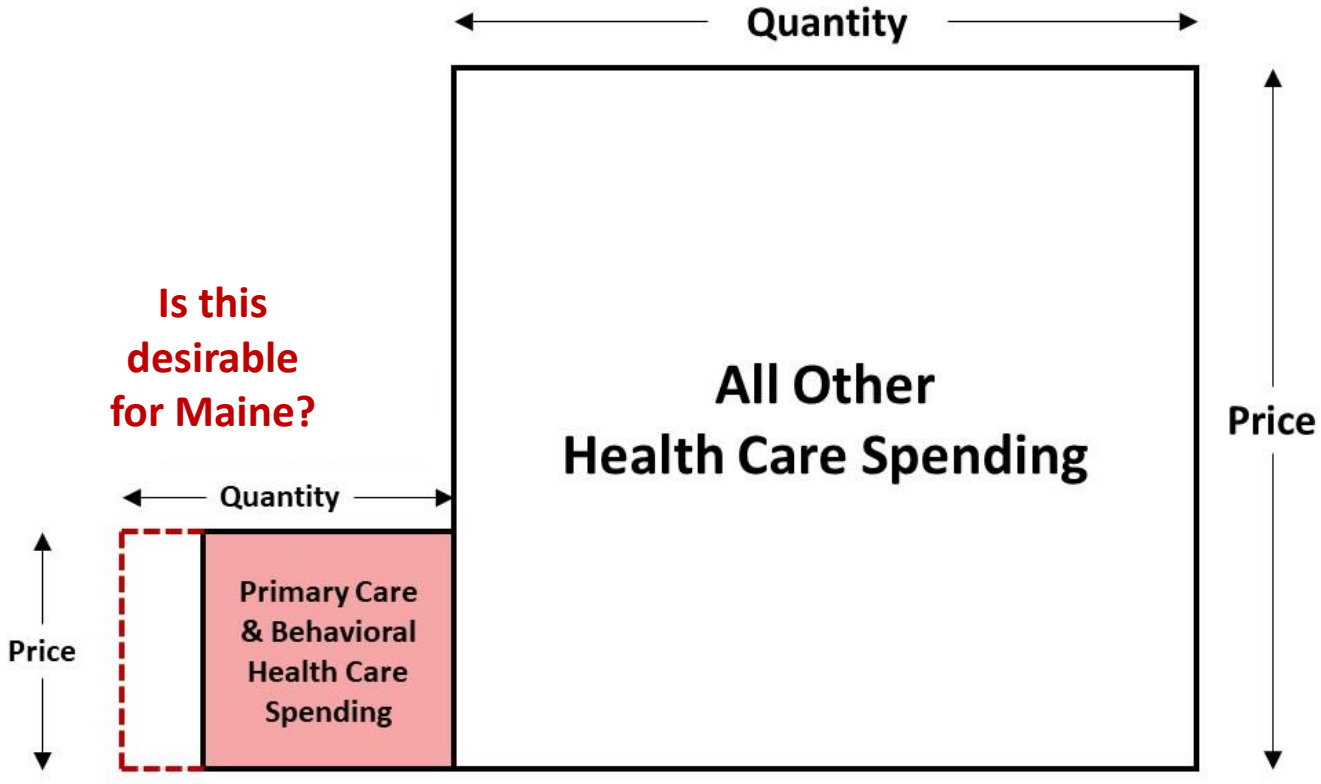


Potential Response #1: Raise prices by 1-2%



Potential Response #2: Increase visits by 1-2%

- See more patients, and/or
- Bill more visits per patient



Cost control: Total spending growth cap in year 5?
If so: key tradeoffs → redistribution

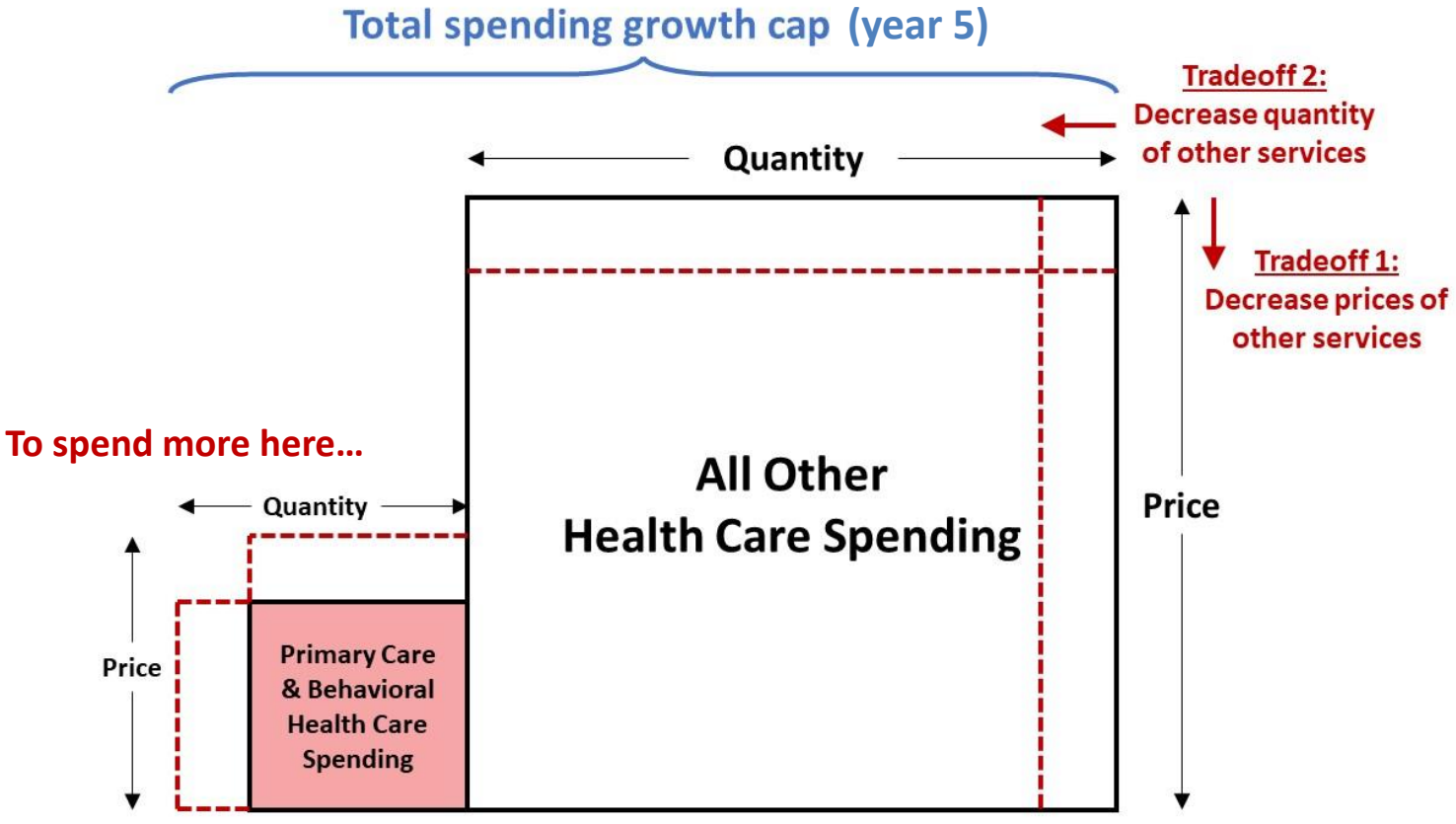
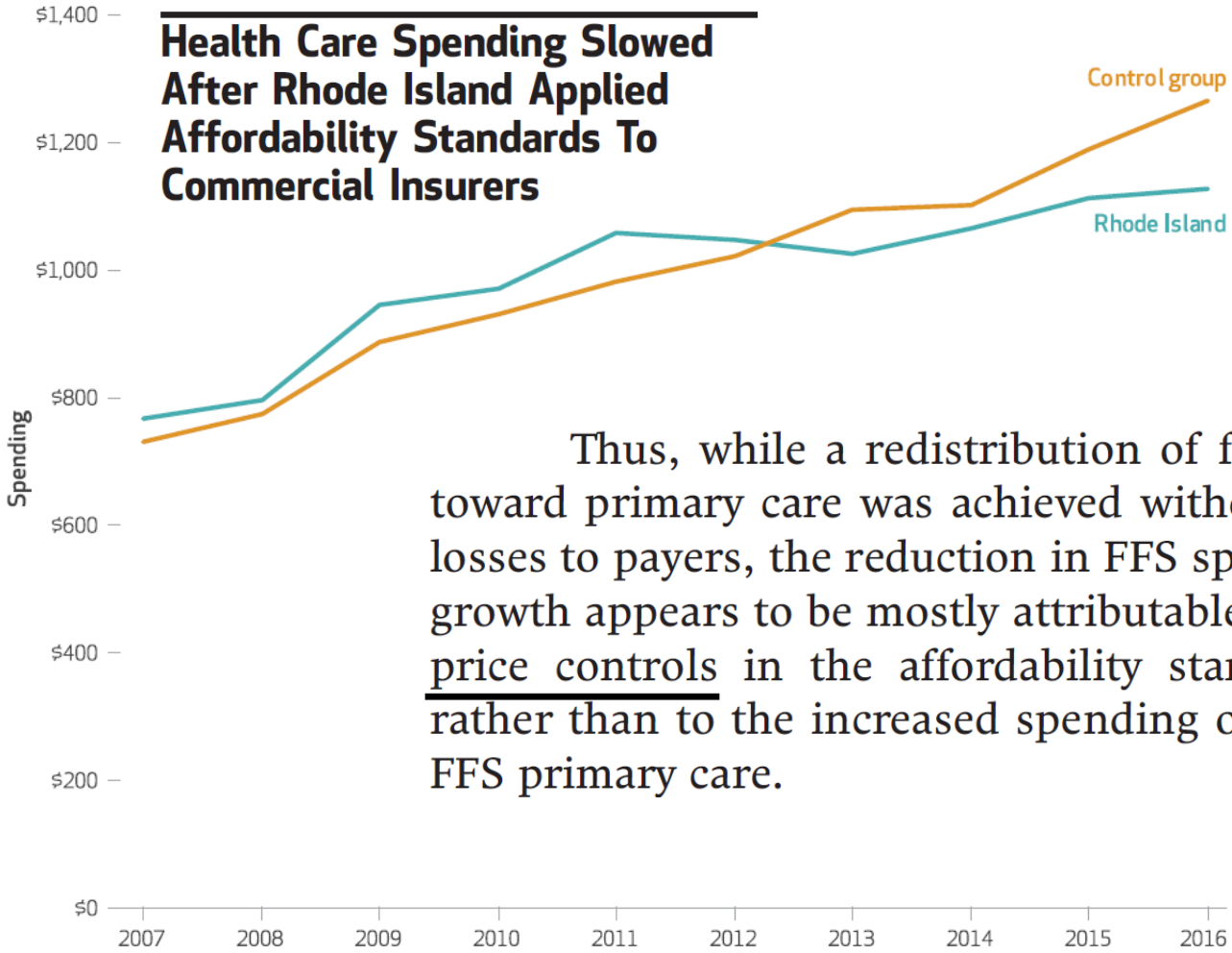


EXHIBIT 2

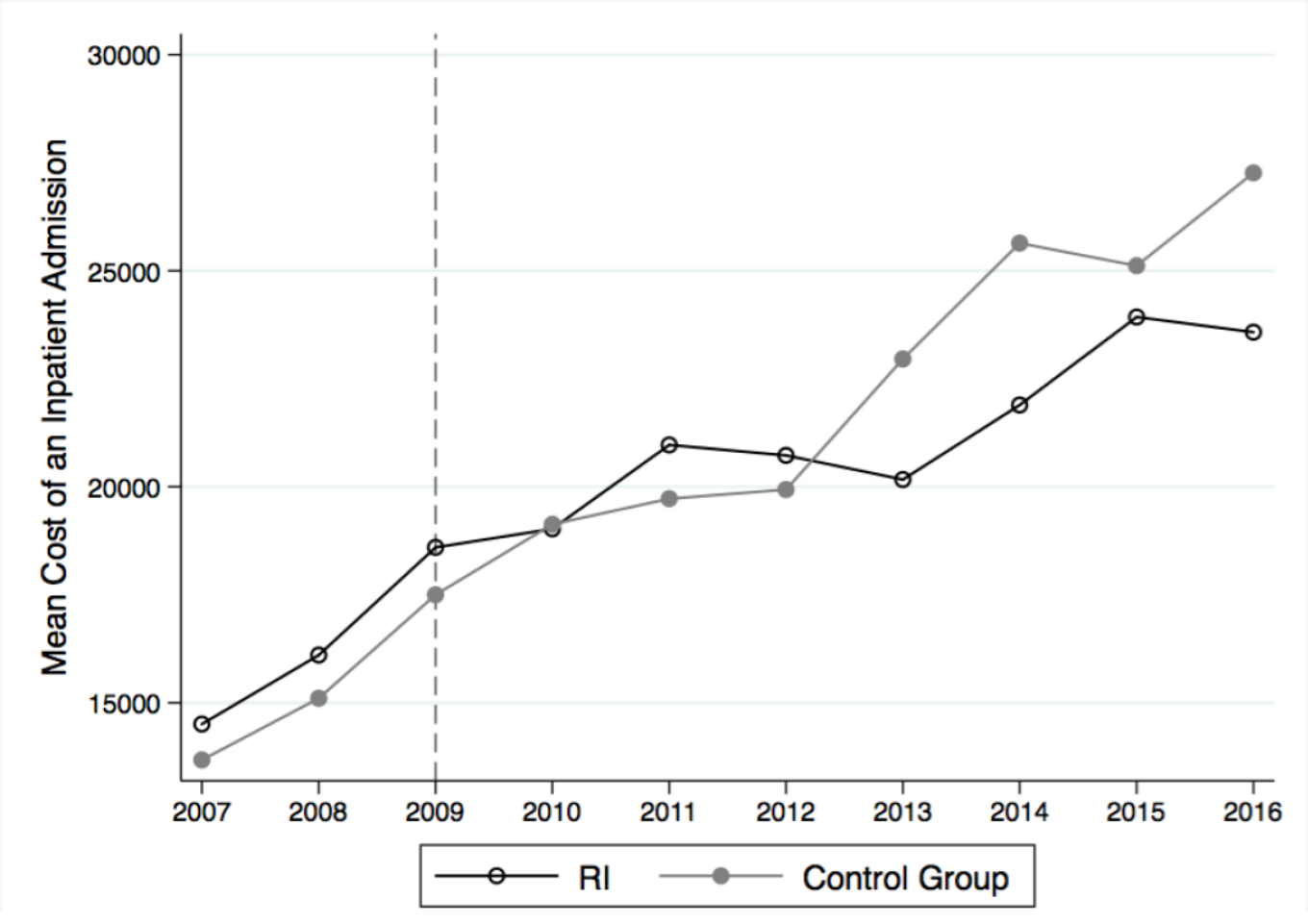
Quarterly per enrollee fee-for-service spending in the Rhode Island and control-group cohorts, 2007–16



Thus, while a redistribution of funding toward primary care was achieved without net losses to payers, the reduction in FFS spending growth appears to be mostly attributable to the price controls in the affordability standards, rather than to the increased spending on non-FFS primary care.

Baum A, Song Z, Landon BE, Phillips RS, Bitton A, Basu S. *Health Affairs*. 2019.

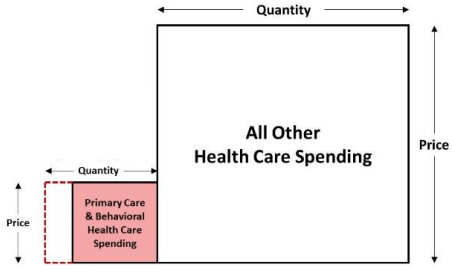
Exhibit A9. Unadjusted Spend per Inpatient Admission in the Rhode Island Cohort and the Control Group Cohort



Baum A, Song Z, Landon BE, Phillips RS, Bitton A, Basu S. *Health Affairs*. 2019.

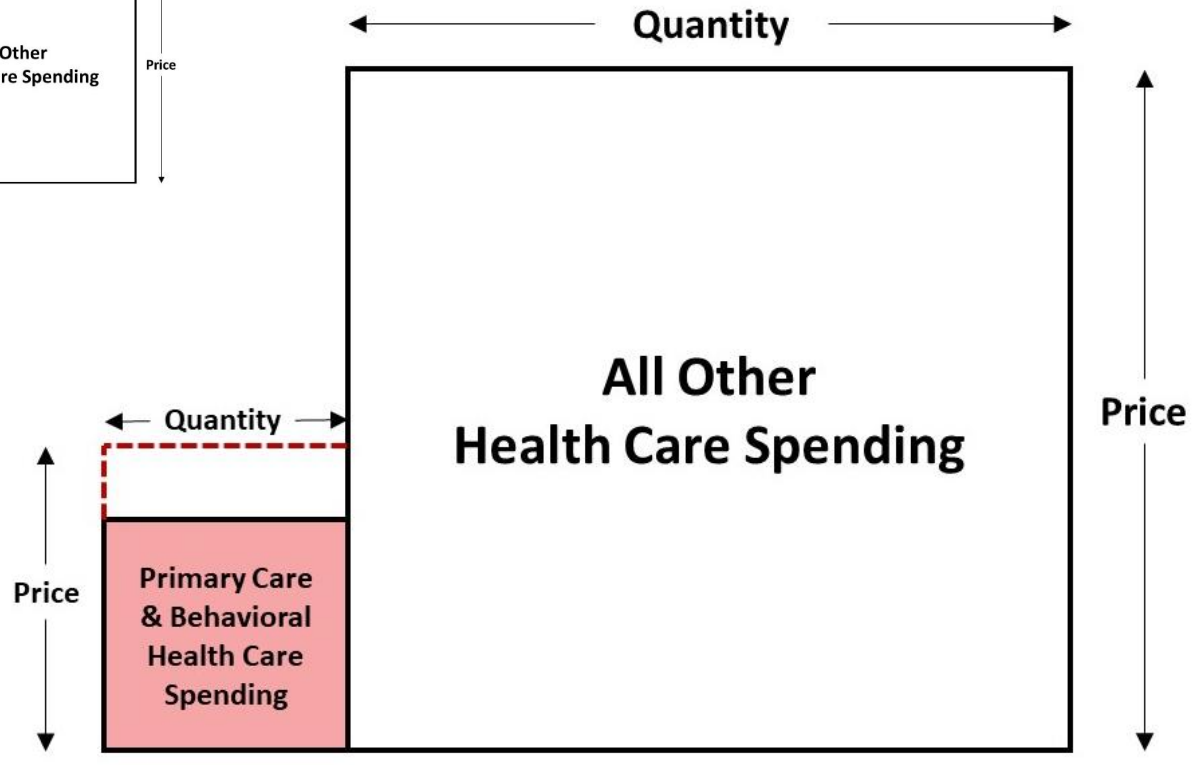
Small Provider

No market power to ↑ prices.
Relies on ↑ visits or consolidate.



Big Provider

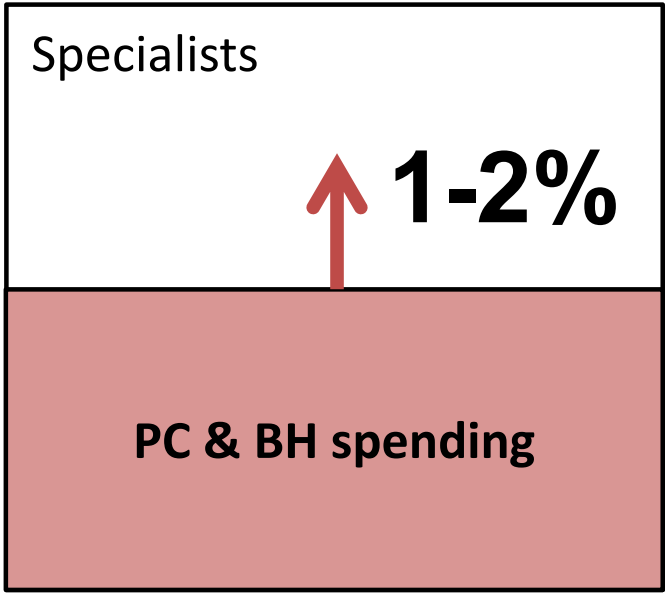
Could ↑ prices or ↑ visits.
May be easier to just ↑ prices.



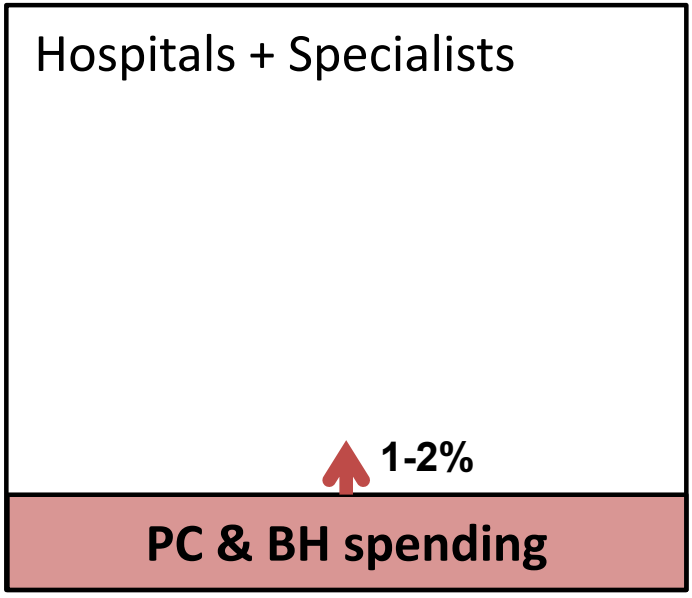
Equity of the Investment

Does each covered life receive the same boost?

