Report of Colorado Primary Care Spending and Alternative Payment Model Use, 2017-2019

November 2020

CENTER FOR IMPROVING
VALUE IN HEALTH CARE

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BACKGROUND

The Center for Improving Value in Health Care (CIVHC) provides this report of primary care and alternative payment models (APM) spending (2017-2019) to the Colorado Insurance Commissioner for use by the Primary Care Payment Reform Collaborative (the Collaborative), established by Colorado House Bill 19-1233. The Collaborative's goal is to reduce health care costs by increasing utilization of primary care. This report measures progress towards that goal, as required by statute:

CRS 25.5-1-204(3)(c)(II) - Report includes the percentage of medical expenses allocated to primary care, the share of payments that are made through nationally recognized alternative payment models, and the share of payments that are not paid on a fee-for-service or per-claim basis.

The report is based on carrier-submitted information about primary care and total medical spending from claims and non-claims payments under fee-for-service (FFS) and APMs.

REPORT CONTENT

Primary care and APM spending as a percentage of total medical spending is presented for 2017, 2018 and 2019, by line of business (Commercial, Medicaid and Medicare Advantage) in Table 1. Primary care spending as a percentage of medical spending by carrier for 2019 is described in Table 2.

In this report, primary care spending and total medical spending exclude dental and prescription drug spending. All lines of business except Medicare Fee-for-Service are included in the report.

The calculation of medical and primary care spending utilized claim payments submitted through the CO APCD and non-claim payments collected through the APM files (*Appendix 1*). The approach to defining and collecting primary care spending was informed by the Primary Care Payment Reform Collaborative's recommended definition of primary care, and operationalized with input from the Collaborative members and the Division of Insurance (*Appendix 2*). The Collaborative also recommended collecting APM data using the nationally recognized Health Care Payment Learning and Action Network (HCP LAN) Alternative Payment Model framework (*Appendix 3*). More information on the HCP LAN initiative and the APM framework can be found here.

FINDINGS

Key observations include highlights from the report of primary care spending for 2017-2019 by payment model (Table 1).

- In 2019, primary care spending as a percentage of total medical spending in Colorado across all reported lines of business was 9.0%. This percentage has been increasing slightly year over year; primary care spending accounted for 8.9% of total medical spending in 2018 and accounted for 7.8% in 2017.
    - The percentage of primary care spending in Colorado, excluding Kaiser Permanente and Denver Health payments, is 7.2% in 2019, 6.8% in 2018 and 5.4% in 2017. Kaiser Permanente and Denver Health are not subject to the targets for primary care investment in HB19-1233 due to their unique integrated payer-provider systems.
- Primary care spending as a percentage of total medical spending varies by payer type. In 2019, primary care accounted for 9.3% of Commercial medical spending, 12.2% of Medicare Advantage medical spending, and 6.1% of Medicaid medical spending.

    - The percentage of primary care spending in Colorado in 2019, excluding Kaiser Permanente and Denver Health payments, is 5.9% of Commercial medical spending, 11.4% of Medicare Advantage medical spending, and 6.3% of Medicaid medical spending. Kaiser Permanente and Denver Health are not subject to the targets for primary care investment in HB19-1233 due to their unique integrated payer-provider systems.

- In 2019, 13.7% of ***all medical spending*** was paid through value-based APM arrangements[1]. This also varies by payer type – 17.5% of Commercial, 18.8% of Medicare Advantage, and 4.5% of Medicaid medical spending was paid through value-based APMs.

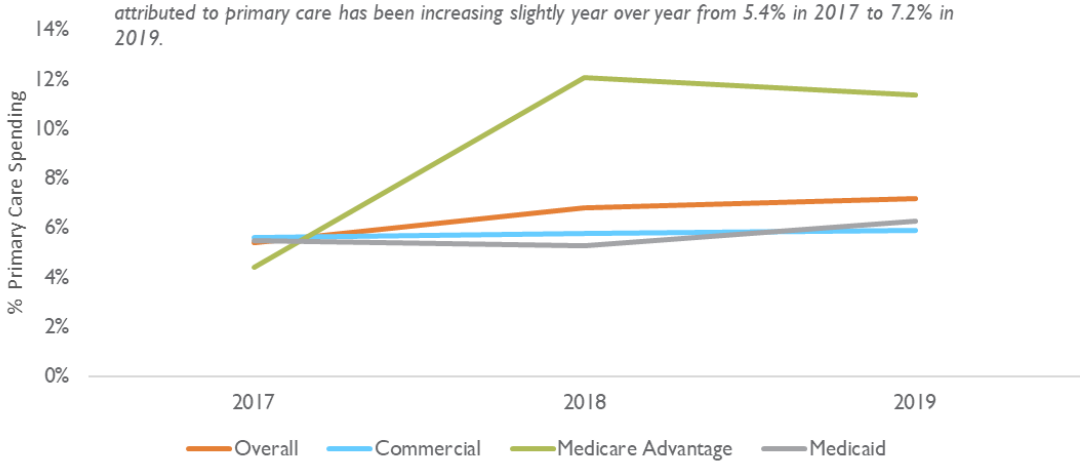
    - Value-based APMs built on a fee-for-service model – including Foundational Payments for Infrastructure & Operations (category 2A), Pay for Reporting (category 2B), Pay for Performance (category 2C), Shared Savings with Upside Risk Only (category 3A), and Shared Savings with Downside Risk (category 3B) - account for a small percentage (1.9%) of ***all medical spending***. By contrast, population-based APMs linked to quality (Condition-Specific Population-Based Payment, Comprehensive Population-Based Payment, and Integrated Finance & Delivery System) account for 11.9% of medical spending in 2019.

- Of ***all primary care spending*** in 2019, traditional fee-for-service payment arrangements accounted for 41.0% of spending. The remaining 59.0% of primary care spending occurred through APMs, including non-value-based and value-based arrangements. Of primary care spending made through APMs, the highest percentage flowed through Integrated Finance & Delivery Systems (category 4C). This indicates primary care in Colorado is largely being financed through advanced value-based payment arrangements.

    - Value-based APMs built on a fee-for-service model - including Foundational Payments for Infrastructure & Operations (category 2A), Pay for Reporting (category 2B), Pay for Performance (category 2C), Shared Savings with Upside Risk Only (category 3A), and Shared Savings with Downside Risk (category 3B) - account for a small percentage (5.0%) of ***all primary care spending***. By contrast, population-based APMs linked to quality (Condition-Specific Population-Based Payment, Comprehensive Population-Based Payment, and Integrated Finance & Delivery System) account for 38.9% of primary care spending in 2019.

[1] *Value-based APM arrangements do not include risk-based payments and capitated payments not linked to quality (3N and 4N HCP LAN categories respectively).*

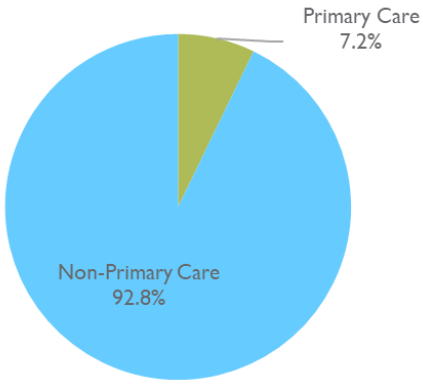
Overall, the percentage of total medical spending, excluding Kaiser Permanente and Denver Health, attributed to primary care has been increasing slightly year over year from 5.4% in 2017 to 7.2% in 2019.



Payments for primary care account for

7.2%

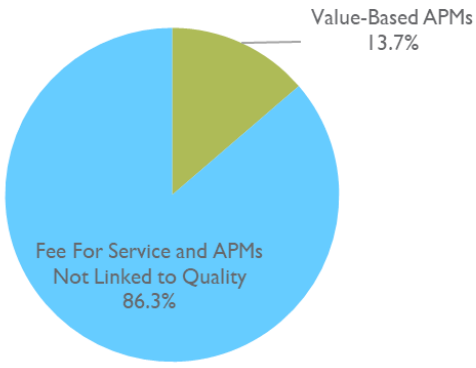
of total medical spending, excluding Kaiser and Denver Health, in 2019.



Payments under value-based alternative payment arrangements account for

13.7%

of total medical spending in 2019.



DATA SOURCES

This report was developed from two sources of data: 1) the annual Alternative Payment Model (APM) files submitted by carriers that are involved in alternative payments to providers, and 2) claims submitted by carriers to the Colorado All Payer Claims Database (CO APCD). Details about these two data sources are described below.

