CIVHC
CENTER FOR IMPROVING
**VALUE** IN HEALTH CARE

# Primary Care Spending and Alternative Payment Model Use in Colorado

2022-2024

(Submitted November 2025)

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## Background

The Center for Improving Value in Health Care (CIVHC) provides this report of primary care and alternative payment model (APM) spending (2022-2024) 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 2024 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: 2022, 2023, and 2024. Primary care and APM spending for 2024, 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*). For the 2025 report, APM submissions used a new method of categorizing payments. Rather than the HCP-LAN categories, payers used the Expanded Non-Claims Payment Framework (or Expanded Framework) to better align the CO APCD APM layout with the Common Data Layout for Non-claim payments (CDL-NCP). More information on these categories 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 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 2022-2024 by payment model (Table 1).

Since 2021, CIVHC has 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 has been that utilization decreased during the stay-at-home order but has since rebounded to pre-pandemic levels or higher in some cases. For this report, no payers reported a decrease in investment or cessation of APMs as a direct result of the COVID-19 pandemic in their qualitative responses.

The data demonstrate that investments in primary care, as a percentage of medical spending, increased overall between 2022 and 2024. The data also show that APM investment, as a percentage of medical and primary care spending, decreased slightly from 2023 to 2024. While most payers described no significant changes to their arrangements with providers, some 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.

This year, CIVHC saw a decrease in Medicaid and CHP+ total spending. This is likely due to the process of ending the COVID-19 Public Health Emergency (PHE) and programs like Medicaid and CHP+ returning to normal operations. This means that people who were receiving continuous coverage from Medicaid or CHP+ during PHE are now no longer eligible, resulting in a drop in payer spending and enrollment.

## Primary Care Spending

- In 2024, primary care spending as a percentage of ***all medical spending*** (excluding pharmacy and dental) in Colorado across all reported payer types was 15.7%. Primary care spending accounted for 16.8% of total medical spending in 2023 and 14.8% of total medical spending in 2022.

- The percentage of primary care spending in Colorado, excluding Kaiser Permanente and Denver Health payments[1], is 15.8% in 2024, 17.1% in 2023 and 14.6% in 2022.
- Primary care spending as a percentage of all medical spending varies by payer type. In 2024, primary care accounted for 7.8% of commercial medical spending, 24.3% of Medicare Advantage medical spending, 16.5% of Medicaid medical spending, and 12.4% of CHP+ medical spending.
  - The percentage of primary care spending in Colorado in 2024, excluding Kaiser Permanente and Denver Health payments, is 4.8% of commercial medical spending, 27.6% of Medicare Advantage medical spending, 16.5% of Medicaid medical spending, and 10.1% of CHP+ spending.

## APM Spending

- In 2024, 33.5% of ***all medical spending*** across all reported lines of business was paid through value-based APM arrangements[2]. This also varies by payer type – 22.8% of commercial, 42.3% of Medicare Advantage, 37.1% of Medicaid, and 5.6% 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 20.3% of ***all medical spending***.
  - Value-based APM arrangements that are population-based and linked to quality (LAN Categories 4A, 4B, and 4C) account for 13.2% of ***all medical spending*** in 2024.
  - Excluding Kaiser Permanente and Denver Health, 27.5% of ***all medical spending*** was paid through value-based APM arrangements in 2024. 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 9.8% of commercial, 32.5% of Medicare Advantage, 36.8% of Medicaid, and 0.0% of CHP+ in 2024.
- In 2024, 58% of ***all primary care spending*** across all reported lines of business was paid through value-based APM arrangements.

*[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).*

- Of primary care spending made through APMs, the highest percentage flowed through capitated payments not linked to quality (category 4N).
  - Value-based APM arrangements built on a FFS model (LAN categories 2A, 2B, 2C, 3A, and 3B) account for 15.1% of ***all primary care spending*** in 2024.
  - Value-based APM arrangements that are population-based and linked to quality (LAN Categories 4A, 4B, and 4C) account for 42.9% of ***all primary care spending*** in 2024.

