



PRIMARY CARE SPENDING AND ALTERNATIVE PAYMENT MODEL USE IN COLORADO, 2020-2022

Submitted November 2023

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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 (2020-2022) 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 overall 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 total 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 annual file information submitted by health insurance payers (also known as carriers) to CIVHC about primary care and total medical spending from claims and non-claims payments under fee-for-service (FFS) and APMs. CIVHC began collecting APM data as part of the Colorado All Payer Claims Database (CO APCD) Data Submission Guide in 2019.

REPORT CONTENT

Primary care and APM spending as a percentage of total medical spending is presented for 2022 by line of business (commercial, Medicare Advantage, Medicaid, and CHP+) in Table 1. The accompanying Excel file includes this information for all three years of data included in the analysis: 2020, 2021, and 2022. Primary care and APM spending for 2022, as a percentage of medical spending and by payer, is described in Table 2.

In this report, primary care spending and total medical spending exclude dental and prescription drug spending. This analysis includes commercial, Medicaid and Medicare Advantage payers, but does not include Medicare fee-for-service (FFS), the majority of self-insured employer covered lives, or federal health insurance programs such as the Veterans Administration, Tricare, and Indian Health Services.

Medical and primary care spending were calculated using claim payments submitted through the Colorado All Payer Claims Database (CO APCD) and non-claim payments collected through the APM files ([Appendix 1](#)). The approach to collecting and reporting primary care spending was informed by the 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 using the nationally recognized Health Care Payment Learning and Action Network (HCP LAN) Alternative Payment Model framework to categorize APMs ([Appendix 3](#)). More information on the HCP LAN initiative and the APM framework can be found [here](#).

In 2021, based on the recommendations of the Collaborative and in consultation with the Division of Insurance, CIVHC updated the file specifications to include plan paid amounts in order to assess payer investment in primary and value-based care. The specifications were also updated to include a prospective payment indicator to analyze prospective versus retrospective payments. Additional details on these changes can be found in [Appendix 1](#).

Additionally, CIVHC collects Medicaid-adjacent data from multiple organizations, including MCO/HMOs and Regional Accountable Entities (RAEs). As of 2023, CIVHC included a section detailing Medicaid payers by RAE region in Table 2 of the accompanying Excel file, which was initially aggregated at just the line of business and payer name.

FINDINGS

Key observations include highlights from the report of primary care spending for 2020-2022 by payment model (Table 1).

CIVHC collected qualitative information from all payers who submit an APM file to assess the impact of the COVID-19 pandemic on their organizations' investments in primary care and alternative payment models. For primary care, the general consensus was that utilization decreased during the stay-at-home order but has since rebounded to pre-pandemic levels or higher in some cases. The data demonstrates that investments in primary care, as a percentage of medical spending, increased overall between 2020 and 2022.

No payers reported a decrease in investment or cessation of APMs as a direct result of the COVID-19 pandemic in their qualitative responses. Most payers described no significant changes to their arrangements with providers. Some payers reported increased investment through the implementation of new pilot programs, one-time relief payments, or increased prospective payments in response to a decrease in utilization. The data shows that APM investment, as a percentage of medical and primary care spending, increased for all payers from 2020 to 2021.

PRIMARY CARE SPENDING

- In 2022, primary care spending as a percentage of **all medical spending** (excluding pharmacy and dental) in Colorado across all reported payer types was 15.2%. Primary care spending accounted for 13.9% of total medical spending in 2021 and 12.9% of total medical spending in 2020.

- The percentage of primary care spending in Colorado, excluding Kaiser Permanente and Denver Health payments¹, is 15.1% in 2022, 13.6% in 2021 and 12.0% in 2020.
- Primary care spending as a percentage of **all medical spending** varies by payer type. In 2022, primary care accounted for 8.5% of commercial medical spending, 17.7% of Medicare Advantage medical spending, 19.1% of Medicaid medical spending, and 14.7% of CHP+ medical spending.
 - The percentage of primary care spending in Colorado in 2022, excluding Kaiser Permanente and Denver Health payments, is 5.0% of commercial medical spending, 19.7% of Medicare Advantage medical spending, 19.1% of Medicaid medical spending, and 11.7% of CHP+ spending.

APM SPENDING

- In 2022, 36.1% of **all medical spending** across all reported lines of business was paid through value-based APM arrangements². This also varies by payer type – 24.1% of commercial, 47.8% of Medicare Advantage, 40.1% of Medicaid, and 7.3% of CHP+ medical spending was paid through value-based APMs.
 - Value-based APM arrangements built on an FFS model (LAN categories 2A, 2B, 2C, 3A, and 3B) account for 21.0% of **all medical spending**.
 - Value-based APM arrangements that are population-based and linked to quality (LAN Categories 4A, 4B, and 4C) account for 15.1% of **all medical spending** in 2022.
 - Excluding Kaiser Permanente and Denver Health, 31.0% of **all medical spending** was paid through value-based APM arrangements in 2022. With the exclusion of Kaiser Permanente and Denver Health, the percentage of all medical spending paid through value-based APM arrangements by payer type was 9.7% of commercial, 35.1% of Medicare Advantage, 41.2% of Medicaid, and 0.0% of CHP+ in 2022.
- Of **all primary care spending** in 2022, APMs, including non-value-based and value-based arrangements, accounted for 82.7% of spending. The remaining 17.3% of primary care spending occurred through traditional FFS payment arrangements. Of primary care

¹ Kaiser Permanente and Denver Health are not currently subject to the required targets for primary care investment established through Colorado Regulation 4-2-72 due to their unique integrated payer-provider systems.

² Value-based APM arrangements do not include risk-based payments and capitated payments not linked to quality (3N and 4N HCP LAN categories respectively).

spending made through APMs, the highest percentage flowed through Pay for Performance (category 2C).

- Value-based APM arrangements built on a FFS model (LAN categories 2A, 2B, 2C, 3A, and 3B) account for 14.7% of **all primary care spending** in 2022.
- Value-based APM arrangements that are population-based and linked to quality (LAN Categories 4A, 4B, and 4C) account for 53.1% of **all primary care spending** in 2022.

ADDITIONAL METRICS³:

SPENDING PER MEMBER PER MONTH:

- In 2022 and across all lines of business, **total medical** spending per member per month (PMPM) was \$322.21. **Primary care** spending PMPM was \$48.83.
 - **Total medical expenditures** expressed as spending PMPM vary by payer type. In 2022, total medical expenditures PMPM were \$472.13 for commercial, \$689.38 for Medicare Advantage, \$220.06 for Medicaid, and \$162.53 for CHP+.
 - Similar to total medical expenditures, **primary care expenditures** expressed as spending per member per month vary also by payer type. In 2022, primary care expenditures PMPM were \$40.03 for Commercial, \$121.90 for Medicare Advantage, \$41.93 for Medicaid, and \$23.83 for CHP+.