ANNUAL ALTERNATIVE PAYMENT MODELS (APM) FILES:

Carriers were first required to submit APM files in 2019. APM files capture the payments to providers that fall outside of the traditional fee-for-service structure. The reported information is aggregated at the billing provider and line of business level. The APM files provide a more comprehensive glimpse into the expenditures for medical care.

In last year's initial submission of APM files, carriers were instructed to submit APM data for members covered by group policies sold/issued in Colorado (situs), and for members residing in Colorado for policies sold on the individual market. However, after analyzing carrier submissions, it was discovered that the situs definition captured only about 50% of Colorado resident members of several large national carriers. This year, CIVHC changed the geographic selection criteria from Colorado contract situs to Colorado residency to better capture member data and understand the impacts of primary care and alternative payment models on Colorado residents only.

In addition, last year carriers were instructed to categorize their APM payments using a framework developed by the Oregon Health Authority. This year, based on the recommendations of the Collaborative and in consultation with the Division of Insurance, CIVHC updated the categorization to the national standard HCP LAN framework. This nationally recognized framework facilitates comparison of Colorado data to national data and other state data. A crosswalk of last year's categorization to the HCP LAN framework can be found in *Appendix 4.*

The reported results are based on APM data submitted by carriers for the first time under the current specifications, using the LAN categories. A considerable effort was made to validate carrier data after it was submitted on September 30th, but CIVHC was unable to address all gaps in time for publishing this report. APM submissions from Humana could not be included in this report due to data inconsistencies that need further research. Instead, spending for fee-for-service calculated from the CO APCD is reported for Humana.

Additional details about the methods to collect APM information and estimate primary care spending can be found in *Appendix 1*.

APM submissions relate only to total medical expenses. Carriers did not submit APM data for dental, vision, or pharmacy services.

COLORADO ALL PAYER CLAIMS DATABASE (CO APCD) CLAIMS:

A handful of active medical claims submitters to the CO APCD were exempt from submitting an APM file because the carriers do not currently provide APM payments to providers. The spending for these carriers is calculated using CO APCD claims data submissions and reported separately. A list of these exempt reporters is in *Appendix 1*.

RESULTS

TABLE 1: PRIMARY CARE & APM SPENDING, BY LINE OF BUSINESS (2017-2019)

Payer Type	Year	Measure	Total	Fee For Service	2A - Foundational Payments for Infrastructure & Operations	2B - Pay For Reporting	2C - Pay for Performance	3A - Shared Savings with Upside Risk Only	3B - Shared Savings with Downside Risk	3N - Risk Based Payments NOT Linked to Quality	4A - Condition-Specific Population-Based Payment	4B - Comprehensive Population-Based Payment	4C - Integrated Finance & Delivery System	4N - Capitated Payments NOT Linked to Quality
Total	2019	Total Medical Spending	$ 15,737,061,851	$ 12,926,571,128	$ 42,949,704	$ 162,825	$ 93,006,733	$ 123,447,039	$ 38,211,733	$ (2,063,626)	$ 133,046,303	$ 6,428,040	$ 1,726,013,255	$ 649,288,717
		Primary Care Spending	$ 1,415,147,889	$ 580,298,830	$ 11,814,995	$ -	$ 29,616,691	$ 25,683,656	$ 3,715,503	$ 155,218	$ 10,667,553	$ 3,064,182	$ 536,824,447	$ 213,306,815
		% Primary Care Spending	9.0%	4.5%	27.5%	0.0%	31.8%	20.8%	9.7%	*	8.0%	47.7%	31.1%	32.9%
	2018	Total Medical Spending	$ 14,514,379,974	$ 11,770,279,569	$ 26,487,986	$ 675,428	$ 139,959,736	$ 148,420,749	$ 34,996,006	$ 871,267	$ 80,087,524	$ 2,691,084	$ 1,729,295,683	$ 580,614,943
		Primary Care Spending	$ 1,291,181,375	$ 516,092,257	$ 9,538,030	$ 142,607	$ 12,557,856	$ 14,422,784	$ 2,278,680	$ 91,431	$ 11,348,892	$ 2,054,963	$ 545,652,659	$ 177,001,215
		% Primary Care Spending	8.9%	4.4%	36.0%	21.1%	9.0%	9.7%	6.5%	10.5%	14.2%	76.4%	31.6%	30.5%
	2017	Total Medical Spending	$ 13,120,568,493	$ 10,960,510,895	$ 46,051,792	$ -	$ 114,171,571	$ 123,585,403	$ 7,569,488	$ -	$ 19,622,331	$ 6,424	$ 1,464,090,118	$ 384,960,470
		Primary Care Spending	$ 1,026,708,326	$ 494,799,325	$ 6,414,499	$ -	$ 5,346,916	$ 15,885,411	$ 197,020	$ -	$ 11,519,969	$ -	$ 487,183,942	$ 5,361,246
		% Primary Care Spending	7.8%	4.5%	13.9%		4.7%	12.9%	2.6%		58.7%	0.0%	33.3%	1.4%
Commercial	2019	Total Medical Spending	$ 7,059,954,785	$ 5,650,338,683	$ 23,880,219	$ 162,825	$ 17,656,082	$ 99,583,029	$ 36,789,044	$ 207,575	$ 15,835,075	$ 14,339	$ 1,042,902,446	$ 172,585,469
		Primary Care Spending	$ 655,659,287	$ 261,058,821	$ 11,047,451	$ -	$ 732,007	$ 5,560,165	$ 2,514,619	$ 100,715	$ 422,937	$ -	$ 366,808,226	$ 7,414,346
		% Primary Care Spending	9.3%	4.6%	46.3%	0.0%	4.1%	5.6%	6.8%	48.5%	2.7%	0.0%	35.2%	4.3%
	2018	Total Medical Spending	$ 7,011,604,646	$ 5,581,523,861	$ 19,521,177	$ 675,428	$ 16,992,846	$ 127,532,731	$ 34,995,982	$ 188,216	$ 14,107,430	$ 10,031	$ 1,048,531,386	$ 167,525,557
		Primary Care Spending	$ 650,535,767	$ 255,500,329	$ 8,624,905	$ 142,607	$ 740,468	$ 5,184,327	$ 2,278,680	$ -	$ 549,364	$ -	$ 370,547,035	$ 6,968,052
		% Primary Care Spending	9.3%	4.6%	44.2%	21.1%	4.4%	4.1%	6.5%	0.0%	3.9%	0.0%	35.3%	4.2%
	2017	Total Medical Spending	$ 6,492,390,031	$ 5,257,314,502	$ 45,686,391	$ -	$ 18,242,877	$ 106,914,464	$ 7,569,146	$ -	$ 8,636,730	$ 6,424	$ 884,517,709	$ 163,501,788
		Primary Care Spending	$ 579,234,755	$ 232,410,472	$ 6,117,578	$ -	$ 364,011	$ 8,146,038	$ 197,020	$ -	$ 935,096	$ -	$ 325,839,569	$ 5,224,971
		% Primary Care Spending	8.9%	4.4%	13.4%		2.0%	7.6%	2.6%		10.8%	0.0%	36.8%	3.2%
Medicare Advantage	2019	Total Medical Spending	$ 3,743,006,015	$ 2,778,167,260	$ 282,271	$ -	$ 5,030,620	$ 12,035,311	$ 1,200,922	$ 424,826	$ 1,845,097	$ -	$ 683,089,838	$ 260,929,869
		Primary Care Spending	$ 456,289,560	$ 87,217,564	$ 78,912	$ -	$ 4,959,482	$ 12,035,311	$ 1,200,884	$ 50,874	$ 1,825,272	$ -	$ 170,003,524	$ 178,917,737
		% Primary Care Spending	12.2%	3.1%	28.0%		98.6%	100.0%	100.0%	12.0%	98.9%		24.9%	68.6%
	2018	Total Medical Spending	$ 3,197,645,359	$ 2,250,215,536	$ 107,330	$ -	$ 2,966,182	$ 15,143,622	$ -	$ 485,027	$ 2,225,926	$ -	$ 672,820,258	$ 253,681,478
		Primary Care Spending	$ 408,530,236	$ 61,583,312	$ 4,540	$ -	$ 2,910,218	$ 5,011,031	$ -	$ 87,020	$ 2,159,996	$ -	$ 170,092,784	$ 166,681,335
		% Primary Care Spending	12.8%	2.7%	4.2%		98.1%	33.1%		17.9%	97.0%		25.3%	65.7%
	2017	Total Medical Spending	$ 2,691,283,647	$ 2,085,039,716	$ 78,493	$ -	$ 4,923,396	$ 15,924,506	$ -	$ -	$ 2,790,502	$ -	$ 543,261,471	$ 39,265,562
		Primary Care Spending	$ 214,835,201	$ 56,301,087	$ 46,932	$ -	$ 4,860,904	$ 7,730,163	$ -	$ -	$ 2,566,404	$ -	$ 143,193,435	$ 136,276
		% Primary Care Spending	8.0%	2.7%	59.8%		98.7%	48.5%			92.0%		26.4%	0.3%
Medicaid	2019	Total Medical Spending	$ 4,934,101,051	$ 4,498,065,185	$ 18,787,214	$ -	$ 70,320,031	$ 11,828,699	$ 221,767	$ (2,696,027)	$ 115,366,131	$ 6,413,701	$ 20,971	$ 215,773,379
		Primary Care Spending	$ 303,199,042	$ 232,022,446	$ 688,632	$ -	$ 23,925,202	$ 8,088,180	$ -	$ 3,629	$ 8,419,343	$ 3,064,182	$ 12,697	$ 26,974,731
		% Primary Care Spending	6.1%	5.2%	3.7%		34.0%	68.4%	0.0%	*	7.3%	47.8%	60.5%	12.5%
	2018	Total Medical Spending	$ 4,305,129,968	$ 3,938,540,172	$ 6,859,479	$ -	$ 120,000,708	$ 5,744,395	$ 24	$ 198,024	$ 63,754,167	$ 2,681,053	$ 7,944,038	$ 159,407,907
		Primary Care Spending	$ 232,115,371	$ 199,008,616	$ 908,584	$ -	$ 8,907,170	$ 4,227,427	$ -	$ 4,411	$ 8,639,533	$ 2,054,963	$ 5,012,840	$ 3,351,828
		% Primary Care Spending	5.4%	5.1%	13.2%		7.4%	73.6%	0.0%	2.2%	13.6%	76.6%	63.1%	2.1%
	2017	Total Medical Spending	$ 3,936,894,815	$ 3,618,156,677	$ 286,908	$ -	$ 91,005,297	$ 746,433	$ 342	$ -	$ 8,195,099	$ -	$ 36,310,938	$ 182,193,121
		Primary Care Spending	$ 232,638,371	$ 206,087,765	$ 249,989	$ -	$ 122,000	$ 9,211	$ -	$ -	$ 8,018,469	$ -	$ 18,150,937	$ -
		% Primary Care Spending	5.9%	5.7%	87.1%		0.1%	1.2%	0.0%		97.8%		50.0%	0.0%

