Randolph S. Sergent, Esq, Chairman
Ben Steffen, Executive Director

December 5, 2023

The Honorable Wes Moore
Governor
State House, 100 State Circle
Annapolis, Maryland 21401

The Honorable Bill Ferguson
President of the Senate
H-107, State House
100 State Circle
Annapolis, MD 21401

The Honorable Adrienne A. Jones
Speaker of the House of Delegates
H-101, State House
100 State Circle
Annapolis, MD 21401

Re: SB0734/CH0667 (2), 2022 - Maryland Health Care Commission - Primary Care Report and Workgroup (MSAR #14326)

Dear Governor Moore, President Ferguson, and Speaker Jones,

SB0734/CH0667(2), 2022 - Maryland Health Care Commission – Primary Care Report and Workgroup, required the Maryland Health Care Commission (MHCC) to provide a report, beginning December 1, 2024, and each year thereafter, to the Governor and the General Assembly containing an analysis of primary care investment, ways to improve the quality of and access to primary care services, and any findings and recommendations. Prior to submitting the annual reports MHCC must establish a plan for the analysis and report after receiving input and agreement from workgroup participants and provide the plan to the Governor and the General Assembly by December 1, 2023.

The report will guide annual reporting to the Governor and the legislature beginning in 2024 that minimally includes: (1) an analysis of primary care investment over the immediately preceding year, including data stratified by zip code and county, in relation to total health care spending over the previous year; (2) ways to improve the quality of and access to primary care services, with special attention to increasing health care equity, reducing health care disparities, and avoiding increased costs to patients and the health care system; and (3) any findings and recommendations of MHCC.

We appreciate your consideration. If you have any questions or if we may provide you with any further information, please do not hesitate to contact me at ben.steffen@maryland.gov or 410-764-3566 or Ms. Tracey DeShields, Director of Policy Development and External Affairs, at tracey.deshields2@maryland.gov or 410-764-3588.

Sincerely,

Ben Steffen,
Executive Director

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The Honorable Pamela Beidle, Chair, Senate Finance
The Honorable Clarence Lam, Senator, Senate Finance
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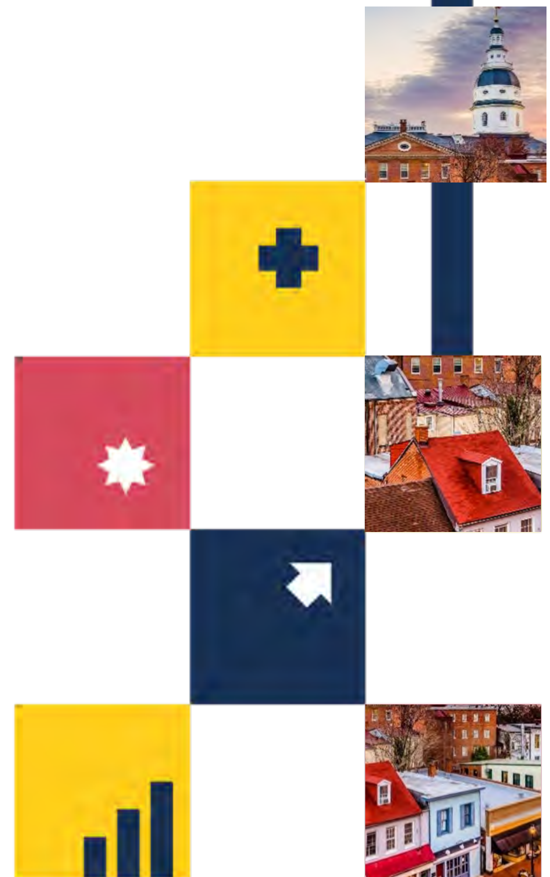
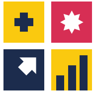


Primary Care Investment
Analysis and Reporting Plan

October 2023

Randolph S. Sergent, Esq.
CHAIRMAN

Ben Steffen
EXECUTIVE DIRECTOR



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OVERVIEW

Senate Bill 734, *Maryland Health Care Commission – Primary Care Report and Workgroup*, was enacted in 2022 under Article II, Section 17(c) of the Maryland Constitution ("Chapter 667" or "the Act")[1] and requires the Maryland Health Care Commission ("MHCC") to annually conduct an analysis of primary care and make recommendations on the level of primary care investment relative to overall health care spending. The Act requires MHCC to form a Primary Care Workgroup ("Workgroup") with representation from certain stakeholders to obtain input on the scope and methodology for the analysis. By December 1, 2023, MHCC must submit a Primary Care Analysis and Reporting Plan ("Plan") to the Governor and General Assembly. The Plan described herein will guide annual reporting to the legislature beginning in 2024 that minimally includes: (1) an analysis of primary care investment over the immediately preceding year, including data stratified by zip code and county, in relation to total health care spending over the previous year; (2) ways to improve the quality of and access to primary care services, with special attention to increasing health care equity, reducing health care disparities, and avoiding increased costs to patients and the health care system; and (3) any findings and recommendations of MHCC. The Plan framework is summarized in the table below.

Primary Care Analysis and Reporting Plan Framework	
Domain	**Description**
Primary Care Investment Definition	• Encompasses primary care office visits, preventive care, and a broad set of other services when performed by family medicine, general practice, internal medicine, preventive medicine, pediatrician, geriatrician, nurse practitioner, or physician assistant o Includes primary care providers delivering primary care services in a nursing home, Federally Qualified Health Center, urgent care center, retail clinic, or other non-traditional setting o Behavioral health services are included when provided by a primary care provider o Obstetric and gynecologic services are part of the definition when performed by a primary care provider
Covered Services Billed under a Primary Care Provider's Taxonomy	• Includes those services performed by a nurse midwife or behavioral health provider o Requires the provider to be integrated into a primary care practice where services are billed under the taxonomy code of the primary care provider
Investment Target	• Increase primary care investment beginning in 2024 through 2029 o Aim to achieve 10 percent of total medical spending for overall total primary care spending by 2030

[1] Chapter 667 of the 2022 Laws of Maryland. Available at: www.mgaleg.maryland.gov/2022RS/chapters_noln/Ch_667_sb0734E.pdf.

Primary Care Analysis and Reporting Plan Framework	
Domain	**Description**
	○ Include a relative improvement goal of approximately one percent annually ○ Adjust relative improvement goal periodically to achieve the aim
Investment Approach	• A primary care investment target aligned across commercial payers and a different target for Medicaid and the MCOs ○ Review annually and adjust as needed to achieve the statewide relative improvement goal ○ An accountability mechanism for meeting targets and in using investments to enhance primary care
Investment Calculation	• Spending per member per month and as a percent of total medical expense ○ Place of service filters will be applied ○ Pharmacy spending and rebates, dental, and other supplemental expenditures will be excluded from the calculations ○ Non-fee-for-service spending will be excluded in the 2024 analysis and final report; use of this data will be considered in 2025

INVESTMENT RATIONALE

Despite evidence that a strong foundation of primary care yields better outcomes, such care has been underfunded nationally.[2] On average, U.S. primary care spending accounts for nearly 7 percent of total expenditures[3] compared to almost 14 percent by other industrialized countries.[4,5] Health care per capita in the U.S. costs more than twice as much as peer countries, and the U.S. experiences worse outcomes on life expectancy, rates of chronic disease, and other critical measures.[6] Primary care experts, including Barbara Starfield, M.D.,[7] have demonstrated through research that increased investments in primary care have a beneficial effect on quality of care, access to care, and mortality. Dr. Starfield went on to substantiate that

[2] The Commonwealth Fund, *Primary Care in High-Income Countries: How the United States Compares*, March 2022. Available at: www.commonwealthfund.org/publications/issue-briefs/2022/mar/primary-care-high-income-countries-how-united-states-compares.

[3] JAMA, *Primary Care Spending in the United States, 2002-2016*, May 2020. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC7235902/.

[4] Organisation for Economic Co-operation and Development, Deriving Preliminary Estimates of Primary Care Spending under the SHA 2011 Framework, March 2019. Available at: www.oecd.org/health/health-systems/Preliminary-Estimates-of-Primary-Care-Spending-under-SHA-2011-Framework.pdf.

[5] Baillieu R, Kidd M, Phillips R, et al, BMJ Global Health, *The Primary Care Spend Model: A Systems Approach to Measuring Investment in Primary Care*, 2019. Available at: www.pubmed.ncbi.nlm.nih.gov/31354975/.

[6] The Commonwealth Fund, *U.S. Health Care from Global Perspective, 2022: Accelerating Spending, Worsening Outcomes.* Available at: www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022.

[7] Health Affairs, *Remembering Barbara Starfield: A Primary Care Champion*, June 2011. Available at: www.healthaffairs.org/do/10.1377/forefront.20110613.011731/.

the effectiveness of health care systems in the U.S. and across developed countries could be measured by the percent of health care dollars dedicated to primary care.[8, 9, 10]

Underinvestment in primary care contributes in part to workforce challenges.[11, 12] Between 2005 and 2015, the national share of the physician workforce devoted to primary care declined from around 44 percent to 37 percent.[13] A shortage of primary care physicians has received national attention. By 2030, it is projected there will be a shortage of about 35,000 primary care physicians.[14] Nearly 42 percent of states are taking steps to increase investments in primary care through enacted and pending legislation (see Appendix B).[15] Investment strategies vary between voluntary and required. A few states have strategies to gradually increase investment targets as payers achieve cost savings.[16] States with higher primary care investments have reported better outcomes and lower rates of emergency department visits.[17]

In 2019, the National Academies of Sciences, Engineering, and Medicine convened an Implementing High-Quality Primary Care Committee ("Committee") to build on the 1996 recommendations in the Institute of Medicine report, *Primary Care: America's Health in a New Era*.[18] The Committee released a report in 2021 with recommendations to address the challenges facing primary care.[19] The recommendations include five objectives: (1) pay for primary care teams to care for people, not for physicians to deliver services; (2) ensure that high-quality primary care is available to all in every community; (3) train primary care teams where people

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[8] Starfield, B., Shi, L., & Macinko, J. *Contribution of Primary Care to Health Systems and Health*. The Milbank Quarterly, 83(3), 457-502, 2005. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/.