PROSPECTIVE PAYMENTS:

- Prospective payments refer to any payments made to providers in advance of services rendered, and are typically based on predetermined payment amounts for services. Across all lines of business, 22.3% of **all medical spending** in 2022 was paid on a prospective basis.
 - Excluding FFS, 54.2% of **all medical spending through an alternative payment model** was paid on a prospective basis in 2022.
 - 99.3% of Category 4 payments, 14.5% of Category 3, and 14.5% of Category 2 payments were made prospectively.
 - Excluding Kaiser Permanente and Denver Health, 13.2% of **all medical spending** and 27.6% of **all medical spending through an alternative payment model** was paid prospectively.
- The percentage of spending paid on a prospective basis varies by payer type; these differences are driven by both the overall percentage of spending paid through an APM

³ Note that these additional metrics are not displayed in the supplemental tables and other data.

arrangement as well as the predominant APM for each population. For example, Category 4 payment models are prospective by definition. Consequently, market segments that are dominated by these models will also pay a large percentage of their medical spending on a prospective basis.

- Of **all medical spending** in 2022, 20.8% of commercial, 35.5% of Medicare Advantage, 17.7% of Medicaid, and 7.3% of CHP+ was paid prospectively.
- Of **all spending through an alternative payment model**, 76.5% of commercial, 56.8% of Medicare Advantage, 41.8% of Medicaid, and 98.4% of CHP+ was paid prospectively.

MEMBER COST SHARING:

- Across all lines of business, payer organizations covered 94.0% of **all medical spending** in 2022; members were responsible for 6.0% of the costs. Excluding Medicaid and CHP+, which has minimal member liability, payer organizations covered 89.0% of all medical spending across commercial and Medicare Advantage plans, and members were responsible⁴ for the remaining.
 - Excluding Medicaid and CHP+, payer organizations covered 93.1% of **all primary care spending** in 2022. Payer investment in primary care has been steady for the past three years; health plans covered 93.3% of primary care expenditures in 2020 and 93.3% in 2021.
- In commercial lines of business only, payer organizations covered 85.7% of **all medical spending** in 2022; members were responsible³ for 14.3% of the costs.
 - Payer investment in primary care for commercially insured members slightly decreased in 2022 compared to 2020; payer organizations covered 88.7% of primary care expenditures in 2020, 86.4% in 2021, and 86.1% in 2022.

⁴ Note that this calculation only includes payments directly to providers. It does not include premiums paid by members to payer organizations.

Overall, the percentage of total medical spending, excluding Kaiser and Denver Health, attributed to primary care has increased from 12% in 2020 to 15% in 2022.

Figure 1: Percent of Primary Care Spending by Payer Over Time, 2020-2022

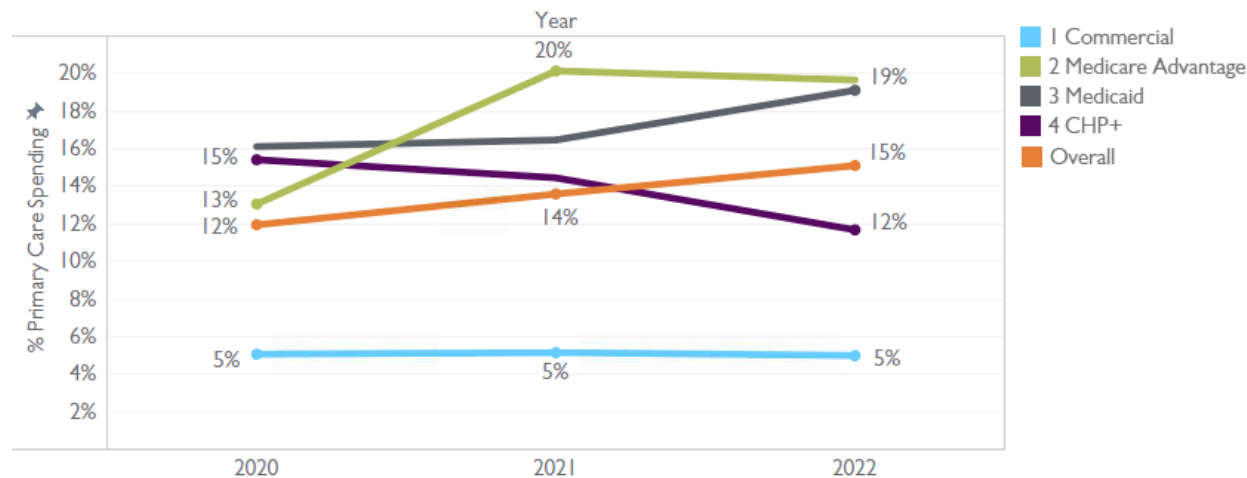


Figure 2: Share of Primary Care Spending, 2022.

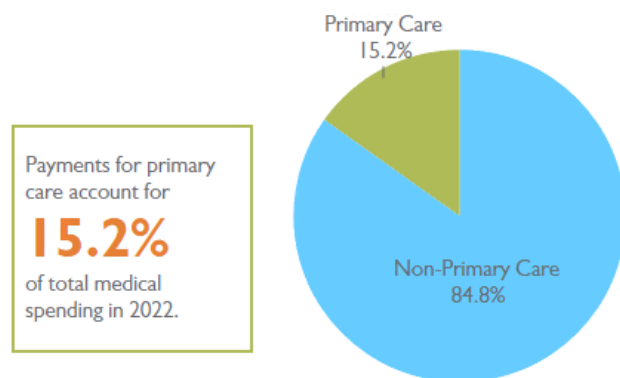
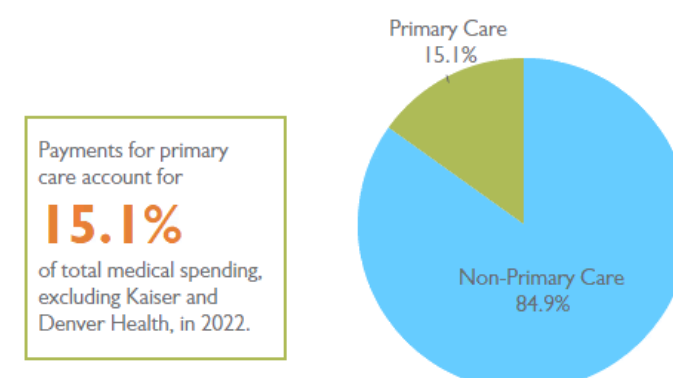


Figure 3: Share of Primary Care Spending, excluding Kaiser and Denver Health, 2022.



Note: The denominator (total medical spending) does not include pharmacy expenditures.

Figures 4: Share of Primary Care Spending by APM Category, 2022.