** The 2019 3N total expenditures include a significant negative reimbursement from a single payer in addition to other payers' 3N arrangements which include primary care.*

TABLE 2: PRIMARY CARE SPENDING, BY LINE OF BUSINESS AND CARRIER (2019)

The following tables report medical expenditures stratified by both line of business and carrier for 2019.

Carriers with multiple lines of business appear more than once.

Commercial 2019 - *Source: claims and non-claims from APM Submissions*			
Carrier Name	% Primary Care Spending	Primary Care Spending	Total Medical Spending
Aetna	5.3%	$ 24,646,258	$ 460,958,101
Anthem	5.4%	$ 51,001,519	$ 944,639,623
Bright Health	6.5%	$ 5,177,025	$ 79,070,798
Cigna	5.8%	$ 46,250,451	$ 802,926,902
Denver Health	1.5%	$ 4,042,355	$ 267,408,030
Kaiser	17.3%	$ 379,436,287	$ 2,192,999,057
Rocky Mountain Health Plans	4.9%	$ 4,448,248	$ 91,443,336
United Employer	6.8%	$ 109,845,284	$ 1,614,916,690
USHEALTH Group	0.0%	$ -	$ 13,009,619
Medicare Advantage 2019 - *Source: claims and non-claims from APM Submissions*			
Carrier Name	% Primary Care Spending	Primary Care Spending	Total Medical Spending
Aetna	4.2%	$ 2,565,764	$ 60,373,688
Anthem	4.3%	$ 16,001,352	$ 374,190,181
Bright Health	4.9%	$ 440,214	$ 9,007,838
Denver Health	0.7%	$ 445,850	$ 64,859,378
Kaiser	14.5%	$ 172,630,238	$ 1,189,706,057
Rocky Mountain Health Plans	15.4%	$ 6,109,561	$ 39,798,461
United Medicare	17.9%	$ 228,761,357	$ 1,276,995,171

Medicaid 2019 - *Source: claims and non-claims from APM Submissions*			
Carrier Name	% Primary Care Spending	Primary Care Spending	Total Medical Spending
Beacon	0.0%	$ 20,068	$ 121,508,652
Colorado Community Health Alliance	13.8%	$ 25,165,660	$ 181,863,863
Colorado Access	12.6%	$ 43,999,655	$ 349,320,607
Denver Health	3.7%	$ 6,660,668	$ 181,270,643
HCPF	5.2%	$ 198,977,775	$ 3,856,878,152
Kaiser	0.5%	$ 76,776	$ 14,537,120
Rocky Mountain Health Plans	12.4%	$ 28,298,440	$ 228,722,013
Commercial 2019 - *Source: claims from APCD (Carriers exempt from APM submissions)*			
Carrier Name	% Primary Care Spending	Primary Care Spending	Total Medical Spending
AFLAC	0.0%	$ -	$ 110,944
Allegiance Benefit Plan Management	5.7%	$ 2,406,413	$ 41,959,884
Ameriben	9.1%	$ 1,063,094	$ 11,657,906
American Enterprise	0.0%	$ -	$ 343,148
Friday Health Plans	4.7%	$ 1,774,369	$ 37,839,675
HealthSCOPE Benefits	4.2%	$ 519,354	$ 12,322,993
HealthSmart	2.8%	$ 257,194	$ 9,155,292
Humana	6.8%	$ 3,197,013	$ 46,720,066
Meritain Health	4.5%	$ 1,046,486	$ 23,474,307
State Farm	5.5%	$ 301,389	$ 5,514,859
UCHealth Plan	8.1%	$ 771,492	$ 9,506,591
UMR	4.9%	$ 18,026,105	$ 365,616,323
UnitedHealthcare Individual	4.6%	$ 790,561	$ 17,244,906
UnitedHealthcare Physical Health	0.0%	$ -	$ 645
UnitedHealthcare Student	5.9%	$ 658,391	$ 11,115,092
Medicare Advantage 2019 - *Source: claims from APCD (Carriers exempt from APM submissions)*			
Carrier Name	% Primary Care Spending	Primary Care Spending	Total Medical Spending
American Enterprise	1.3%	$ 3,515,209	$ 263,160,648
Humana	5.7%	$ 25,752,354	$ 453,127,425
Insurance Administrative Solutions	2.6%	$ 67,562	$ 2,574,274
UnitedHealthcare Physical Health	0.0%	$ 100	$ 9,212,894

LIMITATIONS

To facilitate the adoption of the HCP LAN framework to define the Alternative Payment Models data submission, CIVHC and DOI held several multi-payer calls, received expert consultation from Catalyst for Payment Reform, and engaged in one-on-one discussions and technical assistance with carriers. Though CIVHC put a considerable amount of effort into ensuring this report contains high-quality information, it is important to note that this is the first year CIVHC collected APM data under the current specifications. As time progresses, CIVHC and the carriers will inevitably gain more expertise about APM arrangements and the appropriate LAN categorizations, and apply this knowledge to future collection of these files.

Beyond the broad limitations, readers of this report should consider the following:

- We estimate the impact of Humana's excluded APM submission will not materially change the overall primary care spending. Based on Humana's APCD submissions, they account for approximately 3% of total medical spending in 2019. Further, the percentage of total medical spending paid under APMs 2C (Pay for Performance), 3A (Shared Savings – Upside Only), and 3B (Shared Savings with Downside and Upside Risk) would likely increase.
- Though CIVHC and the DOI put a considerable amount of effort towards sharing and discussing the new HCP LAN framework to categorize payment models with carriers, potential gaps in common understanding remain. CIVHC and the DOI will continue working with Colorado carriers to calibrate carriers' responses and ensure consistency between carrier data.
- The definition of primary care (*Appendix 2*) relies heavily on provider taxonomy requirements. CIVHC could not validate some carriers' claims-based primary care spending data against claims submitted to the CO APCD due to carrier differences in associated taxonomy codes for providers.
- To reduce the risk of "double counting" payments, CIVHC worked closely with the various Medicaid payer organizations, also known as Regional Accountable Entities (RAEs), to ensure accurate reporting. CIVHC instructed RAES to only report payments to providers. Payments from HCPF to the RAEs (i.e., payments from one payer entity to another) were not included in the APM calculations. This instruction eliminates "double counting" the payments HCPF made to the various RAEs and MCOs, and therefore eliminates the primary source of data redundancies. It also impacts HCPF's reported spending through APMs, making them appear lower. Payments to RAEs are included in the data submission, but are not reflected in this report.