## Additional Metrics[3]:

### Spending Per Member Per Month:

- In 2024 and across all lines of business, ***total medical*** spending per member per month (PMPM) was $382.21. ***Primary care*** spending PMPM was $59.91.
  - ***Total medical expenditures*** expressed as spending PMPM vary by payer type. In 2024, total medical expenditures PMPM were $510.11 for commercial, $919.51 for Medicare Advantage, $238.54 for Medicaid, and $186.61 for CHP+.
  - Similar to total medical expenditures, ***primary care expenditures*** expressed as spending per member per month vary also by payer type. In 2024, primary care expenditures PMPM were $39.79 for Commercial, $223.26 for Medicare Advantage, $39.34 for Medicaid, and $23.09 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, 18.9% of ***all medical spending*** in 2024 was paid on a prospective basis.

- Excluding FFS, 47.6% of ***all medical spending through an alternative payment model*** was paid on a prospective basis in 2024.
- 98.8% of Category 4 payments, 9.5% of Category 3, and 2.5% of Category 2 payments were made prospectively.
- Excluding Kaiser Permanente and Denver Health, 15.4% of ***all medical spending*** and 48.9% of ***all medical spending through an alternative payment model*** was paid prospectively.

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

[3]

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 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 2024, 13.7% of commercial, 32.9% of Medicare Advantage, 13.9% of Medicaid, and 5.1% of CHP+ was paid prospectively.
- Of ***all spending through an alternative payment model***, 60% of commercial, 52.2% of Medicare Advantage, 35.9% of Medicaid, and 91.1% of CHP+ was paid prospectively.

## Member Cost Sharing:

- Across all lines of business, payer organizations covered 93.6% of ***all medical spending*** in 2024; members were responsible for 6.4% of the costs. Excluding Medicaid and CHP+, which has minimal member liability, payer organizations covered 89.5% of all medical spending across commercial and Medicare Advantage plans, and members were responsible[4] for the remaining 10.5%.
  - Excluding Medicaid and CHP+, payer organizations covered 94.5% of ***all primary care spending*** in 2024. Payer investment in primary care has been steady for the past three years; health plans covered 93.5% of primary care expenditures in 2022 and 95.5% in 2023.
- In commercial lines of business only, payer organizations covered 85.1% of ***all medical spending*** in 2024; members were responsible[3] for 14.9% of the costs.
  - Payer investment in primary care for commercially insured members slightly decreased in 2024 compared to 2023; payer organizations covered 86.6% of primary care expenditures in 2022, 86.2% in 2023, and 83.9% in 2024.

*[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 attributed to primary care has increased from 15% in 2022 to 16% in 2024.