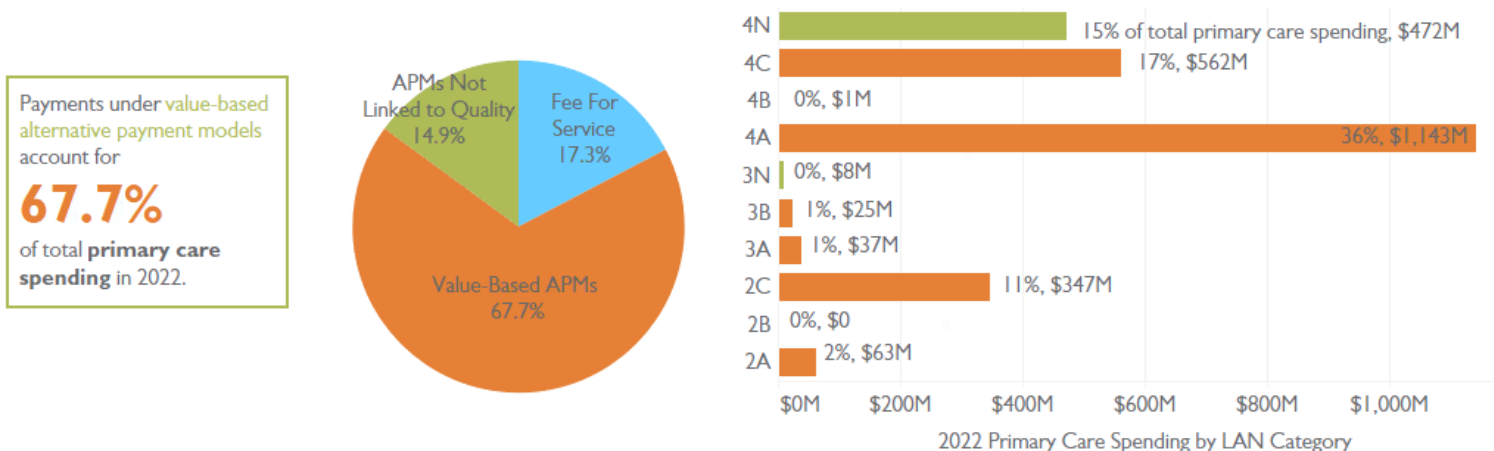
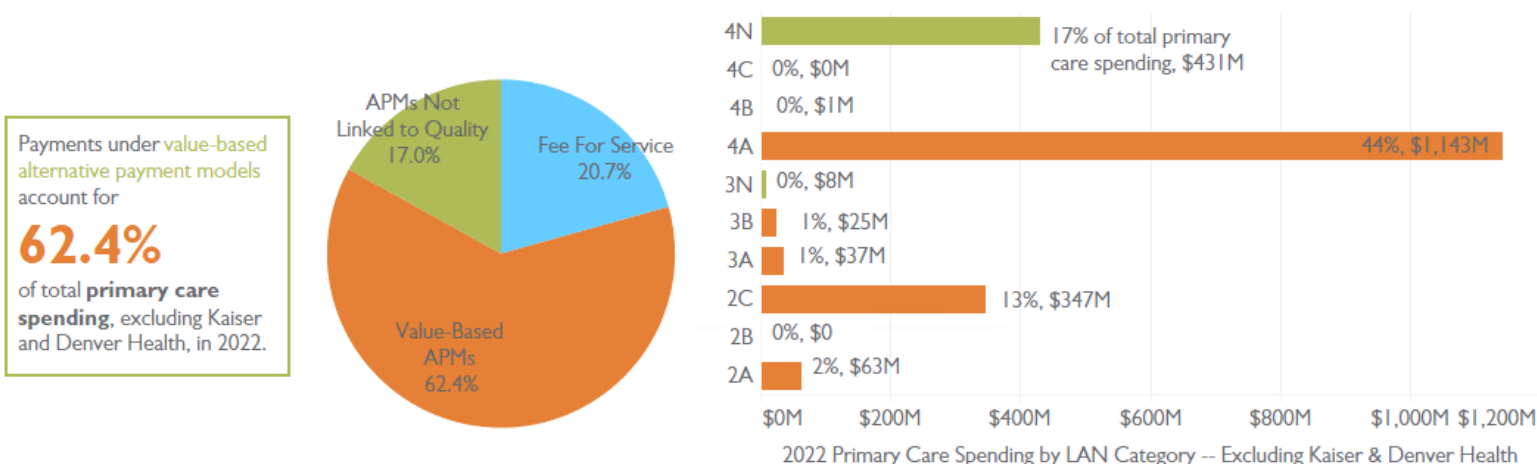


Figure 5: Share of Primary Care Spending by APM Category, excluding Kaiser and Denver Health, 2022.



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

Figure 6: Share of Total Medical Spending by APM Category, 2022.

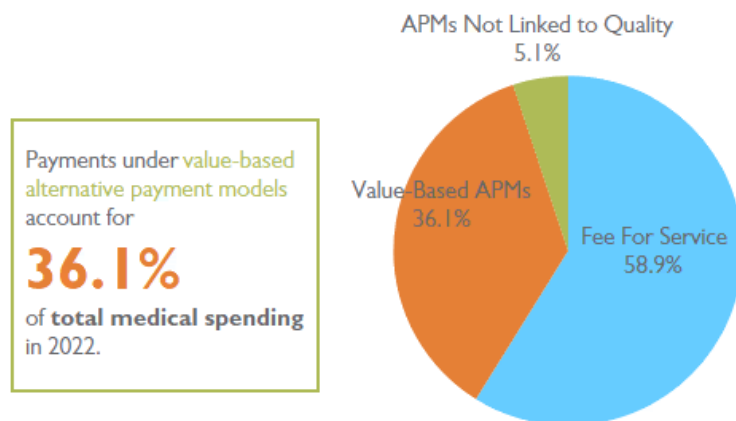
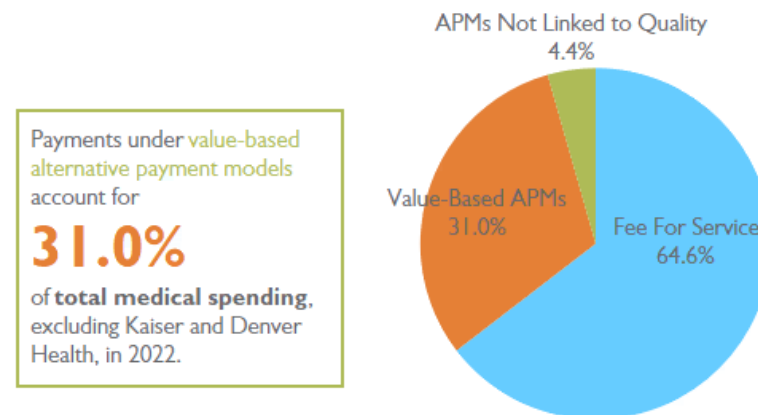


Figure 7: Share of Total Medical Spending by APM Category, excluding Kaiser and Denver Health, 2022.



Notes:

The denominator (total medical spending) does not include pharmacy expenditures.

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

Figure 8: Primary Care Spending of Total Medical Spending by Payer Type, 2020-2022.

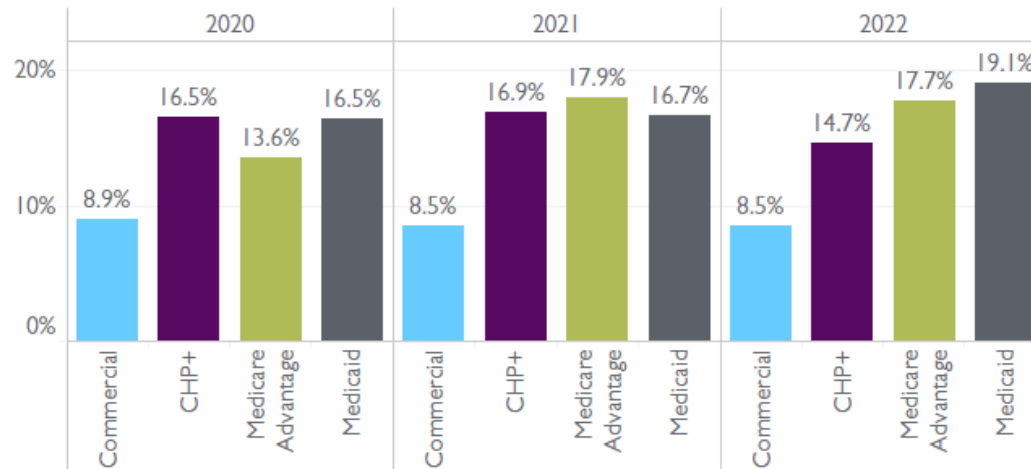


Figure 9: Primary Care Spending by Member Months by Payer, 2020-2022.