NEXT STEPS

Looking toward the future of Primary Care Spending reporting, CIVHC has identified the following next steps to improve data collection and reporting.

- Reconsider the timeline for when the Primary Care Spending report is due to the Division of Insurance. The APM files are due to CIVHC on September 30 each year, and the validation efforts can take up to two months. The turnaround between September 30 and the December 15 deadline for the Primary Care Payment Reform Collaborative to publish an annual recommendations report is tighter than desired. The recommendations should be informed by the Primary Care Spending report, and receiving the data so late makes consideration and incorporation of the findings difficult if not impossible.
- Clarify claims vs non-claims definition in the Data Submission Guide to eliminate confusion from carriers.
- Add fields to the APM and Control Total specifications in the Data Submission Guide to differentiate between the carrier portion of primary care/total spending and the member portion. This change will allow organizations like the DOI to evaluate the impacts regulations have on the proportion of carrier spending on primary care.
- Formally collect qualitative information from carriers related to their alternative payment contracts with providers to help aid in proper LAN categorization.
- Use Primary Care Workforce Directory data, collected and maintained by the Colorado Department of Public Health and Environment, as an external validation of primary care providers' taxonomies.
- Improve methodologies to capture data for behavioral health providers providing mental health and substance abuse disorder service in integrated primary care settings.

APPENDIX 1. DETAILED METHODOLOGICAL INFORMATION

The following information provides further details related to the methodology to develop this report.

The APM submission guide differentiated between "claims payments" and "non-claims payments." Please see the definition here:

- Claims payments fields (AM010 and AM012) should include payments that were directly tied to a claim. These transactions would be found in the Medical Claims (MC) files submitted to CIVHC each month. It should include both the member portion and the plan paid portion (i.e., the total allowed amount).
- Non-claims payments fields (AM011 and AM013) should include payments made outside of the claim transaction. This would include transactions such as incentive payments, capitation payments, payments for infrastructure, and any payments from the provider to the payer (i.e., penalties) in downside risk arrangements.

Please note that claims payments are *not* synonymous with traditional fee-for-service payments. Claims payments are often an essential part of the structure of an alternative payment model. Further, non-claims payments are also not synonymous with alternative payment models.

A handful of active medical claims submitters to the CO APCD were exempt from submitting an APM file because they are not involved in alternative payment model payments to providers. Further, some medical claims submitters only administrate claims on behalf of Medicare Supplemental members. Medicare Supplemental data is not intended to be included in the APM submission. The primary care spending for these carriers is calculated using the CO APCD and reported separately. Below is the list of medical submitters that only reimburse providers on a fee-for-service basis or only submit Medicare Supplemental data:

Carrier	Exemption Reason
United Health Care (Individual, student, and Med Sup submitter codes)	FFS only
UMR	FFS only
American Enterprise	FFS only
State Farm	Med Sup
Physicians Mutual	Med Sup
USAA Enterprise	Med Sup
Friday Health Plans	FFS only
Insurance Administration	Med Sup
C.S.I. Life	Med Sup
AmeriBen/IEC Group	FFS only

UCHealth Plan Administrators	FFS only
Meritain Health	FFS only
HealthSmart Benefit Solutions	FFS only
Allegiance Benefit Plan Management	FFS only

More information on the submission instructions carriers received can be found here.

PRIMARY CARE CALCULATION

The calculation of primary care spending as a percentage of total medical spending can be represented by this equation:

$$\frac{\text{Claims-based payments for primary care} + \text{Non-claims-based payments for primary care}}{\text{Total claims-based payments} + \text{Total non-claims-based payments}}$$

Claims-Based Payments for Primary Care: Payments for primary care services as defined in the Data Submission Guide (DSG, see *Appendix 4*) that are tied to a claim. The calculation includes both the plan portion and the member portion. The numbers for this calculation come from two sources: 1) the claim-based spending identified as primary care from carriers that were required to submit an APM file, and 2) claims that qualify as primary care in the CO APCD for carriers exempt from submitting an APM file.

Non-Claims-Based Payments for Primary Care: Payments made to primary care providers (providers associated with taxonomies in the DSG primary care definition, see *Appendix 4*), outside of the claim transaction. This calculation is sourced only from the APM submissions. Please note that claims payments are *not* synonymous with traditional fee-for-service payments. Claims payments are often an essential part of the structure of an alternative payment model.

Total Claims-Based Payments: All medical services payments that are tied to a claim. This calculation includes both the plan portion and the member portion. The numbers for this calculation come from two sources: 1) the total claim-based spending from carriers that were required to submit an APM file, and 2) claims that qualify as primary care in the CO APCD for carriers exempt from submitting an APM file.

Total Non-Claims-Based Payments: All payments to medical providers made outside of the claim transaction. This calculation is sourced only from the APM submissions. Please note that claims payments are *not* synonymous with traditional fee-for-service payments. Claims payments are often an essential part of the structure of an alternative payment model.

APPENDIX 2. PRIMARY CARE DEFINITION

CIVHC is using the definition established by the Colorado Primary Care Payment Reform Collaborative. This definition was operationalized as payments made to primary care providers for primary care services. Included in this definition are services delivered by behavioral health providers who practice in an integrated primary care setting.

The primary care definition consists of two components that should be summed to produce total claim-based primary care payments:

A. **Outpatient services delivered by primary care providers** (which includes OB/GYN providers), defined by a combination of primary care provider taxonomy and primary care CPT-4 procedure codes
B. **Outpatient services delivered by behavioral health providers, nurse practitioners and physician assistants (other provider taxonomies)**, defined by a combination of the "other" provider taxonomies and primary care CPT-4 procedure codes AND billed by a primary care provider (defined by primary care taxonomy).

Include services delivered in an outpatient setting and exclude facility claims and inpatient services.

The following chart provides details on the *claims-based* primary care definition:

Component	Procedure Requirement		Service Provider Taxonomy Requirement		Billing Provider Taxonomy Requirement
A	Primary Care (defined by CPT-4 codes in *Table 5* below)	+	Primary Care (defined by taxonomies in *Table 3* below)	+	None
B	Primary Care (defined by CPT-4 codes in *Table 5* below)		Other Primary Care (defined by taxonomies in *Table 4* below)		Primary Care (defined by taxonomies in *Table 3* below)

Please note that, for CPT-4 procedure codes that describe global services for vaginal or Cesarean deliveries, payments should be multiplied by 60% to approximate the payments for antepartum and postpartum services only.

The *non-claims* primary care definition includes the following:

- Providers with specialties in the primary care taxonomy (Table 3)
- Behavioral health providers with a specified taxonomy (Table 4) that deliver care that is integrated with primary care (i.e., either within the primary care practice or through working relationships that involve close communication and collaboration with primary care providers)
- Nurse Practitioners (NP) and Physician Assistants (PA) that deliver primary care or work within a primary care practice

TABLE 3: PRIMARY CARE PROVIDER TAXONOMIES

Taxonomy Code	Description	Taxonomy Type
261QF0400X	Federally Qualified Health Center	Organization
261QP2300X	Primary care clinic	Organization
261QR1300X	Rural Health Center	Organization
261QC1500X	Community Health	Organization
261QM1000X	Migrant Health	Organization
261QP0904X	Public Health, Federal	Organization
261QS1000X	Student Health	Organization
207Q00000X	Physician, family medicine	Individual
207R00000X	Physician, general internal medicine	Individual
208000000X	Physician, pediatrics	Individual
208D00000X	Physician, general practice	Individual
363LA2200X	Nurse practitioner, adult health	Individual
363LF0000X	Nurse practitioner, family	Individual
363LP0200X	Nurse practitioner, pediatrics	Individual
363LP2300X	Nurse practitioner, primary care	Individual
363LW0102X	Nurse practitioner, women's health	Individual
363AM0700X	Physician's assistant, medical	Individual
207RG0300X	Physician, geriatric medicine, internal medicine	Individual
2083P0500X	Physician, preventive medicine	Individual
364S00000X	Certified clinical nurse specialist	Individual
163W00000X	Nurse, non-practitioner	Individual
207QG0300X	Allopathic & Osteopathic Physicians/Family Medicine, Geriatric Medicine	Individual
207QA0000X	Family Medicine - Adolescent Medicine	Individual
207QA0505X	Family Medicine - Adult Medicine	Individual
207QB0002X	Family Medicine - Obesity Medicine	Individual
207QG0300X	Family Medicine - Geriatric Medicine	Individual
207QS0010X	Family Medicine - Sports Medicine	Individual
207RA0000X	Internal Medicine - Adolescent Medicine	Individual