**Figure 1: Percent of Primary Care Spending by Payer Over Time, 2022-2024**

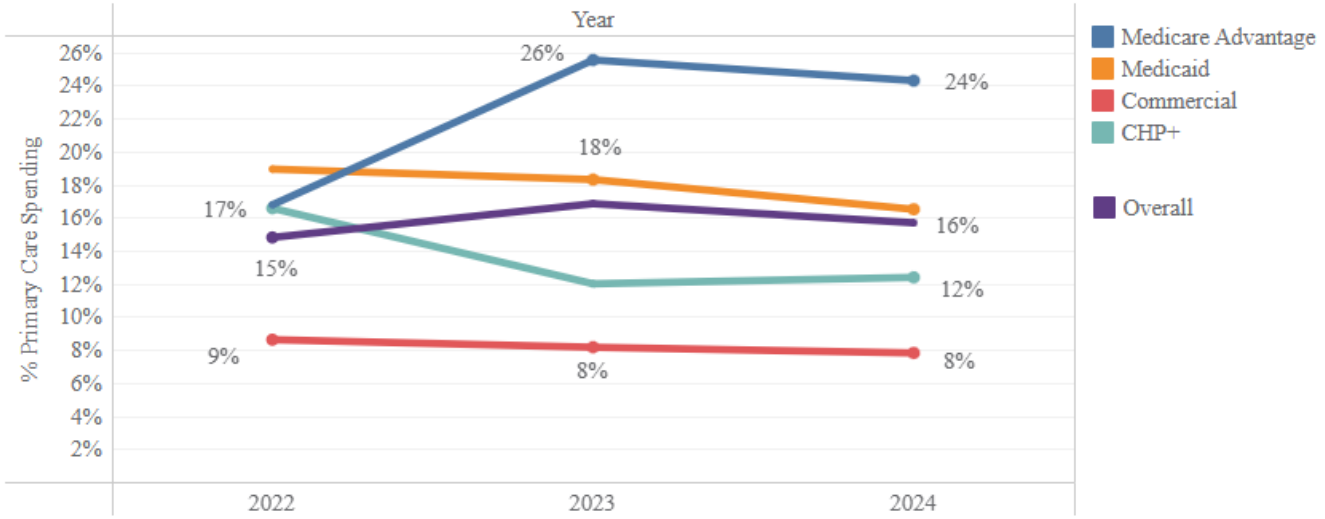



**Figure 2: Share of Primary Care Spending, 2024.**

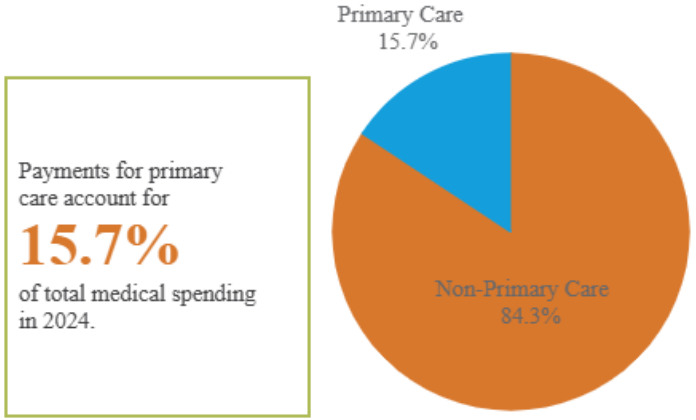
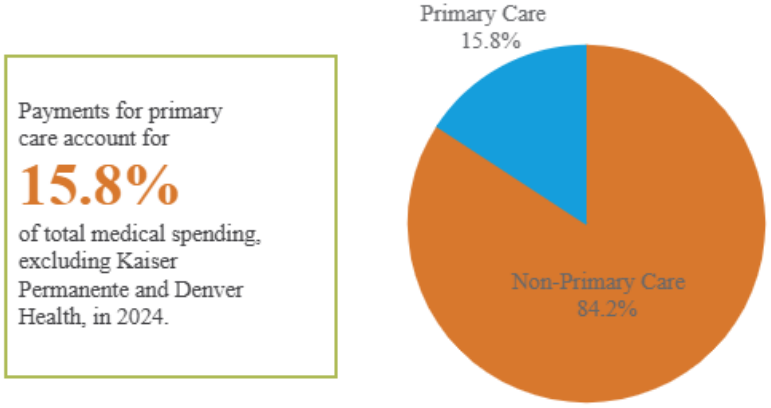



**Figure 3: Share of Primary Care Spending, excluding Kaiser Permanente and Denver Health, 2024.**




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

# Primary Care Spending and Alternative Payment Model Use in Colorado

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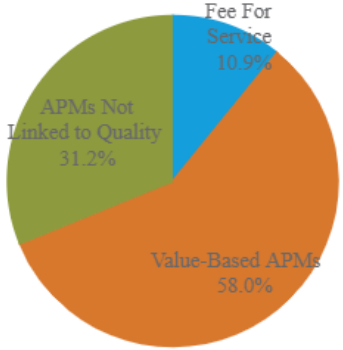
**Figures 4: Share of Primary Care Spending by APM Category, 2024.**

Payments under value-based alternative payment models account for

**58.0%**

of total **primary care spending** in 2024.