[9] Shi, L., B. Starfield, B. Kennedy, and I. Kawachi. "*Income Inequality, Primary Care, and Health Indicators.'' Journal of Family Practice* 48 (4):275–84, 1999. Available at: https://pubmed.ncbi.nlm.nih.gov/10229252/.

[10] Macinko J, Starfield B, Shi L, "*The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970–1998*", Health Services Research Review. Available at: www.onlinelibrary.wiley.com/doi/epdf/10.1111/1475-6773.00149.

[11] The Lancet Global Health, *Prioritising the Health and Care Workforce Shortage: Protect, Invest, Together*, May 17, 2023. Available at: www.thelancet.com/journals/langlo/article/PIIS2214-109X(23)00224-3/fulltext.

[12] FIERCE Healthcare, *US Primary Care System Suffering From 'Chronic Lack of Adequate Support,' Scorecard Report Finds*, February 2023. Available at: www.fiercehealthcare.com/providers/us-primary-care-system-suffering-chronic-lack-adequate-support-scorecard-report-finds.

[13] Christopher Barbey, Nikhil Sahni, Robert Kocher, and Michael E. Chernew, "*Physician Workforce Trends and Their Implications for Spending Growth*" Health Affairs, July 2017. Available at: www.healthaffairs.org/do/10.1377/forefront.20170728.061252/full/.

[14] Health Resources & Services Administration, *National Center for Health Workforce Analysis, November 2022: Primary Care Workforce: Projections, 2020-2035*. Available at: www.bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Primary-Care-Projections-Factsheet.pdf.

[15] Primary Care Collaborative, State Primary Care Investment Initiative dashboard, May 2023. Available at: www.pcpcc.org/primary-care-investment/legislation/map.

[16] California Health Care Foundation, *Investing in Primary Care: Lessons from State-Based Efforts*, April 2022. Available at: www.chcf.org/wp-content/uploads/2022/03/InvestingPCLessonsStateBasedEfforts.pdf.

[17] Milbank Memorial Fund, *Investing in Primary Care: A State-Level Analysis*, July 2019. Available at: www.milbank.org/publications/investing-in-primary-care-a-state-level-analysis/.

[18] National Academies of Sciences, Engineering, and Medicine, Primary *Care: America's Health in a New Era*, 1996. Available at: nap.nationalacademies.org/read/5152/chapter/1.

[19] National Academies of Sciences, Engineering, and Medicine, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care, Rebuilding the Foundation of Health Care,* 2021. Available at: www.doi.org/10.17226/25983.

live and work; (4) design information technology that serves the patient, family, and care team; and (5) ensure high-quality primary care is implemented in the U.S.[20]

MARYLAND LANDSCAPE

Primary care is an essential cornerstone of the health care system to achieve greater equity and better health for all.[21] Maryland is considered an early pioneer in advancing alternative care delivery models that reward primary care providers for delivering high-quality and cost-efficient care. In 2011, MHCC launched a three-year pilot, the Maryland Multi-Payor Patient Centered Medical Home Program ("MMPP"), to test the model of care in support of legislation passed during the 2010 session of the General Assembly.[22] A unique feature of the pilot was participation by Medicaid and the five largest carriers in the State: Aetna; CareFirst BlueCross BlueShield; Cigna Health Care, Mid-Atlantic Region; Coventry Health Care; and UnitedHealthcare, Mid-Atlantic Region. The Federal Employees Health Benefit Plan, Maryland State Employees Health Benefit Plan, and TRICARE participated voluntarily.[23] The pilot included 52 practices and was extended through 2016.[24]

Value-based care ("VBC" or "non-fee-for-service") models are increasingly being embraced by governments, payers, employers, providers, and consumers. VBC models include diverse risk levels and reimbursement. Maryland and the federal government embarked on the Total Cost of Care ("TCOC") Model in January 2019.[25] The Health Services Cost Review Commission ("HSCRC") partnered with the Centers for Medicare & Medicaid Services ("CMS") in 2019 on the TCOC Model to progressively transform care delivery across the health care system. The TCOC Model sets a per capita limit on Medicare spending and holds the State fully at risk for Medicare beneficiaries' total cost of care.[26] The HSCRC leverages VBC approaches to redesign care delivery on an all-payer basis. Among other things, the TCOC Model incentivizes hospitals and non-hospital providers to engage in care transformation partnerships across care settings. A central element of the TCOC Model is the Maryland Primary Care Program ("MDPCP" or

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[20] The National Academies of Sciences, Engineering, Medicine, *Implementing High-Quality Primary Care, Rebuilding the Foundation of Health Care*, 2021. Available at: www.ldi.upenn.edu/wp-content/uploads/2022/02/nasem-primary-care2021.pdf.

[21] Milbank Memorial Fund, *Payers Can Advance Equity by Strengthening Primary Care*, December 2021. Available at: www.milbank.org/news/payers-can-advance-equity-by-strengthening-primary-care/#:~:text=Good%20evidence%20shows%20that%20investing%20in%20high-quality%20primary,many%20of%20our%20health%20statistics%20lag%20as%20well.

[22] Chapters 5 and 6, 2010 laws of Maryland. Available at: mgaleg.maryland.gov/2010rs/billfile/sb0855.htm and mgaleg.maryland.gov/2010rs/billfile/hb0929.htm.

[23] Maryland Annotated Code. Health-General. § 19-1A-02., (Senate Bill 855 | House Bill 929 - 2010). Carriers with over $90M in premiums for health benefit plans in the State in the most recent reporting year were classified as large carriers.

[24] Program findings indicated the pilot met goals related to improvements in care coordination, communication, monitoring, and standardization that contributed to successful practice transformation: Maryland Health Care Commission, *Evaluation of the Maryland Multi-Payor Patient Centered Medical Home Program, Final Report,* July 2015. Available at: mhcc.maryland.gov/mhcc/pages/apc/apc/documents/MMPP_Evaluation_Final_Report_073115.pdf.

[25] Maryland's prior approach to hospital payment was known as the "Maryland All-Payer Medicare Model Contract" from January 1, 2014, through December 31, 2018. The All-Payer Model's success metrics were based on enhancing quality, improving health outcomes, and constraining the growth of Medicare costs for hospital inpatient and outpatient services.

[26] More information is available at: innovation.cms.gov/innovation-models/md-tccm.

"program"),[27] which is similar to other CMS VBC models (e.g., Comprehensive Primary Care Plus, Primary Care First, Making Care Primary, and Advancing All-Payer Health Equity Approaches and Development Model). The MDPCP launched in 2019. Around 538 practices participate in the MDPCP program.[28]

VBC – Payer Initiatives

VBC initiatives aim to support the health care system in creating more value for patients by enabling pathways that promote comprehensive and longitudinal care and prioritize quality and outcomes. Past care delivery modernization efforts relied on fee-for-service models to address equity matters with a focus on access.[29] Fee-for-service models that reward providers for volume and quantity of services provided are counterintuitive to promoting population health.[30] VBC models that reward quality of care provided in relation to patient outcomes are slowly gaining traction in Maryland. In 2022, the General Assembly passed legislation that expands the VBC arrangements that private payers and providers can enter.[31] The law allows providers to voluntarily contract with private payers in either a two-sided incentive arrangement or a capitation arrangement, similar to arrangements that exist in other states.

Improving health outcomes relative to the cost of care is an aspiration embraced across the health care continuum. Moving from fee-for-service to payment for value will take time. As the health care landscape continues to evolve with the adoption of VBC models, short-term financial risks are more likely to increase before longer-term costs decline. These short-term risks have proven to be stumbling blocks in the adoption of VBC models, particularly for smaller practices. Maryland law does not permit payers to mandate participation in a VBC model, nor does it permit payers to penalize practices that do not join a VBC model.

In 2023, payers began reporting data on non-fee-for-service expenses to MHCC's All-Payer Claims Data Base ("APCD").[32, 33] The MHCC uses APCD data to promote health care cost and

[27] The Health Services Cost Review Commission: *Maryland's Total Cost of Care Model* is a contract between the State and the Center for Medicare and Medicaid Innovations that holds the State at risk for the total cost of care for Medicare Beneficiaries and commits the State to a sustainable growth rate in per capita total cost of care spending. Available at: www.hscrc.maryland.gov/Pages/tcocmodel.aspx.

[28] Information about the MDPCP is available at: www.health.maryland.gov/mdpcp/Pages/practices.aspx.

[29] Spooner et al. International Journal for Equity in Health 20:223, *Improving Access to Primary Health Aare: A Cross-case Comparison Based on a Priori Program Theory,* 2021. Available at: www.doi.org/10.1186/s12939-021-01508-0.

[30] Lumina Health Partners, *Success in Risk-Based Contracts: Building the Right Level of Incentives,* September 2019. Available at: www.luminahp.com/podcast/success-in-risk-based-contracts-building-the-right-level-of-incentives.

[31] *Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization,* Chapter 297 Laws of Maryland, 2022. The law clarifies that providers or a set of health care providers that accepts capitated payments is not engaging in the business of insurance and is not considered to be performing acts of an insurance business.

[32] APCDs are large state databases that include medical claims, pharmacy claims, dental claims, and eligibility and provider files collected from private and public payers. More information about APCDs is available at: www.ahrq.gov/data/apcd/index.html#:~:text=All%2Dpayer%20claims%20databases%20(APCDs,from%20private%20and%20public%20payers.

[33] Roughly 20 states have an APCD; about five states are collecting data on non-fee-for-services expenses and three states are pursuing collection.

quality transparency and monitor utilization.[34] A summary of payers' VBC initiatives in the State follows.