207RB0002X	Internal Medicine - Obesity Medicine	Individual
207RS0010X	Internal Medicine - Sports Medicine	Individual
2080A0000X	Pediatrics - Adolescent Medicine	Individual
2080B0002X	Pediatrics - Obesity Medicine	Individual
2080S0010X	Pediatrics - Sports Medicine	Individual
363LC1500X	Nurse Practitioner - Community Health	Individual
363LG0600X	Nurse Practitioner - Gerontology	Individual
363LS0200X	Nurse Practitioner - School	Individual
364SA2200X	Clinical Nurse Specialist - Adult Health	Individual
364SC1501X	Clinical Nurse Specialist - Community Health/Public Health	Individual
364SC2300X	Clinical Nurse Specialist - Chronic Health	Individual
364SF0001X	Clinical Nurse Specialist - Family Health	Individual
364SG0600X	Clinical Nurse Specialist - Gerontology	Individual
364SH1100X	Clinical Nurse Specialist - Holistic	Individual
364SP0200X	Clinical Nurse Specialist - Pediatrics	Individual
364SS0200X	Clinical Nurse Specialist - School	Individual
364SW0102X	Clinical Nurse Specialist - Women's Health	Individual
207V00000X	Physician, obstetrics and gynecology	OB/GYN
207VG0400X	Physician, gynecology	OB/GYN
363LX0001X	Nurse practitioner, obstetrics and gynecology	OB/GYN
367A00000X	Physician Assistants & Advanced Practice Nursing Providers/Midwife, Certified Nurse	OB/GYN
207VX0000X	OB/GYN- Obstetrics	OB/GYN

TABLE 4: OTHER PRIMARY CARE PROVIDER TAXONOMIES

Taxonomy Code	Description	Taxonomy Type
363L00000X	Nurse practitioner	Nurse Practitioner
363A00000X	Physician's assistant	Physician's Assistant
2084P0800X	Physician, general psychiatry	Behavioral Health
2084P0804X	Physician, child and adolescent psychiatry	Behavioral Health
363LP0808X	Nurse practitioner, psychiatric	Behavioral Health
1041C0700X	Behavioral Health & Social Service Providers/Social Worker, Clinical	Behavioral Health
2084P0805X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Geriatric Psychiatry	Behavioral Health
2084H0002X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Hospice & Palliative Medicine	Behavioral Health
261QM0801X	Ambulatory Health Care Facilities/Clinic/Center, Mental Health- CMHC	Behavioral Health
101Y00000X	Counselor	Behavioral Health
101YA0400X	Counselor - Addiction (SUD)	Behavioral Health
101YM0800X	Counselor - Mental Health (Note: Counselor working in MAT programs in FQHC)	Behavioral Health
101YP1600X	Counselor - Pastoral	Behavioral Health
101YP2500X	Counselor - Professional (Note: Counselor in FQHC)	Behavioral Health
101YS0200X	Counselor - School	Behavioral Health
102L00000X	Psychoanalyst	Behavioral Health
103T00000X	Psychologist (Note: Clinical Psychologist in FQHC)	Behavioral Health
103TA0400X	Psychologist - Addiction	Behavioral Health
103TA0700X	Psychologist - Adult Development and Aging (Note: Clinical Psychologist in FQHC)	Behavioral Health
103TB0200X	Psychologist - Cognitive and Behavioral	Behavioral Health
103TC0700X	Psychologist - Clinical	Behavioral Health
103TC1900X	Psychologist - Counseling	Behavioral Health
103TC2200X	Psychologist - Clinical Child & Adolescent	Behavioral Health
103TE1000X	Psychologist - Educational	Behavioral Health
103TE1100X	Psychologist - Exercise & Sports	Behavioral Health

103TF0000X	Psychologist - Family	Behavioral Health
103TH0004X	Psychologist - Health	Behavioral Health
103TH0100X	Psychologist - Health Service	Behavioral Health
103TM1700X	Psychologist - Men & Masculinity	Behavioral Health
103TM1800X	Psychologist - Mental Retardation & Developmental Disabilities	Behavioral Health
103TP0016X	Psychologist - Prescribing (Medical)	Behavioral Health
103TP0814X	Psychologist - Psychoanalysis	Behavioral Health
103TP2700X	Psychologist - Psychotherapy	Behavioral Health
103TP2701X	Psychologist - Group Psychotherapy	Behavioral Health
103TR0400X	Psychologist - Rehabilitation	Behavioral Health
103TS0200X	Psychologist - School	Behavioral Health
103TW0100X	Psychologist - Women	Behavioral Health
104100000X	Social Worker	Behavioral Health
1041S0200X	Social Worker - School	Behavioral Health
106H00000X	Marriage & Family Therapist (Note: Psychotherapist in FQHC)	Behavioral Health

TABLE 5: PRIMARY CARE SERVICES (CPT-4 PROCEDURE CODES)

Procedure Code	Description
10060	DRAINAGE OF SKIN ABSCESS
10061	DRAINAGE OF SKIN ABSCESS
10080	DRAINAGE OF PILONIDAL CYST
10120	REMOVE FOREIGN BODY
10121	REMOVE FOREIGN BODY
10160	PUNCTURE DRAINAGE OF LESION
11000	DEBRIDE INFECTED SKIN
11055	TRIM SKIN LESION
11056	TRIM SKIN LESIONS 2 TO 4
11100	BIOPSY SKIN LESION
11101	BIOPSY SKIN ADD-ON
11200	REMOVAL OF SKIN TAGS <W/15
11201	REMOVE SKIN TAGS ADD-ON
11300	SHAVE SKIN LESION 0.5 CM/<
11301	SHAVE SKIN LESION 0.6-1.0 CM
11302	SHAVE SKIN LESION 1.1-2.0 CM
11303	SHAVE SKIN LESION >2.0 CM
11305	SHAVE SKIN LESION 0.5 CM/<
11306	SHAVE SKIN LESION 0.6-1.0 CM
11307	SHAVE SKIN LESION 1.1-2.0 CM
11310	SHAVE SKIN LESION 0.5 CM/<
11311	SHAVE SKIN LESION 0.6-1.0 CM
11400	EXC TR-EXT B9+MARG 0.5 CM<
11401	EXC TR-EXT B9+MARG 0.6-1 CM
11402	EXC TR-EXT B9+MARG 1.1-2 CM
11403	EXC TR-EXT B9+MARG 2.1-3CM
11420	EXC H-F-NK-SP B9+MARG 0.5/<
11421	EXC H-F-NK-SP B9+MARG 0.6-1

11422	EXC H-F-NK-SP B9+MARG 1.1-2
11423	EXC H-F-NK-SP B9+MARG 2.1-3
11720	DEBRIDE NAIL 1-5
11730	REMOVAL OF NAIL PLATE
11750	REMOVAL OF NAIL BED
11765	EXCISION OF NAIL FOLD TOE
11900	INJECT SKIN LESIONS </W 7
11976	REMOVE CONTRACEPTIVE CAPSULE
11980	IMPLANT HORMONE PELLET(S)
11981	INSERT DRUG IMPLANT DEVICE
11982	REMOVE DRUG IMPLANT DEVICE
11983	REMOVE/INSERT DRUG IMPLANT
12001	RPR S/N/AX/GEN/TRNK 2.5CM/<
12042	INTMD RPR N-HF/GENIT2.6-7.5
15839	EXCISE EXCESS SKIN & TISSUE
17000	DESTRUCT PREMALG LESION
17003	DESTRUCT PREMALG LES 2-14
17004	DESTROY PREMAL LESIONS 15/>
17110	DESTRUCT B9 LESION 1-14
17111	DESTRUCT LESION 15 OR MORE
17250	CHEM CAUT OF GRANLTJ TISSUE
17281	DESTRUCTION OF SKIN LESIONS
17340	CRYOTHERAPY OF SKIN
19000	DRAINAGE OF BREAST LESION
20005	I&D ABSCESS SUBFASCIAL
20520	REMOVAL OF FOREIGN BODY
20550	INJ TENDON SHEATH/LIGAMENT
20551	INJ TENDON ORIGIN/INSERTION
20552	INJ TRIGGER POINT 1/2 MUSCL
20553	INJECT TRIGGER POINTS 3/>