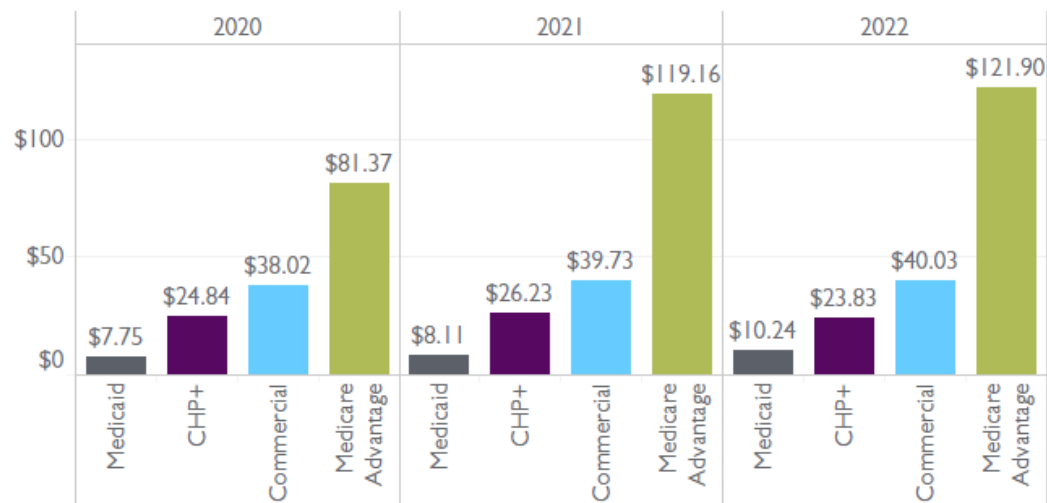


Figure 10: Share of Prospective Payments out of Primary Care Spending, excluding FFS, by APM Category, 2022.

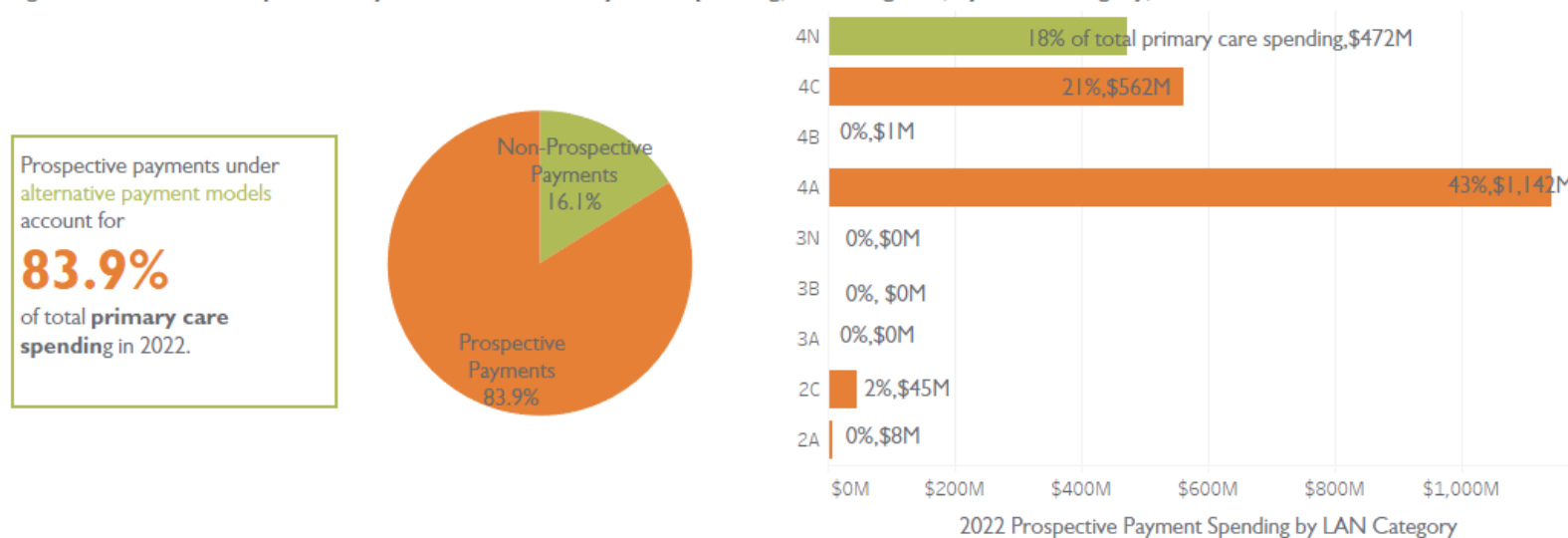


Figure 11: Share of Prospective Payments Out of Primary Care Spending, excluding FFS, by APM Category, excluding Kaiser and Denver Health, 2022.

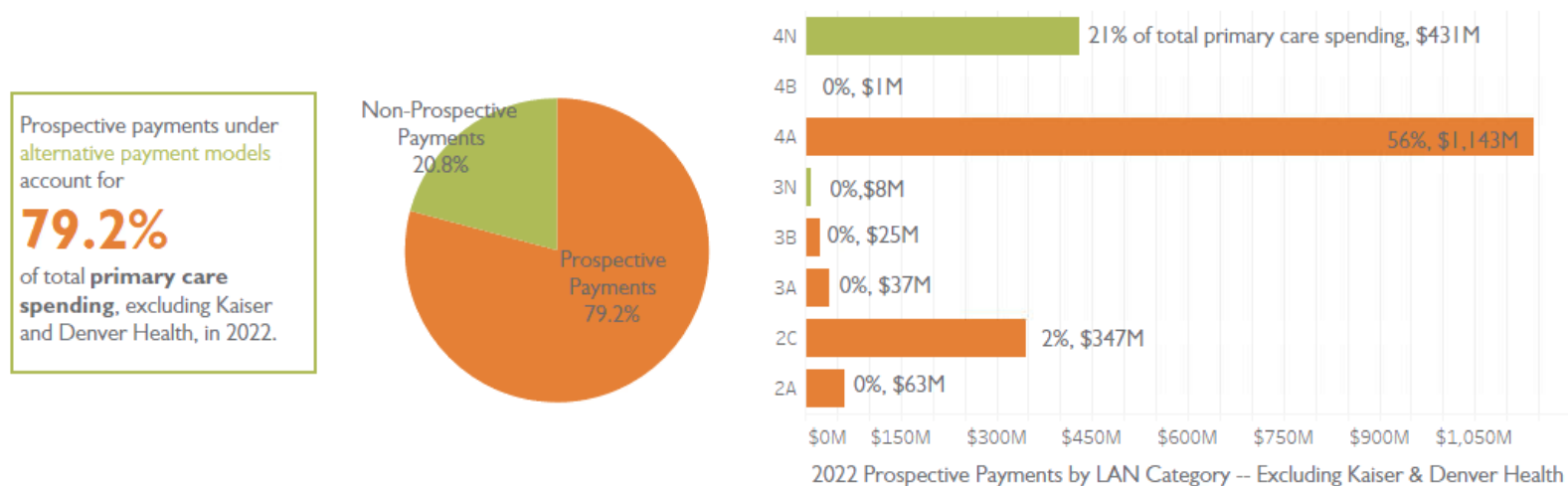


Figure 12: Share of Prospective Payments out of Total Medical Spending, excluding FFS, 2022.