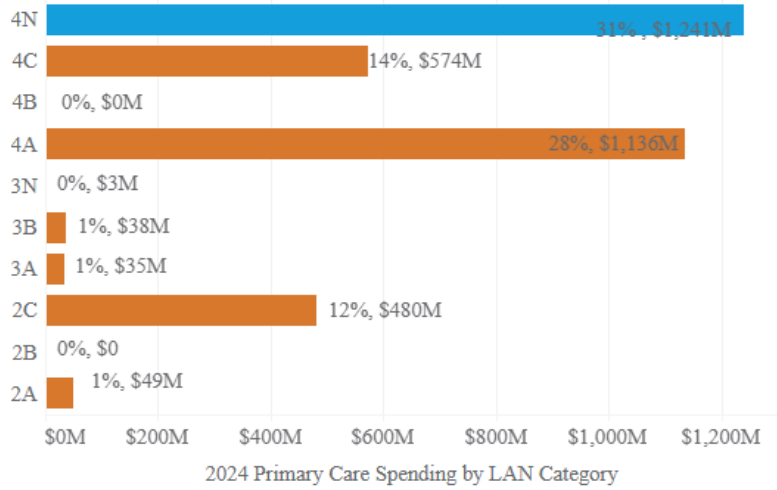
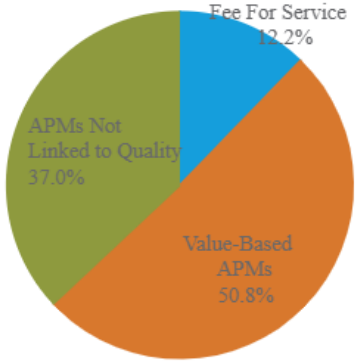



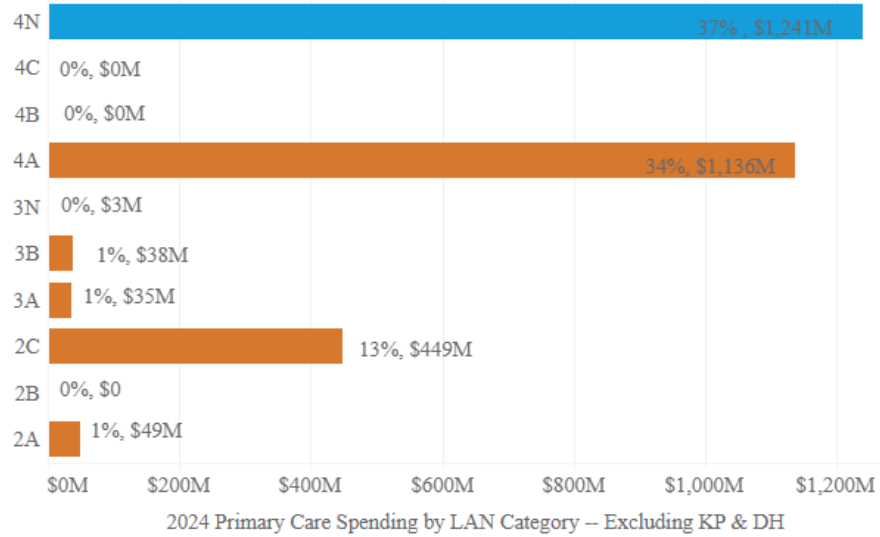

**Figure 5: Share of Primary Care Spending by APM Category, excluding Kaiser Permanente (KP) and Denver Health (DH), 2024.**

Payments under value-based alternative payment models account for

**50.8%**

of total **primary care spending**, excluding Kaiser Permanente and Denver Health, in 2024.