20600	DRAIN/INJ JOINT/BURSA W/O US
20605	DRAIN/INJ JOINT/BURSA W/O US
20610	DRAIN/INJ JOINT/BURSA W/O US
20612	ASPIRATE/INJ GANGLION CYST
36415	ROUTINE VENIPUNCTURE
36416	CAPILLARY BLOOD DRAW
54050	DESTRUCTION PENIS LESION(S)
54056	CRYOSURGERY PENIS LESION(S)
55250	REMOVAL OF SPERM DUCT(S)
56405	I & D OF VULVA/PERINEUM
56420	DRAINAGE OF GLAND ABSCESS
56501	DESTROY VULVA LESIONS SIM
56515	DESTROY VULVA LESION/S COMPL
56605	BIOPSY OF VULVA/PERINEUM
56606	BIOPSY OF VULVA/PERINEUM
56820	EXAM OF VULVA W/SCOPE
56821	EXAM/BIOPSY OF VULVA W/SCOPE
57061	DESTROY VAG LESIONS SIMPLE
57100	BIOPSY OF VAGINA
57105	BIOPSY OF VAGINA
57135	REMOVE VAGINA LESION
57150	TREAT VAGINA INFECTION
57170	FITTING OF DIAPHRAGM/CAP
57410	PELVIC EXAMINATION
57420	EXAM OF VAGINA W/SCOPE
57421	EXAM/BIOPSY OF VAG W/SCOPE
57452	EXAM OF CERVIX W/SCOPE
57454	BX/CURETT OF CERVIX W/SCOPE
57455	BIOPSY OF CERVIX W/SCOPE
57456	ENDOCERV CURETTAGE W/SCOPE

57500	BIOPSY OF CERVIX
57505	ENDOCERVICAL CURETTAGE
58100	BIOPSY OF UTERUS LINING
58110	BX DONE W/COLPOSCOPY ADD-ON
58120	DILATION AND CURETTAGE
58300	INSERT INTRAUTERINE DEVICE
58301	REMOVE INTRAUTERINE DEVICE
59025	FETAL NON-STRESS TEST
59200	INSERT CERVICAL DILATOR
59300	EPISIOTOMY OR VAGINAL REPAIR
59400	OBSTETRICAL CARE
59409	OBSTETRICAL CARE
59410	OBSTETRICAL CARE
59412	Vaginal Delivery, Antepartum and Postpartum Care Procedures * 60% of payment
59414	Under Vaginal Delivery, Antepartum and Postpartum Care Procedures * 60% of payment
59425	ANTEPARTUM CARE ONLY
59426	ANTEPARTUM CARE ONLY
59430	CARE AFTER DELIVERY
59510	CESAREAN DELIVERY
59514	CESAREAN DELIVERY ONLY
59515	CESAREAN DELIVERY
59515	Cesarean delivery only *** 60% of payment**
59610	Routine obstetric care incl. VBAC delivery *** 60% of payment**
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps) *** 60% of payment**
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care *** 60% of payment**
59618	ATTEMPTED VBAC DELIVERY
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery * 60% of payment
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care *** 60% of payment**

59820	CARE OF MISCARRIAGE
69200	CLEAR OUTER EAR CANAL
69209	REMOVE IMPACTED EAR WAX UNI
69210	REMOVE IMPACTED EAR WAX UNI
76801	OB US < 14 WKS SINGLE FETUS
76802	OB US < 14 WKS ADDL FETUS
76805	OB US >= 14 WKS SNGL FETUS
76810	OB US >= 14 WKS ADDL FETUS
76811	OB US DETAILED SNGL FETUS
76812	OB US DETAILED ADDL FETUS
76813	OB US NUCHAL MEAS 1 GEST
76814	OB US NUCHAL MEAS ADD-ON
76815	OB US LIMITED FETUS(S)
76816	OB US FOLLOW-UP PER FETUS
76817	TRANSVAGINAL US OBSTETRIC
76818	FETAL BIOPHYS PROFILE W/NST
76819	FETAL BIOPHYS PROFIL W/O NST
90460	IM ADMIN 1ST/ONLY COMPONENT
90461	IM ADMIN EACH ADDL COMPONENT
90471	IMMUNIZATION ADMIN
90472	IMMUNIZATION ADMIN EACH ADD
90473	IMMUNE ADMIN ORAL/NASAL
90474	IMMUNE ADMIN ORAL/NASAL ADDL
90785	PSYTX COMPLEX INTERACTIVE
90791	PSYCH DIAGNOSTIC EVALUATION
90792	PSYCH DIAG EVAL W/MED SRVCS
90832	PSYTX W PT 30 MINUTES
90833	PSYTX W PT W E/M 30 MIN
90834	PSYTX W PT 45 MINUTES
90837	PSYTX W PT 60 MINUTES

90846	FAMILY PSYTX W/O PT 50 MIN
90847	FAMILY PSYTX W/PT 50 MIN
92551	PURE TONE HEARING TEST AIR
92552	PURE TONE AUDIOMETRY AIR
92558	EVOKED AUDITORY TEST QUAL
92567	TYMPANOMETRY
92585	AUDITOR EVOKE POTENT COMPRE
92587	EVOKED AUDITORY TEST LIMITED
92588	EVOKED AUDITORY TST COMPLETE
94010	BREATHING CAPACITY TEST
94014	PATIENT RECORDED SPIROMETRY
94015	PATIENT RECORDED SPIROMETRY
94016	REVIEW PATIENT SPIROMETRY
94060	EVALUATION OF WHEEZING
94070	EVALUATION OF WHEEZING
94375	RESPIRATORY FLOW VOLUME LOOP
96101	PSYCHO TESTING BY PSYCH/PHYS
96102	PSYCHO TESTING BY TECHNICIAN
96103	PSYCHO TESTING ADMIN BY COMP
96110	DEVELOPMENTAL SCREEN W/SCORE
96111	DEVELOPMENTAL TEST EXTEND
96127	BRIEF EMOTIONAL/BEHAV ASSMT
96150	ASSESS HLTH/BEHAVE INIT
96151	ASSESS HLTH/BEHAVE SUBSEQ
96156	Health behavior assessment or re-assessment
96160	PT-FOCUSED HLTH RISK ASSMT
96161	CAREGIVER HEALTH RISK ASSMT
96372	THER/PROPH/DIAG INJ SC/IM
97802	MEDICAL NUTRITION INDIV IN
97803	MED NUTRITION INDIV SUBSEQ

97804	MEDICAL NUTRITION GROUP
98925	OSTEOPATH MANJ 1-2 REGIONS
98926	OSTEOPATH MANJ 3-4 REGIONS
98927	OSTEOPATH MANJ 5-6 REGIONS
98928	OSTEOPATH MANJ 7-8 REGIONS
98929	OSTEOPATH MANJ 9-10 REGIONS
98960	SELF-MGMT EDUC & TRAIN 1 PT
98961	SELF-MGMT EDUC/TRAIN 2-4 PT
98962	5-8 patients
98966	HC PRO PHONE CALL 5-10 MIN
98969	ONLINE SERVICE BY HC PRO
99000	SPECIMEN HANDLING OFFICE-LAB
99024	POSTOP FOLLOW-UP VISIT
99050	MEDICAL SERVICES AFTER HRS
99051	MED SERV EVE/WKEND/HOLIDAY
99056	MED SERVICE OUT OF OFFICE
99058	OFFICE EMERGENCY CARE
99071	PATIENT EDUCATION MATERIALS
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity or diabetic instructions)
99173	VISUAL ACUITY SCREEN
99174	OCULAR INSTRUMNT SCREEN BIL
99177	OCULAR INSTRUMNT SCREEN BIL
99188	APP TOPICAL FLUORIDE VARNISH
99201	OFFICE/OUTPATIENT VISIT NEW
99202	OFFICE/OUTPATIENT VISIT NEW
99203	OFFICE/OUTPATIENT VISIT NEW
99204	OFFICE/OUTPATIENT VISIT NEW
99205	OFFICE/OUTPATIENT VISIT NEW
99211	OFFICE/OUTPATIENT VISIT EST