Organization 1
No hospitals



Organization 2
With hospitals



Invest through global payments

NOT driven by the price or quantity of fee-for-service billing codes

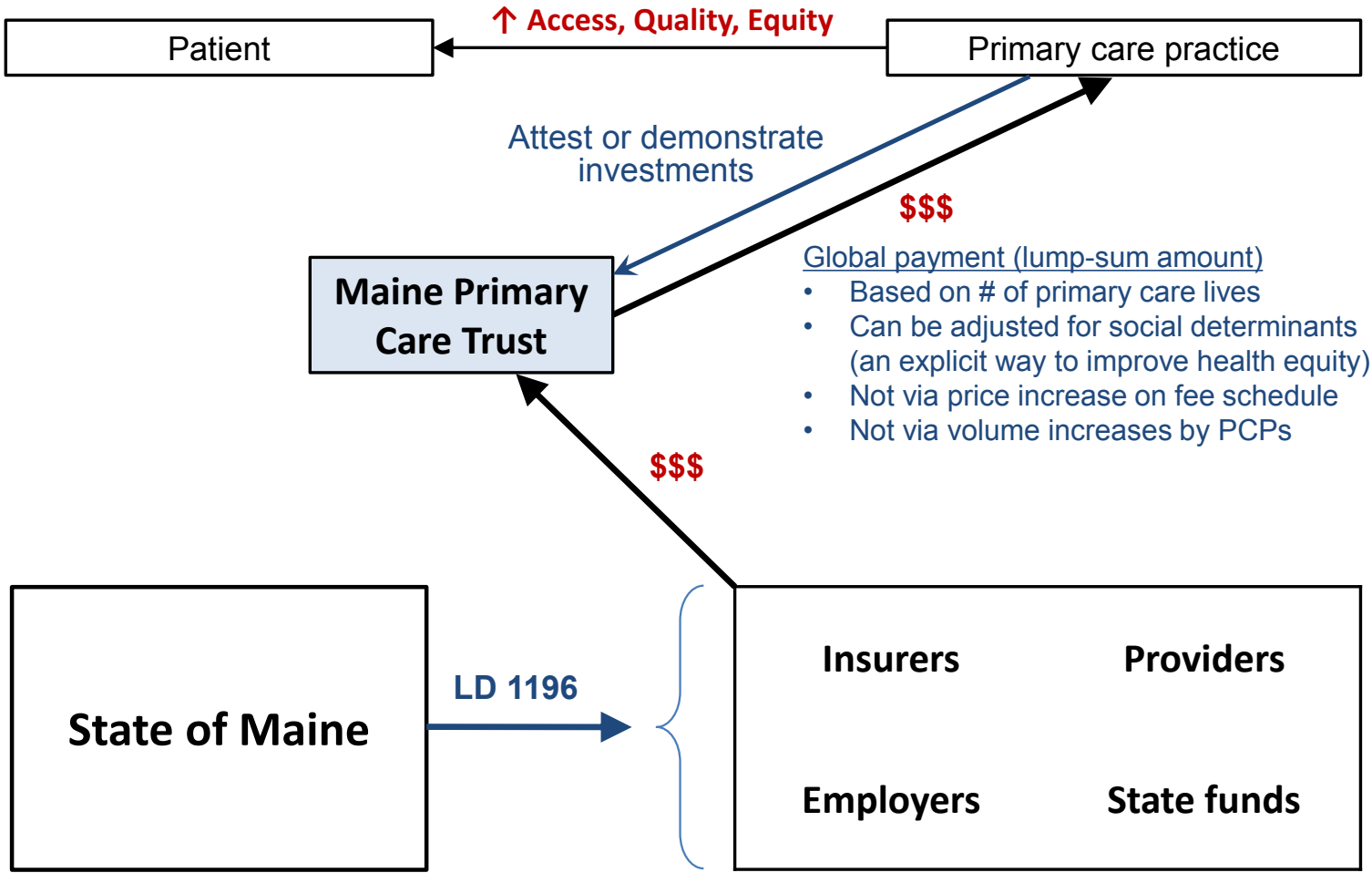
A payment directly to practices, which are accountable for enhancing PC & BH

Example PC Practice Enhancements

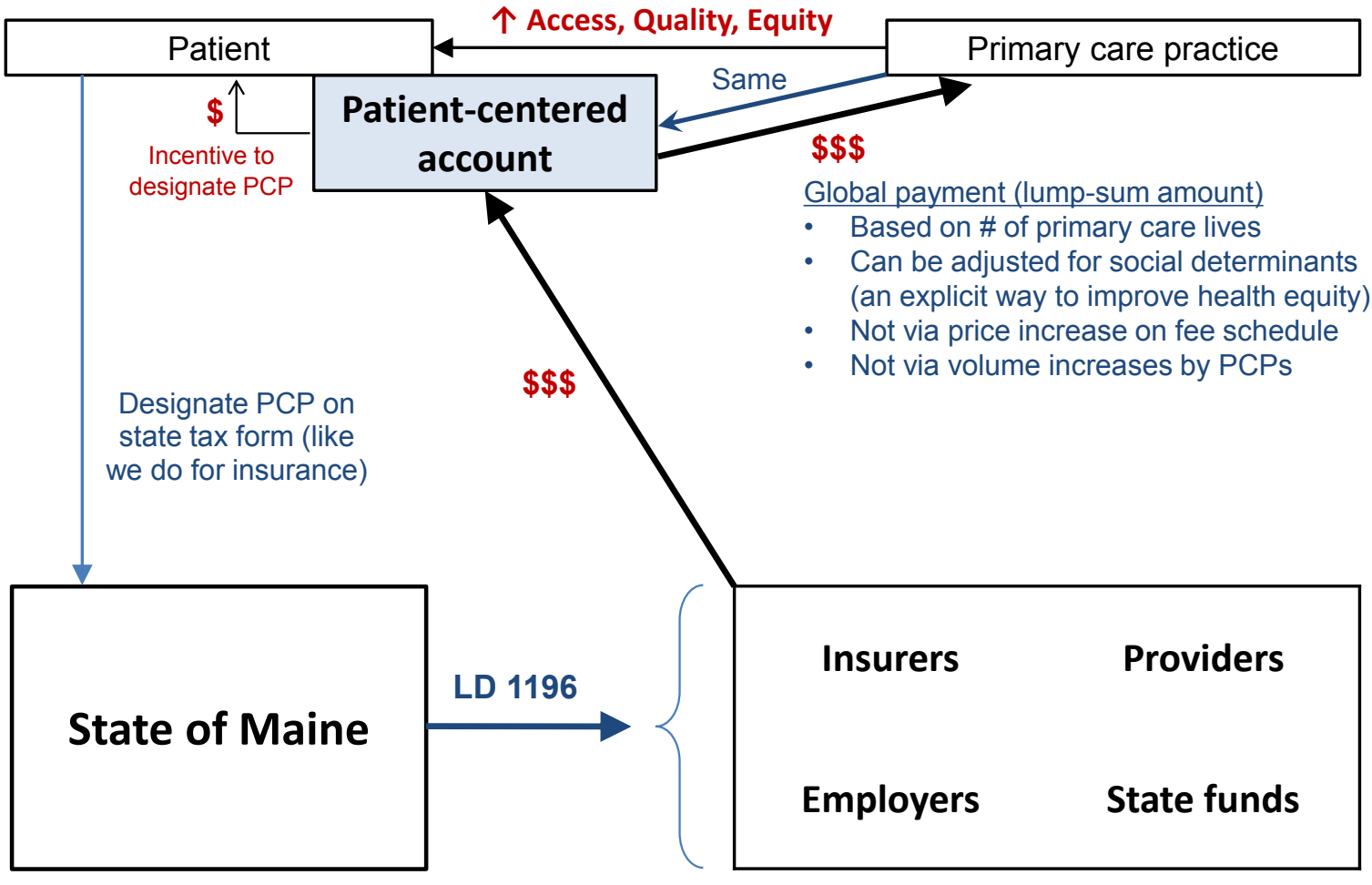
(and, in turn, accountability for using the investment)

1. Integrated Behavioral Health
2. Addiction Care and Treatment
3. Care Managers/Social Workers
4. Group Visits
5. Health Coaches
6. Medical Scribes
7. Integrated Palliative Care
8. Community Health Workers
9. TeleHealth: Video, Email, Phone
10. Walk In/Urgent Care Availability
11. Evening/Weekend Availability
12. Home Care
13. Patient Advisory Groups
14. Collaboration with Pharmacists

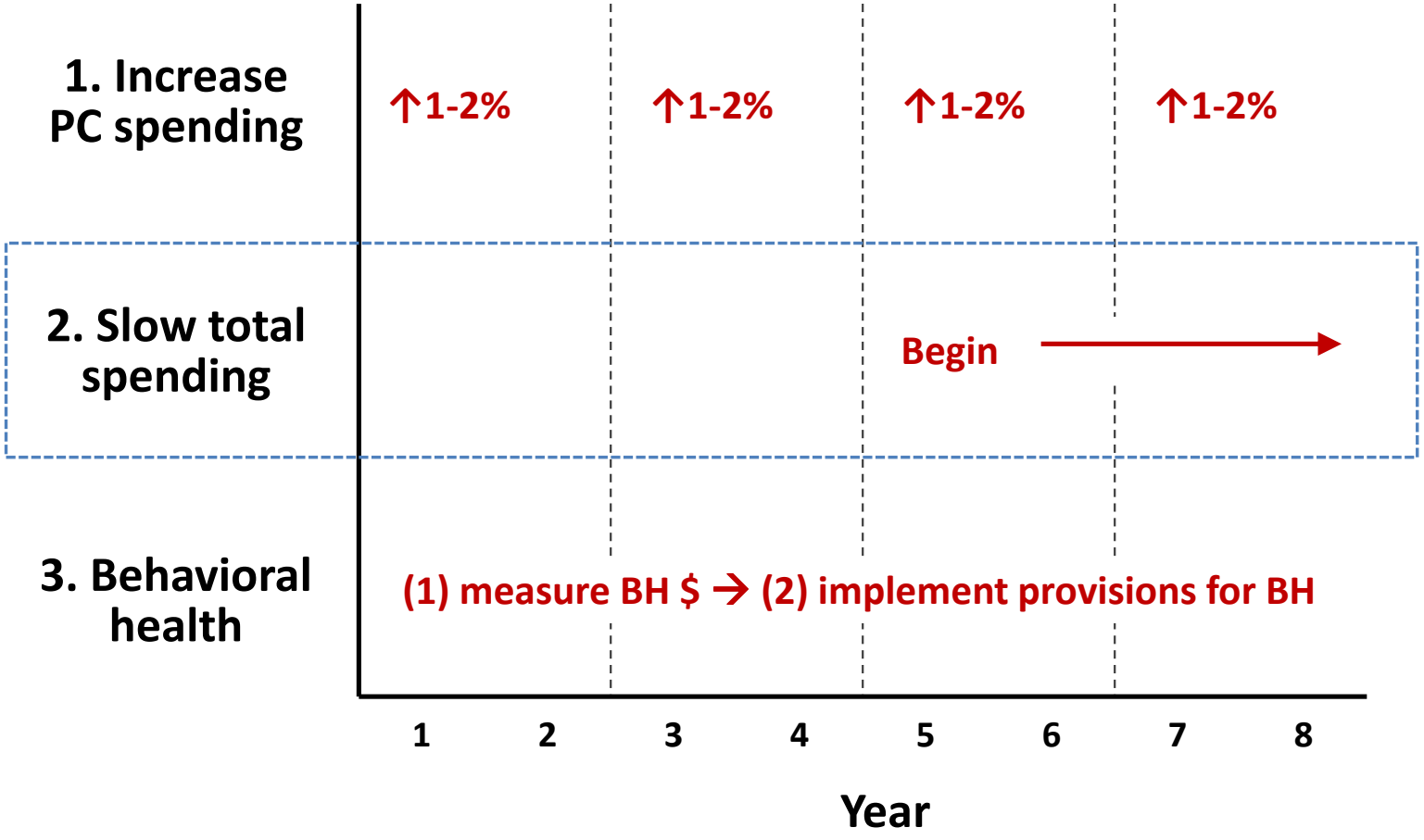
Model 1: Maine Primary Care Trust



Model 2: Patient-Centered Account



LD 1196


1. Increase PC spending
↑1-2%
↑1-2%
↑1-2%
↑1-2%
2. Slow total spending
Begin
3. Behavioral health
(1) measure BH $ → (2) implement provisions for BH
1
2
3
4
5
6
7
8
Year

VIEWPOINT

Will Increasing Primary Care Spending Alone Save Money?

Zirui Song, MD, PhD
Department of Health Care Policy, Harvard Medical School, Boston, Massachusetts; and Department of Medicine, Massachusetts General Hospital, Boston.

Suhas Gondi, BA
Harvard Medical School, Boston, Massachusetts.

Primary care, defined as core functions that patients receive from their usual source of care, is an essential component of health care and is associated with better-quality care, patient experience, and outcomes including lower mortality.[1] Observational studies have also linked primary care to lower levels of spending.[2] However, from a policy perspective, a key question is whether increasing primary care spending by a state or the nation would slow the growth of total health care spending.

In recent years, policymakers have increasingly considered spending more on primary care to improve population health and slow total spending. Rhode Island statutorily required commercial insurers to increase the proportion of health care spending on primary care by 1 percentage point per year, raising statewide primary care spending from $47 million to $74 million over 7 years.[3] Other states, including Delaware, Vermont, Maine, Oregon, and West Virginia, have passed or considered similar legislation. In May 2019, Colorado passed a bill that sets targets for primary care investments with the exception of commercial insurers, as savings were explained by lower prices without changes in utilization.[4] Evaluation of the federal Comprehensive Primary Care initiative, which enhanced core primary care functions such as care continuity and caregiver engagement, showed that monthly payments to primary care practices to support care management did not generate net savings despite reducing emergency department visits.[5] In the program's first 3 years, Medicare spending declined by $16, $10, and $2 per beneficiary per month, respectively, which did not offset the average $16 care management fee.[6] While cross-sectional analyses have found lower levels of spending in areas with a higher ratio of primary care physicians to specialists, longitudinal analyses have found that the share of primary care physicians in an area is not correlated with spending growth.[7]

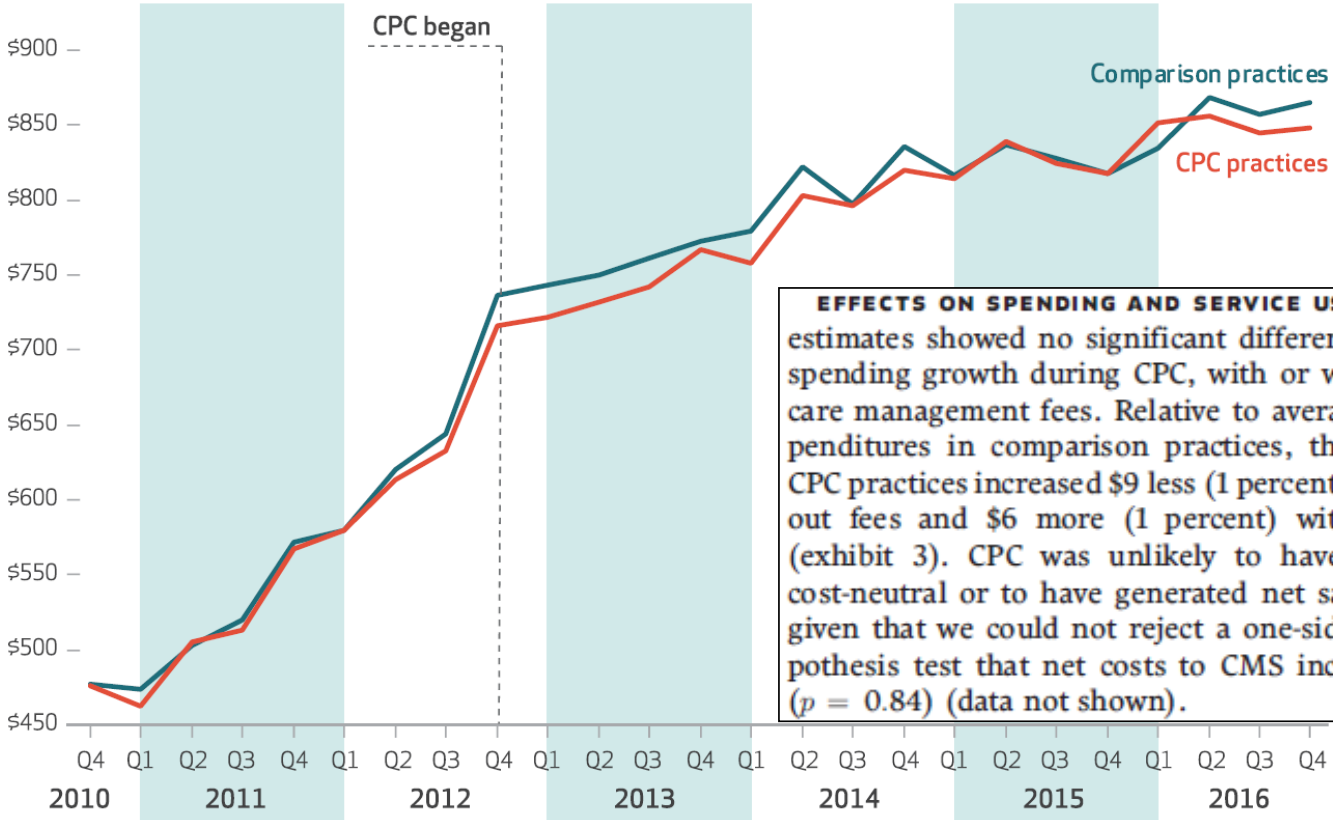
Why is evidence of greater primary care spending saving money lacking? Given spending is the product of the prices and quantities of services, savings require a decrease in prices, quantities, or both. If primary care spend-

The Comprehensive Primary Care Initiative: Effects On Spending, Quality, Patients, And Physicians

Peikes D, Dale S, Ghosh A, Taylor EF, Swankoski K, O'Malley AS, Day TJ, Duda N, Singh P, Anglin G, Sessums LL, Brown RS. *Health Affairs*. 2018.

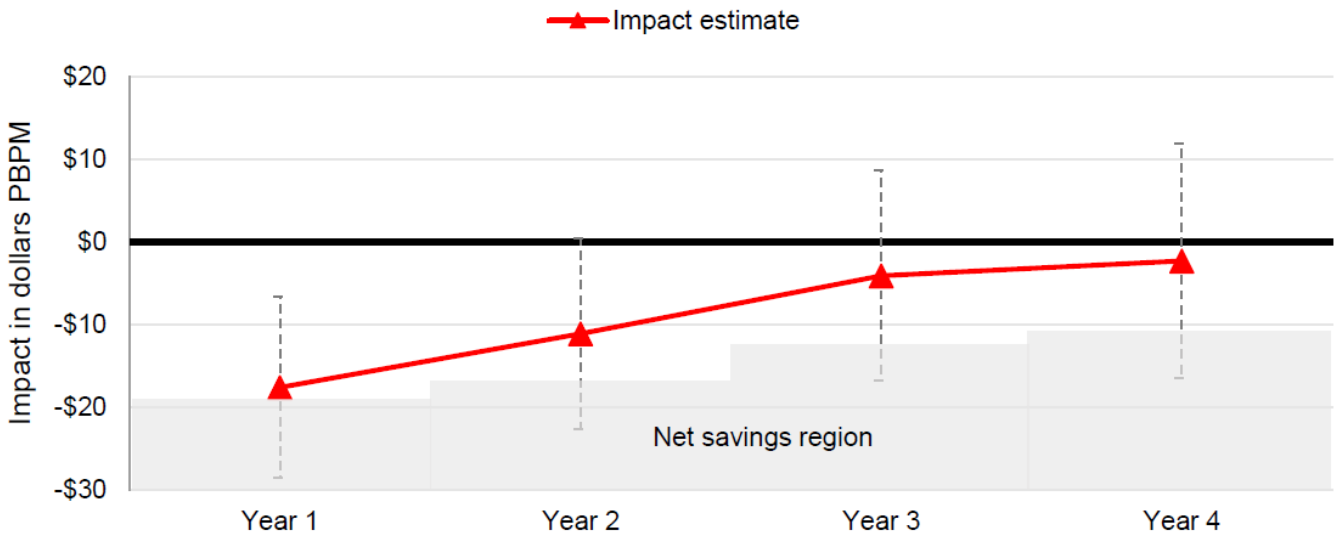
EXHIBIT 2

Predicted mean Medicare expenditures per patient per month for practices in the Comprehensive Primary Care Initiative (CPC) and matched comparison practices, by quarter, 2010–16



EFFECTS ON SPENDING AND SERVICE USE Our estimates showed no significant differences in spending growth during CPC, with or without care management fees. Relative to average expenditures in comparison practices, those in CPC practices increased $9 less (1 percent) without fees and $6 more (1 percent) with fees (exhibit 3). CPC was unlikely to have been cost-neutral or to have generated net savings, given that we could not reject a one-sided hypothesis test that net costs to CMS increased ($p = 0.84$) (data not shown).

Figure ES.8. Estimated impact of CPC on Medicare FFS expenditures without care management fees, by year



CPC did not generate enough savings to offset the care management fees for Medicare FFS beneficiaries. Including CPC's Medicare FFS care management fees (which averaged $15 per beneficiary in our intent-to-treat [ITT] analysis), average monthly Medicare expenditures per beneficiary increased by 1 percent or $6 more for CPC than for comparison practices over the 51 months. This difference was not significantly different from zero (p = 0.35, 90 percent CI -$4, $16). Findings from a Bayesian analysis also showed a high probability (94 percent) of some gross savings but almost a zero probability that the savings were sufficient to cover the care management fee. Therefore, it is unlikely that CPC was cost neutral or generated net savings for Medicare.

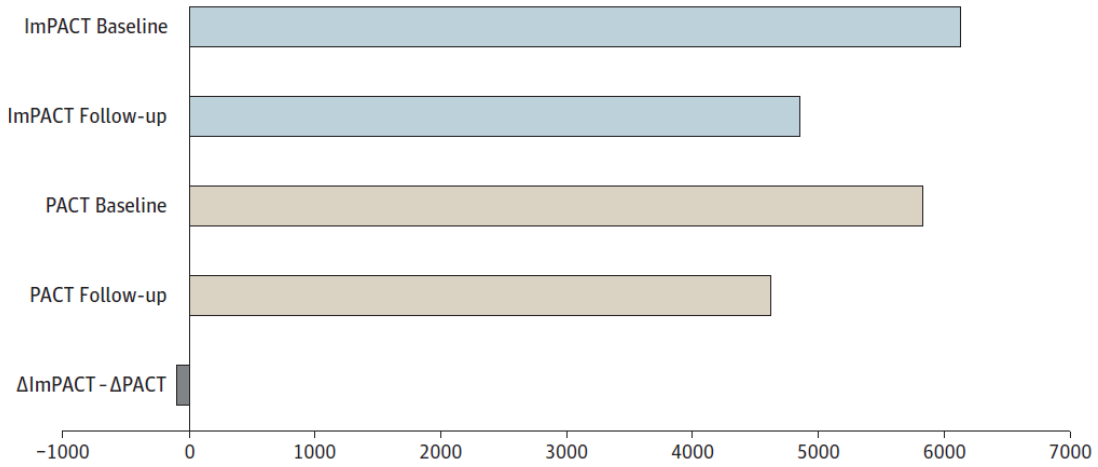
Peikes D, et al. Mathematica. 2018.

JAMA Internal Medicine | Original Investigation

Effect of an Intensive Outpatient Program to Augment Primary Care for High-Need Veterans Affairs Patients

A Randomized Clinical Trial

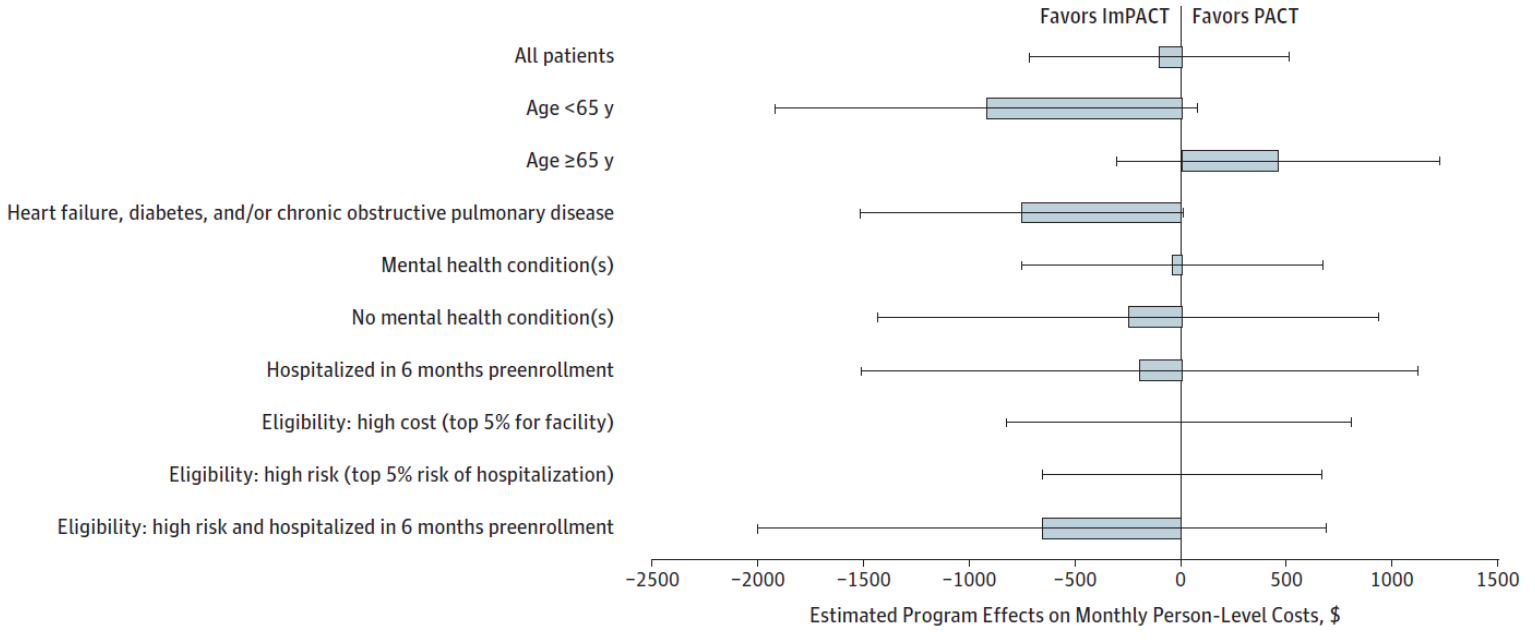
Figure 2. Mean Unadjusted Monthly Costs per Person for Intensive Management PACT (ImPACT) and Patient Aligned Care Team (PACT) Patients During Baseline and Follow-up Periods



This figure presents mean unadjusted monthly costs per person (including ImPACT encounter costs) during the baseline and follow-up periods, for the ImPACT and PACT patients who were alive and present as of February 1, 2013. If patients died or left the facility, their costs were set to 0 and missing, respectively, for subsequent months. ΔImPACT − ΔPACT indicates the change in monthly costs for ImPACT patients minus the change in monthly costs for PACT patients (ie, a negative number corresponds to a larger decline in costs over the study period among patients in ImPACT, compared with patients in PACT).

Zulman et al. *JAMA Internal Medicine*. 2017.