Aetna

Aetna's VBC arrangements are designed to incentivize primary care providers to achieve a level of performance on defined targets using select Healthcare Effectiveness Data and Information Set ("HEDIS") quality measures. Coordinated care management services promote connected care across the network for those with acute and chronic diseases. Physicians collaborate with each other and clinical teams to assure patient satisfaction and improved health outcomes. Data and analytics are used to create actionable information for care teams.[35]

CareFirst BlueCross BlueShield ("CareFirst")

CareFirst's PCMH program is designed to incentivize and provide resources, data, and programs to assist providers in delivering quality, cost efficient care. The PCMH program places an emphasis on helping providers dispense comprehensive, coordinated care for their CareFirst patients with multiple chronic conditions. A panel, or group of primary care providers, is the basic performance unit of the PCMH program. Incentives are contingent upon meeting quality score and engagement requirements.[36]

Cigna

Cigna's programs function like Accountable Care Organizations and work with multi-specialty groups; fully integrated delivery systems; physician hospital organizations; and Independent Physician Associations/Independent Practice Associations.[37] Practice care coordinators work closely with Cigna's case managers to ensure that patients receive needed screenings and follow-up care and have access to educational materials that can help them manage their health. A practice receives financial incentives if it meets defined targets.[38]

UnitedHealthcare ("UHC")

UHC incentivizes providers who deliver better outcomes and reduce the cost of care. Providers are supported by technology that provides member-specific recommendations. Patients are referred to high-quality, cost-effective primary, specialty, urgent, post-acute, behavioral, and ambulatory care providers. UHC's model centers on whole-person care to reduce hospital readmissions.[39]

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[34] COMAR 10.25.06, *Maryland Medical Care Data Base and Data Collection*, Medical Care Data Base Submission Manual, 2023. Available at: https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb_data_submission.aspx.
[35] More information is available at: www.aetna.com/insurance-producer/aetna-whole-health.html.
[36] More information is available at: provider.carefirst.com/carefirst-resources/provider/pdf/adult-2023-pcmh-program-description-and-guidelines-final.pdf.
[37] More information is available at: www.aha.org/accountable-care-organizations-acos/accountable-care-organizations.
[38] More information is available at: www. newsroom.cigna.com/2021-02-04-Cigna-Collaborative-Care-for-Specialists.
[39] More information is available at: sustainability.uhg.com/content/dam/sustainability-report/2021/pdf/2021-sustainability-report.pdf.

PLAN OVERVIEW

The Plan serves as a strategic planning framework that will evolve over time to achieve primary care investment and care delivery goals. Revisioning investments in primary care will help address longstanding challenges that fall heavily on disadvantaged communities and improve linkages with community-based resources. The Plan contains several domains identified by the Workgroup that provide the foundation to guide primary care analysis activities. Activities begin in 2024 and will lead to the development of recommendations that may require policy, regulation, or legislation. Other domains will be considered periodically to ensure the Plan keeps pace with the evolving primary care landscape. The domains are a starting point and are viewed by stakeholders as appropriate to quantify and measure achievements in primary care investments.

Definition

The Workgroup's definition of primary care was informed by the Act as well as national and State efforts to frame primary care narrowly and broadly. Notably, multiple definitions of primary care exist, making comparisons and consensus-building difficult. States tend to cluster primary care providers and services into narrow and/or broad definitions based on parameters established by a national multi-stakeholder membership organization.[40] Narrow definitions tend to include traditional provider type categories (e.g., general practitioners, internal medicine, and pediatrics) and traditional primary care services including office visits and preventative care. Broad definitions tend to be more expansive to include other categories of services and/or providers (e.g., obstetrics and gynecology, behavioral health, and clinical social workers).

The Workgroup favors a definition of primary care that encompasses office visits, preventive care, and a broad set of other services when performed by physicians, nurse practitioners, and physician assistants in family medicine, general practice, internal medicine, pediatrics, and geriatrics. This includes providers delivering primary care services in a nursing home, Federally Qualified Health Center ("FQHC"), urgent care center ("UCC"), retail clinic ("RC"), or other non-traditional settings. Behavioral health services and services performed by a nurse midwife are included in the definition when the billing provider has a primary care taxonomy.[41] Obstetric and gynecologic services are part of the definition when performed by a primary care provider (see Appendix D).

[40] The Primary Care Collaborative is a not-for-profit founded in 2006 and dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home. More information is available at: www.thepcc.org/.

[41] A taxonomy code is a code that describes the provider or organization's type, classification, and the area of specialization. Information on taxonomy codes is available at: https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/medicare-provider-and-supplier-taxonomy-crosswalk.

Rationale

The Workgroup's proposed hybrid approach to defining primary care will allow for benchmarking performance nationally and regionally using available data from other states that have adopted a primary care investment initiative. Most states with such initiatives use a hybrid approach that considers provider taxonomy codes and services. Many states also have an APCD to support claims analyses. The Workgroup's definition ensures expenditures attributed to primary care providers can be extracted from claims data.

Setting the Investment Target

Strengthening primary care requires investing in a system that addresses specific patient needs with a focus on comprehensiveness, coordination, and continuity of care. The Workgroup supports an overall primary care investment target for private payers of approximately 10 percent by 2030. The investment target accounts for different benefit packages across private payers. Private payer spending statewide is fairly consistent across payers and ranges between 5-7 percent (as of 2021). More time is needed to collect and analyze data for Medicaid and nine Managed Care Organizations (MCOs). An investment target for Medicaid and the MCOs will be identified in 2024. For the most part, MCOs typically invest a greater share in primary care as compared to private payers.[42] The Workgroup will take into account primary care spend by Medicaid and the MCOs in formulating an investment target, which will likely vary across MCOs.

Investment Strategy

1. A primary care investment target aligned across private payers and a different target for Medicaid and the MCOs.
2. A relative improvement goal of approximately one percent annually adjusted by payer type periodically to achieve the aim.
3. Inclusion of potential future investment offset(s) for the increased investment.
4. An accountability mechanism for meeting targets and in using investments to enhance primary care.

Rationale

Increased primary care investments have potential to strengthen care delivery and incentivize more providers to specialize in primary care.[43] The 10 percent target establishes a goal that

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[42] KFF, *10 Things to Know About Medicaid Managed Care,* March 2023. Maryland is one of 41 states that use capitated managed care models to deliver services in Medicaid. Available at: www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/#endnote_link_580036-10.

[43] Health Affairs, *The Key To Improving Population Health And Reducing Disparities: Primary Care Investment,* July 2022. Available at: www.healthaffairs.org/content/forefront/primary-care-investment-key-improving-population-health-and-reducing-disparities.

private payers largely support, which helps build momentum across payers toward a shared goal that will lead to higher quality, greater equity, and reduced costs.[44] Some Workgroup participants prefer the target be closer to 14 percent. An annual relative improvement assessment of progress toward achieving the investment target will identify where changes to the goal are required. Any adjustment will be based on payers' measurable performance to achieve the target and the ability of practices to invest funding to strengthen primary care. The Workgroup's investment target coincides with national primary care investment efforts. This includes more than a dozen states that allocate a greater proportion of the health care dollar to primary care.[45] The MHCC convened meetings with five states (Colorado, Oregon, Rhode Island, Vermont, and Virginia). Insights from lessons learned were considered by the Workgroup.

Methodology

The Workgroup proposed calculating primary care spending as a percent of total medical expenses and as a per member per month (PMPM) amount. APCD data will be used for the analysis. A payer specific analysis will assess attainment of the investment target and determine relative improvement goals based on taxonomy codes, services, procedures, and screenings (see Appendix C).[46] Place of service[47] filters will be applied to identify primary care services delivered in an office setting, outpatient hospital setting, FQHC, UCC, RC, nursing home, and other select non-traditional settings. Pharmacy spending and rebates,[48] dental, and other supplemental expenditures will be excluded from the calculations. Non-fee-for-service spending will be excluded in the 2024 analysis and report; use of this data will be considered in 2025.[49]

Rationale

The strategy is analogous with other states that have adopted primary care investment goals. Calculating the percentage of total medical expenses provides a comparison to other care costs. A PMPM analysis provides a view of spending at the patient level. Measuring overall primary care spending from claims data is viewed as an effective means to focus attention on spending rates.[50] Payers have different methods for calculating primary care investment that is generally based on a PMPM calculation. The MHCC will collaborate with payers using a comparable

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[44] World Health Organization, *Building the Economic Case for Primary Health Care: A Scoping Review*, 2018. Available at: www.who.int/docs/default-source/primary-health-care-conference/phc---economic-case.pdf.
[45] See n. 40, *Supra.*
[46] The list does not include certain services performed by a very limited number of primary care providers.
[47] Place of service are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. More information is available at: www.cms.gov/Medicare/Coding/place-of-service-codes.
[48] This approach may be reconsidered if pharmacy rebate information becomes available.
[49] In 2023, private payers are required to report on expenditures related to VBC models. Some information on Medicare non-fee-for-service spending is currently available.
[50] National Library of Medicine, *Measuring and Increasing Investment in Primary Care: Delaware Marches On,* December 2019. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC8389159/.

definition to support accurate reporting and will report progress as a percent of total medical expense and PMPM.

Measuring Progress

The Workgroup supports using the four pillars of primary care articulated by Dr. Starfield to gauge the primary care investment impact (see Appendix D). The four pillars for measuring primary care structures and processes include: (1) First Contact, the usual entry point into the health care delivery system; (2) Continuous Care, longitudinal care to help the patient and provider build a relationship that fosters mutual understanding and awareness of expectations; (3) Coordinated Care, links visits and services to ensure patients receive appropriate care for their health needs; and (4) Comprehensive Care, a wide range of services typical of primary care. APCD data and aggregate measures will be used to assess the impact of increased primary care spending. The Workgroup will consider approaches to assess all primary care spending[51] (i.e., non-primary care provider categories that deliver primary care services) to inform the debate on investment progress. A review of measures is targeted to begin in 2025.

Rationale

Making a substantive primary care investment requires establishing mechanisms to collect data to determine the adequacy of the investment.[52,53] Nearly 90 percent of states with a primary care investment use APCDs to measure the extent to which primary care goals are achieved.[54] Claims and aggregate measures provide a construct for assessment of the investment on health outcomes, patient satisfaction, and cost. Although publicly available tools exist, more time is needed for the Workgroup to evaluate such tools. A review of all primary care spending using a combination of other assessment methods will provide an opportunity to gain new insights into the impact of primary care investments on payers, providers, and consumers.