99212	OFFICE/OUTPATIENT VISIT EST
99213	OFFICE/OUTPATIENT VISIT EST
99214	OFFICE/OUTPATIENT VISIT EST
99215	OFFICE/OUTPATIENT VISIT EST
99334	DOMICIL/R-HOME VISIT EST PAT
99336	DOMICIL/R-HOME VISIT EST PAT
99337	DOMICIL/R-HOME VISIT EST PAT
99339	Individual physician supervision of a patient requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian), and/or key caregiver(s) involved in patient's care; integration of new information into the medical treatment plan; and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
99340	30 minutes or more
99341	HOME VISIT NEW PATIENT
99342	HOME VISIT NEW PATIENT
99343	HOME VISIT NEW PATIENT
99344	HOME VISIT NEW PATIENT
99345	HOME VISIT NEW PATIENT
99347	HOME VISIT EST PATIENT
99348	HOME VISIT EST PATIENT
99349	HOME VISIT EST PATIENT
99350	HOME VISIT EST PATIENT
99354	PROLONG E&M/PSYCTX SERV O/P
99355	PROLONG E&M/PSYCTX SERV O/P
99358	PROLONG SERVICE W/O CONTACT
99359	PROLONG SERV W/O CONTACT ADD
99366	TEAM CONF W/PAT BY HC PROF
99367	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician
99368	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
99381	INIT PM E/M NEW PAT INFANT

99382	INIT PM E/M NEW PAT 1-4 YRS
99383	PREV VISIT NEW AGE 5-11
99384	PREV VISIT NEW AGE 12-17
99385	PREV VISIT NEW AGE 18-39
99386	PREV VISIT NEW AGE 40-64
99387	INIT PM E/M NEW PAT 65+ YRS
99391	PER PM REEVAL EST PAT INFANT
99392	PREV VISIT EST AGE 1-4
99393	PREV VISIT EST AGE 5-11
99394	PREV VISIT EST AGE 12-17
99395	PREV VISIT EST AGE 18-39
99396	PREV VISIT EST AGE 40-64
99397	PER PM REEVAL EST PAT 65+ YR
99401	PREVENTIVE COUNSELING INDIV
99402	PREVENTIVE COUNSELING INDIV
99403	PREVENTIVE COUNSELING INDIV
99404	PREVENTIVE COUNSELING INDIV
99406	BEHAV CHNG SMOKING 3-10 MIN
99407	BEHAV CHNG SMOKING > 10 MIN
99408	AUDIT/DAST 15-30 MIN
99409	Alcohol and/or drug assessment or screening
99411	PREVENTIVE COUNSELING GROUP
99412	PREVENTIVE COUNSELING GROUP
99420	Administration and interpretation of health risk assessments
99421	Online digital evaluation and management service for an established patient for up to 7 days cumulative time during the 7 days, 5-10 minutes
99422	Online digital evaluation and management service for an established patient for up to 7 days cumulative time during the 7 days, 11-20 minutes
99423	Online digital evaluation and management service for an established patient for up to 7 days cumulative time during the 7 days, 21 or more minutes
99429	UNLISTED PREVENTIVE SERVICE
99441	PHONE E/M PHYS/QHP 5-10 MIN

99442	PHONE E/M PHYS/QHP 11-20 MIN
99443	PHONE E/M PHYS/QHP 21-30 MIN
99444	ONLINE E/M BY PHYS/QHP
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, > 16 minutes
99455	WORK RELATED DISABILITY EXAM
99456	DISABILITY EXAMINATION
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
99458	each additional 20 minutes (List separately in addition to code for primary procedure
99461	INIT NB EM PER DAY NON-FAC
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
99474	separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient
99484	CARE MGMT SVC BHVL HLTH COND
99487	CMPLX CHRON CARE W/O PT VSIT
99489	CMPLX CHRON CARE ADDL 30 MIN
99490	CHRON CARE MGMT SRVC 20 MIN
99491	Chronic care management services at least 30 minutes
99492	1ST PSYC COLLAB CARE MGMT
99493	SBSQ PSYC COLLAB CARE MGMT
99494	1ST/SBSQ PSYC COLLAB CARE
99495	TRANS CARE MGMT 14 DAY DISCH
99496	TRANS CARE MGMT 7 DAY DISCH
99497	ADVNCD CARE PLAN 30 MIN
99498	ADVNCD CARE PLAN ADDL 30 MIN

0500F	INITIAL PRENATAL CARE VISIT
0501F	PRENATAL FLOW SHEET
0502F	SUBSEQUENT PRENATAL CARE
0503F	POSTPARTUM CARE VISIT
1000F	TOBACCO USE ASSESSED
1031F	SMOKING & 2ND HAND ASSESSED
1032F	PT received Tobacco Cessation Information
1033F	TOBACCO NONSMOKER NOR 2NDHND
1034F	CURRENT TOBACCO SMOKER
1035F	SMOKELESS TOBACCO USER
1036F	TOBACCO NON-USER
1111F	DSCHRG MED/CURRENT MED MERGE
1220F	PT SCREENED FOR DEPRESSION
3016F	PT SCRND UNHLTHY OH USE
3085F	SUICIDE RISK ASSESSED
3351F	NEG SCRN DEP SYMP BY DEPTOOL
3352F	NO SIG DEP SYMP BY DEP TOOL
3353F	MILD-MOD DEP SYMP BY DEPTOOL
3354F	CLIN SIG DEP SYM BY DEP TOOL
3355F	CLIN SIG DEP SYM BY DEP TOOL
4000F	TOBACCO USE TXMNT COUNSELING
4001F	TOBACCO USE TXMNT PHARMACOL
4004F	PT TOBACCO SCREEN RCVD TLK
4290F	Alcohol and/or drug assessment or screening
4293F	Pt screened for high risk sexual behavior
4306F	Alcohol and/or Drug use counseling services
4320F	Alcohol and/or Drug use counseling services
90848 - 90899	Services to patients for evaluation and treatment of mental illnesses that require psychiatric services
96158-96159	Health behavior intervention, individual face-to-face
96164-96165	Health behavior intervention, group (two or more patients), face-to-face

96167-96168	Health behavior intervention, family (with the patient present), face-to-face
96170-96171	Health behavior intervention, family (without the patient present), face-to-face
97151-97158	Behavior Identification Assessment, administered by QHP, each 15 minutes of QHP's time face-to-face with patient and/or guardian(s)/caregivers(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
98967-98968	Non-physician telephone services
G0008	ADMIN INFLUENZA VIRUS VAC
G0009	ADMIN PNEUMOCOCCAL VACCINE
G0010	ADMIN HEPATITIS B VACCINE
G0101	CA SCREEN; PELVIC/BREAST EXAM
G0123	SCREEN CERV/VAG THIN LAYER
G0179	MD RECERTIFICATION HHA PT
G0180	MD CERTIFICATION HHA PATIENT
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
G0396	ALCOHOL/SUBS INTERV 15-30MN
G0397	Alcohol or substance abuse assessment
G0402	INITIAL PREVENTIVE EXAM
G0403	EKG FOR INITIAL PREVENT EXAM
G0404	EKG TRACING FOR INITIAL PREV
G0405	EKG INTERPRET & REPORT PREVE
G0438	PPPS, INITIAL VISIT
G0439	PPPS, SUBSEQ VISIT
G0442	ANNUAL ALCOHOL SCREEN 15 MIN
G0443	BRIEF ALCOHOL MISUSE COUNSEL
G0444	DEPRESSION SCREEN ANNUAL
G0445	HIGH INTEN BEH COUNS STD 30M
G0447	BEHAVIOR COUNSEL OBESITY 15M

G0463	HOSPITAL OUTPT CLINIC VISIT
G0476	HPV COMBO ASSAY CA SCREEN
G0502	Initial psychiatric collaborative care management
G0503	Subsequent psychiatric collaborative care management
G0504	Initial or subsequent psychiatric collaborative care management
G0505	Cognition and functional assessment
G0506	COMP ASSES CARE PLAN CCM SVC
G0507	Care management services for behavioral health conditions
G0513	PROLONG PREV SVCS, FIRST 30M
G0514	Prolonged preventive service
G2058	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month;
G2064-G2065	Comprehensive care management services for a single high-risk disease
H0002	ALCOHOL AND/OR DRUG SCREENIN
H0031	MH HEALTH ASSESS BY NON-MD
H0049	ALCOHOL/DRUG SCREENING
H1000	PRENATAL CARE ATRISK ASSESSM
H1001	ANTEPARTUM MANAGEMENT
Q0091	OBTAINING SCREEN PAP SMEAR
S0610	ANNUAL GYNECOLOGICAL EXAMINA
S0612	ANNUAL GYNECOLOGICAL EXAMINA
S0613	ANN BREAST EXAM
S0622	PHYS EXAM FOR COLLEGE
S9444	Parenting Classes, non-physician provider, per session
S9445	PT EDUCATION NOC INDIVID
S9446	PT EDUCATION NOC GROUP
S9447	Infant safety (including cardiopulmonary resuscitation classes nonphysician provider, per session)
S9449	WEIGHT MGMT CLASS
S9451	EXERCISE CLASS
S9452	Nutrition classes non-physician provider per session