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, 2024.**

Payments under value-based alternative payment models account for

**33.5%**

of **total medical spending** in 2024.

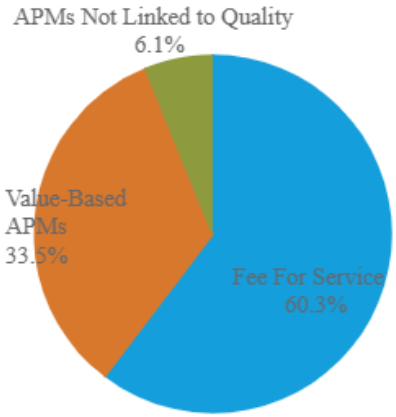
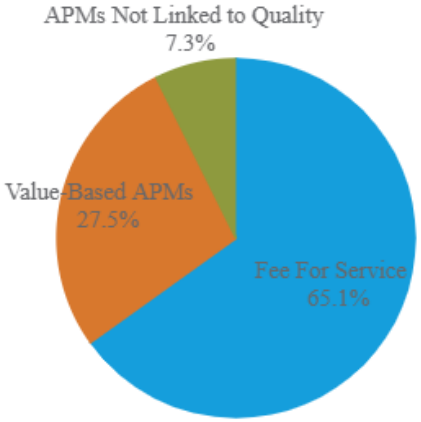



**Figure 7: Share of Total Medical Spending by APM Category, excluding Kaiser Permanente and Denver Health, 2024.**

Payments under value-based alternative payment models account for

**27.5%**

of **total medical spending**, excluding Kaiser Permanente and Denver Health, in 2024.




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, 2022-2024.

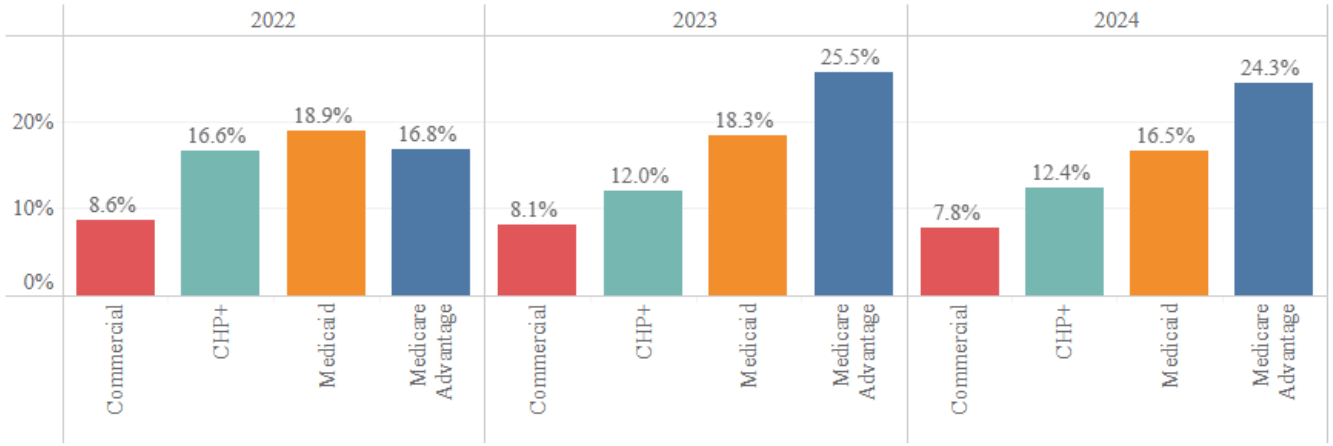



Figure 9: Primary Care Spending by Member Months by Payer, 2022-2024.