ON THE HORIZON

Over the next year, the Workgroup will explore opportunities to advance primary care policies that make sustainable and systematic improvements in access to care, equity, quality of care, efficiency, and cost control. The Workgroup will finalize investment targets for Medicaid and will also consider whether to factor in primary mental health care delivered by an MCO. Setting standards that place equity at the forefront for how investments are used is a key activity. Approaches for payers and providers that tie investments to VBC models that require strong

[51] Bailit MH, Friedberg MW, Houy ML. *Standardizing the Measurement of Commercial Health Plan Primary Care Spending*, Milbank Memorial fund report, July 25, 2017. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC6626519/#R8:~:text=https%3A//www.milbank.org/publications/standardizing%2Dmeasurement%2Dcommercial%2Dhealth%2Dplan%2Dprimary%2Dcare%2Dspending/.
[52] Starfield B., *Primary Care: Concept, Evaluation, and Policy*. New York: Oxford University Press; 1992.
[53] Starfield B, Shi L, Macinko J. *Contribution of Primary Care to Health Systems and Health*. The Milbank Quarterly 2005; 83:457–502.
[54] States with an APCD, www.apcdcouncil.org/apcd-legislation-state, were compared to states with a primary care investment goal, www.thepcc.org/primary-care-investment/legislation/map.

advanced primary care standards will be contemplated. The Workgroup will identify pilots to launch in 2025 that test innovative investment approaches. The Workgroup will also explore causes and potential strategies where increased investment can begin to address workforce shortages and the unequal distribution of the primary care providers in Maryland. In 2024, first year data analysis will allow the Workgroup to assess the need to adjust the investment target and approaches to measuring progress, among other things.

The law provides a unique opportunity to impact primary care through investment strategies that align across multiple payers. Advancing primary care has been an MHCC strategic priority for more than a decade. The MHCC operated the MMPP program from 2011 through 2016 and has participated in MDPCP program planning and policy development since its inception (2017). Most recently (2021), MHCC launched the *Advancing Practice Transformation in Ambulatory Practices Program* to help practices prepare to transition into VBC models.[55] The MHCC will collaborate with stakeholders to build alignment that maximizes the benefit of increased investment in primary care and results in a high-functioning health care system.

LIMITATIONS

Various perspectives were shared among the Workgroup and carefully considered. Some Workgroup participants expressed less than full support for certain Plan elements; dissenting views are not included in the Plan. A nationally recognized definition of primary care does not exist, which limits the ability to make precise state comparisons. The definition used in the Plan is unique to Maryland and includes components from states with an investment initiative.[56] Providers self-designate their taxonomy code and may select more than one, which makes it difficult to obtain provider counts. The impact of potential discrepancies and accuracy of taxonomy codes was not determined. The Plan excludes taxonomy codes of specialists that may render primary care services. The APCD offers unique opportunities for calculating primary care investments. However, data from some populations is omitted, including self-insured plans (due to the 2016 *Gobeille v. Liberty Mutual Insurance Company* Supreme court case),[57] Health Maintenance Organization plans, the uninsured, and worker's compensation.

ACKNOWLEDGEMENTS

The MHCC commends the commitment of stakeholders that serve on the Workgroup and contributed to the preparations of the *Primary Care Investment Analysis and Reporting Plan.* A sincere thanks to Mary Jo Condon, Principal Consultant at Freedman HealthCare LLC, for her contributions.

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[55] Maryland Health Care Commission website available at:
https://mhcc.maryland.gov/mhcc/Pages/apc/apc_icd/apc_icd_practice_transformation.aspx.

[56] See n. 40, *Supra.*

[57] Gobeille v. Liberty Mut. Ins. Co., 577 U.S. ___ ,2016. The Supreme Court affirmed. ERISA expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan," 29 U.S.C. 1144(a) and, therefore, preempts a state law that has an impermissible "connection with" ERISA plans.

APPENDIX A: WORKGROUP MEMBERSHIP

MEMBERSHIP CATEGORY	ORGANIZATION	NAME
Maryland General Assembly	Senate	Clarence Lam
Maryland Primary Care Program	MDPCP/MDH	Chad Perman
Health Services Cost Review Commission	HSCRC	William Henderson
Maryland Insurance Administration	MIA	Karen Lam
Health Care Financing Division of the Maryland Department of Health	Medicaid	Tricia Roddy
Maryland Academy of Family Physicians	MDAFP	Amar Duggirala Poolesville Family Practice
Maryland Chapter of the American Maryland Academy of Pediatrics	MDAAP	Jeffrey Bernstein Pediatric and Adolescent Care of Silver Spring
Maryland Section of the American College of Obstetricians and Gynecologists	MDACOG	Ishrat Rafi Ascension Saint Agnes
Maryland Nurses Association	MNA	Christie Simon-Waterman The Johns Hopkins Hospital
Maryland Affiliate of American College of Nurse Midwives	Maryland Affiliate of ACNM	Mette Ramanathan University of Maryland St. Joseph Medical Center
Maryland Community Health System	MCHS	Salliann Alborn
Mid-Atlantic Association of Community Health Centers	MACHC	Nora Hoban

MEMBERSHIP CATEGORY	ORGANIZATION	NAME
Maryland Hospital Association	MHA	Laura Russell
Accountable Care Organization	Aledade	Tyler Blanchard
Primary Care	MEDIS, LLC	Michael Barr
	Johns Hopkins Clinical Alliance	Sarah Johnson Conway
	Patient First	Theresa Noe
	University of Maryland School of Medicine	Niharika Khanna
Payer	CareFirst BlueCross BlueShield	Russell Lewis, Jr.
	Funk & Bolton P.A.	Matthew Celentano
	Kaiser Permanente of the Mid-Atlantic	Tinisha Cheatham
	Amerigroup Maryland, Inc. & Maryland MCO Association	Kathleen Loughran
Health Services Researcher with Expertise in Primary Care	Johns Hopkins Bloomberg School of Public Health	Jill Marsteller
Other Representatives	Health Care For All	Rev. William Johnson, Jr., Community Chaplain for the Johns Hopkins Health System
	MidAtlantic Business Group on Health	John Miller
	Perdue Farms	Dawn Carey

MEMBERSHIP CATEGORY	ORGANIZATION	NAME
	State of Maryland	Christina Kuminski
	Independent Consultant/ Retired Senior Health Actuary at U.S. Office of Personnel Management	Ronald Gresch

Biographies

Salliann Alborn, BSN– MCHS Representative
Ms. Alborn is the Chief Executive Officer for Maryland Community Health System ("MCHS") and has over 30 years of experience advising governmental, health insurance and managed care organizations. Prior to joining MCHS, Ms. Alborn served as the Executive Director of the Robert Wood Johnson Foundation's Health Impaired Elderly Program, and Chair of the Maryland Dental Action Coalition.

Michael Barr, MD, MBA, MACP, FRCP – Primary Care Representative
Dr. Barr is a board-certified internist and President of MEDIS, LLC, a health care consulting company. He has over 30 years of health care related experience. Previously, he served as the Executive Vice President of the Quality Measurement & Research Group at the National Committee for Quality Assurance and as Senior Vice President at the American College of Physicians. Dr. Barr also served as an MHCC Commissioner.

Jeffrey Bernstein, MD – MDAAP Representative
Dr. Bernstein is a Managing Partner at Pediatric and Adolescent Care of Silver Spring. He has over 34 years of experience practicing primary care general pediatrics. Dr. Bernstein also serves on several boards and committees including the Board of Governors for the Privia Quality Network—Mid-Atlantic and the Clinical Performance, Payer, and Finance Committees of Privia Medical Group.

Tyler Blanchard, BS – Accountable Care Organization Representative
Mr. Blanchard has led Aledade's multi-payer Accountable Care Organizations in Delaware, Maryland, and the District of Columbia as Market President for the last eight years. He also leads Aledade's Care Transformation Organization within the Maryland Primary Care Program. Mr. Blanchard serves as a Payment and Attribution Committee Member on the Delaware Health Care Commission's Primary Care Reform Collaborative.

Dawn Carey, MBA – Consumer Employer Representative
Ms. Carey is the Senior Director of Health and Wellness Programs at Perdue Farms. She has over nine years of experience supporting Perdue Farms' onsite wellness centers, which provides primary care to associates and dependents. Previously, Ms. Carey served as Perdue Farms' Corporate Healthworks Manager.

Matthew Celentano – Payer Representative
Mr. Celentano has served as Government Relations Specialist with Funk & Bolton, P.A. for more than five years. He manages and advises State trade associations and works with stakeholders on legislation and matters related to the regulation of insurance in Maryland. Prior to joining the firm, Mr. Celentano served for 16 years as Deputy Director of the Maryland Citizens' Health Initiative.

Tinisha Cheatham, DO – Payer Representative
Dr. Cheatham is a board-certified family medicine physician with over 17 years of experience. She serves as Physician in Chief of the Mid-Atlantic Permanente Medical Group for the Baltimore service area. In this role, Dr. Cheatham is responsible for a staff of clinicians that provide care to over 134,000 patients across the Baltimore metropolitan area.

Sarah Johnson Conway, MD – Primary Care Representative
Dr. Conway is the Chief Medical Officer of the Johns Hopkins Clinical Alliance, a clinically integrated network of physicians driving value-based care and quality efforts. She has been practicing internal medicine for nearly seven years. Previously, Dr. Conway served as the Medical Director of Care Coordination for the Johns Hopkins Care Transformation Organization.

Amar Duggirala, DO, MPH, FAAFP – MDAFP Representative
Dr. Duggirala is a board-certified family physician with 18 years of experience in primary care delivery, including two years at the University of Maryland Medical Center. He is the owner and Medical Director of Poolesville Family Practice and has extensive experience in primary care reimbursement. Dr. Duggirala also serves as an adjunct clinical instructor at the University of Maryland School of Medicine.

Ronald Gresch, MAAA, ASA – Consumer Representative
Mr. Gresch is a consultant for the U.S. Office of Personnel Management ("OPM") where he focuses on improving Medicare integration and participation, long term care insurance, and the Postal Service Reform Act of 2022. He has 42 years of federal government experience. Prior to his retirement, Mr. Gresch served as a Senior Health Actuary at OPM and was the primary negotiator of health insurance premiums for the Federal Employees Health Benefits Program.