S9454	Stress management classes non-physician provider per session
S9470	NUTRITIONAL COUNSELING, DIET
T1015	CLINIC SERVICE

APPENDIX 3. PAYMENT ARRANGEMENT CATEGORIES[2]

Category Code	Value	Definition/Example
01	Fee for Service	Payments made on a traditional fee-for-service model, no link to quality and value. These are traditional FFS payments that are not adjusted to account for infrastructure investments, provider reporting of quality data, for provider performance on cost and quality metrics. Diagnosis-related groups (DRGs) that are not linked to quality are included in Category 1.
2A	Foundational Payments for Infrastructure and Operations	Payments for infrastructure investments that can improve the quality of patient care (e.g., payments designated for staffing a care coordination nurse or upgrading to electronic health records).
2B	Pay for Reporting	Payments (incentives or penalties) to report quality measurement results.
2C	Pay-for-Performance	Payments (incentives or penalties) based on performance in meeting goals for quality measures (e.g. bonuses for quality performance).
3A	APMs with Shared Savings	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Does not include penalties when cost or utilization targets are not met (e.g., shared savings with upside risk only).
3B	APMs with Shared Savings and Downside Risk	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Includes penalties representing a portion of the losses that result when a cost or utilization target is not met (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk).
3N	Risk Based Payments NOT Linked to Quality	Payments representing a share of savings generated when a cost or utilization target is met and no quality targets exist (e.g., episode-based payments for procedures without quality measures and targets).
4A	Condition-Specific Population-Based Payment	Payments for the comprehensive treatment of specific conditions (e.g., payments for specialty services, such as oncology or mental health). Bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering only chemotherapy payments. Also, payments that are prospective and population-based and cover all care delivered by particular types of clinicians (e.g., orthopedics).
4B	Comprehensive Population-Based Payment	Payments that are prospective and population-based, and cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct, (e.g. global budgets or full/percent of premium payments)

[2] *Health Care Payment Learning & Action Network. Alternative Payment Models APM Framework. 2017.*

4C	Integrated Finance and Delivery System	Payments that also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. In some cases, these integrated arrangements consist of insurance companies that own provider networks, while in other cases they consist of delivery systems that offer their own insurance products (e.g. global budgets or full/percent of premium payments in integrated systems)
4N	Capitated Payments NOT Linked to Quality	Payments that are prospective and population-based, but not linked to quality.

APPENDIX 4. MAPPING OF 2019 APM CATEGORIES TO 2020 HCP LAN CATEGORIES

2019 APM Categories			HCP LAN Categories		
Code	**Value**	**Definition/Example**	**Code**	**Value**	**Definition/Example**
FS	FFS	Payments made to a billing provider under a traditional fee-for-service model, where each service rendered to a patient is separately reimbursed. FFS includes: Diagnosis Related Groups (DRGs), per-diem payments, fixed procedure code-based fee schedule (e.g. Medicare's Ambulatory Payment Classifications (APCs), claims-based payments adjusted by performance measures, and discounted charges-based payments.	01	Fee for Service	Payments made on a traditional fee-for-service model, no link to quality and value. These are traditional FFS payments that are not adjusted to account for infrastructure investments, provider reporting of quality data, for provider performance on cost and quality metrics. Diagnosis-related groups (DRGs) that are not linked to quality are in Category 1.
OT	Other, Non-FFS	All other payments made to a billing provider which are not based on a FFS model, including payments for health information technology structural changes; payments or expenses for supplemental staff or supplemental activities integrated into the practice, such as practice coaches, patient educators, or patient navigators; and other infrastructure payments.	2A	Foundational Payments for Infrastructure and Operations	Payments for infrastructure investments that can improve the quality of patient care. (e.g., payments designated for staffing a care coordination nurse or upgrading to electronic health records).
No direct mapping to a 2019 APM Category			2B	Pay for Reporting	Payments (incentives or penalties) to report quality measurement results.
PP	Pay for Performance /Payment Penalty	Annual payments or penalties made to a billing provider for performance against non-financial goals (quality and utilization metrics) during reporting year.	2C	Pay-for-Performance	Payments (incentives or penalties) based on performance in meeting goals for quality measures (e.g. bonuses for quality performance).

SH	Shared Savings / Shared Risk	Annual payments or penalties made to the billing provider for performance against spending targets during reporting year.	3A	APMs with Shared Savings	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Does not include penalties when cost or utilization targets are not met. (e.g., shared savings with upside risk only).
			3B	APMs with Shared Savings and Downside Risk	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Includes penalties representing a portion of the losses that result when a cost or utilization target is not met (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk).
BU	Bundled / Episode-Based	Payments made to a billing provider where a set budget was set for a defined episode of care for a specific condition (e.g. knee replacement) delivered by providers across multiple provider types	3B	APMs with Shared Savings and Downside Risk	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Includes penalties representing a portion of the losses that result when a cost or utilization target is not met (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk).
			4A	Condition-Specific Population-	Payments for the comprehensive treatment of specific conditions (e.g., payments for specialty services, such as oncology or mental health). Bundled payments for cancer care fall under

				Based Payment	Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering only chemotherapy payments. Also, payments that are prospective and population-based and cover all care delivered by particular types of clinicians (e.g., orthopedics).
PC	Patient-Centered Primary Care Home / Patient-Centered Medical Home	Payment for recognition as a Patient-Centered Primary Care Home (PCPCH) or other type of Patient-Centered Medical Home (PCMH), including recognition under a proprietary PCMH initiative. Only reported for payments exclusively for PCPCH or other PCMH recognition. FFS, pay-for-performance, shared savings, and capitation payments made for members in a PCPCH or other PCMH should be reported under those payment arrangement categories.	Multiple, depending on arrangement structure		Payments for recognition as PCPH or PCHM are assigned depending on payment arrangement: ● Fee-for-service – Category 01; ● Infrastructure payments – Category 2A; ● Pay-for-performance – Category 2C; ● Shared savings – Category 3A; ● Shared savings with downside risk – Category 3B; ● Population-based payments – Category 4A or 4B
No direct mapping to a 2019 APM Category			3N	Risk Based Payments NOT Linked to Quality	Payments representing a share of savings generated when a cost or utilization target is met and no quality targets exist (e.g., episode-based payments for procedures without quality measures and targets)

CU	Capitation – Unspecified	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for a set of services for a defined population, for which it cannot be determined if the arrangement is a global budget or limited budget arrangement.	Multiple, depending on arrangement structure		These are population-based payments, but categorization depends on a) whether they are prospective or retrospective, b) the breadth of services covered and c) whether payments are linked to quality: Retrospective payment – Category 3A or Category 3B Retrospective payment and not linked to quality – Category 3N Prospective payment and: Condition-specific – Category 4A Comprehensive – Category 4B Integrated finance and delivery system – Category 4C Not linked to quality – Category 4N
LB	Limited Budget	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for a non-comprehensive set of services to be delivered by a single provider organization (e.g. capitated primary care or oncology services)	Multiple, depending on arrangement structure		These are population-based payments, but categorization depends on a) whether they are prospective or retrospective, b) the breadth of services covered and c) whether payments are linked to quality:

					Retrospective payment – Category 3A or Category 3B Prospective payment – Category 4A
GB	Global Budget	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for either a: ● Comprehensive set of services for a broadly defined population ● Defined set of services, where certain benefits such as BH or Rx are carved out and not part of the budget Must, at a minimum, include physician services and IP/OP hospital services.	Multiple, depending on arrangement structure		These are population-based payments, but categorization depends on a) whether they are prospective or retrospective, b) the breadth of services covered and c) whether payments are linked to quality: Retrospective payment – Category 3A or Category 3B Prospective payment – Category 4B
ID	Integrated Delivery System	One or more legal entities encompassing financing and delivery of a full-spectrum of healthcare services under a mutually exclusive contract agreement. Resources and decision-making rights are shared across entities, and reimbursement is not dependent on services provided.	4C	Integrated Finance and Delivery System	Payments that also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. In some cases, these integrated arrangements consist of insurance companies that own provider networks, while in other cases they consist of delivery systems that offer their own insurance products (e.g.

					global budgets or full/percent of premium payments in integrated systems).
No direct mapping to a 2019 APM Category			4N	Capitated Payments NOT Linked to Quality	Payments that are prospective and population-based, but not linked to quality.