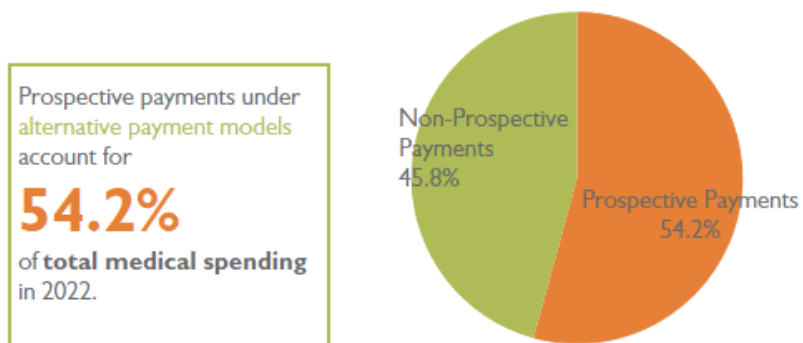
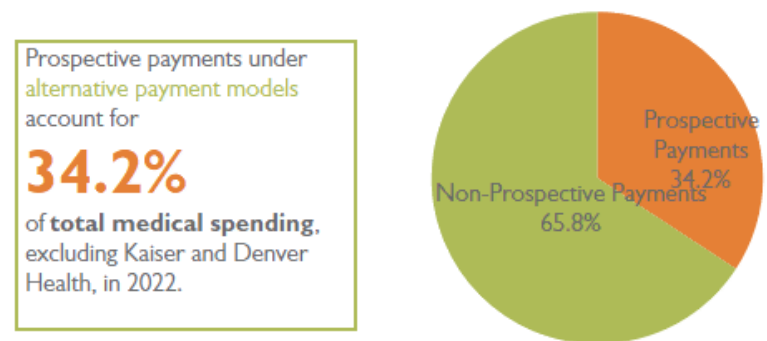


Figure 13: Share of Prospective Payments out of Total Medical Spending, excluding FFS, excluding Kaiser and Denver Health, 2022.



DATA SOURCES

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

In addition to data collected from the Colorado Department of Health Care Policy & Financing (HCPF), CIVHC collects Medicaid data from multiple entities, including Managed Care Organizations (MCOs), Health Maintenance Organizations (HMOs) and Regional Accountable Entities (RAEs). Each organization submits an APM file that includes payments made directly from the organization to medical providers. To ensure that Medicaid payments are not double-counted, HCPF payments to other Medicaid organizations are not included in the report. This report only includes Medicaid payments made directly to providers from HCPF, MCOs/HMOs, and RAEs. CIVHC met with each organization multiple times to confirm that the expenditures submitted in their file adhered to this instruction, that statewide programs (e.g. Accountable Care Collaborative) were represented consistently in each submission, and that CIVHC represented the complex Medicaid landscape accurately in this report.

ANNUAL ALTERNATIVE PAYMENT MODELS (APM) FILES:

At time of submission of the November 22nd, 2023 report, CIVHC received APM submissions from 16 payers in 2023, all of which have signed attestation.

The APM submission process involves each payer submitting a test file in July; a test file review period during which CIVHC validates the files and shares the findings to the payers; each payer submitting a production file in September; and a second validation period. In addition, CIVHC requires a C-suite level executive from each payer organization to attest in writing to the accuracy and validity of their APM submissions. As a result of the enhancements to the validation process implemented in 2021, as well as the continued learning from payers, CIVHC is confident the data in this year's report represents an accurate picture of APM investments across Colorado to date.

Payers were first required to submit APM files in 2019. APM files capture the payments to providers that fall outside of the traditional FFS structure. The reported information is aggregated at the billing provider and payer type level. The APM files provide important insights into spending across the health care system in Colorado beyond claims-based payments submitted on a monthly basis to the CO APCD.

Prior to the 2020 APM file submissions, CIVHC adopted the nationally recognized HCP LAN framework for categorizing APM data. This was a departure from the original methodology used to collect this data for the first time in 2019. Some payers had difficulties adjusting to the HCP LAN framework, and did not consistently report FFS dollars associated with an APM under the proper payment arrangement category. As a result, the APM investment reported in the

2020 Primary Care report was slightly understated. CIVHC prioritized this issue in the 2021 APM data collection and implemented the enhanced data collection process. In 2021, to facilitate the continued application of the HCP LAN framework for APM data submission, CIVHC and DOI held several multi-payer calls, received expert consultation from Catalyst for Payment Reform, and engaged in multiple one-on-one discussions and technical assistance with each payer. CIVHC also produced and updated a lengthy submission manual for payers to reference when developing their files. During the 2021 data submission process, CIVHC met with each payer at least once prior to submission of both test and production files and provided additional support to verify findings and aid the payers in revising their files to meet specifications.

In 2021, CIVHC added a qualitative summary of each payer's APM contracts to the submission requirements. Payers summarized the key elements of each contract (e.g. is it population based, are there measures of quality, does it include claims-based and/or non-claims payments?). This information is invaluable when validating the APM data and specifically addresses the category confusion that acted as one of the major limitations of 2020's report. For example, if a payer described their contract as including both claims and non-claims payments, CIVHC was able to validate that the APM expenditure data included in both of these payment types under the appropriate payment arrangement category. Another key benefit of the contract summary is that it often facilitates conversations between the payers' provider contracting subject matter experts and the data teams that produce the APM files to ensure that the APM files accurately reflect their business practices.

In 2021, CIVHC also implemented the attestation requirement mentioned above. Once APM files passed all validation criteria, CEO/CFOs at each organization were required to attest to the accuracy and validity of the summarized results. This attestation creates greater transparency to the payers in how CIVHC is summarizing and reporting on their data as well as an additional level of validation to ensure data quality, integrity, and accuracy. All 16 payers included in this report attested to the information submitted in their APM files.

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

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

COLORADO ALL PAYER CLAIMS DATABASE (CO APCD) CLAIMS

Some payers who are active medical claims submitters to the CO APCD were exempt from submitting an APM file because the payers are not involved in APM payments to providers. The spending for these payers is calculated using CO APCD claims data submissions. These expenditures are included in the total medical spending denominator used throughout the report. A list of these exempt reporters is in Appendix 1.