William Henderson – HSCRC Representative
Mr. Henderson is the Principal Deputy Director for Medical Economics and Data Analytics at the Health Services Cost Review Commission ("HSCRC"). In this role, he gathers, manages, and analyzes data for the Maryland Total Cost of Care Model and the regulatory operations of HSCRC. Mr. Henderson has over 19 years of experience in data research and analytics. Previously, he led analytics for a national specialty managed care company.

Nora Hoban – MACHC Representative
Ms. Hoban is the Chief Executive Officer of the Mid-Atlantic Association of Community Health Centers ("MACHC") where she oversees the overall operations. She has 10 years of executive management experience and more than 25 years of policy and data analytics, project and financial management, and provider payment expertise. Prior to joining MACHC, Ms. Hoban served as Senior Vice President at the Maryland Hospital Association.

William Johnson, Jr., DDiv – Consumer Representative
Dr. Johnson is a community chaplain for the Johns Hopkins Health System. He works to improve community health outcomes by connecting faith communities to health system resources, as well as providing compassionate spiritual care to patients and community members. Dr. Johnson has held various positions within the State of Maryland for nearly 33 years.

Niharika Khanna, MBBS, MD, DGO – Primary Care Representative
Dr. Khanna is a board-certified family care physician with over 30 years of experience. She serves as a Professor of Family and Community Medicine and as the Associate Chair, Population Health Sciences at the University of Maryland School of Medicine. Dr. Khanna has worked in various aspects of practitioner and graduate education, including as Director of the Maryland Learning Collaborative.

Christina Kuminski – Consumer Employer Representative
Ms. Kuminski is the Director of Employee Benefits at the State of Maryland. She has over 25 years of account management experience in the insurance industry. Before joining the State, Ms. Kuminksi served in various managerial and executive positions including as an Account Manager for Sedgwick and as an Account Executive for Hodge, Hart & Schleifer, Inc.

Clarence Lam, MD, MPH – Maryland General Assembly Representative
Dr. Lam is Maryland's 12th Legislative District representative for the counties of Anne Arundel and Howard. He is a board-certified physician in preventive medicine at the Johns Hopkins Bloomberg School of Public Health and serves as the program director of the preventive medicine residency program. Dr. Lam is an attending physician at the occupational health clinic at the Johns Hopkins Applied Physics Laboratory.

Karen Lam, MBA – MIA Representative
Ms. Lam is Chief, Health Insurance and Managed Care, in the Life and Health Division at the Maryland Insurance Administration ("MIA"). She has over 30 years of experience in the insurance industry. Ms. Lam oversees and manages the review of insurance form filings and contracts including providers and pharmacy benefit managers. Prior to joining MIA, Ms. Lam worked as an independent compliance consultant.

Russell Lewis, Jr, MD – Payer Representative
Dr. Lewis is the Medical Director for CareFirst BlueCross BlueShield and a board-certified internist with more than 20 years of experience. He was previously a clinical assistant professor of Family and Community Medicine at the University of Maryland School of Medicine. Dr. Lewis also served as Associate Chief Medical Officer of Baltimore Medical System ("BMS") and as Center Medical Director of BMS Highlandtown Healthy Living Center.

Kathleen Loughran – Payer Representative
Ms. Loughran is the Vice President of Government Relations for Amerigroup. She has more than 28 years of experience advising government and for-profit organizations on health care issues in commercial and Medicaid markets. Prior to joining Amerigroup, Ms. Loughran was Associate Commissioner of Policy and Government Affairs at the Maryland Insurance Administration.

Jill Marsteller, PhD, MPP – Health Services Researcher with Expertise in Primary Care Representative
Dr. Marsteller is a Professor of Health Policy and Management at the Johns Hopkins ("JH") Bloomberg School of Public Health with joint appointments in the JH School of Medicine and the Carey School of Business. Dr. Marsteller has nearly 30 years of experience in health services research with a focus on how to provide best-evidence care in a range of health care delivery settings.

John Miller – Health Care Association Employer Representative
Mr. Miller is the Executive Director of MidAtlantic Business Group on Health ("MABGH"). MABGH is an organization for business and health collaboration that helps employers design health benefits to maximize employee health while controlling cost. Mr. Miller has more than 25 years of experience working with employer groups on health-related matters.

Theresa Noe, MBA – Primary Care Representative
Ms. Noe has been the Vice President, Strategic Innovation and Partnerships at Patient First for about eight years. She is responsible for managing executive relationships with health plans, brokers, employers, health systems, and community providers. Ms. Noe's prior positions include serving as principal architect of HCA's Virginia Care Partners, LLC, and Vice President of Strategic Planning at HCA Healthcare – Capital Division.

Chad Perman, MPP – MDPCP Representative
Mr. Perman is the Executive Director of the Maryland Primary Care Program Management Office ("MDPCP PMO") with seven years of experience in integrating public health and primary care. He oversees Maryland's partnership with the Centers for Medicare & Medicaid Services, including negotiations with federal partners. Mr. Perman previously served as the Director of Health Systems Transformation within the Maryland Department of Health's Office of Population Health Improvement.

Ishrat Rafi, MD, MPH – MDACOG Representative
Dr. Rafi is a clinical and administrative obstetrician and gynecologist with more than 20 years of experience. Her prior positions include serving in leadership positions at Saint Agnes Ascension as Department Chairperson for OB/GYN, and Operating Room and Surgical Director. She is currently the Saint Agnes Ascension's Patient Safety Quality Medical Director and Minimally Invasive Gynecology Director. Dr. Rafi is the current MD Section Vice Chairperson of the American Congress of Obstetricians and Gynecologists.

Mette Ramanathan, CNM, FNP – Maryland Affiliate of ACNM Representative
Ms. Ramanathan is dual certified as a nurse-midwife and a family nurse practitioner. She has been working clinically as a dual practitioner for over 13 years. Ms. Ramanathan currently serves as a nurse-midwife at Saint Joseph Hospital within the University of Maryland Medical System. Before joining Saint Joseph Hospital, she held clinical positions in urgent care and school-based health clinics.

Tricia Roddy, MHSA – Medicaid Representative
Ms. Roddy is the Deputy Medicaid Director at the Maryland Department of Health and has served a 21-year tenure with the Maryland Medicaid program. She has extensive knowledge and applied experience in Medicaid operations and innovation and health service transformation. Prior to joining the Maryland Department of Health, Ms. Roddy worked in management consulting and strategy services.

Laura Russell, MPH – MHA Representative
Ms. Russell is Director of Health Care Payment at the Maryland Hospital Association with seven years of experience in public health and population health management. She has worked on key issues related to alternative payment models for care transformation efforts, including advanced primary care, and community health initiatives. Ms. Russell was previously a population health program manager at the University of Maryland Medical System.

Christie Simon-Waterman, DNP, CRNP, RN – MNA Representative
Dr. Simon-Waterman is the President of the Maryland Nurses Association ("MNA") and a certified registered nurse practitioner at The Johns Hopkins Hospital. She has over 26 years of experience in the health care industry and serves on multiple health care committees for the MNA and the Nurse Practitioner Association of Maryland. Dr. Simon-Waterman previously served as Director of Nursing at Future Care Health and Management Corporation.

APPENDIX B: STATE-LEVEL PRIMARY CARE INVESTMENT LEGISLATION

As of October 2023

Source: Primary Care Collaborative, *State Primary Care Investment Initiatives*. Available at: www.pcpcc.org/primary-care-investment/legislation/map.

APPENDIX C: TECHNICAL SPECIFICATIONS

Primary Care Taxonomy Codes

As of May 02, 2023

Count	Taxonomy Code	Description	PC Taxonomy Codes
1	207Q00000X	Physician, family medicine	Y
2	207R00000X	Physician, general internal medicine	Y
3	208000000X	Physician, pediatrics	Y
4	208D00000X	Physician, general practice	Y
5	363LA2200X	Nurse practitioner, adult health	Y
6	363LF0000X	Nurse practitioner, family	Y
7	363LP0200X	Nurse practitioner, pediatrics	Y
8	363LP2300X	Nurse practitioner, primary care	Y
9	363AM0700X	Physician's assistant, medical	Y
10	207RG0300X	Physician, geriatric medicine, internal medicine	Y
11	364S00000X	Certified clinical nurse specialist	Y
12	163W00000X	Nurse, non-practitioner	Y
13	207QA0000X	Family Medicine - Adolescent Medicine	Y
14	207QA0505X	Family Medicine - Adult Medicine	Y
15	207QG0300X	Family Medicine - Geriatric Medicine	Y
16	207RA0000X	Internal Medicine - Adolescent Medicine	Y
17	2080A0000X	Pediatrics - Adolescent Medicine	Y
18	363LC1500X	Nurse Practitioner - Community Health	Y
19	363LG0600X	Nurse Practitioner - Gerontology	Y
20	363LS0200X	Nurse Practitioner - School	Y
21	364SA2200X	Clinical Nurse Specialist - Adult Health	Y
22	364SC1501X	Clinical Nurse Specialist - Community Health/Public Health	Y
23	364SC2300X	Clinical Nurse Specialist - Chronic Health	Y
24	364SF0001X	Clinical Nurse Specialist - Family Health	Y
25	364SG0600X	Clinical Nurse Specialist - Gerontology	Y
26	364SP0200X	Clinical Nurse Specialist - Pediatrics	Y
27	364SS0200X	Clinical Nurse Specialist - School	Y
28	363L00000X	Nurse practitioner	Y
29	363A00000X	Physician's assistant	Y

The following Taxonomy codes can only be included as PCP with restrictions. Restrict on only home health and hospice procedure codes: 99374, 99375, 99376, 99377, 99378, G0179, G0180, G0181, G0182

Count	Taxonomy Code	Description	PC Taxonomy Codes
30	207QH0002X	Family Medicine - Hospice Palliative	Y*
31	207RH0002X	Internal Medicine, Hospice and Palliative Medicine	Y*
32	2080H0002X	Pediatrics, Hospice and Palliative Medicine	Y*

* *Include with restrictions*

Restrict on revenue codes for clinic and professional services: 0510, 0515, 0517, 0519, 0520, 0521, 0523, 0529, 0960, 0969, 0983