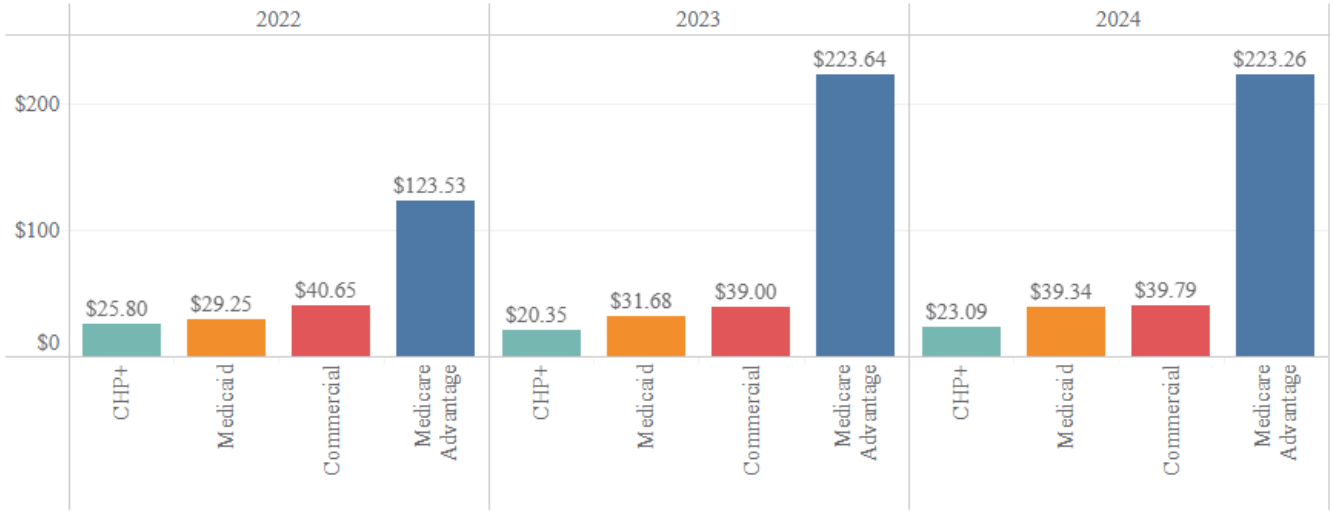


**Figure 10: Share of Prospective Payments out of Primary Care Spending, excluding FFS, by APM Category, 2024.**

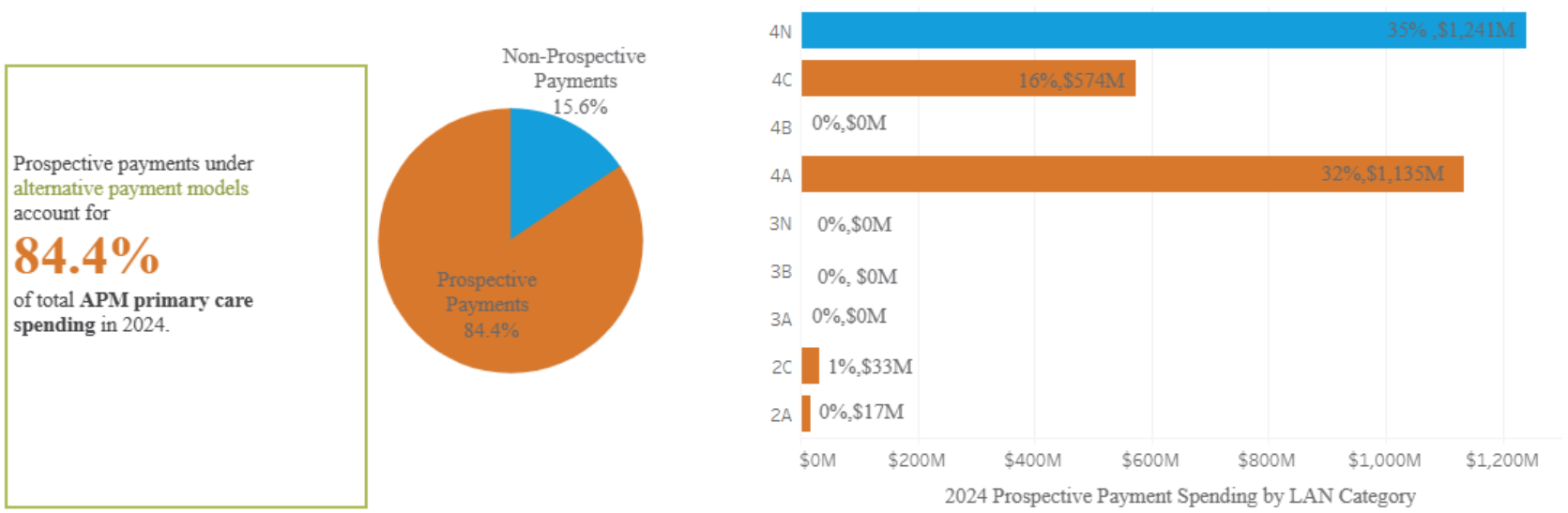



**Figure 11: Share of Prospective Payments Out of Primary Care Spending, excluding FFS, by APM Category, excluding