Figure 3. Estimated Program Effects on Monthly Person-Level Costs Among Patients in Intensive Management PACT (ImPACT) vs Patient Aligned Care Team (PACT)

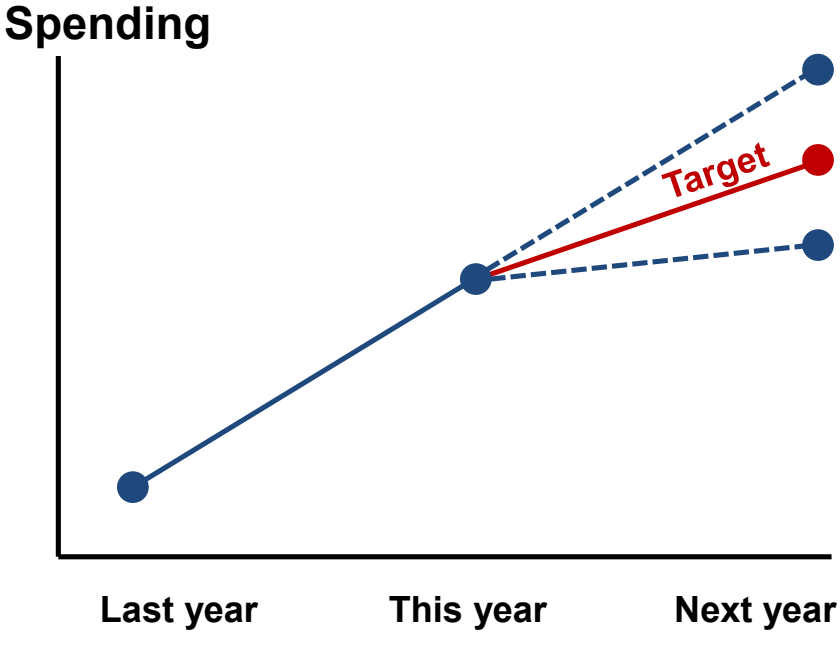


This figure presents adjusted difference-in-difference estimates for the ImPACT program's effects on monthly person-level costs. Estimates are presented for the intention-to-treat population, and for subgroups of patients with key sociodemographic and clinical characteristics at baseline. The difference-in-differences estimate corresponds to the change in monthly costs among patients in ImPACT, minus the change in costs for patients in PACT. A negative program effect corresponds to a larger decline in costs over the study period among patients in ImPACT, compared with patients in PACT. Changes in monthly costs were estimated using linear regression, controlling for patient fixed effects. If patients died or left the facility, their costs were set to 0 and missing, respectively, for subsequent months. The gray bars and error bars represent difference-in-difference estimates and standard errors, respectively, for ImPACT's effects on monthly person-level costs.

Zulman et al. *JAMA Internal Medicine*. 2017.

Global Budget / ACO Contract

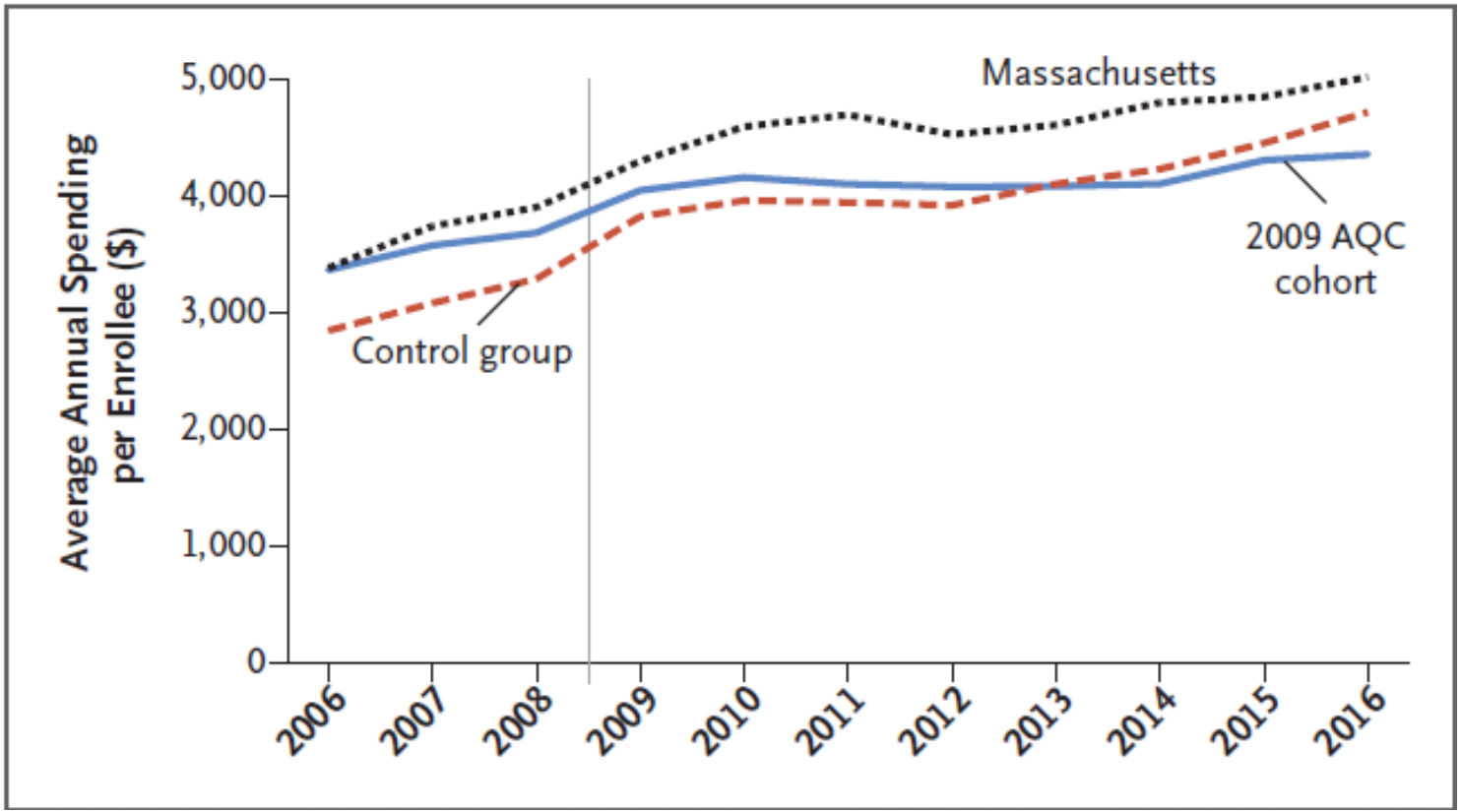
Prospective spending target (risk-adjusted) for provider organizations



	1-sided Contract	2-sided Contract
Excess	--	Penalty
Savings	Reward	Reward
	No Risk	Risk
	"Spending Target"	"Global Budget"

+ Bonuses for performance on quality measures

2-sided contract – Example from Massachusetts (BCBS Alternative Quality Contract – "AQC")



Song Z, Ji Y, Safran DG, Chernew ME. *New England Journal of Medicine*. 2019

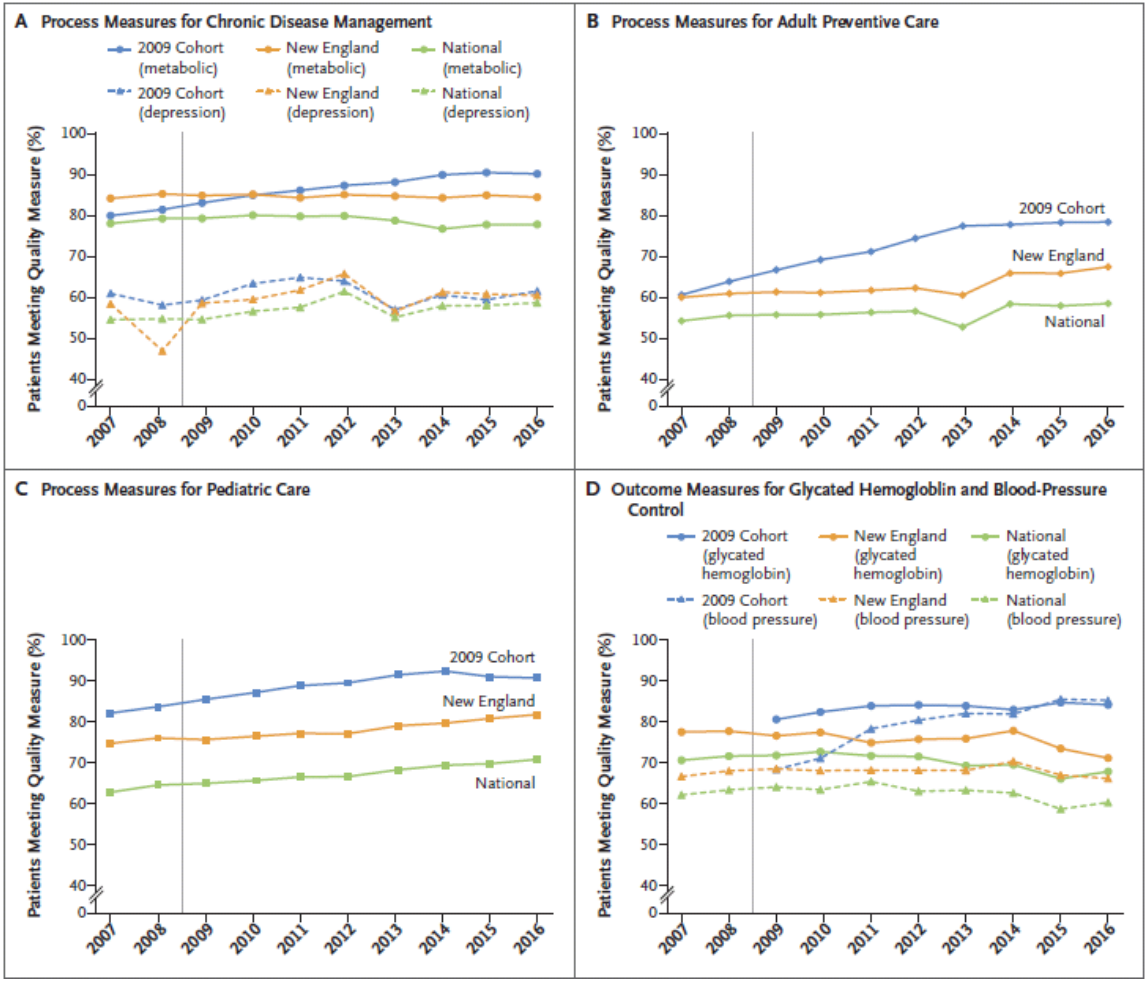
Changes in Quantity of Care Under the AQC

Table 3. Changes in Utilization in the 2009 AQC and Control Populations.*

Category of Service†	2009 AQC Cohort			Control Group			Difference in Differences‡		
	Pre-AQC (2006–2008)	Post-AQC (2009–2016)	Difference	Pre-AQC (2006–2008)	Post-AQC (2009–2016)	Difference	Unadjusted	Adjusted (95% CI)	Relative Change
	number of services/1000 enrollees/yr								%
Preventive care									
Colonoscopy	178.3	181.9	3.6	141.1	133.5	–7.6	11.2	18.3 (5.8 to 30.8)	10.1
Mammography	1333.7	1565.3	231.7	943.6	1116.1	172.5	59.1	60.2 (–15.7 to 136.2)	3.8
Imaging									
Radiography or echocardiography	874.3	840.0	–34.3	754.8	801.1	46.2	–80.6	–40.0 (–72.5 to –7.6)	–4.8
CT	128.4	99.3	–29.1	99.1	89.3	–9.9	–19.2	–13.5 (–21.0 to –6.0)	–13.6
MRI/PET/nuclear imaging	143.0	108.0	–35.0	126.1	109.4	–16.7	–18.3	–4.8 (–16.1 to 6.6)	–4.4
Specialty-drug prescription	54.4	62.5	8.1	50.6	60.6	10.0	–1.9	–13.1 (–24.7 to –1.5)	–21.0
Laboratory test	7929.5	8232.4	302.9	5766.1	6365.4	599.3	–296.4	–1365.9 (–1728.3 to –1003.4)	–16.6
Office visit or consultation	4122.6	4352.0	229.4	3967.0	4149.6	182.6	46.8	–74.4 (–183.6 to 34.8)	–1.7
Emergency department visit	279.3	273.6	–5.7	170.4	183.7	13.2	–18.9	–34.8 (–57.1 to –12.5)	–12.7
Inpatient admission	54.9	53.3	–1.7	52.5	50.5	–2.0	0.4	0.9 (–2.1 to 3.8)	1.6

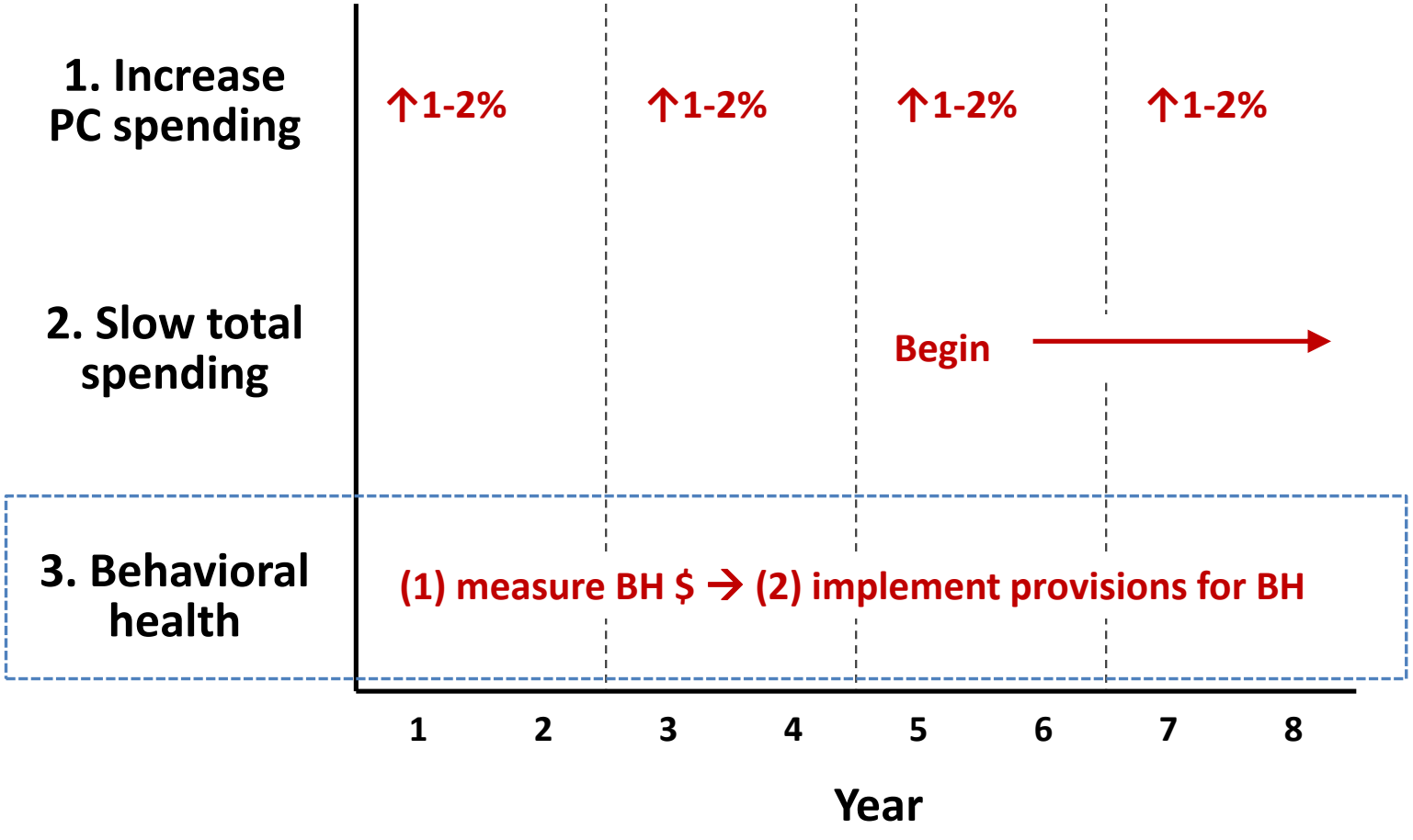
Song Z, Ji Y, Safran DG, Chernew ME. *New England Journal of Medicine*. 2019

Changes in Quality of Care Under the AQC



Song Z, Ji Y, Safran DG, Chernew ME. *New England Journal of Medicine*. 2019

LD 1196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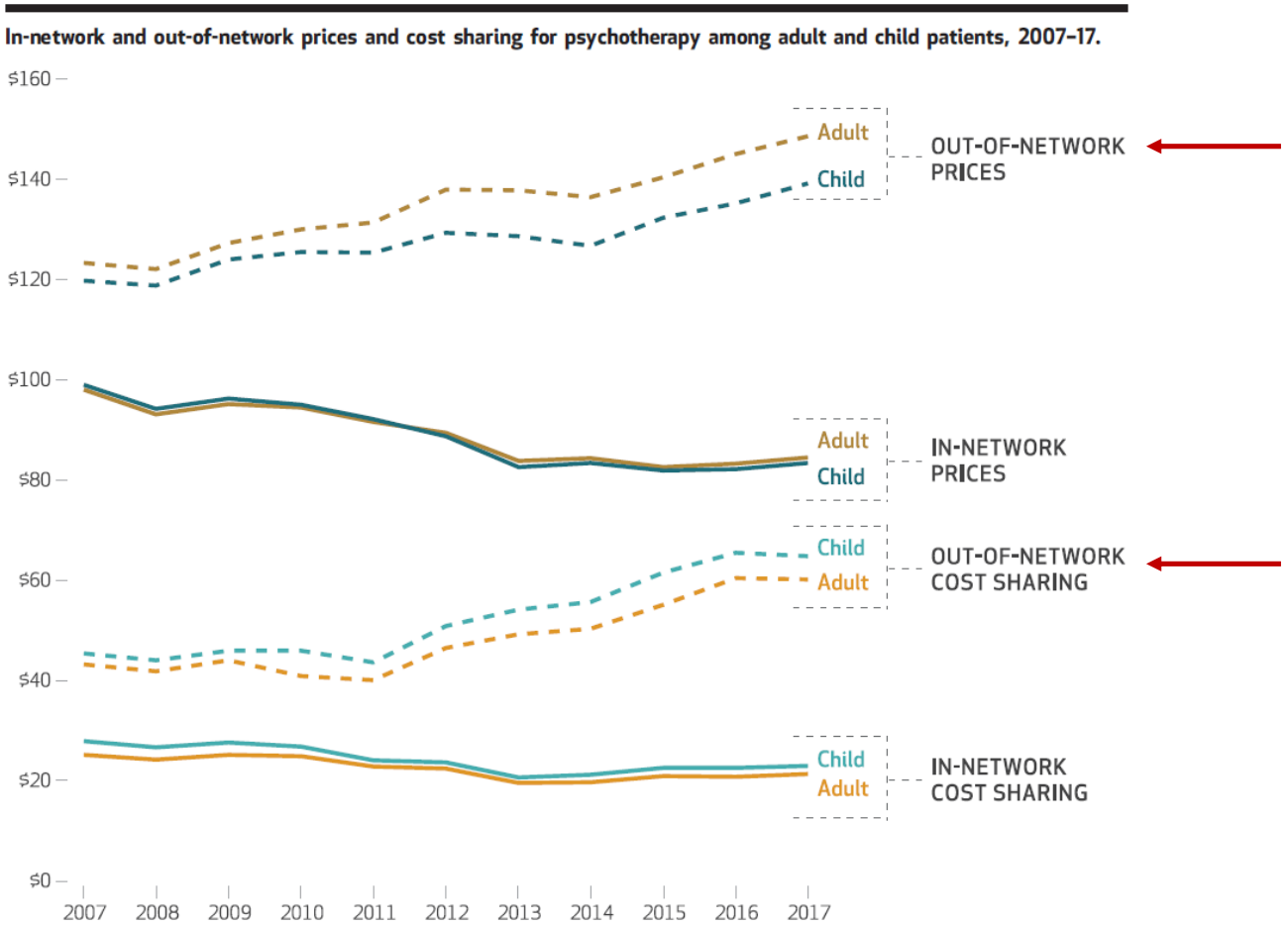
Year

Behavioral Health Market is Unique



Benson N, Song Z. *Health Affairs*. 2020

HEALTHCARE
PURCHASER
ALLIANCE
OF MAINE

LD 1196

The Employer Perspective

October 25th, 2021

Purchaser Perspective: Executive Summary

- Purchasers support an investment in primary care
- It is not the "if but the how"
- The investment needs to be tied to specific objectives and outcomes such as:

  - Linked to **growth caps** on the total cost of care from year 1 (as specified in the LD **"The group health plan shall meet the targets required in this paragraph without increasing spending on total health expenditures"**).
  - Improved clinical outcome metrics (i.e., chronic care conditions)
  - Improved patient access and engagement
  - Promotion of digital technologies to improve patient care and communication.
  - Leveraging and accounting for the current significant additional (non-claim-based payments) already being made to many primary care providers by commercial payors, which range between $4-$7+ PMPM. Medicare and MaineCare also are making significant additional payments as well…


The Solution: Let’s
Ready, Aim, Fire

Purchaser Concerns

- Current medical cost trends are unsustainable for:
  - Employees and families (stagnating real wage growth and household budgets)
  - Private employers large and small
  - Individual market
  - Public entities (towns, school districts, State health plan, University System, etc.)
- Wide variations in cost, quality, and access with little accountability for outcomes
- Medical price increases that are multiples of CPI
- The current significant investment in the additional payments made to some primary care practices by all payors have not produced the original expected value proposition of a compelling improvement in clinical outcomes and a reduction in the total cost of care.

Maine Patient-Centered Medical Home Model…

Been There, Done That

Description:

- The Maine Patient-Centered Medical Home Pilot was launched in January of 2010. The payers endorsed a three-component payment model that includes: (1) a new, up-front "per member, per month" care management fee paid to PCMH practices, (2) continued fee-for-service payments, and (3) payment that recognizes excellent performance by the practice, whenever possible.

Payment Model Today:

- Payers have continued to make similar investments in primary care

Results:

- For our purchasers they have not seen any outcome metrics that supports these payments have improved clinical outcomes, access, or affordability to justify the additional investment.

Financial Investment

- For 2021, the cost for one HPA member was approximately $4 PMPM, which represents an annual cost of over $2.4 million. In aggregate the current investment is approximately $6m for our members. Statewide for all payors the current additional investment is in the 10's of millions.

Controlling Total Cost of Care Considerations

Addresses Affordability

Controls pricing

- "The Health Care Cost Institute's (HCCI) Health Care Cost and Utilization Report found that, from 2014 to 2018, prices accounted for about 75 percent of the increase in spending above inflation

Popular Myths vs Reality (Rand 3.0)

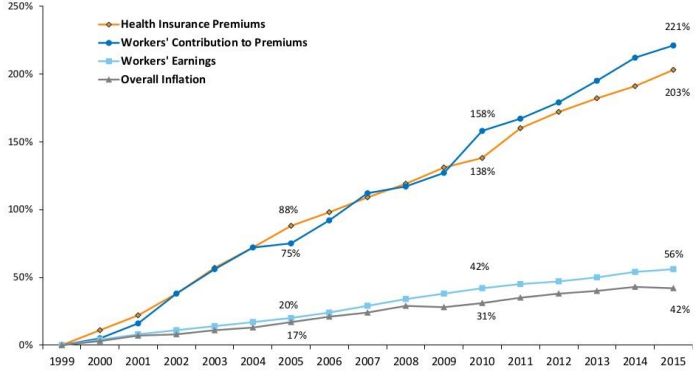
- There is little relationship between pricing and payor mix
- There is little relationship between pricing and the quality of care

Little evidence that just investing in primary care alone reduces the total cost of care – in fact, it is likely to increase

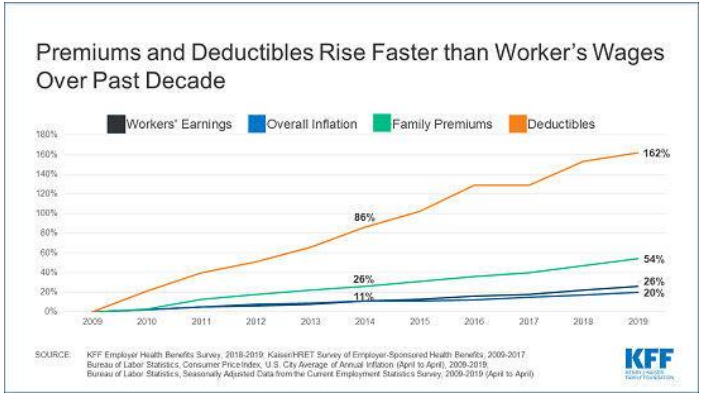
What Other States are Doing

THE PROBLEM: AFFORDABILITY

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2015



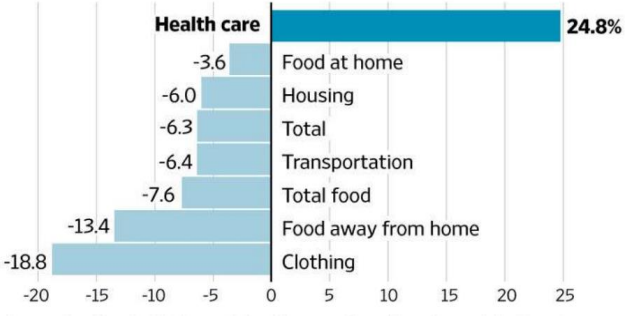
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2015 (April to April).