Count	Taxonomy Code	Description	PC Taxonomy Codes
33	261QF0400X	Federally Qualified Health Center	Y*
34	261QP2300X	Primary Care Clinic	Y*
35	261QR1300X	Rural Health Center	Y*
36	261QP2300X	Clinic/Center Primary Care	Y*
37	282NR1301X	Rural Hospital	Y*
38	261QC0050X	Critical Access Hospital	Y*
39	282NC0060X	Critical Access Hospital	Y*

* *Include with restrictions*

Core Primary Care Services

As of May 02, 2023

Count	Code	Description
1	90460	Immunization Admin 1St/Only Component 18 Years<
2	90461	Immunization Admin Each Addl Component 18 Years<
3	90471	Immunization Admin 1 Vaccine Single/Combo
4	90472	Immunization Admin Each Add-On Single/Combo
5	90473	Immunization Admin Oral/Nasal Single/Combo
6	90474	Immunization Admin Oral/Nasal Addl Single/Combo
7	96160	Pt-Focused Hlth Risk Assmt
8	96161	Caregiver Health Risk Assmt
9	98966	Hc Pro Phone Call 5-10 Min
10	98967	Non-Physician Telephone Services 11-20 Min
11	98968	Non-Physician Telephone Services 21-30 Min
12	98969	Online Service By Hc Pro
13	99078	Phys/QHP Education Materials for Pts In Group Setting
14	99173	Visual Acuity Screen
15	99202	Office/OutPt Visit New 15-29 Min
16	99203	Office/OutPt Visit New 30-44 Min
17	99204	Office/OutPt Visit New 45-59 Min
18	99205	Office/OutPt Visit New 60-74 Min
19	99211	Office/OutPt Visit Est
20	99212	Office/OutPt Visit Est 10-19 Min
21	99213	Office/OutPt Visit Est 20-29 Min
22	99214	Office/OutPt Visit Est 30-39 Min
23	99215	Office/OutPt Visit Est 40-54 Min
24	99241	Office Or Other OutPt Consultations 15 Min
25	99242	Office Or Other OutPt Consultations 30 Min
26	99243	Office Or Other OutPt Consultations 40 Min
27	99244	Office Or Other OutPt Consultations 60 Min
28	99245	Office Or Other OutPt Consultations 80 Min
29	99339	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 15-29 Min
30	99340	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 30 Min
31	99341	Home Visit New Pt 20 Min
32	99342	Home Visit New Pt 30 Min
33	99343	Home Visit New Pt 45 Min
34	99344	Home Visit New Pt 60 Min
35	99345	Home Visit New Pt 75 Min
36	99347	Home Visit Established Pt 15 Min
37	99348	Home Visit Established Pt 25 Min
38	99349	Home Visit Established Pt 40 Min
39	99350	Home Visit Established Pt 60 Min

Count	Code	Description
40	99358	Prolong Service W/O Contact
41	99359	Prolong Serv W/O Contact Add 30 Min
42	99360	Standby Service
43	99366	Team Conf W/ Pt By Healthcare Prof 30 Min W/Physician
44	99367	Team Conf W/Out Pt By Healthcare Prof 30 Min W/Physician
45	99368	Team Conf W/Out Pt By Healthcare Prof 30 Min W/Out Physician
46	99374	Home/Nursing Facility Visits 15-29 Min
47	99375	Home/Nursing Facility Visits 30 Min
48	99377	Supervision Hospice Patient/Month 15-29 Min
49	99378	Supervision Hospice Patient/Month 30 Minutes/>
50	99381	Init Pm E/M New Pat Infant
51	99382	Init Pm E/M New Pat 1-4 Yrs
52	99383	Prev Visit New Age 5-11
53	99384	Prev Visit New Age 12-17
54	99385	Prev Visit New Age 18-39
55	99386	Prev Visit New Age 40-64
56	99387	Office Visit - New Pt 65+ Yrs
57	99391	Periodic Pm Reeval Est Pat Infant 1>
58	99392	Prev Visit Est Age 1-4
59	99393	Prev Visit Est Age 5-11
60	99394	Prev Visit Est Age 12-17
61	99395	Prev Visit Est Age 18-39
62	99396	Prev Visit Est Age 40-64
63	99397	Per Pm Re-eval Est Pat 65+ Yr
64	99401	Preventive Counseling Indiv 15 Min
65	99402	Preventive Counseling Indiv 30 Min
66	99403	Preventive Counseling Indiv 45 Min
67	99404	Preventive Counseling Indiv 60 Min
68	99421	Online Digital Evaluation And Management Service For An Established Pt For Up To 7 Days Cumulative Time During The 7 Days, 5-10 Min
69	99422	Online Digital Evaluation And Management Service For An Established Pt For Up To 7 Days Cumulative Time During The 7 Days, 11-20 Min
70	99423	Online Digital Evaluation And Management Service For An Established Pt For Up To 7 Days Cumulative Time During The 7 Days, 21 Or More Min
71	99429	Unlisted Preventive Service
72	99441	Phys/Qhp Telephone Evaluation 5-10 Min
73	99442	Phone E/M Phys/Qhp 11-20 Min
74	99443	Phys/Qhp Telephone Evaluation 21-30 Min
75	99446	Interprofessional Electronic Health Assessment 5-10 Min
76	99447	Interprofessional Electronic Health Assessment 11-20 Min
77	99448	Interprofessional Electronic Health Assessment 21-30 Min
78	99449	Interprofessional Electronic Health Assessment 31 Min <
79	99451	Interprofessional Electronic Health Assessment 5 Min >

Count	Code	Description
80	99452	Interprofessional Electronic Health Record Referral Service(S) Provided By A Treating Physician Health Care Professional, > 16 Min
81	99453	Remote Monitoring Physiologic Parameters Initial
82	99454	Remote Monitoring Physiologic Parameters Programed Transmission
83	99457	Remote Physiologic Monitoring Treatment Management Services, First 20 Min
84	99458	Remote Physiologic Monitoring Treatment Management Services, Additional 20 Min
85	99473	Self-Measured Blood Pressure; Pt Education/Training And Device Calibration
86	99474	Separate Self-Measurements Of Two Readings One Min Apart, Twice Daily Over A 30-Day Period (Minimum Of 12 Readings)
87	99483	Assmt & Care Planning Pt W/Cognitive Impairment
88	99487	Complex Care W/O Pt Vsit 60 Min
89	99489	Complex Chronic Care Addl 30 Min
90	99490	Chron Care Mgmt Srvc 20 Min
91	99491	Chronic Care Management Services At Least 30 Min
92	99495	Trans Care Mgmt 14 Day Disch
93	99496	Trans Care Mgmt 7 Day Disch
94	99497	Advncd Care Plan 30 Min
95	99498	Advncd Care Plan Addl 30 Min
96	G0008	Admin Influenza Virus Vaccine
97	G0009	Admin Pneumococcal Vaccine

Behavioral Health CPT Module

As of May 02, 2023

Count	Code	Description
1	90785	Add-on code specific for psychiatric service
2	90791	Psych Diagnostic Evaluation
3	90792	Psych Diag Eval W/Med Services
4	90832	Psychotherapy 30 Min W/ Pt
5	90833	Psychotherapy 30 Min W/ Pt And Evaluation
6	90834	Psychotherapy 45 Min W/Pt
7	90836	Psychotherapy 45 Min W/Pt
8	90837	Psychotherapy 60 Min W/Pt
9	90838	Psychotherapy 60 Min W/Pt
10	90839	Crisis Psychotherapy Session W/Pt
11	90840	Crisis Psychotherapy 90 Min W/Pt
12	90845	Psychoanalysis
13	90846	Family Psychotherapy W/O Pt 50 Min
14	90847	Family Psychotherapy W/ Pt 50 Min
15	90849	Psychotherapy session with group of Pts' families
16	90853	Group psychotherapy session
17	90863	Provider prescribes/reviews meds after psychotherapy services
18	90865	Provider administers narcotic drug to induce hypnotic state that helps diagnosis/Tx
19	90867	Provider performs TMS to improve depression symptoms
20	90868	Provider performs TMS to improve depression symptoms
21	90869	Provider performs a subsequent redetermination of the minimum intensity of electrical pulses for Pt undergoing TMS
22	90870	Provider applies an electric current to the Pt's brain for the purpose of producing a seizure or series of seizures to alleviate symptoms of mental disorder
23	90875	Provider performs 30 min of psychophysiological therapy using biofeedback training
24	90876	Provider performs 45 min of psychophysiological therapy using biofeedback training
25	90880	Hypnotherapy
26	90882	Provider works with outside agencies/employers/other providers regarding Pts physical environment to manage psychiatric Pt's medical care
27	90885	Provider reviews medical records of the Pt pertaining to psychiatric evaluation to establish diagnosis/Tx plan
28	90887	Provider explains the results of psychiatric/medical exams or other procedures about the Pt’s care to the Pt’s family/caregivers
29	90889	Provider prepares report on Pt's mental state for other providers of care
30	90899	Other psychiatric services or procedures
31	96110	Developmental Screen W/Score
32	96116	Neuropsychological Testing and Assessment
33	96121	Neuropsychological Testing and Assessment