Kaiser Permanente (KP) and Denver Health (DH), 2024.**

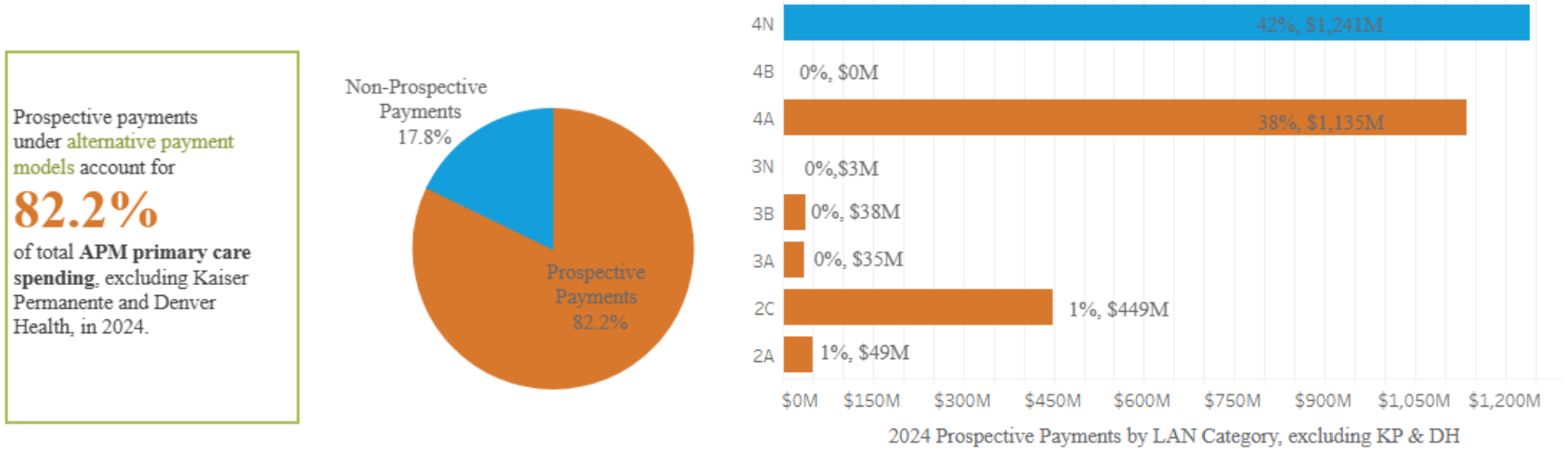


**Figure 12: Share of Prospective Payments out of Total Medical Spending, excluding FFS, 2024.**

Prospective payments under alternative payment models account for

**47.6%**

of **total APM medical spending** in 2024.