THE PROBLEM: AFFORDABILITY

Impact on Family Budgets

% change in middle-income households' spending on basic needs (2007-2014)



*"Twenty years of wage stagnation on the middle class has been 95% caused by **exploding healthcare costs**."*

Source: "Twenty years of wage stagnation on the middle class has been 95% caused by exploding healthcare costs," Anna Louie Sussman, "Burden of Health-Care Costs Moves to the Middle Class," *Wall Street Journal*, August 25, 2016. Available at: https://www.wsj.com/articles/burden-of-health-care-costs-moves-to-the-middle-class-1472166246 and Dave Chase, "Economic Development 3.0: Playing the Health Car," January 2017. Available at: https://www.linkedin.com/pulse/economic-development-30-playing-health-card-dave-chase/.

Impact on State Funding

State of Massachusetts Funding: 2001–2014

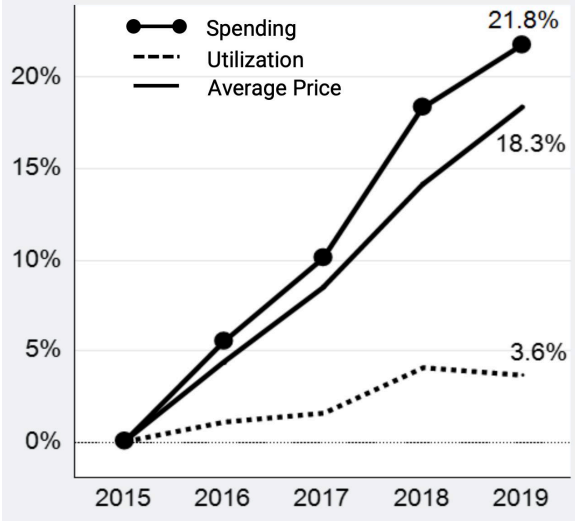
+37%
Healthcare
Spending

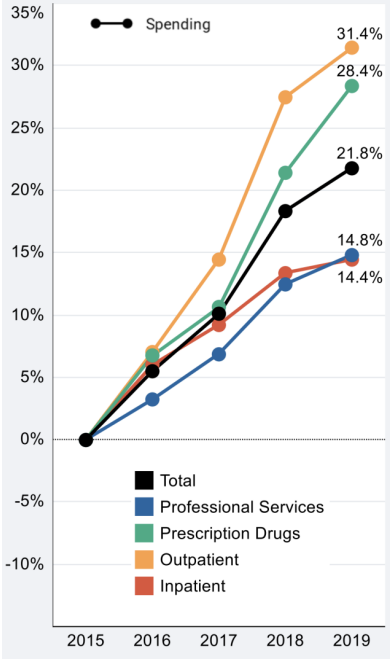
-50% Local Aid
-31% Public Health
-22% Mental Health
-14% Infrastructure, Housing, & Econ. Dev.
-13% Law & Public Safety
-12% Education
-11% Human Services

Source: Dave Chase, "Unleashing the American Dream by Thwarting the Healthcare Heist," Health Rosetta, January 2017. Available at: https://www.linkedin.com/pulse/economic-development-30-playing-health-card-dave-chase/.

PRICES, NOT UTILIZATION, DRIVING COSTS

Cumulative Change in Spending per Person, Utilization, and Average Price since 2015





Cumulative Change in Spending per Person, Utilization, and Average Price by Service Category

Source: Health Care Cost Institute, *2019 Health Care Cost and Utilization Report*. Available at: https://healthcostinstitute.org/images/pdfs/HCCI_2019_Health_Care_Cost_and_Utilization_Report.pdf..

THE PROBLEM: High Cost, Low Quality

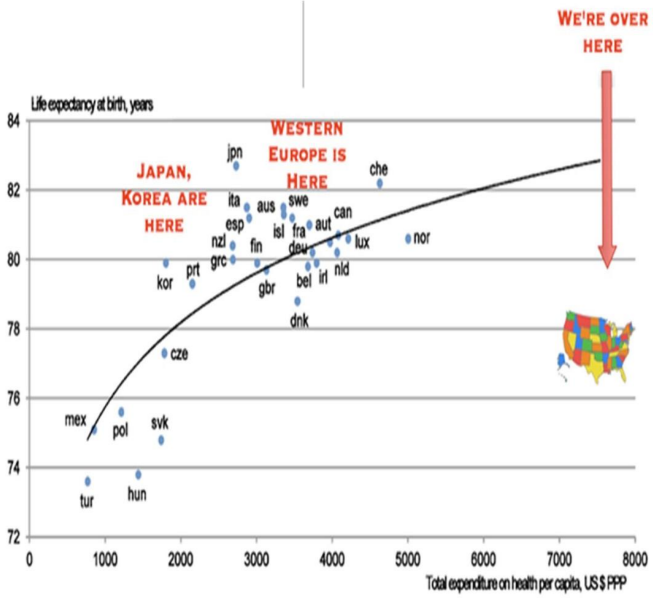


EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

Top 2*

Middle

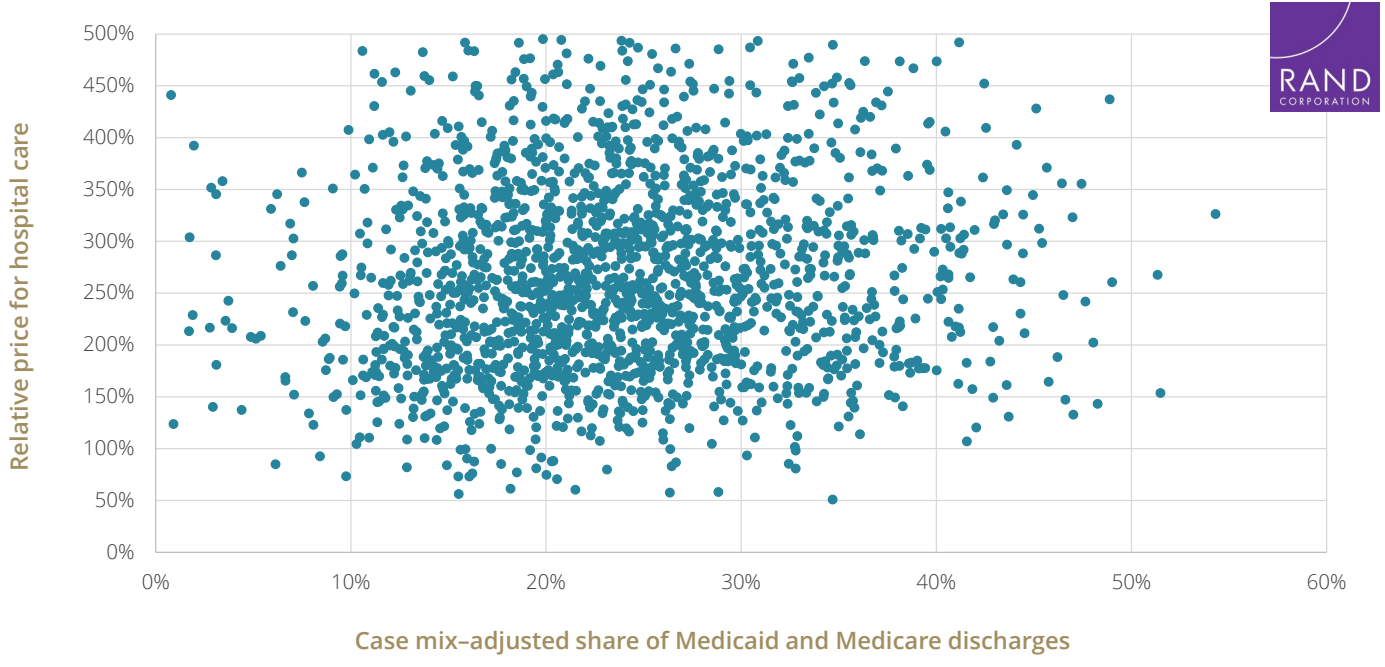
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.

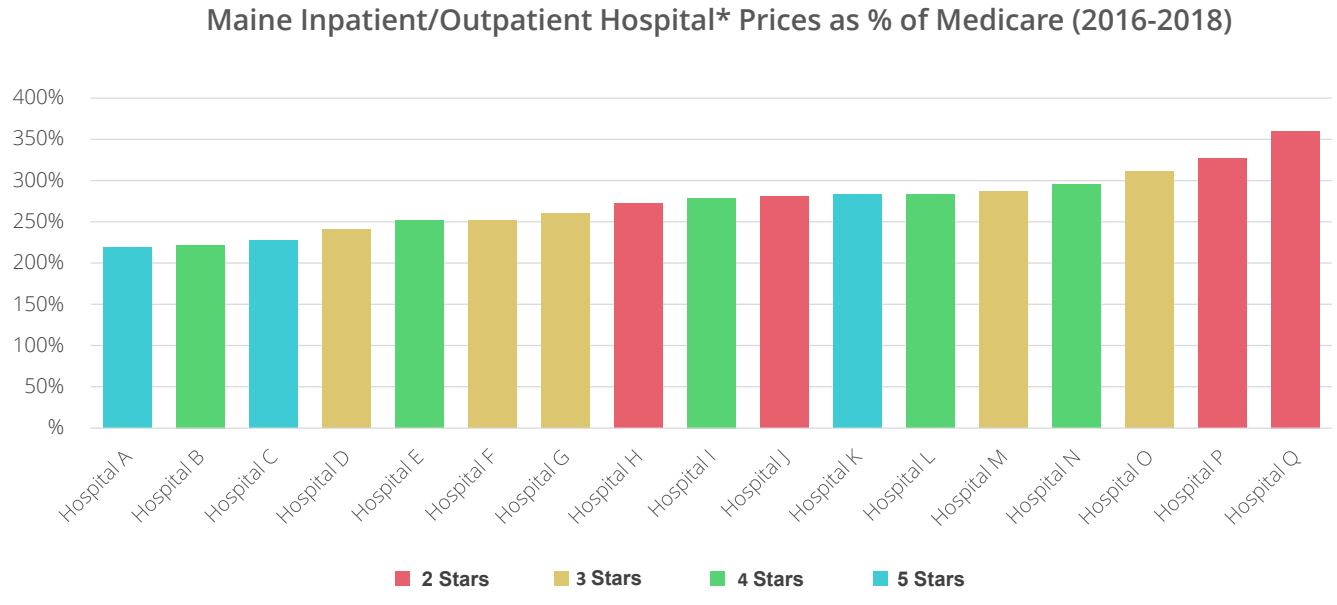
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011*; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

MYTH: PAYER MIX EXPLAINS PRICE VARIATION



Source: Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, 2020. Available at: https://www.rand.org/pubs/research_reports/RR4394.html.

MYTH : COST & QUALITY ARE CORRELATED



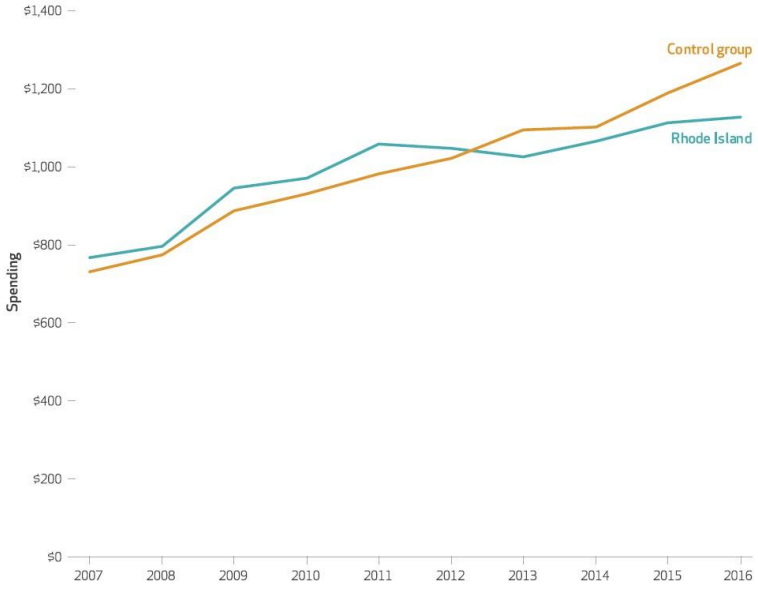
* Excludes Critical Access Hospitals
Notes: Prices are a percent of Medicare (2016-2018). 10/18 CMS Star Ratings. Prices are calculated based on allowed amounts paid by private employer-sponsored health plans.

Source: Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, 2020. Available at: https://www.rand.org/pubs/research_reports/RR4394.html.

WHAT DROVE SAVINGS IN RHODE ISLAND?

EXHIBIT 2

Quarterly per enrollee fee-for-service spending in the Rhode Island and control-group cohorts, 2007–16



Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers

2013.[8] Thus, while a redistribution of funding toward primary care was achieved without net losses to payers, the reduction in FFS spending growth appears to be mostly attributable to the price controls in the affordability standards, rather than to the increased spending on non-FFS primary care.

Source: Baum A, Song Z, Landon BE, Phillips RS, Bitton A, Basu S. Health Affairs. 2019.

GROWTH CAPS IN OTHER STATES

	5-Year Average (2010-2014)	10-Year Average (2005-2014)	20-Year Average (1995-2014)	Cost Growth Benchmark
Connecticut	2.4%	3.9%	4.8%	3.4% for 2021 3.2% for 2020 2.9% for 2023-2025
Massachusetts	3.0%	4.7%	5.1%	3.6% for 2013-2017 3.1% for 2018-2022
Delaware	5.1%	5.7%	5.6%	3.8% for 2019 3.5% for 2020 3.25% for 2021 3.0% for 2022-2023
Rhode Island	2.6%	3.7%	5.3%	3.2% for 2019-2022
Oregon	5.3%	5.9%	5.7%	3.4% for 2021-2025 3.0% for 2026-2030

- States started with target values that were 59-70% of their 20-year growth, and dropped those values over time to 52-60%, except for Rhode Island which kept a steady target at 60% of the State's 20-year growth.
- Note that the averages reflect data not available to Massachusetts when it set its targets.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditure Data: National Health Expenditures by State of Residence, June 2017.

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  - Linked to **growth caps** on the total cost of care from year 1 (as specified in the LD **"The group health plan shall meet the targets required in this paragraph without increasing spending on total health expenditures"**).
  - Improved clinical outcome metrics (i.e., chronic care conditions)
  - Improved patient access and engagement
  - Promotion of digital technologies to improve patient care and communication.
  - Leveraging and accounting for the current significant additional (non-claim-based payments) already being made to many primary care providers by commercial payors, which range between $4-$7+ PMPM. Medicare and MaineCare also are making significant additional payments as well…

MaineHealth

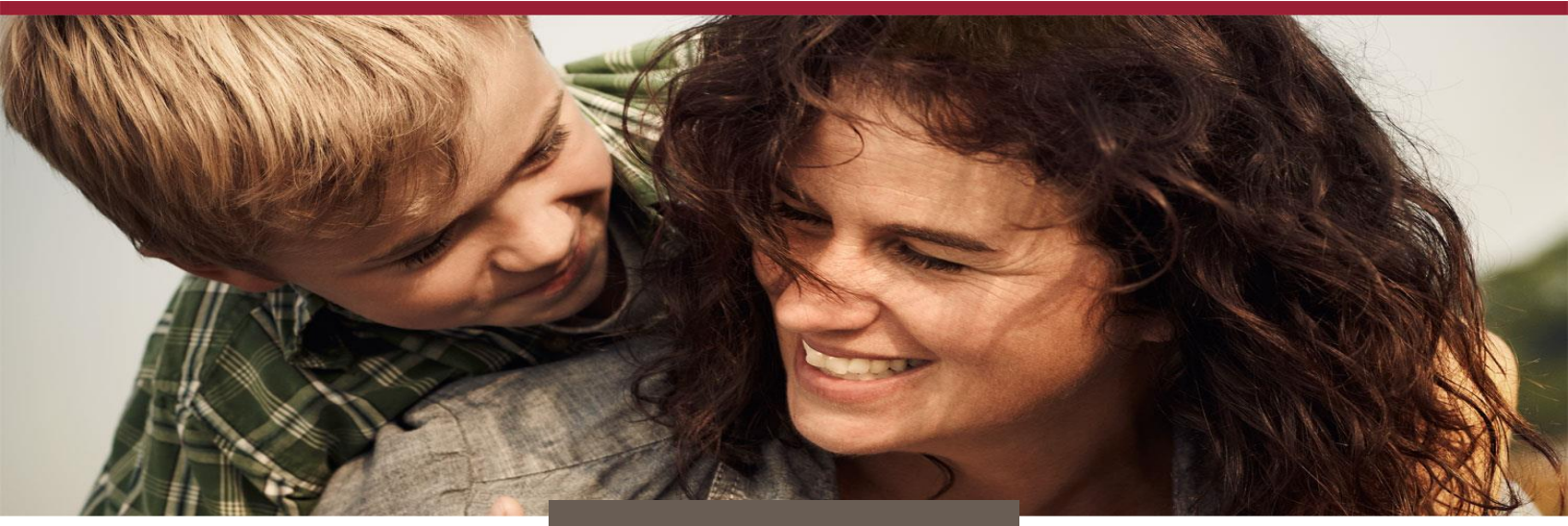
LD 1196 – MaineHealth Perspective

October 22, 2021

Rob Chamberlin, MD, MBA

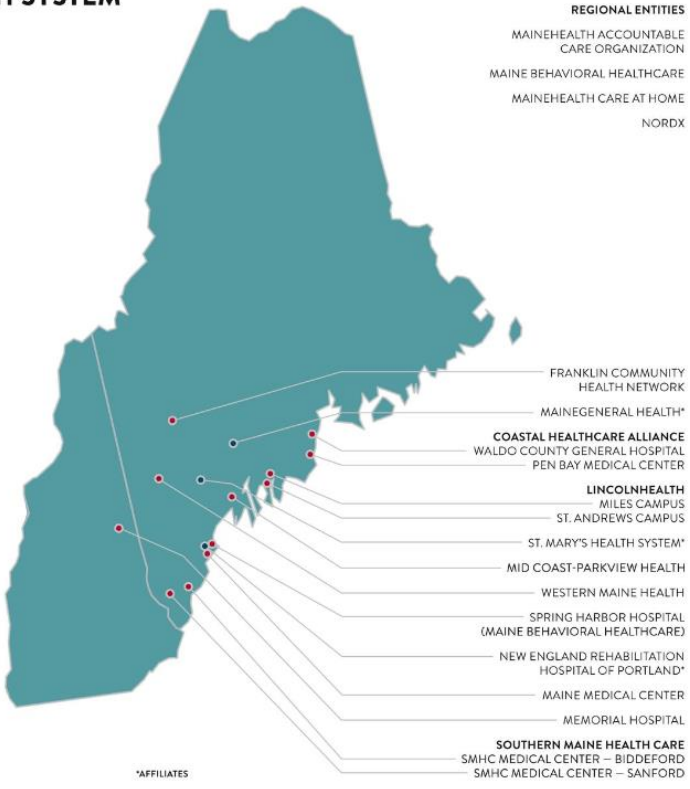
Outline

- MaineHealth Overview
- Support of Primary Care and Behavioral Health
- Opposition to cost cap mandated by LD 1196
- Support for payment reform



Our Vision: "Working together so our communities are the healthiest in America"

THE MAINEHEALTH SYSTEM



MaineHealth's Primary Care System

- We are the largest primary care system in the state
- 50+ primary care practices across MaineHealth
- ~325 PCPs
- Care for over 200,000 primary care patients, and growing
- The MaineHealth ACO includes another ~35 primary care physicians and APPs. However, this number has dropped significantly over the past 5 years.

MaineHealth is Committed to Primary Care

- Primary Care access is one of five top priorities for MH
- MaineHealth continues to invest in services to expand primary care teams:
  - Integrated Behavioral Health in 100% of our 74 primary care practices
  - Care Management
  - Clinical pharmacists embedded in primary are offices
  - Integrated Medication Assisted Therapy program
  - Larger primary care teams (more RNs, MAs, etc.)
- MaineHealth invests $90 million annually in behavioral health and primary care

Maine Behavioral Healthcare – State's Largest BH Provider

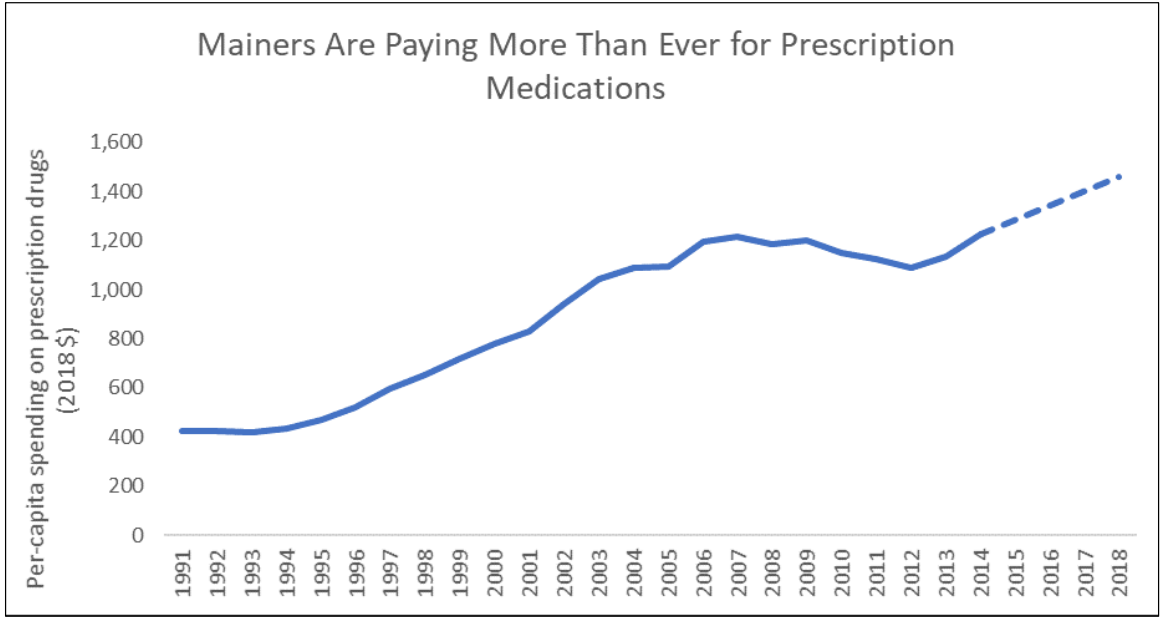
- **Mission:** To provide a seamless and compassionate continuum of care through a community of providers collaborating to promote recovery and the overall mental and physical well-being of the people we serve.
- **Care Team Members** – 100 Psychiatrists, Nurse Practitioners, & Physician Assistants, 130 Clinicians, 70 Case Managers, 40 Peer Recovery Support
- **Inpatient services-** 170 Inpatient Psychiatric Beds throughout MaineHealth System (PBMC 18; Mid Coast Hospital 13, SHH 100, MMC 21, SMHC Sanford 18 (will be up to 40)
- **Inpatient ED** MBH Crisis workers involved at WCGH, PBMC, Miles, MCH, SMHC, and Franklin.
- **Residential and Community Rehabilitation Services** – MBH has 12 sites and serve 78 clients. PNMI residences serve adults with mental illness
- **Ambulatory Services** – 11 MBH locations, 65 MMP Locations, 3 Emergency Departments

Total Cost of Care

- LD 1196 language: "…meet the targets required in this subsection by reducing avoidable health care spending without increasing spending on total health expenditures."