Count	Code	Description
34	96125	Standard cognitive performance testing
35	96127	Brief Emotional/Behav Assmt
36	96130	Psychological testing evaluation services by physician or other QHP
37	96131	Psychological and Neuropsychological Testing Evaluation Services
38	96132	Neuropsychological testing evaluation services by physician or other QHP
39	96133	Psychological and Neuropsychological Testing Evaluation Service
40	96136	Psychological and Neuropsychological Test Administration and Scoring
41	96137	Psychological and Neuropsychological Test Administration and Scoring
42	96138	Psychological or neuropsychological test administration/scoring by technician
43	96139	Psychological and Neuropsychological Test Administration and Scoring
44	96146	Psychological or neuropsychological test administration, automated
45	96156	Health Behavior Assessment Or Re-Assessment
46	96158	Health Behavior Intervention, Individual Face-To-Face 30 Min
47	96159	Health Behavior Intervention, Individual Face-To-Face 15 Min
48	96164	Health Behavior Intervention, Group (2<) Face-To-Face 30 Min
49	96165	Health Behavior Intervention, Group (2<) Face-To-Face 15 Min
50	96167	Health Behavior Intervention, Family (W/ Pt) Face-To-Face 30 Min
51	96168	Health Behavior Intervention, Family (W/ Pt) Face-To-Face 15 Min
52	96170	Health Behavior Intervention, Family (W/Out Pt) Face-To-Face 30 Min
53	96171	Health Behavior Intervention, Family (W/Out Pt), Face-To-Face 15 Min
54	97151	Behavior Identification Assessment, Administered By QHP, Each 15 Min Of QHP'S Time
55	97152	Behavior Identification-Supporting Assessment, Administered By One Technician Under The Direction Of A Physician Or Other Qualified Health Care Professional, Face-To-Face With The Pt, Each 15 Min
56	97153	Adaptive Behavior Treatment By Protocol, Administered By Technician Under The Direction Of A Physician Or Other Qualified Health Care Professional, Face-To-Face With One Pt, Each 15 Min
57	97154	Group Adaptive Behavior Treatment By Protocol, Administered By Technician Under The Direction Of A Physician Or Other Qualified Health Care Professional, Face-To-Face With Two Or More Pts, Each 15 Min
58	97155	Adaptive Behavior Treatment With Protocol Modification, Administered By Physician Or Other Qualified Health Care Professional, Which May Include Simultaneous Direction Of Technician, Face-To-Face With One Pt, Each 15 Min
59	97156	Family Adaptive Behavior Treatment Guidance, Administered By Physician Or Other Qualified Health Care Professional (With Or Without The Pt Present), Face-To-Face With Guardian(S)/Caregiver(S), Each 15 Min
60	97157	Multiple-Family Group Adaptive Behavior Treatment Guidance, Administered By Physician Or Other QHC Professional (W/O Pt Present), Face-To-Face With Multiple Sets Of Guardians/Caregivers, Each 15 Min
61	97158	Group Adaptive Behavior Treatment With Protocol Modification, Administered By Physician Or Other Qualified Health Care Professional, Face-To-Face With Multiple Pts, Each 15 Min
62	97530	Therapeutic Activities (BH providers only)
63	97535	Self-care/Home management training (BH providers only)
64	97802	Medical Nutrition Indiv In
65	97803	Med Nutrition Indiv Subseq
66	97804	Medical Nutrition Group
67	98960	Self-Mgmt Educ & Train 1 Pt

Count	Code	Description
68	98961	Self-Mgmt Educ/Train 2-4 Pt
69	98962	Self-Mgmt Educ/Train 5-8 Pt
70	99199	Unlisted special service, procedure, or report (BH provider only)
71	99406	Behav Chng Smoking 3-10 Min
72	99407	Behav Chng Smoking > 10 Min
73	99408	Audit/Dast 15-30 Min
74	99409	Alcohol/Substance Screen & Intervention >30 Min
75	99411	Preventive Counseling Group 30 Min (tobacco)
76	99412	Preventive Counseling Group 60 Min (tobacco)
77	99484	Care Mgmt Svc Bhvl Health Conditions 20 Min
78	99492	1St Psyc Collab Care Mgmt
79	99493	Sbsq Psyc Collab Care Mgmt
80	99494	1St/Sbsq Psyc Collab Care
81	1000F	Tobacco Use Assessed
82	1031F	Smoking & 2Nd Hand Assessed
83	1032F	Current Tobacco Smoker Or 2nd Hand Exposed
84	1033F	Tobacco Nonsmoker Not Exposed 2nd Hand
85	1034F	Current Tobacco Smoker
86	1035F	Current Smokeless Tobacco User
87	1036F	Current Tobacco Non-User
88	1111F	Dschrg Med/Current Med OutPt Record
89	1220F	Pt Screened For Depression
90	3016F	Pt Screened For Unhlthy Alcohol Use
91	3085F	Suicide Risk Assessed
92	3351F	Neg Scrn Depression Symptoms By Dep Tool
93	3352F	No Sig Dep Symp By Dep Tool
94	3353F	Mild-Mod Dep Symp By Deptool
95	3354F	Clin Sig Dep Sym By Dep Tool
96	3355F	Clin Sig Dep Sym By Dep Tool
97	4000F	Tobacco Use Cessation Intervention Counseling
98	4001F	Tobacco Use Cessation Intervention Pharmacologic
99	4004F	Pt Tobacco Screen And Cessation Intervention
100	4290F	Pt Screened For Injection Drug Use (HIV)
101	4293F	Pt Screened For High Risk Sexual Behavior (HIV)
102	4306F	Pt Counseled Psychosicial/Pharmacologic Opioid Addiction
103	4320F	Pt Counseled Psychosicial/Pharmacologic Alcohol Dependence
104	G0442	Annual Alcohol Screen 15 Min
105	G0443	Brief Alcohol Misuse Counsel
106	G0444	Depression Screen Annual 15 Min
107	G2067	Medicated Assisted Treatment
108	G2068	Medicated Assisted Treatment
109	G2069	Medicated Assisted Treatment
110	G2070	Medicated Assisted Treatment
111	G2071	Medicated Assisted Treatment
112	G2072	Medicated Assisted Treatment

Count	Code	Description
113	G2073	Medicated Assisted Treatment
114	G2074	Medicated Assisted Treatment
115	G2075	Medicated Assisted Treatment
116	G2076	Medicated Assisted Treatment
117	G2077	Medicated Assisted Treatment
118	G2078	Medicated Assisted Treatment
119	G2079	Medicated Assisted Treatment
120	G2080	Medicated Assisted Treatment
121	G9004	Coordinated care fee, risk adjusted low, initial (BH provider only)
122	G9005	Coordinated care fee, risk adjusted maintenance (BH provider only)
123	G9006	Coordinated care fee, home monitoring (BH provider only)
124	G9007	Coordinated care fee, scheduled team conference (BH provider only)
125	G9008	Coordinated care fee, physician coordinated care (BH provider only)
126	G9009	Coordinated care fee, risk adjusted maintenance, level 3 (BH provider only)
127	G9010	Coordinated care fee, risk adjusted maintenance, level 4 (BH provider only)
128	G9011	Coordinated care fee, risk adjusted maintenance, level 5 (BH provider only)
129	G9012	Other specified case management service (BH provider only)
130	H0001	Alcohol and/or drug assessment
131	H0002	Behavioral Health Screening To Admit To Treatment Program
132	H0004	Behavioral health counseling and therapy, 15 Min
133	H0007	Alcohol and/or drug services; crisis intervention (outPt)
134	H0010	Alcohol and/or drug services
135	H0011	Alcohol and/or drug services; acute detoxification
136	H0012	Alcohol and/or drug services; sub-acute detoxification
137	H0013	Alcohol and/or drug services; acute detoxification
138	H0014	Alcohol and/or drug services; ambulatory detoxification
139	H0015	Alcohol and/or drug services; intensive outpatient
140	H0016	Alcohol and/or drug services; medical/somatic
141	H0017	Behavioral health; residential, without room and board, per diem
142	H0018	Behavioral health; short-term residential, without room and board
143	H0019	Behavioral health; long-term residential, without room and board
144	H0020	Alcohol and/or drug services; methadone administration and/or service
145	H0022	Alcohol and/or drug intervention service (planned facilitation)
146	H0023	Behavioral health outreach service (planned approach to reach a targeted population)
147	H0031	Mental Health Assess By Non-MD
148	H0032	Mental health service plan development by non-physician
149	H0033	Oral medication administration, direct observation
150	H0034	Medication training and support, per 15 minutes
151	H0035	Mental health partial hospitalization, treatment, less than 24 hours
152	H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
153	H0037	Community psychiatric supportive treatment program
154	H0038	Self-help/peer services, per 15 minutes
155	H0039	Assertive community treatment, face-to-face, per 15 minutes
156	H0040	Assertive community treatment program, per diem
157	H0047	Alcohol and/or drug abuse services, NOS

Count	Code	Description
158	H0049	Alcohol/Drug Screening
159	H0050	Alcohol and/or drug services, brief intervention, per 15 min
160	G0396	Alcohol/Subs Misuse Intervention 15-30 Min
161	G0397	Alcohol/Subs Misuse Intervention 30 Min <

Behavioral Health Taxonomy Module

As of May 02, 2023

Count	Taxonomy Code	Description	BH Taxonomy
1	2084P0800X	Physician, general psychiatry	Include if Billing Provider is a PCP
2	2084P0804X	Physician, child, and adolescent psychiatry	Include if Billing Provider is a PCP
3	363LP0808X	Nurse practitioner, psychiatric	Include if Billing Provider is a PCP
4	1041C0700X	Behavioral Health & Social Service Providers/Social Worker, Clinical	Include if Billing Provider is a PCP
5	2084P0805X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Geriatric Psychiatry	Include if Billing Provider is a PCP
6	2084H0002X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Hospice & Palliative Medicine	Include if Billing Provider is a PCP
7	261QM0801X	Ambulatory Health Care Facilities/Clinic/Center, Mental Health- CMHC	Include if Billing Provider is a PCP
8	101Y00000X	Counselor	Include if Billing Provider is a PCP
9	101YA0400X	Counselor - Addiction (SUD)	Include if Billing Provider is a PCP
10	101YM0800X	Counselor - Mental Health (Note: Counselor working in MAT programs in FQHC)	Include if Billing Provider is a PCP
11	101YP1600X	Counselor - Pastoral	Include if Billing Provider is a PCP
12	101YP2500X	Counselor - Professional (Note: Counselor in FQHC)	Include if Billing Provider is a PCP
13	101YS0200X	Counselor – School	Include if Billing Provider is a PCP
14	102L00000X	Psychoanalyst	Include if Billing Provider is a PCP
15	103T00000X	Psychologist (Note: Clinical Psychologist in FQHC)	Include if Billing Provider is a PCP
16	103TA0400X	Psychologist - Addiction	Include if Billing Provider is a PCP
17	103TA0700X	Psychologist - Adult Development and Aging	Include if Billing Provider is a PCP
18	103TB0200X	Psychologist - Cognitive and Behavioral	Include if Billing Provider is a PCP
19	103TC0700X	Psychologist - Clinical	Include if Billing Provider is a PCP
20	103TC1900X	Psychologist - Counseling	Include if Billing Provider is a PCP
21	103TC2200X	Psychologist - Clinical Child & Adolescent	Include if Billing Provider is a PCP
22	103TE1000X	Psychologist - Educational	Include if Billing Provider is a PCP