RESULTS

TABLE 1: TOTAL MEDICAL AND PRIMARY CARE SPENDING BY PAYMENT MODEL AND PAYER TYPE (2022)

Results for 2020-2022 are available in the accompanying Excel document

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	2022	Total Medical Spending	\$ 21,208,576,785	\$ 12,483,591,877	\$ 103,157,652	\$ -	\$ 3,463,441,394	\$ 308,296,972	\$ 576,312,065	\$ 182,456,770	\$ 1,313,884,093	\$ 860,882	\$ 1,880,067,765	\$ 896,507,316
		Primary Care Spending	\$ 3,214,107,994	\$ 556,450,674	\$ 63,073,174	\$ -	\$ 346,548,720	\$ 37,371,708	\$ 24,677,343	\$ 8,496,987	\$ 1,142,754,489	\$ 745,981	\$ 562,050,432	\$ 471,938,485
		% Primary Care Spending	15.2%	4.5%	61.1%	0.0%	10.0%	12.1%	4.3%	4.7%	87.0%	86.7%	29.9%	52.6%
COMMERCIAL	2022	Total Medical Spending	\$ 7,231,176,533	\$ 5,262,904,803	\$ 15,972,789	\$ -	\$ 364,251,976	\$ 282,633,592	\$ 50,925,720	\$ -	\$ 130,853	\$ 746,144	\$ 1,026,409,578	\$ 227,201,080
		Primary Care Spending	\$ 613,109,426	\$ 212,180,736	\$ 7,818,715	\$ -	\$ 745,380	\$ 34,409,789	\$ 4,318,374	\$ -	\$ 5,128	\$ 745,981	\$ 352,757,164	\$ 128,159
		% Primary Care Spending	8.5%	4.0%	49.0%	0.0%	0.2%	12.2%	8.5%	0.0%	3.9%	100.0%	34.4%	0.1%
MEDICARE ADVANTAGE	2022	Total Medical Spending	\$ 4,258,169,719	\$ 1,595,373,102	\$ 318,728	\$ -	\$ 800,022,446	\$ 17,536,478	\$ 370,632,562	\$ 178,504,791	\$ -	\$ 114,738	\$ 847,496,587	\$ 448,170,286
		Primary Care Spending	\$ 752,967,655	\$ 51,720,900	\$ -	\$ -	\$ 34,137,870	\$ 1,908,790	\$ 20,358,969	\$ 8,496,914	\$ -	\$ -	\$ 205,748,752	\$ 430,595,460
		% Primary Care Spending	17.7%	3.2%	0.0%	0.0%	4.3%	10.9%	5.5%	4.8%	0.0%	0.0%	24.3%	96.1%
MEDICAID	2022	Total Medical Spending	\$ 9,622,942,338	\$ 5,536,211,108	\$ 86,866,136	\$ -	\$ 2,298,327,749	\$ 8,121,684	\$ 154,753,783	\$ 3,951,979	\$ 1,313,689,280	\$ -	\$ -	\$ 221,020,619
		Primary Care Spending	\$ 1,833,910,504	\$ 282,131,654	\$ 55,254,458	\$ -	\$ 311,665,469	\$ 1,047,913	\$ -	\$ 73	\$ 1,142,685,401	\$ -	\$ -	\$ 41,125,535
		% Primary Care Spending	19.1%	5.1%	63.6%	0.0%	13.6%	12.9%	0.0%	0.0%	87.0%	0.0%	0.0%	18.6%
CHP+	2022	Total Medical Spending	\$ 96,288,195	\$ 89,102,863	\$ -	\$ -	\$ 839,224	\$ 5,218	\$ -	\$ -	\$ 63,959	\$ -	\$ 6,161,601	\$ 115,331
		Primary Care Spending	\$ 14,120,410	\$ 10,417,384	\$ -	\$ -	\$ -	\$ 5,218	\$ -	\$ -	\$ 63,959	\$ -	\$ 3,544,517	\$ 89,331
		% Primary Care Spending	14.7%	11.7%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	57.5%	77.5%

* The 3B primary care expenditures include recoupements from primary care providers for a single payer.

Additional Note: Total medical expenditures do not include pharmacy spending.



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TABLE 1a: ALTERNATIVE PAYMENT MODELS AS A PERCENTAGE OF PRIMARY CARE SPENDING, BY PAYER TYPE (2022)

Results for 2020-2022 are available in the accompanying Excel document

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	2022	Primary Care Spending	\$ 3,214,107,994	\$ 556,450,674	\$ 63,073,174	\$ -	\$ 346,548,720	\$ 37,371,708	\$ 24,677,343	\$ 8,496,987	\$ 1,142,754,489	\$ 745,981	\$ 562,050,432	\$ 471,938,485
		% of Total Primary Care Spending	100.0%	17.3%	2.0%	0.0%	10.8%	1.2%	0.8%	0.3%	35.6%	0.0%	17.5%	14.7%
COMMERCIAL	2022	Primary Care Spending	\$ 613,109,426	\$ 212,180,736	\$ 7,818,715	\$ -	\$ 745,380	\$ 34,409,789	\$ 4,318,374	\$ -	\$ 5,128	\$ 745,981	\$ 352,757,164	\$ 128,159
		% of Total Primary Care Spending	100.0%	34.6%	1.3%	0.0%	0.1%	5.6%	0.7%	0.0%	0.0%	0.1%	57.5%	0.0%
MEDICARE ADVANTAGE	2022	Primary Care Spending	\$ 752,967,655	\$ 51,720,900	\$ -	\$ -	\$ 34,137,870	\$ 1,908,790	\$ 20,358,969	\$ 8,496,914	\$ -	\$ -	\$ 205,748,752	\$ 430,595,460
		% of Total Primary Care Spending	100.0%	6.9%	0.0%	0.0%	4.5%	0.3%	2.7%	1.1%	0.0%	0.0%	27.3%	57.2%
MEDICAID	2022	Primary Care Spending	\$ 1,833,910,504	\$ 282,131,654	\$ 55,254,458	\$ -	\$ 311,665,469	\$ 1,047,913	\$ -	\$ 73	\$ 1,142,685,401	\$ -	\$ -	\$ 41,125,535
		% of Total Primary Care Spending	100.0%	15.4%	3.0%	0.0%	17.0%	0.1%	0.0%	0.0%	62.3%	0.0%	0.0%	2.2%
CHIP+	2022	Primary Care Spending	\$ 14,120,410	\$ 10,417,384	\$ -	\$ -	\$ -	\$ 5,218	\$ -	\$ -	\$ 63,959	\$ -	\$ 3,544,517	\$ 89,331
		% of Total Primary Care Spending	100.0%	73.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	25.1%	0.6%

Notes:

Total medical expenditures do not include pharmacy spending.

The 3B primary care expenditures include recoupements from primary care providers for a single payer.



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TABLE 2: PRIMARY CARE SPENDING AND VALUE-BASED APM SPENDING, BY NAMED PAYER (2022)

The following tables report medical expenditures stratified by both named payer for 2022.

Payers with multiple lines of business appear more than once.