- Cost caps will result in unintended consequences
  - Increased financial instability
  - Reduced resources for population-health focused interventions

Drivers of Total Cost of Care beyond our control



Runaway increases in the costs of prescription drugs must be stopped - https://www.mecep.org/blog/runaway-increases-in-the-costs-of-prescription-drugs-must-be-stopped/

Drivers of Total Cost of Care beyond our control

MaineHealth supports lowering total healthcare costs and engages heavily in alternative payment models

GOVERNMENTAL

88,901 lives

Medicare Shared Savings Program	45,397
MaineCare Accountable Communities	40,726
Martin's Point US Family Health Plan*	2,778

MEDICARE ADVANTAGE

40,895 lives

Martin's Point Generations Advantage	14,740
Aetna	8,267
Harvard Pilgrim	748
Humana	2,771
United	10,785
AMH Health	3,584

COMMERCIAL

132,803 Lives

Anthem	59,793
Community Health Options	6,165
Harvard Pilgrim	23,988
Aetna	14,646
MaineHealth Self Insured	14,580
Beacon	352
CIGNA	13,279

TOTAL LIVES: 262,599

In addition, we manage 155,358 lives under our behavioral healthcare program

The Goal

- MaineHealth's goal is to meet our vision of improving the health of our communities
- MaineHealth supports increased spending for primary care and behavioral health as means to improve population health
- Tying a total cost of care cap to this bill risks reduction in the very resources we need to invest in.
- Increasing percent of primary care and BH spend by capping spending elsewhere
- MaineHealth further supports payment model reform to improve the value of care delivered to our communities

Northern Light Health

LD 1196 Workgroup

Northern Light Health Briefing
Goal - Alignment of Primary Care Payment Innovation

10.22.2021

Questions & Answers

Benefits to increasing investment in primary care/behavioral health

When structured appropriately investment in primary care and behavioral health will achieve - Improved health care outcomes, longer lives, lower overall cost, improved patient experience, patient centered care with shared decision making together with improved recruitment with increased numbers of primary care providers and behavioral health professionals

Risks of increasing investment in primary care/behavioral health

LD 1196 increases investment in primary care and behavioral health without increasing spending on total health care expenditures - Resulting in negative financial impact on other areas of health care

Controlling Health Care Costs

Transition away from fee for service payments to value-based payments

Northern Light Health Position on LD 1196

Support

✓Multi-Payer Collaboration in Primary Care

✓Payer alignment of primary care value-based payment innovation

Oppose

✓Redistribution payment methodology that financially penalizes sectors of health care

Behavioral Health – Behavioral health is system in crisis, state and federal policy changes must address system failures that result in extended ED boarding for children and adults and extended psychiatric hospitalization due to lack of community-based treatment capacity.

What is Primary Care First?

Primary Care First = Demonstration model sponsored by Medicare and MaineCare to facilitate value-based care and success in population health

- Rewards value & quality by offering an innovative payment structure
- Focus on quality by offering financial incentives or penalties for performance metrics
- Primary Care Practices assume financial risk (limited) and receive performance-based payments through a hybrid payment model that is a balance of a population-based payment (per member per month payments which provides a steady stream of revenue) and flat fee for face-to-face visits for core primary care services
- Supports practice flexibility
- Maine's Multi-Payor model –Medicare Advantage Plan-Humana & MaineCare

Who is Participating in Maine?

17 Primary NLH Care Practices

EMMC	MSSP Attribution	PCF Avg Estimate
Northern Light Primary Care, Internal Medicine	811	1013
Northern Light Primary Care, Husson Ave	604	552
Northern Light Primary Care, Brewer	565	607
Northern Light Primary Care, Orono	523	670
Northern Light Primary Care, Hampden	500	779
Inland		
Northern Light Primary Care, Concourse West	613	857
Northern Light Primary Care, Water St.	418	603
Northern Light Primary Care, Kennedy Memorial Drive	340	348
Mercy		
Northern Light Mercy Internal Medicine	499	681
Northern Light Mercy Primary Care, Windham	357	533
Northern Light Mercy Primary Care, Yarmouth	340	258
Northern Light Mercy Primary Care, Gorham	270	404
Northern Light Mercy Primary Care, West Falmouth	263	436
Northern Light Mercy Primary Care, South Portland	121	234
AR Gould		
Northern Light Primary Care, Presque Isle	971	1154
Northern Light Primary Care, Fort Fairfield	399	199

Other Maine Practices

Organization	Total Practices
InterMed	3
Maine General	11
Maine Health	27
Northern Light Health	17
Total	58

How does the Value-based Payment Structure Work?

- Flat fee primary care visit and a population-based payment for primary care (capitation payment for a definitive list of primary care services) encourages flexibility in delivering patient care
- Increase payments for practices with patients with more complex and chronic needs
- Incentives on 6 measures - potential bonus as well as a 10% downside:
  - Acute Hospital Utilization
  - Patient Experience of Care Survey
  - Diabetes: Hemoglobin A1c Poor Control (>9%)
  - Controlling High Blood Pressure
  - Advance Care Plan
  - Colorectal Cancer Screening

The Total Primary Care Payment is a hybrid payment that incentivizes advanced primary care while **compensating practices with higher-risk patients.**

Population-Based Payment

Payment for service in or outside the office, adjusted for practices caring for higher risk populations. This base rate is the same for all patients within a practice.

Practice Risk Group	Payment (per beneficiary per month*)
Group 1: Average Hierarchical Condition Category (HCC) <1.2	$28
Group 2: Average HCC 1.2-1.5	$45
Group 3: Average HCC 1.5-2.0	$100
Group 4: Average HCC >2.0	$175

Payment will be reduced through calculating a "leakage adjustment" if beneficiaries seek primary care services outside the practice.

Flat Primary Care Visit Fee

Payment for in-person treatment that reduces billing and revenue cycle burden.

$40.82

per face-to-face encounter

Payment amount does not include copayment or geographic adjustment

These payments allow practices to:

- Easily predict payments for face-to-face care
- Spend less time on billing and coding and more time with patients

* PBPM = Per Beneficiary Per Month

*HCC = Hierarchical Condition Category

MaineCare Primary Care 2.0

Primary Care 2.0

Payment Structure:

**Transition Away from FFS*

- ✓ *Population- and risk-adjusted*
- ✓ *Adjusted for performance on <10 measures*
- ✓ *Enhancements available based on practice characteristics and alignment with Accountable Communities program*

Health Affairs Blog – June 9, 2021

A Decade of Value-Based Payment: Lessons Learned And Implications For The Center For Medicare And Medicaid Innovation, Part 1

- Multi-payer models, with participation from Medicare, Medicaid, states, employers and commercial health plans can enable greater system-wide impact.

https://www.healthaffairs.org/do/10.1377/hblog20210607.656313/full/

Behavioral Health

What do we mean? What do we count?

AAMHS
Maine

Alliance for Addiction and Mental Health Services, Maine

Membership: AdCare Educational Institute, Alternative Services, Inc., Aroostook Mental Health Center, Assistance Plus, Catholic Charities Maine, Care and Comfort, Co-Occurring Collaborative Serving Maine, Christopher Aaron Center, Common Ties Mental Health , Community Care , Community Caring Collaborative, Community Concepts, Inc., Community Health & Counseling Services, COR Health Services, Crisis & Counseling, Crossroads Maine, Day One, Genoa Telepsychiatry, Kennebec Behavioral Health, Maine Behavioral Healthcare, Maine Behavioral Health Organization, Maine General Behavioral Health, Mid Coast Hospital Addiction Resources Center (ARC), Milestone Recovery, NFI North Inc., Pathways of Maine, Penquis C.A.P., Inc., Portland Public Health, Portland Recovery Community Center, Rumford Group Homes, SequelCare Maine, Spurwink, Sunrise Opportunities, Tri County Mental Health Services, Wellspring, Inc., Wings for Children & Families, Woodfords Family Services

Mission: ***To advance treatment and recovery-oriented systems of care for Mainers experiencing mental health and substance use challenges through advocacy, leadership, collaboration, and professional development.***

AAMHS Maine

Definition from the legislation:

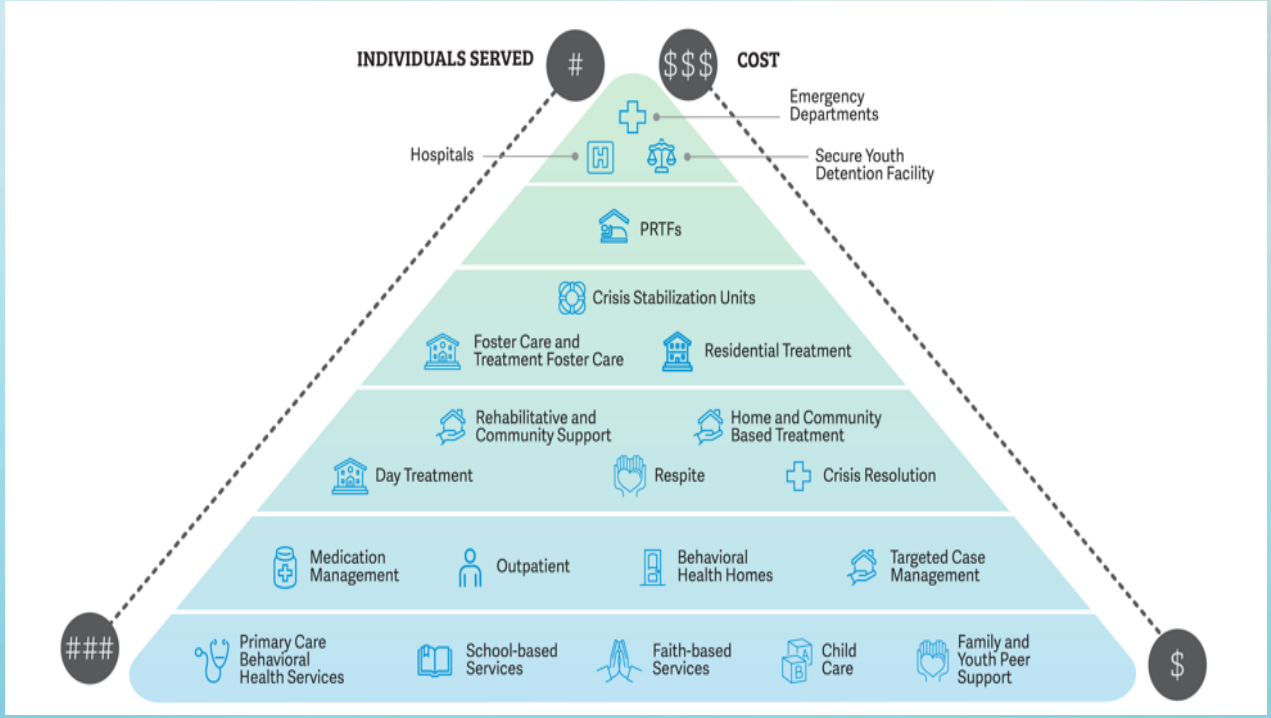
"Behavioral health care" means mental health services, including community-based or peer support treatments for substance use disorder provided by licensed ***health care practitioners*** providing services within their scope of practice, ***regardless of practice setting***.

"Behavioral health care" also includes provider loan repayments and services such as health information technology services, recruitment services and practice transformation services that support the practitioners described in this paragraph in the delivery of behavioral health care services.

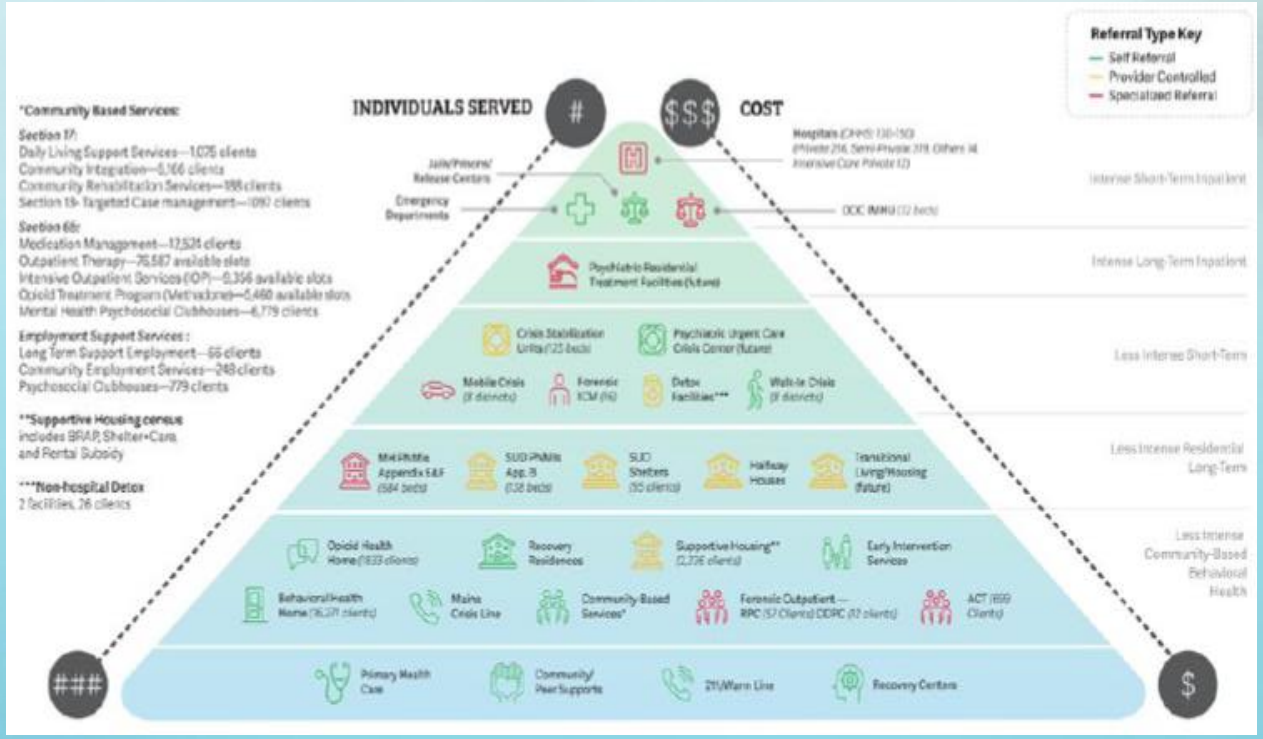
Primary Care Carve Out:

"Primary care practitioners, including family physicians, internists, pediatricians and geriatricians, ***except when*** practicing inpatient care or when practicing in an emergency department or stand-alone urgent care clinic"

The Behavioral Health Pyramid of Care - Children



The Behavioral Health Pyramid of Care - Adults



AAMHS Maine

Behavioral Health Impacts on Chronic Disease*

Question: Are mental health disorders associated with health care utilization and costs among people with chronic diseases?

Findings: In this population-based cohort study of 991,445 Canadian adults, including 156,296 with a mental health disorder, 3-year adjusted mean costs were $38,250 for those with a mental health disorder and $22,280 for those without a mental health disorder. Presence of a mental health disorder was associated with higher rates of hospitalization and emergency department visits, including when considering only visits associated with chronic disease and ambulatory care–sensitive conditions.

* **Association of Mental Health Disorders With Health Care Utilization and Costs Among Adults With Chronic Disease,** Barbora Sporinova, MD; Braden Manns, MD; Marcello Tonelli, MD; et al, *JAMA Netw Open*. 2019;2(8):e199910. doi:10.1001/jamanetworkopen.2019.9910

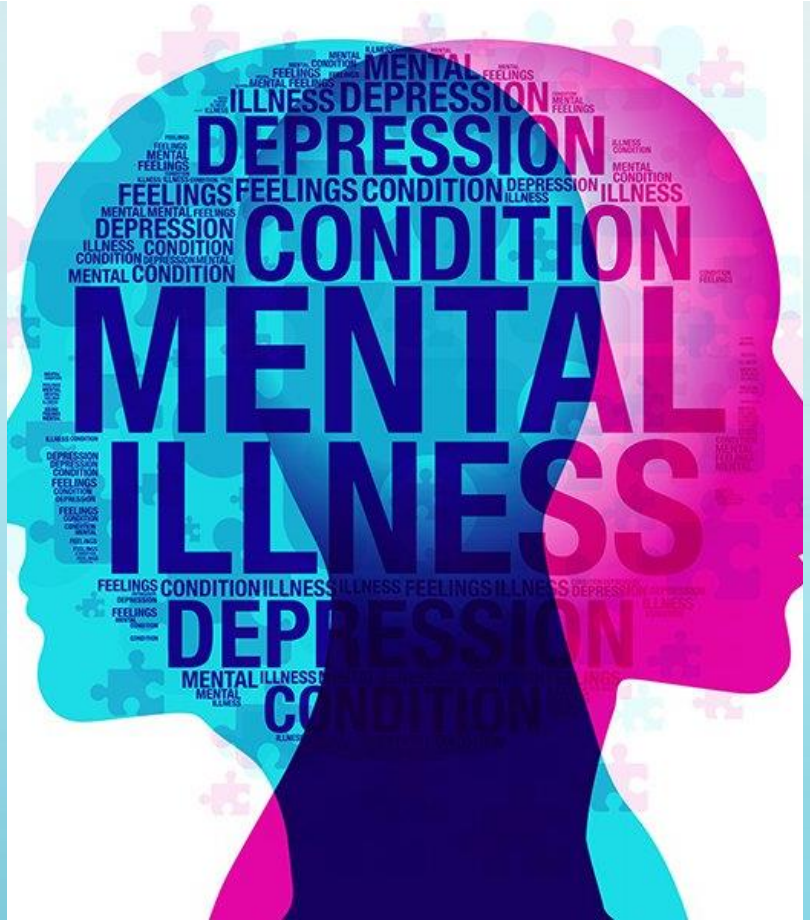
•

AAMHS Maine

Timeframe?

"Phase 1 would implement the printed bill's provisions for Primary Care, while calling for Maine Quality Forum to ***measure Behavioral Health*** spending like it's been doing for Primary Care since 2019."

Covid -19 impacts have increased demand and a broken community based system of care has shifted an unprecedented level of care to higher acuity levels and settings. Do we count these years (2020-2022, maybe even 2023)?



So –
What data do we count?
When do we count it?

What now?

- A behavioral health-specific presentation from the payers, including MaineCare, to discuss what they are doing to address behavioral health care and integrated behavioral health with primary care and what is (and isn't) working.
- Have this Stakeholder Group recommend that the discussion regarding Phase 2 continue and come back for the 131th Legislative Session with recommendations. We need more time for this phase to decide what to count and when to count the data.
- Have this extended timeframe to review and recommend making mental health access equal across provider groups. Private carriers DO NOT cover many critical mental health services.

LD 1196 Work Group

NOVEMBER 16, 2021

KATHERINE PELLETREAU
207-776-8818
KPELLETREAU@MEAHP.COM

Potential savings from increased primary care

- How can we ensure that health care costs do not rise with increased spending on primary care?
- What kind of mechanisms would ensure that monies allocated to primary care would go where intended?
- How can insurers, policy makers and consumers be assured that savings accruing from expanded use of primary care get passed back to purchasers?
- How can we ensure that payments actually go to the provider of care, especially as most primary care providers are employed by hospital systems?

Managing the cost of health care: Use data to drive change

- Focus on the underlying cost drivers
  - Reduce overuse of services i.e. imaging
  - Reduce low-value, unnecessary care
  - Put more focus on outcomes of care provided
  - Put more focus on outcomes of courses and types of medications
- Move towards value-based care
  - Reduce FFS payment strategies – pay for quality not quantity
  - Increase risk-based arrangements including downside as well as upside risk
  - Increase partnerships between providers and carriers to support transitions

Support efforts to measure quality and cost

- Establish an appropriate and agreed upon definition of primary care – see MHDO Report on Primary Care
- Be aware and informed about MHDO's efforts to collect non-claims based payment data (New Rule Ch. 247)
- Track and understand the impact of efforts already underway at the state level to increase access to primary care i.e. clear choice product design, recent legislation waiving cost shares for some primary and behavioral health visits, and the establishment of an Office of Affordable Health Care

Telehealth

- Telehealth has increased exponentially.
- Employers and carriers are working to increase access to virtual primary care.
  - Aetna Virtual Primary Care with Teledoc
  - Anthem Virtual Primary Care – Sydney Health App.
  - Harvard Pilgrim Health Care – Simply Virtual primary care plan with Dr. on Demand
  - Cigna – Virtual Primary Care platform with MDLive
  - Community Health Options – Amwell Virtual Urgent Care and Behavioral Health

Maine LD 1196 Stakeholder Meeting

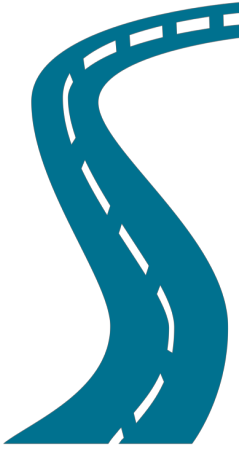
Ten Years Later: One Provider's Perspective on Rhode Island's Mandated Increase in the Primary Care Spend

Al Kurose MD
President, Coastal Medical
SVP for Primary Care & Population Health, Lifespan
December 3, 2021

Coastal Medical
Lifespan. Delivering health with care.®

My Perspectives

- Healthcare in RI since starting residency in 1988
- Primary care internist
- President of primary care driven ACO
- Board director of PCMH demonstration project
- Co-chair of RI Cost Trend Steering Committee
- Member of RI OHIC advisory committees
- Now a large healthcare system exec at Lifespan
- Board director RI Foundation, Healthcentric Advisors



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Impacts of Increased Primary Care Spend in RI: Market Level

- Primary care is more secure *than it would have been*
- Team-based care is more prevalent
- There are more new services for patients
- Population health management and VBP have advanced farther
- Quality performance is better, and RI has an aligned measure set
- Stakeholders across the spectrum are more sophisticated
- We've started to address disparities in access and outcomes
- The big systems have started to pivot toward primary care, pop health

What are the "cause and effect" linkages to primary care spending?

Impacts of Increased Primary Care Spend: Coastal Medical

2011: PCMH model plus nurse care managers & pharmacists

- Payment model: FFS + a few % for P4P on quality + stipends for NCMs & PharmDs

2021: Pod offices supported by array of centralized clinical, admin programs

- Centralized Quality and Transitions of Care teams
- Disease management programs: CHF COPD DM HTN
- Remote patient monitoring, data analytics
- Coastal 365 and Coastal@Home
- Integrated behavioral health, narcotic stewardship
- Call center, Rx refills & prior auths, document management, referrals, anticoag
- 2020: VBP = 33% of top line revenue across 9 TCOC contracts
- In 2021, we chose to join the Lifespan system

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Relentless Pursuit of the Quadruple Aim

Better Health

Better Care

Lower Cost

Increased Provider Satisfaction

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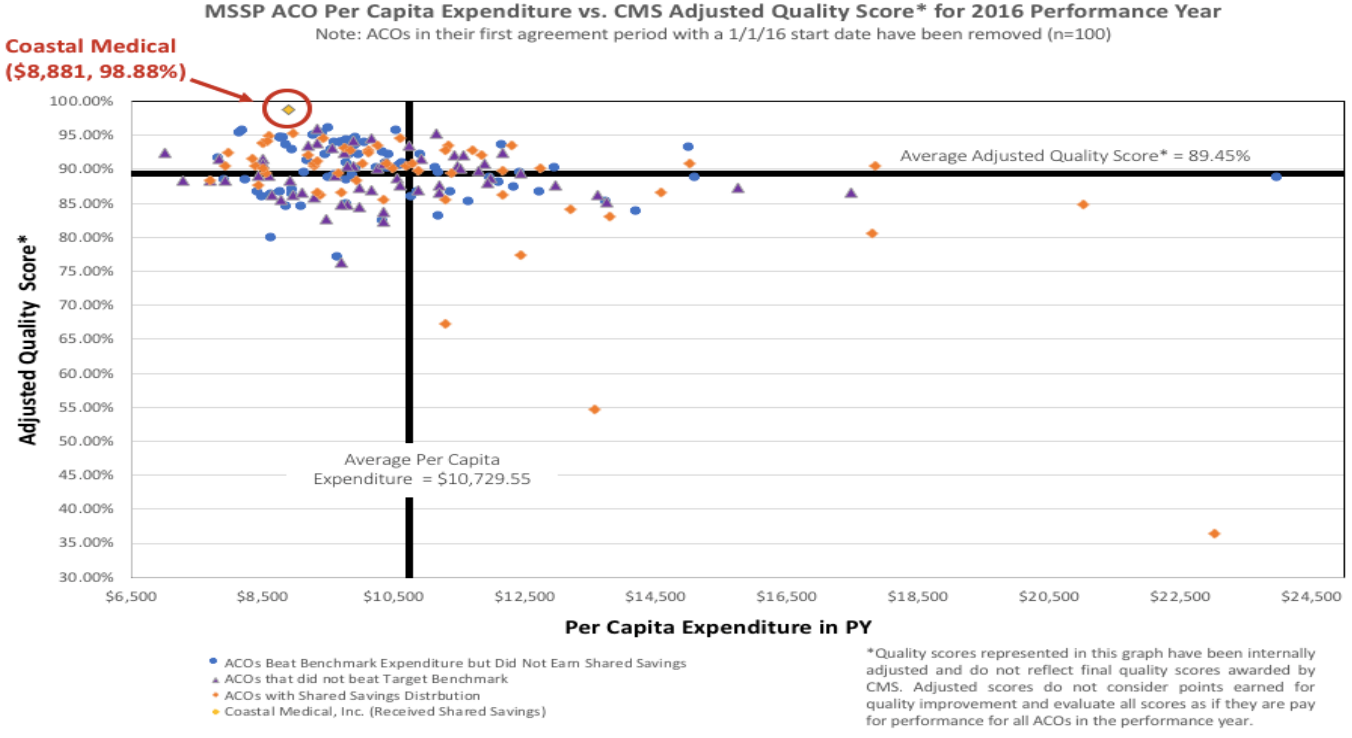
Questions?