OB/GYN Module

As of May 02,2023

Count	Code	Description
1	11976	Remove Contraceptive Capsule
2	11980	Implant Hormone Pellet(s)
3	11981	Insert Drug Implant Device
4	11982	Remove Drug Implant Device
5	11983	Remove W/ Insert Drug Implant
6	56405	I & D Of Vulva/Perineum
7	56420	I & D Of Bartholin Gland Abscess
8	56501	Destroy Vulva Lesions Simple
9	56515	Destroy Vulva Lesion/S Complex
10	56605	Biopsy Of Vulva/Perineum 1 Lesion
11	56606	Biopsy Of Vulva/Perineum
12	56820	Exam Of Vulva W/Scope
13	Q0091	Obtaining pap smear
14	56821	Exam + Biopsy Of Vulva W/Scope
15	57061	Destroy Vaginal Lesions Simple
16	57100	Biopsy Of Vagina Mucosa Simple
17	57105	Biopsy Of Vagina Mucosa Complex
18	57135	Remove Vagina Lesion
19	57150	Treat Vagina Infection
20	57170	Fitting Of Diaphragm/Cap
21	57410	Pelvic Examination Under Anesthesia
22	57420	Exam Of Vagina W/Scope
23	57421	Exam/Biopsy Of Vagina W/Scope
24	57452	Exam Of Cervix W/Scope
25	57454	Exam/Biopsy Of Cervix W/Scope
26	57455	Biopsy Of Cervix W/Scope
27	57456	Endocervical Curettage W/Scope
28	57500	Biopsy Of Cervix
29	57505	Endocervical Curettage
30	58100	Biopsy Of Uterus Lining
31	58110	Biopsy Done W/Colposcopy Add-On
32	58120	Dilation And Curettage
33	58300	Insert Intrauterine Device
34	58301	Remove Intrauterine Device
35	59025	Fetal Non-Stress Test
36	59200	Insert Cervical Dilator
37	59300	Episiotomy Or Vaginal Repair
38	59400	Obstetrical Care
39	59409	Vaginal Delivery
40	59410	Vaginal Delivery + Postpartum Care
41	59412	External Cephalic

Count	Code	Description
42	59414	Delivery Of Placenta
43	59425	Antepartum Care Only 4-6 Visits
44	59426	Antepartum Care Only 7< Visits
45	59430	Postpartum Care Only
46	59510	Routine Ob Care
47	59514	Cesarean Delivery Only
48	59515	Cesarean Delivery Only + Postpartum Care
49	59610	Routine Obstetric Care After Prevs C-Section
50	59612	Vaginal Delivery Only, After Prevs C-Section
51	59614	Vaginal Delivery Only After Prevs C-Section + Postpartum Care
52	59618	Routine Ob Care Post Vaginal Delivery After Prev C-Section
53	59620	C-Section Only After Attempted Vaginal Delivery After Prev C-Section
54	59622	C-Section Only, After Attempted Vaginal Delivery After Prev C- Section + Postpartum Ca
55	59820	Care Of Miscarriage 1St Trimester
56	76801	Ob Us < 14 Wks Single Fetus
57	76802	Ob Us < 14 Wks Addl Fetus
58	76805	Ob Us >= 14 Wks Sngl Fetus
59	76810	Ob Us >= 14 Wks Addl Fetus
60	76811	Ob Us Detailed Single Fetus
61	76812	Ob Us Detailed Addl Fetus
62	76813	Ob Us Nuchal Measure Single Gest
63	76814	Ob Us Nuchal Measure Add-On
64	76815	Ob Us Limited Fetus 1<
65	76816	Ob Us Follow-Up Per Fetus
66	76817	Transvaginal Us Obstetric
67	76818	Fetal Biophys Profile W/Non-Stress Testing
68	76819	Fetal Biophys Profil W/O Non-Stress Testing
69	81000	Urinalysis Dip Stick/Tablet Reagent Non-Auto Microscopy
70	81001	Urinalysis Dip Stick/Tablet Reagent Auto Microscopy
71	81025	Urine Pregnancy Test Visual Color Comparison
72	99465	Delivery/Birthing Resuscitation
73	99502	Home Visit For Newborn Care And Assessment
74	0500F	Initial Prenatal Care Visit
75	0501F	Prenatal Flow Sheet
76	0502F	Subsequent Prenatal Care
77	0503F	Postpartum Care Visit
78	H1000	Prenatal Care At Risk Assessm
79	H1001	Antepartum Management
80	H1005	Prenatal care, at-risk enhanced service package
81	S0610	Annual Gynecological Examine New Pt
82	S0612	Annual Gynecological Examin Established Pt
83	S0613	Annual Breast Exam
84	S4981	Insertion Of Levonorgestrel-Releasing Intrauterine Sys
85	S9447	Infant Safety (Including Cardiopulmonary Resuscitation Classes Nonphysician Provider,

Count	Code	Description
		Per Session)
86	G0101	Cancer Screen; Pelvic/Breast Exam

Place of Service Codes

As of May 02, 2023

Count	POS	Place of Service (POS) Name	Narrow (X)
1	10	Telehealth Provided in Patient's Home	X
2	11	Office	X
3	12	Home	X
4	13	Assisted Living Facility	X
5	14	Group Home	X
6	16	Temporary Lodging	X
7	19	Off Campus- Outpatient Hospital	X
8	22	On Campus- Outpatient Hospital	X
9	26	Military Treatment Facility	X
10	33	Custodial Care Facility	X
11	34	Hospice	X
12	49	Independent Clinic	X
13	50	Federally Qualified Health Center	X
14	53	Community Mental Health Center	X
15	71	Public Health Clinic	X
16	72	N/A – 0	X
17	02	Telehealth Provided Other than in Patient's Home	X
18	04	Homeless Shelter	X
19	05	Indian Health Service Free- standing Facility	X
20	06	Indian Health Service Provider- based Facility	X
21	07	Tribal 638 Free- standing Facility	X
22	08	Tribal 638 Provider-based Facility	X
23	09	Prison/Correctional Facility	X
24	15	Mobile Unit	
25	17	Walk-in Retail Health Clinic	
26	18	Place of Employment- Worksite	
27	20	Urgent Care Facility	
28	21	Inpatient Hospital	
29	23	Emergency Room – Hospital	
30	24	Ambulatory Surgical Center	
31	25	Birthing Center	
32	31	Skilled Nursing Facility	
33	32	Nursing Facility	
34	41	Ambulance – Land	
35	42	Ambulance – Air or Water	
36	51	Inpatient Psychiatric Facility	
37	52	Psychiatric Facility – Partial Hospitalization	
38	54	Intermediate Care Facility/Individuals with Intellectual Disabilities	
39	55	Residential Substance Abuse Treatment Facility	
40	56	Psychiatric Residential Treatment Center	

Count	POS	Place of Service (POS) Name	Narrow (X)
41	57	Non-residential Substance Abuse Treatment Facility	
42	58	Non-residential Opioid Treatment Facility	
43	60	Mass Immunization Center	
44	61	Comprehensive Inpatient Rehabilitation Facility	
45	62	Comprehensive Outpatient Rehabilitation Facility	
46	65	End-Stage Renal Disease Treatment Facility	
47	81	Independent Laboratory	
48	99	Other Place of Service	
49	01	Pharmacy	
50	03	School	

APPENDIX D: FOUR PILLARS OF PRIMARY CARE

Measuring Progress Towards Primary Care Goals

PILLAR 1: FIRST CONTACT		
Operational Element	**Approach**	**Source**
Modality – how the patient interacts with or accesses primary care	Define primary care services; calculate the proportion of those services delivered in various care settings	PCAT APCD
Personnel involved – provider receiving or engaging with the patient	Define primary care services; define primary care providers; calculate the proportion of those services delivered by clinician type	PCAT APCD
Level of first contact – individual provider	Define primary care; calculate the proportion of those services delivered by the same health care professional	PCAT APCD
Level of first contact – assigned care team	Define primary care; calculate the proportion of those services delivered by health care professionals within the same organization	PCAT APCD

PILLAR 2: COMPREHENSIVENESS		
Operational Element	**Approach**	**Source**
Scope of services offered	Analyze claims to see variation in scope of services provided by primary care providers ("PCPs")	PCAT APCD
Depth and breadth of conditions managed by the primary care team, based on the prevalence of health concerns/conditions in the population served	Chronic condition quality measures, admissions, readmissions, emergency department ("ED"), ambulatory care sensitive conditions ("ASCs")	PCAT APCD

PILLAR 2: COMPREHENSIVENESS		
Integrated behavioral health ("BH")	Measure primary care providers performance on standardized measures of quality related to behavioral health	PCAT APCD
	Analyze utilization of recommended BH screenings	PCAT APCD
	Rates of Social Determinants of Health ("SDoH") screening	PCAT APCD

PILLAR 3: COORDINATION		
Operational Element	**Approach**	**Source**
Links between primary and secondary/tertiary levels of care	Readmission rates	PCAT APCD
Links between primary care and behavioral health	Analyze utilization of psych collaborative care codes and other behavioral health integration codes	PCAT APCD
Workforce managing coordination and transitions of care	Readmission rates	PCAT APCD
Long term care management for chronic disease	Chronic condition quality measures, admissions, readmissions, ED, ASCs	PCAT APCD

PILLAR 4: CONTINUITY		
Operational Element	**Approach**	**Source**
Level of continuity	Define and apply primary care attribution; calculate the proportion of those services delivered by the same	PCAT APCD

PILLAR 4: CONTINUITY		
	health care professional and/or health care professionals within the same organization	
Advanced care planning	Analyze use of advanced care planning Current Procedural Terminology ("CPT") codes	PCAT APCD

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