COMMERCIAL 2022							
Carrier Name	% Primary Care Spending	% Value-Based APM Spending	Primary Care Spending	Value-Based APM Spending	Total Medical Spending	Total Prospective Spending	% Prospective Spending
Aetna	5.9%	28.0%	\$ 32,652,351	\$ 154,848,944	\$ 553,902,872	\$ 1,602,072	0.3%
Anthem	5.2%	30.2%	\$ 52,272,892	\$ 306,122,143	\$ 1,013,366,056	\$ 10,448,402	1.0%
Blue Cross Blue Shield of Illinois	3.0%	10.6%	\$ 274,180	\$ 986,221	\$ 9,284,809	\$ -	0.0%
Cigna	3.0%	0.0%	\$ 29,011,615	\$ 24,267	\$ 973,089,083	\$ 43,737,955	4.5%
Denver Health	0.7%	0.0%	\$ 1,764,025	\$ -	\$ 250,275,534	\$ 183,484,965	73.3%
Humana	7.4%	0.0%	\$ 1,985,487	\$ -	\$ 26,693,810	\$ -	0.0%
Kaiser Permanente	17.8%	61.3%	\$ 365,354,157	\$ 1,259,282,571	\$ 2,054,453,227	\$ 1,259,282,570	61.3%
Rocky Mountain Health Plan	3.4%	0.2%	\$ 4,849,432	\$ 301,921	\$ 143,387,590	\$ 19,690	0.0%
UnitedHealthcare**	6.0%	1.4%	\$ 86,700,972	\$ 19,504,584	\$ 1,444,667,987	\$ 7,712,896	0.5%
Allegiance Benefit Plan Management*	5.1%	0.0%	\$ 1,730,746	\$ -	\$ 33,993,230	\$ -	0.0%
Ameriben*	4.9%	0.0%	\$ 1,772,710	\$ -	\$ 35,962,718	\$ -	0.0%
American Enterprise*	0.0%	0.0%	\$ -	\$ -	\$ 782,870	\$ -	0.0%
Employee Benefit Management Services Inc.*	3.3%	0.0%	\$ 2,071,065	\$ -	\$ 62,262,398	\$ -	0.0%
Friday Health Plans*	5.6%	0.0%	\$ 5,658,654	\$ -	\$ 100,746,894	\$ -	0.0%
Harrington Kaiser Permanente*	5.2%	0.0%	\$ 685,519	\$ -	\$ 13,213,514	\$ -	0.0%
HealthSmart*	3.1%	0.0%	\$ 18,726	\$ -	\$ 603,338	\$ -	0.0%
Meritain Health*	4.1%	0.0%	\$ 2,200,656	\$ -	\$ 53,911,635	\$ -	0.0%
UCHealth Plan*	8.8%	0.0%	\$ 885,047	\$ -	\$ 10,012,339	\$ -	0.0%
UMR*	5.2%	0.0%	\$ 23,197,179	\$ -	\$ 442,645,985	\$ -	0.0%
USHEALTH Group*	0.3%	0.0%	\$ 24,011	\$ -	\$ 7,920,643	\$ -	0.0%
MEDICARE ADVANTAGE 2022							
Carrier Name	% Primary Care Spending	% Value-Based APM Spending	Primary Care Spending	Value-Based APM Spending	Total Medical Spending	Total Prospective Spending	% Prospective Spending
Aetna	4.6%	2.4%	\$ 7,941,809	\$ 4,159,330	\$ 172,456,219	\$ -	0.0%
Anthem	4.3%	20.2%	\$ 3,157,774	\$ 14,782,059	\$ 73,182,073	\$ 420,666	0.6%
Blue Cross Blue Shield of Illinois	21.7%	0.0%	\$ 930	\$ -	\$ 4,288	\$ -	0.0%
Denver Health	0.9%	0.0%	\$ 631,829	\$ -	\$ 69,296,692	\$ -	0.0%
Kaiser Permanente	14.7%	74.9%	\$ 208,316,377	\$ 1,064,415,656	\$ 1,421,707,265	\$ 1,064,415,656	74.9%
UnitedHealthcare**	22.8%	42.1%	\$ 516,937,609	\$ 952,764,494	\$ 2,265,257,120	\$ 448,183,086	19.8%
Humana*	6.2%	0.0%	\$ 15,981,326	\$ -	\$ 256,266,062	\$ -	0.0%

TABLE 2: PRIMARY CARE SPENDING AND VALUE-BASED APM SPENDING, BY NAMED PAYER (2022) – Continued

MEDICAID‡ 2022							
Carrier Name	% Primary Care Spending	% Value-Based APM Spending	Primary Care Spending	Value-Based APM Spending	Total Medical Spending	Total Prospective Spending	% Prospective Spending
HCPF	20.0%	40.6%	\$ 1,660,669,515	\$ 3,362,087,002	\$ 8,285,717,562	\$ 1,136,973,635	13.7%
Rocky Mountain Health Plans: RAE 1, MCO	8.8%	37.0%	\$ 24,415,634	\$ 102,531,579	\$ 276,803,715	\$ 88,805,256	32.1%
Carelon: RAEs 2 & 4 (Submitting on behalf of NHP and HCI)	22.2%	22.2%	\$ 34,146,745	\$ 34,146,745	\$ 153,815,008	\$ 59,603,350	38.8%
Colorado Access: RAEs 3 & 5	8.9%	58.7%	\$ 36,207,667	\$ 237,996,259	\$ 405,450,408	\$ 154,753,783	38.2%
Colorado Community Health Alliance: RAEs 6 & 7	14.3%	51.2%	\$ 34,948,114	\$ 124,997,049	\$ 244,157,138	\$ 124,997,048	51.2%
Denver Health: MCO	16.9%	0.0%	\$ 43,522,829	\$ -	\$ 256,998,508	\$ 141,657,344	55.1%
MEDICAID‡ by RAE 2022							
Carrier Name	% Primary Care Spending	% Value-Based APM Spending	Primary Care Spending	Value-Based APM Spending	Total Medical Spending	Total Prospective Spending	% Prospective Spending
HCPF: RAE 1	100.0%	100.0%	\$ 165,283,461	\$ 165,283,461	\$ 165,283,461	\$ 165,283,461	100.0%
Rocky Mountain Health Plan: RAE 1	8.8%	37.0%	\$ 24,415,634	\$ 102,531,579	\$ 276,803,715	\$ 88,805,256	32.1%
HCPF: RAE 2	100.0%	100.0%	\$ 67,373,392	\$ 67,373,392	\$ 67,373,392	\$ 67,373,392	100.0%
Carelon: RAE 2	37.8%	37.8%	\$ 13,245,216	\$ 13,245,216	\$ 34,996,896	\$ -	0.0%
HCPF: RAE 3	100.0%	100.0%	\$ 237,768,109	\$ 237,768,109	\$ 237,768,109	\$ 237,768,109	100.0%
Colorado Access: RAE 3	14.7%	60.3%	\$ 32,844,098	\$ 134,549,173	\$ 223,104,610	\$ 76,599,314	34.3%
HCPF: RAE 4	100.0%	100.0%	\$ 118,015,276	\$ 118,015,276	\$ 118,015,276	\$ 118,015,276	100.0%
Carelon: RAE 4	17.6%	17.6%	\$ 20,901,529	\$ 20,901,529	\$ 118,818,112	\$ 59,603,350	50.2%
HCPF: RAE 5	100.0%	100.0%	\$ 143,750,299	\$ 143,750,299	\$ 143,750,299	\$ 143,750,299	100.0%
Colorado Access: RAE 5	1.9%	54.1%	\$ 2,350,381	\$ 68,054,635	\$ 125,685,653	\$ 50,137,386	39.9%
HCPF: RAE 6	100.0%	100.0%	\$ 160,713,869	\$ 160,713,869	\$ 160,713,869	\$ 160,713,869	100.0%
Colorado Community Health Alliance: RAE 6	12.6%	55.5%	\$ 16,826,175	\$ 73,964,063	\$ 133,353,522	\$ 73,964,063	55.5%
HCPF: RAE 7	100.0%	100.0%	\$ 139,511,698	\$ 139,511,698	\$ 139,511,698	\$ 139,511,698	100.0%
Colorado Community Health Alliance: RAE 7	16.4%	45.9%	\$ 18,121,939	\$ 50,781,528	\$ 110,552,158	\$ 50,781,528	45.9%



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TABLE 2: PRIMARY CARE SPENDING AND VALUE-BASED APM SPENDING, BY NAMED PAYER (2022) – Continued

CHP+ 2022							
Carrier Name	% Primary Care Spending	% Value-Based APM Spending	Primary Care Spending	Value-Based APM Spending	Total Medical Spending	Total Prospective Spending	% Prospective Spending
Colorado Access	12.0%	0.0%	\$ 7,413,716	\$ -	\$ 61,740,212	\$ -	0.0%
Denver Health	28.4%	0.0%	\$ 1,465,224	\$ -	\$ 5,168,058	\$ -	0.0%
Kaiser Permanente	26.0%	49.7%	\$ 3,652,990	\$ 7,000,824	\$ 14,075,688	\$ 7,000,824	49.7%
Rocky Mountain Health Plan	10.5%	0.5%	\$ 1,400,334	\$ 69,177	\$ 13,344,311	\$ 69,177	0.5%
Friday Health Plans*	9.6%	0.0%	\$ 188,145	\$ -	\$ 1,959,926	\$ -	0.0%

* Some 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. Expenditures for these carriers is sourced from the CO ACPD.