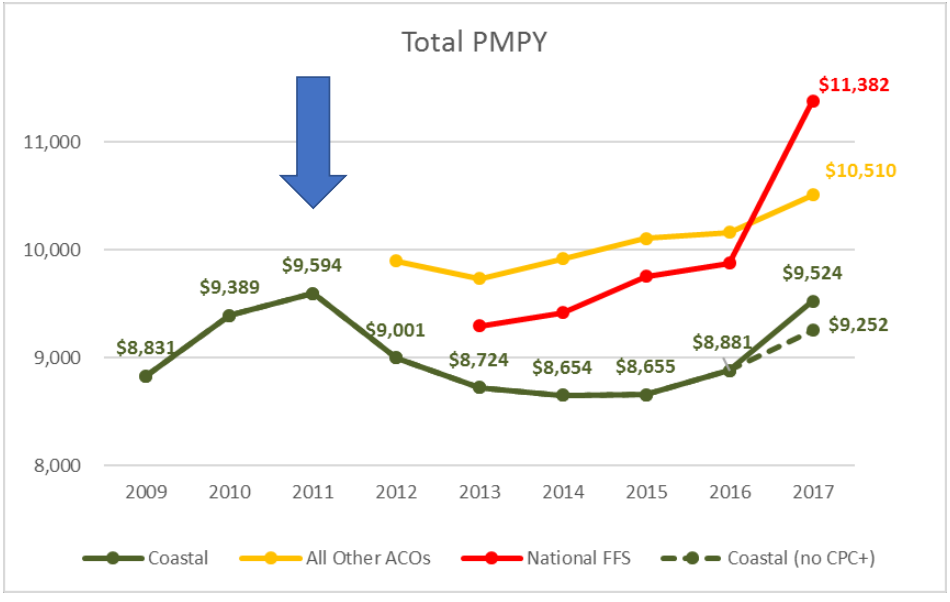
- (extra slides to follow)

Best in Class Performance on Quality and Cost



*Quality scores represented in this graph have been internally adjusted and do not reflect final quality scores awarded by CMS. Adjusted scores do not consider points earned for quality improvement and evaluate all scores as if they are pay for performance for all ACOs in the performance year.

Coastal Broke Its Cost Curve for Medicare Patients in 2011



*2017 National FFS method changed to assignable beneficiaries

**2017 Coastal Medical PMPY increased due to CPC+ payments included in spend

***Estimated Coastal PMPY without CPC+ payments

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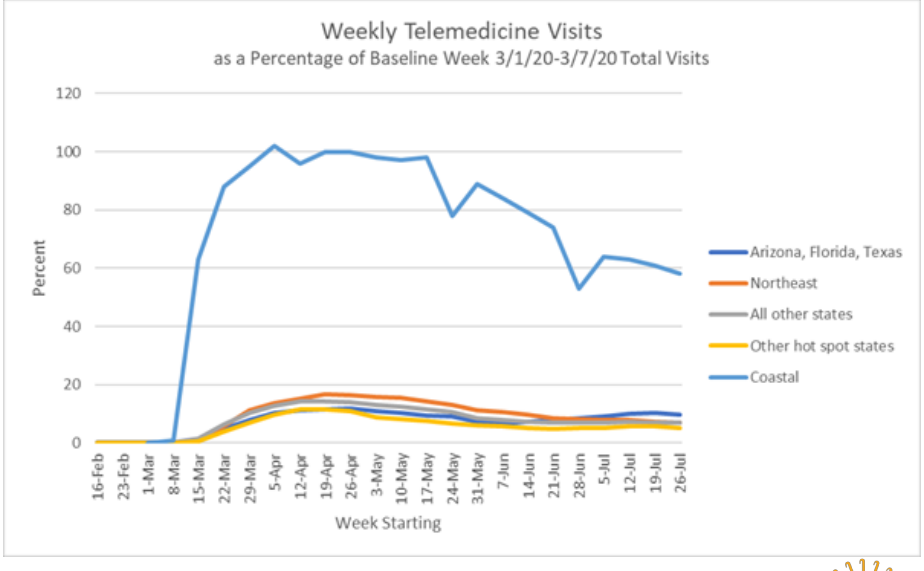
Rapid Implementation of Telemedicine



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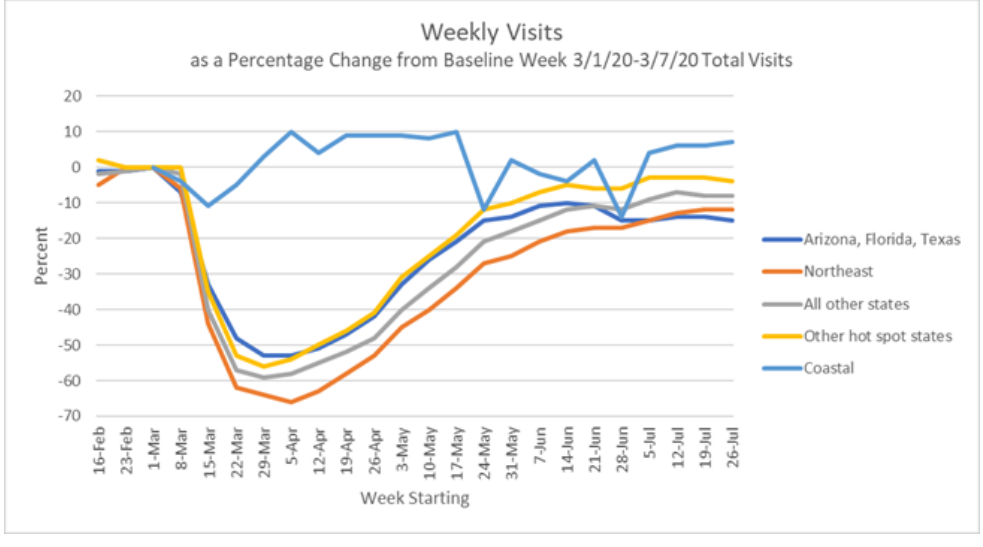
Service to Patients and Productivity



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WE DID IT TOGETHER!

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Milbank Memorial Fund

Using evidence to improve population health.

Maine LD 1196 Stakeholder Meeting

Investments in Primary Care and Behavioral Health

December 3, 2021

Christopher Koller

President, Milbank Memorial Fund

About The Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve population health by connecting leaders and decision-makers with the best available evidence and experience.

We advance our mission by:

- Identifying, informing, and inspiring current and future state health policy leaders to enhance their effectiveness;
- Working with state health policy decision makers on issues they identify as important, particularly in areas related to primary care transformation, sustainable health care costs, and aging, and
- Publishing high-quality, evidence-based publications and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy.

Agenda for Today

1. What is the problem ?
2. Primary Care in Maine
3. Key policy questions and Rhode Island's responses
4. Comparisons with other states
5. Taking the long view

Key Policy Questions

1. What problem(s) are you are trying to solve ?
2. What is your payer group of interest?
3. What branch(es) of government will lead/partner?
4. How specific is your directive?
5. Define “Primary Care”
6. What are your data sources?
7. Enforcement and Oversight?

The Aspiration (2021 NASEM Report)

Updated Definition of Primary Care

"High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities."

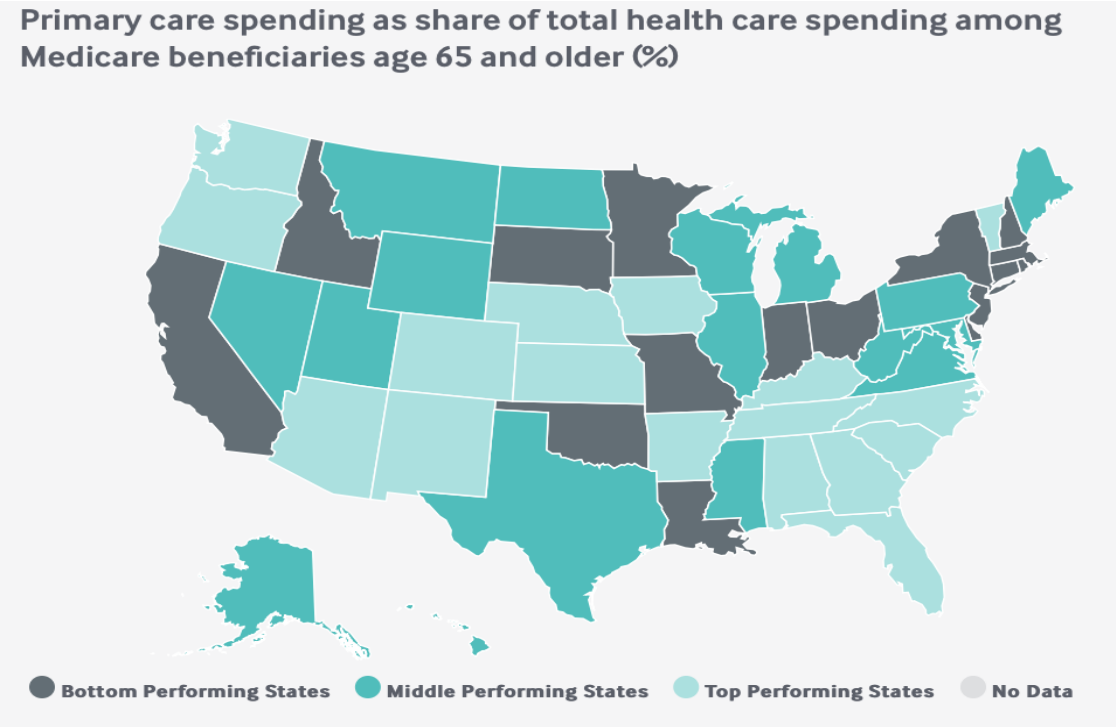
Maine: Strong base to build upon

1. Patient-centered medical programs in MaineCare
2. Collaborations with Medicare
   - 2011-2016 Multipayer Advanced Primary Care Practice demonstration
   - 2021-2025 Medicaid and Medicare in Primary Care First
3. Relatively good performance on initial regional comparison

Challenges remaining:

- Thinking about the whole system – not just payer specific
- Moving from measurement to action

Primary care spending in Medicare: Maine is in the middle of the pack

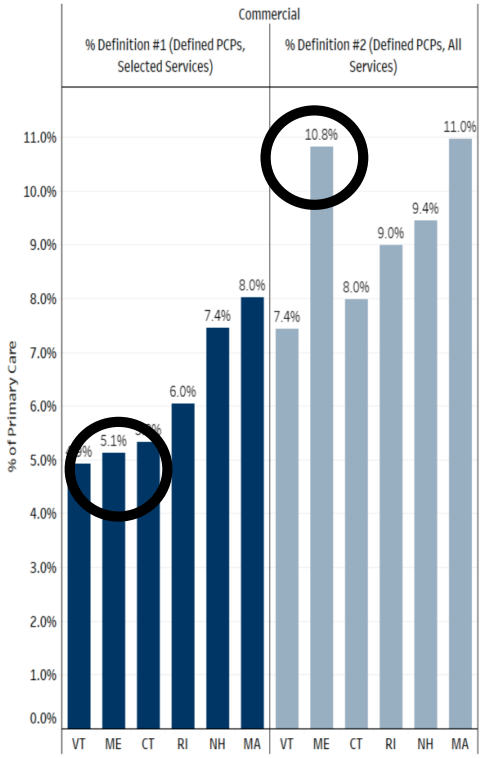


CMS Limited Data Set (LDS)
The Commonwealth Fund © Natural Earth

Milbank Memorial Fund

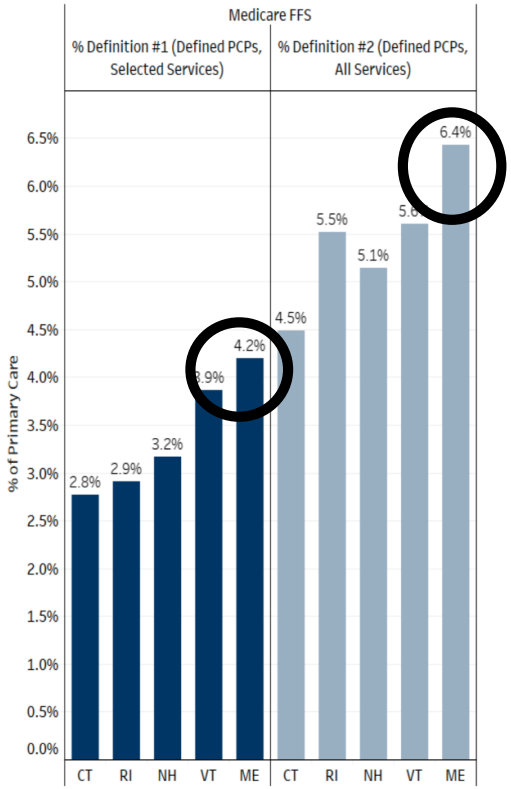
New England Comparisons:
Maine is in the middle on primary care spend for commercial and Medicaid, high for Medicare primary care spend

Figure 3. Primary Care Percentage of Total Medical Payments by State, 2018 – Commercial *



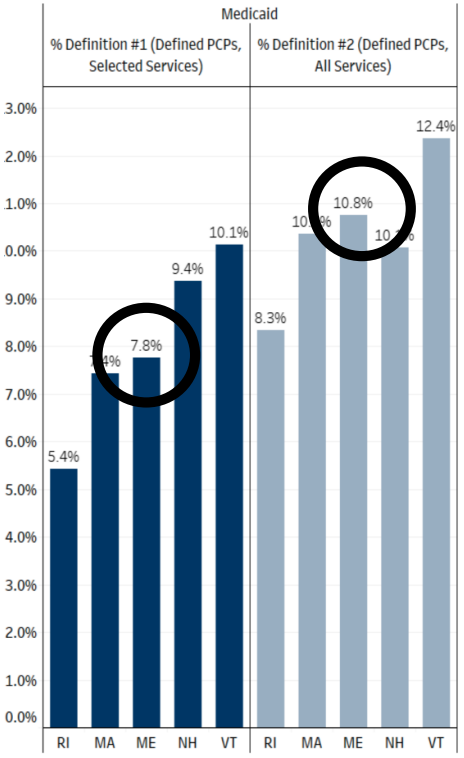
* Massachusetts data: Commercial (2017)

Figure 5. Primary Care Percentage of Total Medical Payments by State, 2018 – Medicare FFS *



* Massachusetts did not report Medicare data

6. Primary Care Percentage of Total Medical Payments by State, 2018 – Medicaid *

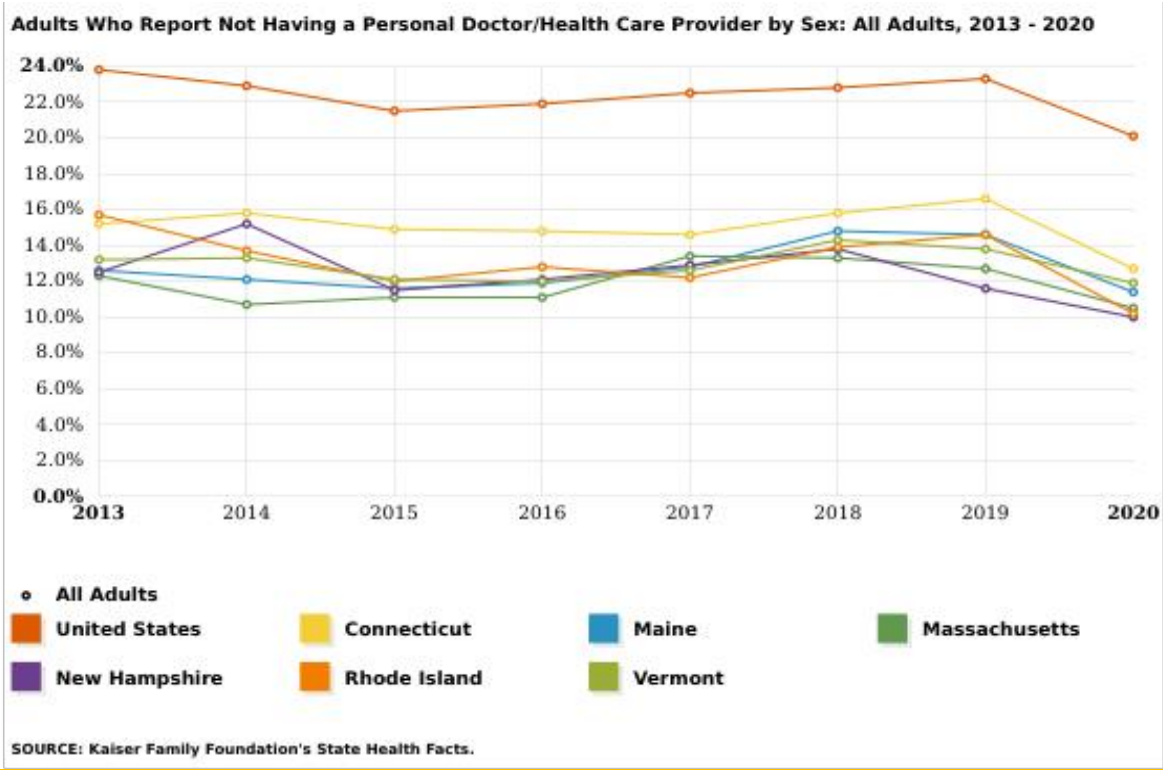


Massachusetts data: Medicaid (2016); Connecticut's Medicaid APCD data was not sufficiently complete for inclusion in the analysis.

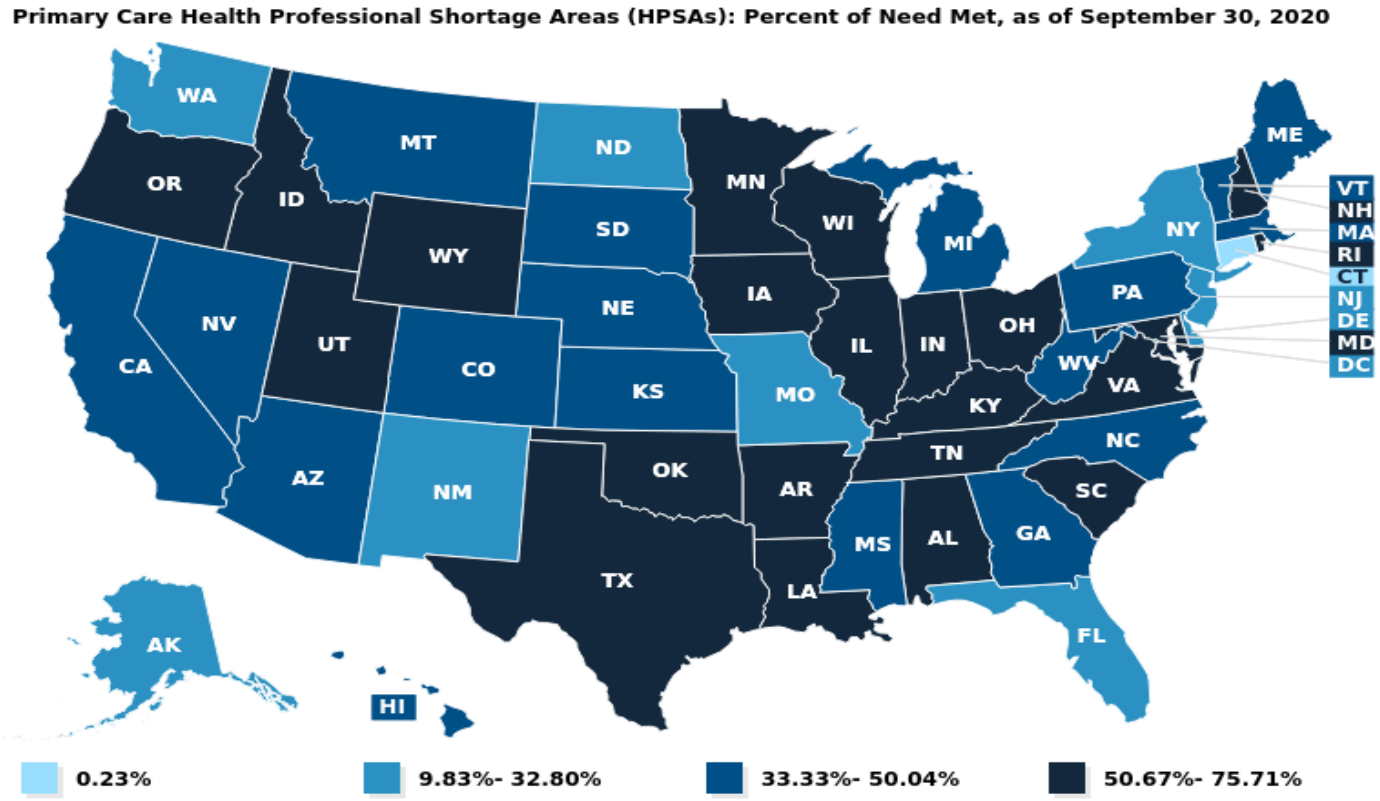
https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf

Milbank Memorial Fund

“Usual source of care” likelihood is relatively strong… as in other New England states



Primary care shortages in Maine can be addressed



SOURCE: Kaiser Family Foundation's State Health Facts.

So, where is the problem in Maine?

All of the US is out of balance for primary care - and suffers shorter lifespans and more health inequities as a result

Easier to work on this from a position of strength

One in eight people without a usual source of care (as in Maine) is still a recipe for population health trouble

 This is a solvable problem for states

Rhode Island Approach (started in 2011)

1. **What problem(s) are you are trying to solve?**

   Primary care (PC) is the only part of the delivery system that can improve population health and reduce inequities – makes it a "common good"

   In the US PC is fragile and weakening (see NASEM report)

   - Implication: market will not fix this

   Problems <u>not</u> addressed in RI's approach include

   - Health care affordability (needs a larger strategy)
   - Resilience of overall delivery system
   - Behavioral health system and access

Rhode Island Approach (continued)

2. **What is your payer group of interest?**
   - Commercial Payer (not Medicaid or Medicare)
   - More payer groups increases chances of success

3. **What branch(es) of government will lead/partner?**
   - Rhode Island Office of the Health Insurance Commissioner (commercial insurance regulator)

Rhode Island Approach (continued)

4. **How specific is your directive?**

   Payers must increase the portion of their medical spending going to primary care by one percentage point a year for five years.

   - Increases cannot be in FFS rates
   - Increases cannot contribute to overall premium increases
   - Allowed a two-year run in

   One aspect of four "Affordability Standards", which have evolved over time.