** UnitedHealthcare expenditures are sourced from both APM submissions and the CO APCD. The two sources represent mutually distinct populations.

Additional Notes:

Total medical expenditures do not include pharmacy.

Value-based APM arrangements do not include risk-based payments and capitated payments not linked to quality (3N and 4N categories respectively).

LIMITATIONS

While this report provides a more complete picture of medical spending in Colorado with the inclusion of non-claims expenditure data, some gaps still remain. The CO APCD does not include all commercial payers, most notably self-insured employer groups, and federal health insurance programs such as the Veterans Administration, Tricare, and Indian Health Services. This analysis also excludes Medicare Fee for Service.

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

- CIVHC and the DOI invested a considerable amount of effort towards ensuring that the HCP LAN framework was appropriately applied by each payer, including the implementation of the enhanced validation steps described in the *Data Sources* section. Though all payers attested to the accuracy of their APM files, potential gaps in understanding may still remain.
 - CIVHC and the DOI will continue working with Colorado payers to ensure consistency among payers' submissions.
- The definition of primary care (*Appendix 2*) relies heavily on provider taxonomy requirements. CIVHC could not validate some payers' claims-based primary care spending data against claims submitted to the CO APCD due to payer differences in associated taxonomy codes for providers. Whenever possible, CIVHC reviewed and validated the payers' provider taxonomy information to quantify the expected difference between the APM files and the CO APCD.
- CIVHC instructed RAEs and MCOs to only report payments to providers. Payments from HCPF to the RAEs and MCOs (i.e., payments from one payer entity to another) were not included in the APM calculations. This prevents double counting the payments HCPF made to the various RAEs and MCOs; and also impacts HCPF's reported spending through APMs, making them appear lower.

NEXT STEPS

Looking toward the future of primary care spending reporting, CIVHC has identified the following next steps to improve data collection and reporting:

- Analyze and report on recoupment data collected this year for first time
- Continue working with carrier representatives to ensure accurate reporting
 - Use various payer forums to talk about APM data collection and criteria used to identify APM categories
 - Continue improving data collection process by clarifying instructions on contract supplement, streamlining data fields required

- Investigate and update as needed new codes that might be used to bill for primary care
- Investigate additional ways to capture Behavioral Health providers 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 (AM012 and AM016) 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 (AM014 and AM018) 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 FFS payments. Claims payments are often an essential part of the structure of an APM. Further, non-claims payments are also not synonymous with APMs.

Some active payers who submit medical claims to the CO APCD were exempt from submitting an APM file because the payers do not currently provide APM payments to providers. The spending for these payers is calculated using CO APCD claims data submissions and reported separately. These expenditures are included in the total medical spending denominator used throughout the report.

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 and is not included in the total medical spending denominator.

Below is the list of medical submitters that only reimburse providers on a FFS basis or only submit Medicare Supplemental data:

Payer	Exemption Reason
Allegiance Benefit Plan Management	FFS only



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AmeriBen/IEC Group	FFS only
American Enterprise	FFS only
Employee Benefits Management Services Inc	FFS only
Friday Health Plans	FFS only
Harrington Kaiser Permanente	FFS only
HealthScope Benefits	FFS only
HealthSmart Benefit Solutions	FFS only
Humana*	FFS only
Meritain Health	FFS only
UCHealth Plan Administrators	FFS only
UMR	FFS only
United Health Care (Individual, student, and Med Sup submitter codes)	FFS only
Aflac	Med Sup
C.S.I. Life	Med Sup
Insurance Administration	Med Sup
Physicians Mutual	Med Sup
State Farm	Med Sup
USAA Enterprise	Med Sup

*Humana requested a waiver for their Medicare Advantage line of business.

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:



Claims-Based Payments for Primary Care: Payments for primary care services as defined in the Data Submission Guide (DSG) 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 payers that were required to submit an APM file, and 2) claims that qualify as primary care in the CO APCD for payers 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 2*) outside of the claim transaction. This calculation is sourced only from the APM submissions. Please note that claims payments are *not* synonymous with traditional FFS payments. Claims payments are often an essential part of the structure of an APM.

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 for all medical spending in the CO APCD for payers 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 FFS payments. Claims payments are often an essential part of the structure of an APM.

PLAN PAID

All four of the payment values listed above also have an associated Payer Portion field. The Payer Portion is a subset of the Total Payment value (or equal to the Total Payment when there is no member liability). The claims-based Payer Portion fields correspond to the data submitted in the Plan Paid field on the monthly CO APCD claims submissions. These new fields were added in 2021 under request of the DOI to understand the impacts of their regulations on primary care spend.

PROSPECTIVE PAYMENT FLAG

Prospective payments refer to any payments made to providers in advance of services rendered. Typically, these are based on predetermined payment amounts for services. In contrast, FFS reimbursement is made retrospectively.

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).

The definition of primary care includes services delivered in an outpatient setting and excludes 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 <i>Table 5</i> below)	+	Primary Care (defined by taxonomies in <i>Table 3</i> below)	+	None
B	Primary Care (defined by CPT-4 codes in <i>Table 5</i> below)		Other Primary Care (defined by taxonomies in <i>Table 4</i> below)		Primary Care (defined by taxonomies in <i>Table 3</i> 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



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Taxonomy Code	Description	Taxonomy Type
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

Taxonomy Code	Description	Taxonomy Type
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



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Taxonomy Code	Description	Taxonomy Type
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

Taxonomy Code	Description	Taxonomy Type
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/<



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Procedure Code	Description
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



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Procedure Code	Description
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



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Procedure Code	Description
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



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Procedure Code	Description
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



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Procedure Code	Description
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



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Procedure Code	Description
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



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Procedure Code	Description
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



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Procedure Code	Description
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



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Procedure Code	Description
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



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Procedure Code	Description
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



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Procedure Code	Description
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	ADVNC D CARE PLAN 30 MIN
99498	ADVNC D 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 SCRND DEP SYMP BY DEPTOOL
3352F	NO SIG DEP SYMP BY DEP TOOL



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Procedure Code	Description
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



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Procedure Code	Description
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



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Procedure Code	Description
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 CATEGORIES⁵

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).

⁵ Health Care Payment Learning & Action Network. *Alternative Payment Models APM Framework*. 2017.



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Category Code	Value	Definition/Example
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).
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.