Rhode Island Approach (continued)

5. **Define "Primary Care"**

   Anything done by general internal medicine, pediatrics and family medicine (not defined in law or regulation)

   Did not have more detail

6. **What are your data sources?**

   Plan self-reporting

   Did not have a Maine Health Data Organization

   Be sure to capture non-claims payments

Rhode Island Approach (continued)

7. **Enforcement and Oversight?**

   Quarterly submissions by plans based on standard template and plan-specific meetings

   Public Accountability

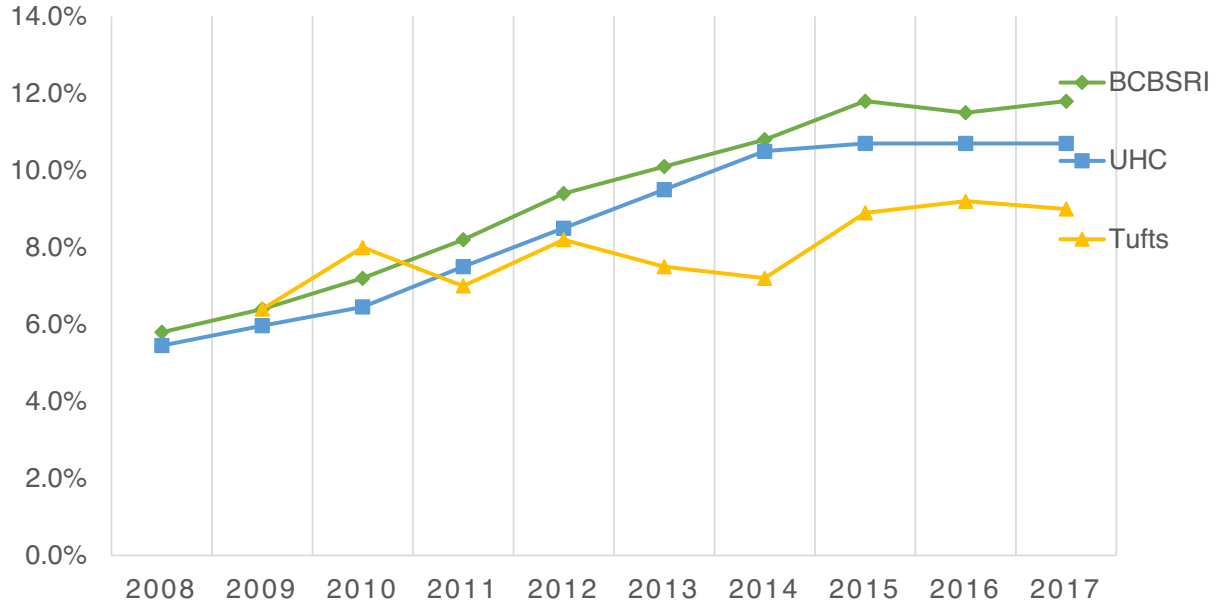
   - Summary reports
   - Review by Consumer Advisory Council and multistakeholder coalition

   Condition for rate approval (initially) eventually put in regulation

Public Accountability for Insurers in Primary Care Investment in Rhode Island

Primary Care Spending as Percent of Total Medical Spending by Insurer (2008-2017)

(Self-insured plan payments not captured)

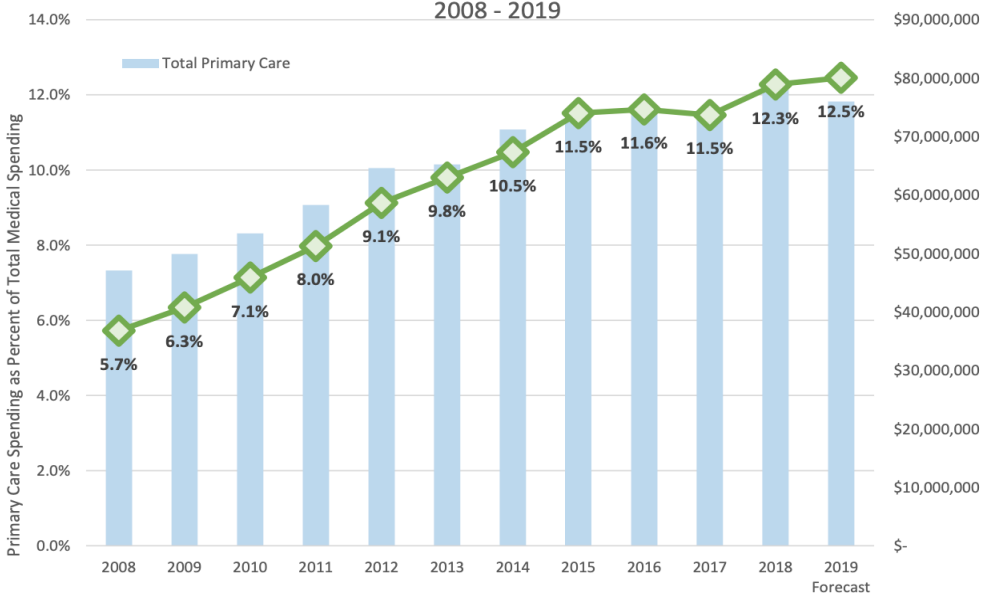


Source: Office of the Health Insurance Commissioner, State of Rhode Island

Milbank Memorial Fund

Public Accountability for Insurers in Primary Care Investment in Rhode Island

Figure 1: Primary Care Spending, Total and as Percent of Total Medical Spending
2008 - 2019



Overall, spending on primary care by commercial health insurers was increasing through 2018. Figure 1 shows total spending on primary care in dollars and as a percentage of total medical spending. All data presented in this graph reflect paid claims and non-claims-based payments.
In 2018, insurers spent 12.3 cents of every fully insured commercial medical dollar on primary care; this was an increase of over 6 cents from 2008 and the most since the Affordability Standards took effect.

Data Note: Expenditures reflect fully insured commercial payments (paid claims and non-claims-based payments) to Rhode Island primary care providers.

http://www.ohic.ri.gov/documents/2020/June/Primary%20Care%20Expenditure%20Data%20Update%20June%202020.pdf

Milbank Memorial Fund

Public Accountability for Insurers in Primary Care Investment in Rhode Island

Figure 2: Distribution of Primary Care Spending Across Types of Payments

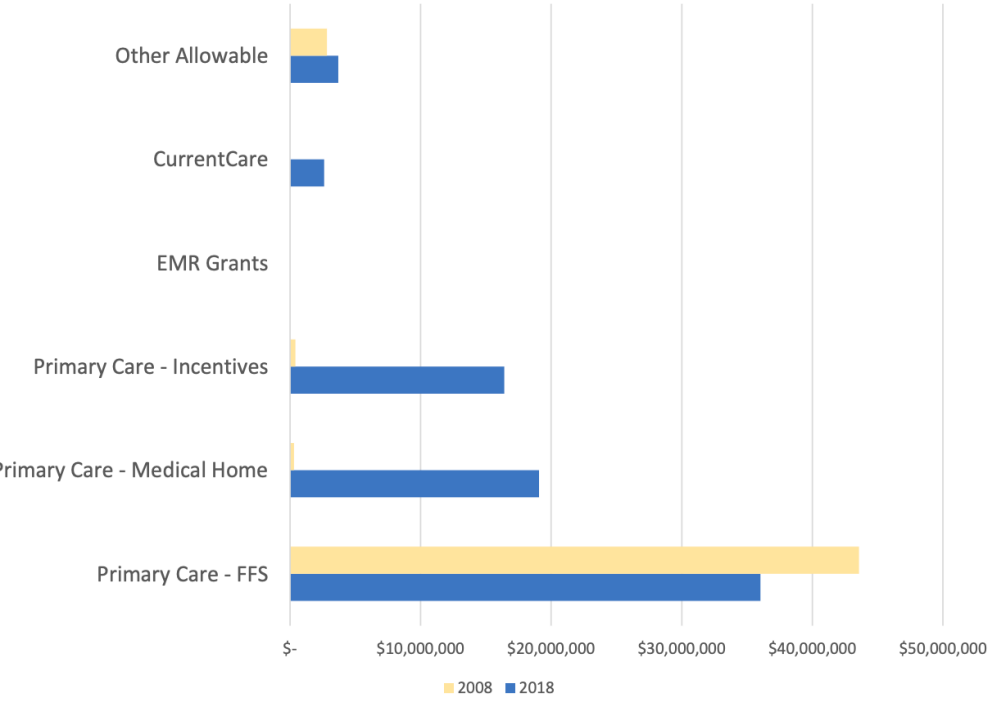


Figure 2 compares the allocation of primary care spending between fee for service (FFS) and non-FFS methods in 2008 and 2018. For the market in 2018, non-FFS investments comprise more than 50% of payments to primary care. The bulk of non-FFS payments represent care management and infrastructure payments to PCMHs and pay for performance incentive payments for quality and cost performance. This coordinated investment reflects market support for comprehensive payment reforms, innovative care delivery models and a patient-centered primary care system.

http://www.ohic.ri.gov/documents/2020/June/Primary%20Care%20Expenditure%20Data%20Update%20June%202020.pdf

Milbank Memorial Fund

Public Accountability for Insurers in Primary Care Investment in Rhode Island

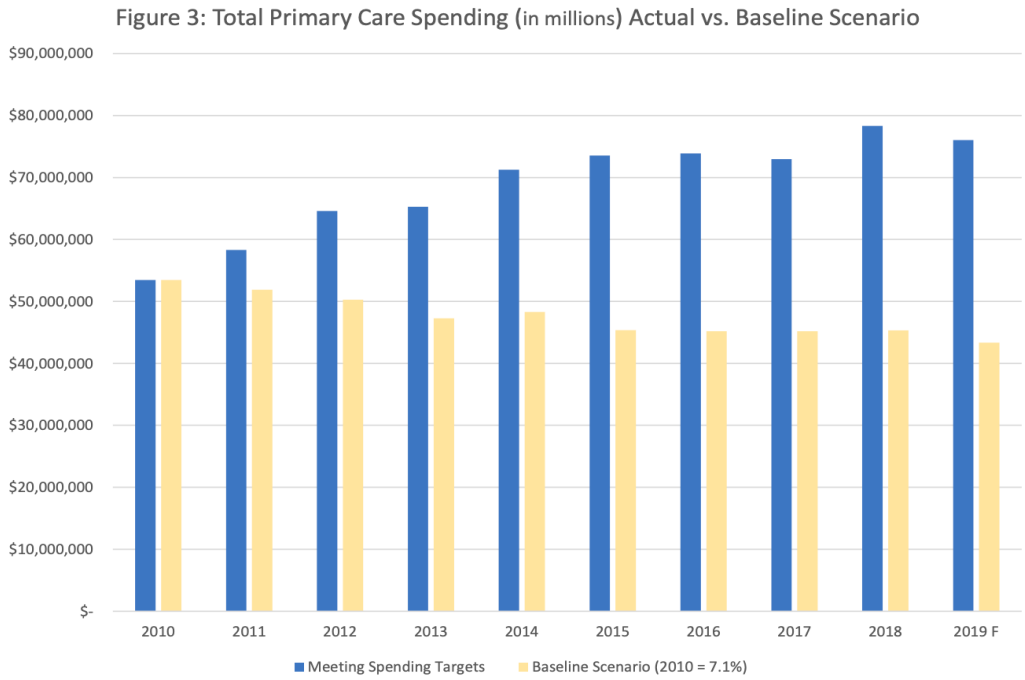


Figure 3 presents actual primary care spending between 2010 and 2019 (forecasted) compared to a counterfactual scenario in which primary care spending remained at its 2010 proportion of total medical spending (7.1%). The aggregate difference between the two scenarios is over $212 million.

http://www.ohic.ri.gov/documents/2020/June/Primary%20Care%20Expenditure%20Data%20Update%20June%202020.pdf

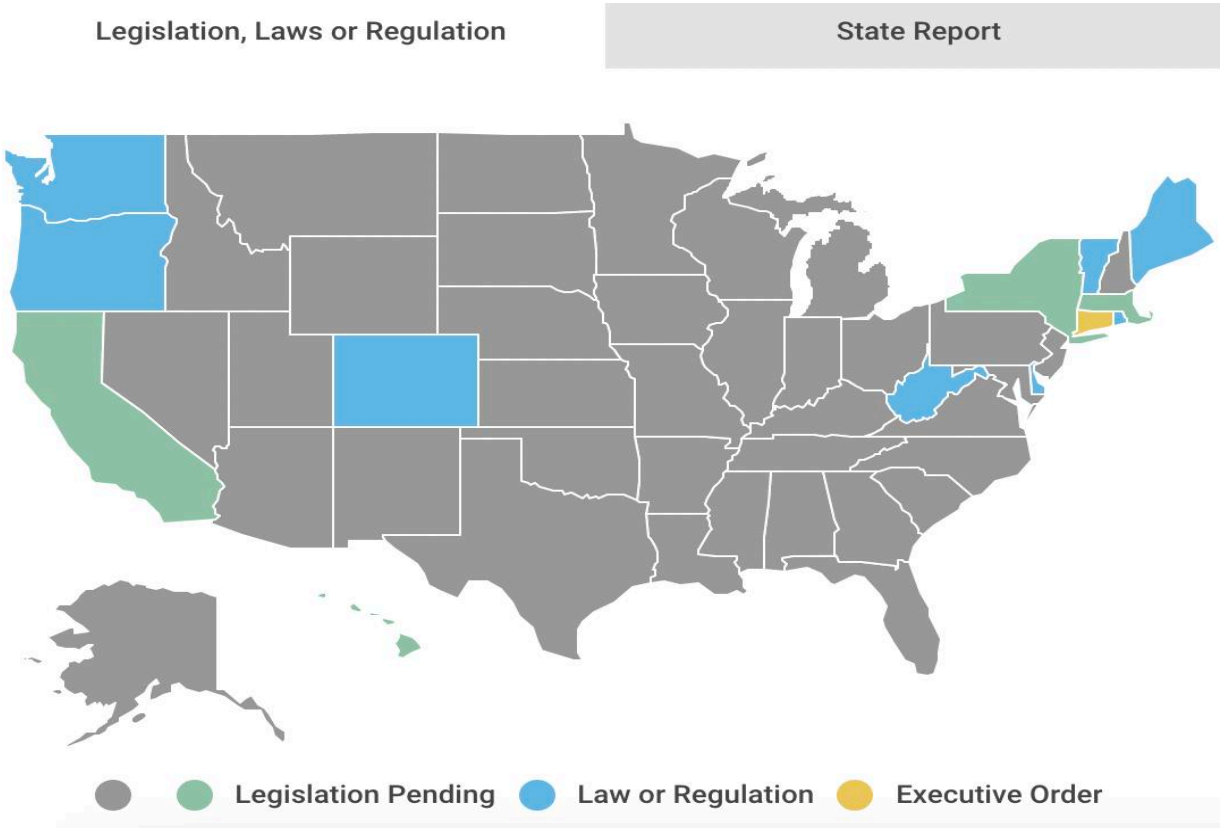
Milbank Memorial Fund

Why do this work ?

Time to Rebalance things…

You Are Not Alone!

State Legislative Activity to Measure or Increase Primary Care Spending (June 2021)



Source: https://www.pcpcc.org/primary-care-investment

Milbank Memorial Fund

Oregon: Assigns responsibility to its Health Care Authority (OHA)

2009: Patient Centered Primary Care Program at OHA and Office of Primary Care established

2011: Law establishing Medicaid Coordinated Care Organizations (CCOs) includes a medical home requirement

2017: Law directs Medicaid, Medicare and commercial payers to increase primary care spending rate to 12% by 2023, OHA to measure compliance and issue annual report, some enforcement capacity created

https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Primary-Care-Spending.aspx

Colorado: State-run commission

House Bill 19-1233 in 2019 established a Primary Care Payment Reform Collaborative at Department of Insurance to:

Recommend a definition of primary care to the Insurance Commissioner;

Advise in the development of broad-based affordability standards and targets for commercial payer investments in primary care;

Coordinate with the All-Payer Claims Database (APCD) to analyze the percentage of medical expenses allocated to primary care by insurers, Health First Colorado (Colorado's Medicaid Program), and Children's Health Plan *Plus* (CHP+);

Report on current health insurer practices and methods of reimbursement that direct greater resources and investments toward health care innovation and care improvement in primary care;

Identify barriers to the adoption of APMs by health insurers and providers and develop recommendations to address these barriers;

Develop recommendations to increase the use of APMs that are not FFS in order to:

- Increase investment in advanced primary care models,
- Align primary care reimbursement models across payers,
- Direct investment toward higher-value primary care services with an aim at reducing health disparities;

Consider how to increase investment in advanced primary care without increasing costs to consumers or increasing the total cost of health care;
Develop and share best practices and technical assistance to health insurers and consumers.
Each year by December 15, the Collaborative publishes primary care recommendations in a report

https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/primary-care-payment-reform

Manage Expectations

Design for the Long Term: Create a Public Priority for Primary Care

Strategies: Initiate legislatively-directed initiatives that either

1. Have an agency to measure primary care spending rates (not sufficient)

OR

2. Establish a commission or a collaborative, and assign to an agency responsibility to
    a) Measure primary care spending rates
    b) Measure categories of spend
    c) Oversee multi-payer primary care reform
    d) Align quality measures
    e) Link to system payment reform efforts
    f) Issue annual reports and recommendations

Multi-stakeholder primary care advisory groups and collaboratives–roles and functions

Questions for consideration:
Who leads?
Who staffs it?
What is its accountability?
What are its resources?

And of course, use data to create focus.

https://www.pcpcc.org/sites/default/files/resources/Lessons%20Learned%20from%20Multi-Stakeholder%20Advisory%20Groups.pdf

Impact on Providers in RI

Questions?

Thoughts on LD 1196 after third stake-holder meeting from Linda Sanborn, 12/1/21

I want to thank Dan Morin and the Maine Medical Association for bringing together interested stakeholders to discuss, refine and improve LD 1196, An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health. I also want to thank Beth Wilson, MD for so ably moderating the discussion. I am participating in the stakeholder group as a retired family physician and legislator who brought forward the bill to measure primary care spending in the 129th legislature as a "first step".

Although I was asked by Ann Woloson, Executive Director for Consumers for Affordable Health Care, to attend these meetings as a member of their board, the comments that follow are my own and I am not speaking for CAHC. I was one of three primary care physicians who met with Rep. Zager before the 130th legislature convened and encouraged Sam to bring this piece of legislation forward. As a family doctor, I know from my training and years of practice what studies have shown to be true, that primary care is the foundation of a robust health care system which leads to better health outcomes, better patient satisfaction, decreased inequities, higher quality care and lower costs.

The most significant take-away from our first stakeholder meeting for me was based on an article Dr. Zirui Song, MD, published August 15, 2019 in JAMA, "*Will Increasing Primary Care Spending Alone Save Money?"*. The answer is clearly no, although that is not to say that this bill is not an important step forward. Dr. Song summed up his implications for policy in the last paragraph of his article:

"To slow total spending while reaping the benefits of primary care, investments in primary care may need to be paired with other interventions in the delivery system. Payment reform for physicians and hospitals, competition or regulation to address prices, and value-based insurance design (which lowers cost-sharing for preventative care) could complement efforts to strengthen primary care. Payers and policymakers might also consider other ways to help primary care avert preventable downstream utilization, such as reducing administrative burden to create more time for patient care, changing malpractice laws to lessen defensive medicine, enabling primary care teams to meet their patient's mental health needs, or equipping practices to address social determinants of avoidable utilization – indeed enhancing the substance of primary care - in place of (or in addition to) spending more on primary care as it is delivered today."

The comments shared by Dr. Song ring true to many us and have been expressed by various stakeholders throughout our three meetings. LD 1196 has always directed any increased payments to be through alternative and value-based methodology, that is, non-FFS payments. What this means to me is supporting investments in both human assets and infrastructure that strengthens team-based primary care including: care managers, counselors, better team integration, and support tools that strengthen care delivery such HIE, financing capital that addresses social determinants of health and behavioral health integration.

Of note, Dr. Song also emphasized that in Rhode Island, where spending in primary care was gradually increased and where simultaneously price controls on commercial insurers were instituted, hospital prices never went down. That is, there were no price cuts. Rather, the growth of price increases was

slowed. According to Dr. Song, the hospital community was able to weather these changes without being “hurt”.

This is one reason that I came away discouraged from our second meeting, where the hospital association spoke out in strong opposition to this bill. What I heard was an unwillingness to even consider proposals to improve the bill or offer alternatives methods of slowing cost-growth to contain overall health care spending. Although Mr. Austin opposes any limits on commercial insurance rate increases by state government, that does not mean targets should not be considered by stakeholders wanting to make health care more affordable. The importance of having all stakeholders on board as willing partners to make health care affordability more sustainable cannot be overstated. Dr. Zager has made a real attempt to bring all stakeholders to the table early in the process so that all concerns can be heard and taken into consideration. I very much appreciated Dr. Wilson’s attempt to get stakeholders to not simply oppose but propose alternatives or opportunities to achieve the basic goals of this legislation.

I found comments by Peter Hayes/Maine Purchasers Alliance informative and useful in our struggle to move forward. I think we can all agree that we need defined targets and metrics to measure outcomes of primary care spending. We need to acknowledge that despite an increased PPM payment to primary care since 2010 under the ACA, there is no evidence of lowered costs or improved outcomes. Clearly, we also need to recognize and account for the non-claims-based payments to primary care. It is my understanding that the MHDO has done the work to make this possible. Collecting and reporting out this data will increase transparency in the system. Most importantly, what I heard from Mr. Hayes was that, with utilization being stable, price increases are driving health care costs and “growth caps are necessary”.

Michelle Probert added that we must differentiate between growth caps and growth rates. I believe this differentiation is critical for buy-in from all stakeholders.

In our third meeting I heard a number of useful recommendations from Darcy Shargo representing the Maine Primary Care Association/FQHCs. Darcy shared a definition of primary care from their Consensus Study Report and suggested its adoption. She recommended using a dash board for transparency in reporting metrics as well as developing a benchmark for spending on behavioral health, as has been done in primary care (and as is suggested in LD 1196). She also recommended doubling down on social determinants of health and investments where needed.

Renee Fay-LeBlanc, MD presented as a frontline clinician and leader of providers at Portland’s FQHC. Her comments were heartfelt and moving with examples of the pressure on primary care providers to provide high quality care without the supports and reimbursements needed to achieve this goal. We must recognize the threat of losing the primary care workforce we already have and need, much less the ability to further grow a sustainable primary care workforce. Her specific recommendations were the very kinds of things I believe LD 1196 could support including workforce development, loan repayments, freeing up more time for providers with their patients, and increased compensation for both visits and non-visits (which I take to be all of the work done by primary care providers when a patient is not necessarily in front of you – medical record entry, follow-up on testing, communicating with staff and specialists, continuing education and so much more).

Kathryn Pelletreau, representing the insurers, wisely advised using data to drive change. In regards to her comments about avoiding low-value care, diagnostics or medication, I would submit that primary

care practitioners are the very providers of care who can and do reduce overuse of services. This is a core part of primary care training and practice. And this is why the continuity and coordination of care provided by primary care can lead to cost savings over time.

Ms. Pelletreau also referred to telehealth. The increased use of telehealth is one of the positive changes that has occurred due to the pandemic. Support and incentives from employers and insurers are much appreciated, especially as telehealth helps to address health care inequities, mental health and substance use disorders. Alternative payment methodologies that include telehealth are another way to support primary care consistent with LD 1196.

Gavin Ducker, MD pointed out how capitation being discussed by various entities now is different from capitation in the past. Capitation for primary care must be based not just the size of the panel, but how complex it is (including disease and social determinants), and how well the panel is managed. Measurable quality outcomes, he suggests, is the only factor of this equation where down risk should be accepted. As alluded to by Dr. Ducker and Dr. Fay-LeBlanc, putting even more risk on an overwhelmed primary care practice is unlikely to be fruitful.

Finally, a discussion about where behavioral health fits in to this conversation, as raised by many, is critical. I agree with those who suggest that the segment of behavioral health we are addressing in this bill is community mental health, which is markedly under resourced and often unavailable/inaccessible. Indeed, if hospitals are to empty their hallways and emergency rooms filled with people experiencing mental health crises, we must invest in supporting community mental health and the integration of mental and physical health in primary care. We have talked about integration of care and value-based purchasing for many years but any progress made has been painfully slow. Attempting to closely paraphrase Darcy Shargo, now is the time to have that nuanced conversation and shared commitment to reduce growth in spending, putting investments where they have the greatest impact.

I am thrilled to have learned Chris Koller from the Millbank Memorial Fund will be speaking with us at our next meeting. I was able to meet Chris and share in some regional state workgroups when I was a state representative. His knowledge and understanding of how other states have improved population health and health care affordability should be most enlightening. We are certainly not alone in this process. We should come prepared with our questions and concerns, ready to learn about what has worked in other states and how Maine can implement the best policy regarding sustainable health care costs.

In the meantime, abiding by the request that we not just oppose, but propose, these are my proposals taken from all I have learned to date regarding LD 1196:

1. Adopt the suggested definition of primary care proposed by the Consensus Study Group.
2. Work to define and measure the spending on community mental health as we did for primary care. Hold off on including BH in the spending targets until better defined and measured.
3. Include non-claims payment data in the measurement of primary care spending.
4. Require the Office of Health Care Affordability to study setting targets for rates of growth of health care spending in order to sustain/improve affordability of health care in Maine. Learn

from what other states have done (Milbank can help us with this). Plan to propose health care cost growth rate targets and primary care spending targets to start by 2024.

5. Measure desired outcomes from increased investments in primary care through alternative or value-based payments. Use a dash board to track the data.
6. Involve the MHDO in providing the metrics and collection of data for the quality improvement measurements we desire, to ensure transparency and accountability.

I also recommend the following recent articles which have helped my understanding of the issues at hand:

Opinion | Why Medical Bills Can Be Lower in Maryland - The New York Times (nytimes.com)

Rhode Island Joins the Peterson-Milbank Program on Sustainable Health Care Costs: A Q&A with the State's Health Insurance Commissioner Patrick Tigue - Milbank Memorial Fund

Opportunities for Aligning Prescription Drug Affordability Boards and Cost-Growth Benchmarks – The National Academy for State Health Policy (nashp.org)

LD 1196 Stakeholder Behavioral Health Committee
Collaborative Statement

Purpose: Maine's behavioral health leadership from Tri-County Behavioral Health, National Association of Social Work, and the Alliance of Addiction and Mental Health Services met to assess policy implications that would:

1) address the workforce shortage of behavioral health providers in Maine,
2) reduce value-free administrative costs & barriers to behavioral healthcare
3) broaden access to behavioral health services, especially in primary care, and
4) improve overall medical (including behavioral health) costs, outcomes and experience of patients, providers and teams.

Background:
Our policy recommendations focus on the continuum of outpatient behavioral health services that includes integrated behavioral health in primary care practices/patient centered medical homes, integrated medical providers in behavioral health organizations, Certified Community Behavioral Health Homes, community behavioral health centers and private group or individual practices.

We use the agreed upon definition of behavioral health providers as *persons who are licensed by the state, whose professional activities address a client's behavioral issues. This includes psychiatrists, psychologists, social workers, psychiatric nurse practitioners, marriage and family counselors, professional clinical counselors, licensed drug/alcohol abuse counselors, and mental health professionals. (AHRQ, 2013).* We would add certified peer counselors to this list.

Integrated behavioral health in primary care is defined as *care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization*. (AHRQ, 2013)

Research has shown that persons with untreated mental health diagnoses have overall healthcare costs that are more than twice as high as those who are mentally well**.** (Davenport, 2020; Azocar, 2019) Adequate treatment of persons with behavioral health disorders can lower overall cost, primarily by reduced emergency room visits and hospitalization days. (ICER 2015)

We believe that adequate pay for behavioral health services is the major contributor to behavioral health work force and access issues. People want to move to Maine, yet need a level of pay commensurate with other states. We want to draw behavioral health professionals to Maine, to contribute to our Maine communities and not choose to work remotely in other states (as many are doing during COVID) to get a decent wage.

Policy Recommendations:

1) Complete the behavioral health service rate analysis and recommendations of the Department of Health and Human Service 2020 Maine Care Rate Evaluation Study by December 31, 2022. Currently most behavioral health outpatient reimbursement comparisons are minimal or lacking compared to the typical five-state medical service comparison rates. This is key information to adequately reimburse for behavioral health services in Maine.
2) Eliminate the need for outpatient medical practices to apply for a behavioral health license to get the higher reimbursement rate given to licensed behavioral health organizations.
3) Eliminate the review/authorization/rationing of behavioral health services through Mainecare's ASO (currently KEPRO). The rationing/authorization step requires extra administrative staffing for licensed organization, rarely effects the treatment, and is not required for the provision of medical care. We believe it is not needed for behavioral health care.
4) Eliminate commercial insurance carve-outs for behavioral health billing and credentialling purposes. This, again, creates the need for a cadre of additional personnel, processes and relationships that is cost prohibitive for behavioral health and medical integrated services in primary care and behavioral health homes.

Respectfully submitted,

Julie M. Schirmer, LCSW
Lynn Stanley, LCSW
President Elect and
Interim Executive Director
NASW Maine

Malory Shaughnessy, MPPM
Executive Director
Alliance for Addiction
and Mental Health
Services

Henry Skinner, MD
Medical Director
Tri-County Mental Health
and Family Psychiatry of
Maine

References:

Davenport, S., Gray, TJ, Melek, S. (2020). How do individual with behavioral health conditions contribute to physical and total healthcare spending. Milliman Research Report. The Bowman Family Foundation. https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx

Peek, CJ (2013). Lexicon for Behavioral Health and Primary Care Integration. Integration Academy. Agency for Health Research and Quality (AHRQ). https://integrationacademy.ahrq.gov/sites/default/files/2020-06/Lexicon.pdf

Davenport, S., Gray, TJ, Melek, S. (2020). How do individual with behavioral health conditions contribute to physical and total healthcare spending. Milliman Research Report. The Bowman Family Foundation. https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx

Azocar F, Bargman EP, Smolskis JM, Groat TD. Optum internal analysis. 2019. https://www.uhc.com/broker-consultant/news-strategies/resources/small-population-large-

expense-managing-the-high-cost-2-percent

Trice, J.M., et al. (2015). Integrating Behavioral Health into Primary Care: A Technology Assessment Final Report. Institute for Economic Review (ICER). jbjb(p(p (nih.gov)
MaineCares' Comprehensive Rate System Evaluation Preliminary Report. (2020). DHHS Announces Rate System Improvements. Department of Health and Human Services. https://www.maine.gov/dhhs/blog/dhhs-announces-mainecare-rate-system-improvements-2021-09-30.

Azocar F, Bargman EP, Smolskis JM, Groat TD. Optum internal analysis. 2019. https://www.uhc.com/broker-consultant/news-strategies/resources/small-population-large-expense-managing-the-high-cost-2-percent

Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

December 15, 2021

Dr. Elizabeth Wilson

(via email to Dan Morin, MMA)

Re: LD 1196: Pre-report Comment

Dear Dr. Wilson;

Please accept these preliminary comments from the Maine Hospital Association (MHA) on behalf of our 36 member hospitals. I have identified these comments as preliminary in anticipation of potentially commenting again after we see the draft report.

In litigation, there is something called a "summary judgement." Generally, a defendant moves for summary judgment prior to there even being a trial. Its essentially a dismissal of the case. The noteworthy pre-condition to a motion for a summary judgment is that the defendant has to accept all of the facts as alleged by the plaintiff. That is, you can't dispute the facts presented, you must take them as alleged.

A summary judgement motion is an "even if" motion; even if everything that has been alleged is true, the plaintiff has not made a case that deserves to go to trial, much less win.

I feel as if that is where we are following the meetings of the LD 1196 work group. As I look back at all the power points presented by supporters of the concepts behind LD 1196, I don't see where they have made even a decent case, much less a compelling case, that Maine in 2022 should copy what Rhode Island did in 2010.

Four positive policy goals were repeatedly invoked by supporters, but their presentations provided no evidence that incorporating Rhode Island policy would achieve these goals in Maine.

To be clear, we understand Rhode Island policy to be: measuring the relative amount spent on primary care to total health care and then artificially increasing that relative amount spent on primary care via a state mandate.

Here are the four policy goals repeatedly cited:

- **Increasing Relative Spending on Primary Care Will Reduce Costs** – Not only was no evidence offered in support of this argument, it was directly refuted by two proponent witnesses. The proponents' very first witness, Dr. Song, advised that based upon his research, state policy forcing an increase in the relative share of spnding on primary care does not reduce overall healthcare expenditures. Other artificial measures (such as blunt spending caps) are responsible for spending reductions[1]. This finding was reiterated by Mr. Koller at Milbank who stated at the meeting that increased spending on primary care would not improve affordability and that it was "other" cost control measures that were responsible for any spending reductions.[2]
- **Increasing Relative Spending on Primary Care Will Improve Quality** – No evidence was offered that state-mandated increases in relative spending on primary care will improve quality. I believe a few different proponent witnesses were asked for data on this point and none could cite any evidence.
- **Increasing Relative Spending on Primary Care Will Improve Access** – No evidence was cited.
- **Increasing Relative Spending on Primary Care Will Improve Equity** – No evidence was cited.

Obviously, if I missed something or misunderstood something that alters the above bullets, I am open to correction.

Based upon the case offered by proponents, before we even offer any rebuttal, there is no argument to be made for Rhode Island's statute. Legislation that largely mimics Rhode Island should be summarily rejected.

This does not mean there is no case to be made on behalf of the value of increasing investment in primary care. It simply means that the artificial, state mandated, relative investment method used in Rhode Island (utilizing a variety of non-fee for service monthly payments) doesn't

[1] Song, Slide 10: *Thus, while a redistribution of funding toward primary care was achieved without net losses to payers, the reduction in FFS spending growth appears to be mostly attributable to the price controls in the affordability standards, rather than to the increased spending on nonFFS primary care*.
[2] Koller, Slide 12.

achieve the universally supported policy goals of reducing costs, and improving quality, access and equity.

Nor does our observation mean that we haven't discussed some important additional steps that Maine could take.

Most of the measures we would support come under the heading of data collection and presentation. We do believe the state has an important role in driving changes in healthcare. However, we don't believe that that role involves blunt state mandates. Instead, the state is uniquely position to collect and disseminate important information that can drive discussions.

The three priority items for further discussion that were offered by other members of the LD 1196 group that we support include:

1. **Defining Behavioral Health Expenditure** – the MHDO undertaking to review primary care spending should be replicated for behavioral health spending in primary care.
2. **Standardized Definitions of Primary Care** – Consistency in defining primary care is important, we recommend that the Maine Health Data Organization definition of primary care be adopted as a standard definition to allow for consistency in various primary care analyses moving forward. MHDO may be collecting non-fee for service primary care spending, if so, we recommend that this information be added to the annual report on primary care spending.
3. **Barriers to VBP Alignment** – Several of our members participate in government payer VBP programs. One barrier to taking up commercial VBP programs is misalignment. VBP shouldn't drive inefficiency. We would support an organized review of those barriers and see if that review can generate solutions.

Thank you for accepting these comments on behalf of Maine's hospitals. We look forward to seeing the draft report and we will be glad to provide further comment if we believe it would be helpful.

Further, we are happy to speak with you at your convenience.

Yours,

Jeffrey Austin
VP of Government Relations

MAINE ASSOCIATION OF HEALTH PLANS

Statement of Position

LD 1196 An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health

Working Group
Convened by the Maine Medical Association

December 14th, 2021

The Maine Association of Health Plans (MeAHP) has five members including Aetna, Anthem Blue Cross and Blue Shield, Cigna, Community Health Options and Harvard Pilgrim Health Care. As of 1/1/2022, membership will also include UnitedHealth Group. Collectively, MeAHP's members provide or administer health insurance coverage to over 600,000 Maine people. The organization's mission is to improve the health of Maine people by promoting affordable, safe, and coordinated healthcare.

Health plans are committed to primary and behavioral health care; however, **the primary and behavioral care spending conversation is incomplete absent discussion of overall cost containment, quality and outcome measures, and a better understanding of non-claims-based payments**.

Fundamental questions must be resolved before moving forward with a proposal such as LD 1196:

- What is the appropriate definition of primary care[1] and does it include pharmacy as well as medical costs?
- What primary care achieves better outcomes and how will those outcomes be measured?
- How can Maine better accelerate the move to risk-based contracting?
- How much is spent by carriers on primary care outside of claims based FFS payments?

[1] MQF 2021 Annual Report on Primary Care Spending, pg. 6, Defining Primary Care.

- What is the definition of behavioral health in the context of a bill like this and what is the current baseline spending?

Overall spending targets need to be considered alongside any push to increase payments in any category of health care services. States that have considered these types of targets usually set them in the context of overall spending caps or global cost growth targets.

Affordability of health insurance is already a pressing issue. Maine has taken steps to address this ongoing problem such as establishing reinsurance in the individual market, providing the Small Business Premium Support Program, and considering merging the individual and small group markets. The Maine Health Data Organization is publishing an annual report on primary care spending and has issued Rule Ch. 247 to collect data on non-claims-based payments. In addition to these efforts, carriers continue to address costs in many ways including analyzing and focusing on the underlying cost of care, working to reduce unnecessary care, and moving towards value-based purchasing in partnership with providers. **Health insurers cannot support a bill that will increase overall health care costs in either the short or longer term.**

Primary care has experienced dramatic changes during COVID and the provision of it is likely to never be the same as pre-pandemic. Carriers have experienced exponential increases in telehealth services for example. Adaptations like this are underway and developing and their overall impact is yet unknown. Carriers and employers are seeking expanded access to primary and behavioral health services via telehealth because their members and employees are demanding them. All of MeAHP's member carriers now offer new virtual primary and behavioral health care options and benefits.

MEMORANDUM

TO: DR. BETH WILSON, WORKGROUP CHAIR, & DAN MORIN, DIR. COMMUNICATIONS & GOV'T AFFAIRS, MMA

FROM: DARCY SHARGO, CEO, MPCA & MPCA'S VBP STCOM

SUBJECT: RECOMMENDATIONS RE: LD 1196

DATE: 12/13/21

CC: ANDY MACLEAN, CEO, MMA; REP. SAM ZAGER

Dr. Wilson and Dan:

As the conveners of the stakeholder group to discuss LD 1196, *Investments in Primary Care and Behavioral Health*, I want to thank you both for the additional opportunity to share our concerns and recommendations on this important issue. Much of the substance of this memo is also reflected in our 11/16/21 presentation to the committee, and also echoes comments what various FQHC representatives shared during the course of the facilitated conversations.

MPCA represents the largest independent primary care network in Maine, in which 20 FQHCs operate tirelessly to provide outstanding care to nearly 200,000 Maine people. Our FQHCs serve 1 in 6 Mainers, often in places without any other point of access. We tend to see populations with substantial social health needs on top of complex medical needs. Thus, we have a strong desire to see the primary care system in Maine grow and thrive to meet the changing needs of Maine people – especially now that COVID is in the mix for the foreseeable future. (FMI, see www.mepca.org)

Given the significant impact Maine's FQHCs have on the primary care system as whole, both in terms of savings to the healthcare system and positive impact in health care quality, there are a couple of things we wanted to point out which didn't get as much "air time" during the course of stakeholder group meetings:

- We have an ongoing concern around the lack of a unified strategy/vision at the state level. We hope that whatever comes from these initial conversations can catalyze various state entities to develop a systemic way to assess and invest in primary care services. Absent that unification, the various initiatives that are at play across the state threaten to cancel one another out. As noted at the end of the presentation we gave to the committee, the Nat'l Academies report[i] has many recommendations about specific ways to organize an approach for implementing high-value primary care. This report should be seen as a roadmap/framework for that endeavor.

- Conversations that focus on primary care investment without any actual additional upfront funding are counter-intuitive. Typically, new value based payment and value based care methodologies succeed by providing additional *and new* funding to primary care providers in order to improve overall chances of meeting the Quadruple Aim. We are puzzled as to why the Primary Care Plus (PC +) program (a MaineCare initiative) and interest in primary care investments are not aligning more closely in service of value based payment and care delivery. On June 18, 2020, the state facilitated a robust dialogue about the importance of further investments in primary care, where there was acknowledgement that both *new and ongoing* investments in primary care bring savings to the system. Yet, LD 1196 and the PC + program operate from the premise of budget neutrality. When pressed on this, we have been told by the state that "there are always winners and losers." Primary Care should not bear these losses.
- Without additional investments in primary care payments that reflect social risk/social determinants of health (SDoH), FQHCs will continue to be disadvantaged since they serve a high proportion of vulnerable populations (e.g., homeless, dual eligibles, etc.). Studies show that health disparities can increase if payments are not adjusted for SDoH complexities. (See "ACOs and Downside Risk." *Health Affairs*, 38(9), p. 1597, September 2019, where the authors note that "Massachusetts and other states have developed innovative risk-adjustment models that incorporate SDoH and emphasize SUD and BH. However, this remains an emerging area of payment reform that needs to evolve rapidly to keep pace with state initiatives to manage Medicaid costs. Further research in this area is essential to ensure that downside risk does not unduly penalize ACOs and exacerbate health disparities among Medicaid beneficiaries.") A solution here could be to allow FQHCs to help the State collect SDoH data to come up with a risk stratification methodology and payment structure that adjusts appropriately for SDoH complexity.

These concerns notwithstanding, we are interested in offering recommendations for action as follows:

1. Align this bill (and/or future legislation) with key recommendations in the Nat'l Academies Report as framework for how/where to make investments in primary care.[ii]
2. Adopt a common definition of primary care as is spelled out in the Nat'l Academies report (this definition was also highlighted by other work group participants): "*High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams*[iii] *that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities*."
3. Conduct a current and ongoing "state of the primary care system" assessment to understand where primary care is at, esp. in light of COVID. This assessment may be already be underway in parts, but it would be important to understand the health of primary care system overall and to track it over time.
4. Use the assessment and other stakeholder processes to draw a direct line between PC investments and the impact on other state priority areas – response to Opiate Crisis, overall economic recovery, ability to recover from and redesign the system after COVID, etc.
5. Conduct a benchmarking exercise on behavioral health spend as was done for primary care.

6. Invest in primary care research, including an ongoing dashboard;[iv] research should also look at the impact of primary care services on downstream costs.
7. Use new Office of Affordable Health Care to drive the implementation of these, and other, recommendations (this idea was echoed by a few other stakeholders as well).

As the Natl' Academies report aptly notes, "high quality primary care is not a commodity service whose value needs to be demonstrated a competitive marketplace but rather a common good to be promoted by responsible public policy." We hope this stakeholder process is the kick-off to more serious discussion about this type of public policy, and we welcome the chance to continue to support these conversations in the future. The considerable success and expertise of the FQHC network can—and should—be considered invaluable to the next phases of this work.

Thank you for your consideration.

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[i] To access report, see https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care

[ii] For example, the National Academies report has recommendations for investments on multiple levels:

MACRO – Create new CHCs, RHCs, IHS sites, support community based training, push practices to embrace community-centric models through accreditation; leverage associations and others to track primary are progress and have a public dashboard/scorecard

MESO – State governments implement payment reform, publish performance on Medicaid standards, incentivize care team development and diversity, increase support for training in community practices – **increase portion of primary care spend**

MICRO – (Individual practices) Empanel uninsured pts, embrace community input into care models, support and training non-clinical team members

[iii] Payment should actually account for each member of a team as opposed to "billable providers." Depending a patient's need, a team could consist of CHWs, pharmacists, nutritionists, or others.

[iv] The report has some recommendations on things to track - incl. measures such as **% of primary care spend across payers, measures "related to paying for team based care and moving away from FFS;" % of population with usual access to primary care, primary care access in medically underserved areas; % of students training in community based settings (FQHCs, RHCs, CAHs**;) % **of PAs, nurses, etc. working in primary care**; % **invest in primary care research**

LD 1196 Stakeholder Committee

We would like to go on record as the Healthcare Purchaser Alliance of Maine representing approximately 150,000 lives that have health insurance provided by both public and private entities in Maine that we support the additional investment in primary care. However, we think the additional investment in primary care cannot and should not be decoupled from the affordability issue. Currently, a significant number of Maine residents are not getting the critical medical, dental and prescription care they should receive due to affordability issues. Increasing the reimbursement and therefore the cost to the patient for primary care will only exasperate the affordability issue in absence of some other form of cost relief.

We heard from several expert speakers that increasing primary care reimbursement in isolation as a strategic lever has not demonstrated a significant improvement in clinical outcomes, access, or affordability.

We believe the following four considerations should be part of the proposed recommendations.

*The increased investment in primary care spend should be directed at specific investments that have a documented and verified direct link to improved clinical outcomes.

*The measurement of the amount spent on primary care needs to be inclusive of both the claims and non-claims-based reimbursements to be able to appropriately benchmark the other state initiatives and to accurately reflect what is being paid for primary care services.

*There needs to be specific identified clinical, access, patient satisfaction and efficiency outcome metrics that are measured and reported annually.

*We believe that affordability cannot and should not be uncoupled from this conversation. We heard every single outside speaker expert in this area state that increasing primary care in isolation will result in increased costs (at least in the short term) without some form of total cost of care regulator. If the recommendation is pushing the total cost of care to the Affordability Board, we should postpone the implementation of the increased primary care investment until they have determined the pathway to affordability.

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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MEMORANDUM

TO: LD 1196 Stakeholder Group
FROM: Michelle Probert, Director, Office of MaineCare Services
DATE: January 14, 2022
RE: Response to the LD 1196 Stakeholder Report

On behalf of the Office of MaineCare Services (MaineCare) and the Maine Department of Health and Human Services (the Department), I appreciate the ongoing conversations during the stakeholder work sessions on LD 1196, *An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health.* The Department shares the goal of multi-payer investment in primary care and behavioral health services, while controlling the growth of health care spending overall. We are also supportive of public reporting on health care spending, quality performance, and other metrics to support population health, economic, and policy goals. This legislation has advanced important conversations related to these goals.

At the same time, the Department continues to have concerns with the bill's application to the MaineCare program due the unique financial, regulatory, and operational elements of Medicaid:

- This bill focuses on relative amounts of spending for health plans and proposes to measure MaineCare's spending against a benchmark set from commercial plans. The MaineCare program provides a different, vastly broader service array than commercial plans: for example, MaineCare provides critical home and community-based, long term services and supports to older adults and individuals with disabilities, and more generous behavioral health coverage. Spending on home- and community-based, long-term services and supports alone, services that are rarely, if ever, covered by commercial plans, comprises almost 45% of MaineCare's annual spending.

  MaineCare recently conducted an analysis as part of its Comprehensive Rate System Evaluation (RSE) comparing reimbursement rates for MaineCare services to those for the same services by other payers. This analysis demonstrated interesting findings in terms of scope of coverage as well as relative reimbursement. For services provided through behavioral health agencies, Maine's commercial payers cover a minority of the codes analyzed in the RSE that MaineCare covers for community-based services, Substance Use Disorder (SUD) services and children's behavioral health services, and slightly more than half of the service codes MaineCare covers for outpatient services. MaineCare rates for SUD services (excluding tobacco cessation) ranged from 143% to 210% of Maine commercial rates. In short, comparing MaineCare's relative primary care and behavioral health spending to that for commercial insurers is not an equitable comparison. We continue

to urge commercial insurers to cover a comprehensive range of behavioral health services for their populations, including crisis services and recovery supports.

- MaineCare is focused on implementing the recommendations from its RSE to right-size rates across the service spectrum and to incorporate value-based purchasing principles to ensure that providers have incentives and accountability to deliver desired outcomes. Enactment of LD 1196 may disrupt these plans by potentially requiring an increase in payments for some providers and a cut to those of others, which may not align with MaineCare's ongoing analysis of the appropriateness of current rates and the broader impact of these rates and reimbursement methodologies on our healthcare system. The Department has proposed legislation to codify reform of MaineCare Rate System, and MaineCare has publicly communicated schedules for rate reviews and updates inclusive of both primary care and behavioral health services in the coming year.

- In addition, unlike commercial health plans, control of MaineCare's reimbursement decisions often lays in considerable part with the legislature. This control would make it nearly impossible to ensure proportional growth of primary care and behavioral health spending without a complex legislative formula with specific appropriations annually to maintain compliance.

Lastly, we believe it's important to reiterate the following potential areas for improvement in this legislation and/or in future related efforts:

- The Department sees for meaningful efforts to achieve health care affordability that will directly benefit consumers, taxpayers, and businesses. Nationally, offices similar to the newly-established Office of Affordable Health Care (OAHC) [1] have elevated conversations and mobilized stakeholders to tackle the complex issues of rising healthcare costs with efforts tailored to local contexts and stakeholders, and demonstrated some promising results[2]. Stakeholders should discuss whether OAHC is the most appropriate and effective owner of the complex questions around growth caps and/or other strategies to reduce growth in health care spending.

- In alignment with the views of many stakeholders involved in the LD 1196 workgroup, the Department believes there is a need for significant additional work to define behavioral health services in the context of this LD. In this ongoing work, we support ensuring there is appropriate attention paid to behavioral and physical health integration as an evidence-based model for care delivery.[3]

[1] LD 120 from the 130th Maine legislature http://legislature.maine.gov/legis/bills/display_ps.asp?LD=120&snum=130

[2] National Association for State Health Policy. "Overview of States' Health Care Cost-Growth Benchmark Programs." https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/ (Accessed January 6, 2022).

[3] Agency for Healthcare Research and Quality. "What is Integrated Behavioral Health?" https://integrationacademy.ahrq.gov/about/integrated-behavioral-health (Accessed January 6, 2022).

- How we pay for health care is nearly as important as what we pay. Alternative Payment Models (APMs) offer a way to align reimbursement with goals for cost-efficient and quality care. The Department has the goal to tie 40% of MaineCare spending to value-based reimbursement by the end of calendar year 2022. MaineCare is making significant progress on its goal: it has already achieved 37% for spending in calendar year 2020. One of its numerous initiatives to achieve this goal is MaineCare's Primary Care Plus (PCPlus) model, currently proposed in rule, which is aligned with Primary Care First, a national, multi-payer initiative from the Center for Medicare and Medicaid Innovation to offer MaineCare primary care providers an opportunity to receive flexible, population-based payments to support increased access to patient-centered primary care. Another initiative includes review of the Certified Community Behavioral Health Clinic model, which would be a major payment and care delivery reform.

  The Department would be supportive of a multi-payer effort in the State of Maine to report on and set goals for statewide adoption of APMs, in alignment with the Health Care Payment Learning & Action Network's (HCP-LAN) APM Measurement Effort, to which MaineCare already contributes.

It has been exciting to hear through this workgroup the broad commitment to alternative payment methods and to building partnership across payers and providers on accountability and rewards for high value care. We look forward to continuing this work together.