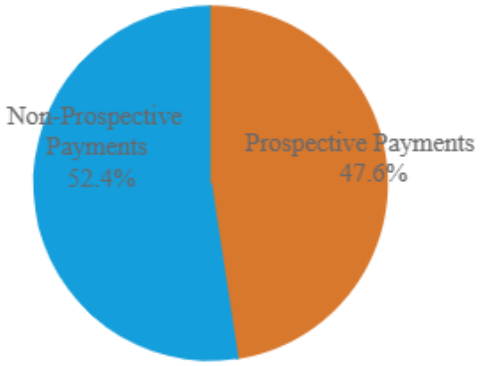
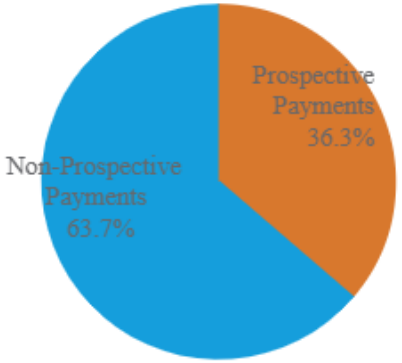



**Figure 13: Share of Prospective Payments out of Total Medical Spending, excluding FFS, excluding Kaiser Permanente and Denver Health, 2024.**

Prospective payments under alternative payment models account for

**36.3%**

of **total APM medical spending**, excluding Kaiser Permanente and Denver Health, in 2024.



## 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 15th, 2025 report, CIVHC received APM submissions from 18 payers in 2025, 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 the 2025 annual APM submission, the HCP LAN category was replaced with the Expanded Non-Claims Payment Framework (or Expanded Framework) to align the CO APCD APM Layout with the Common Data Layout for non-claims payment (CDL-NCP). The Expanded Framework is a new method to categorize and collect non-claims payments data, built upon two models: HCP-LAN and Milbank. The Milbank approach focuses on identifying the purpose of spending, while the HCP-LAN framework categorizes payments based on the level of risk assumed by a provider. In the absence of a national standard for categorizing non-claims payments, the Expanded Framework was created and features more specificity in its categories and subcategories than the Milbank and HCP-LAN frameworks. It also allows for analysis of provider risk by mapping to HCP-LAN categories. For instance, the subcategory, “Population Health and Infrastructure Payments: Practice transformation payments,” is cross-referenced with HCP-LAN category, “Foundational Payments for Infrastructure and Operations”. Another feature of the Expanded Framework is its comprehensive approach to capitation: Category 4, “Capitation and Full Risk Payments,” includes “primary care capitation” and “professional capitation,” which includes specialty services, among its six subcategories. To maintain the consistency of categorization with previous Primary Care reports, CIVHC utilized the Expanded Framework crosswalk provided by the National Association of Health Data Organizations (NAHDO) and presented the payments with the original HCP-LAN categories. Additionally, though not part of the Expanded Framework, payers were directed to continue reporting ‘3N’ and ‘4N’ for Non-Value-Based arrangements. Refer to *Appendix 4* and *Appendix 5* for more information about the Expanded Framework categories/subcategories as well as the mentioned crosswalk.[5]

[5] *This information comes directly from the APM submission manual used by payers and CIVHC.*

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 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 18 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*.

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## Results

### TABLE 1: TOTAL MEDICAL AND PRIMARY CARE SPENDING BY PAYMENT MODEL AND PAYER TYPE (2024)

*Results for 2022-2024 are available in the accompanying Excel document*

**Table 1: Total Medical and Primary Care Spending by Payment Model and Line of Business (2024)**

| Payer Type | Year | Metric | Total Spend | FFS | APM | 2A | 2B | 2C | 3A | 3B | 3N | 4A | 4B | 4C | 4N |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 Total | 2024 | 1 Total Medical Spendi | $ 25,445,773,264.03 | $ 15,355,258,240.10 | $ 10,090,515,023.93 | $ 68,550,589.27 | $- | $ 4,322,576,347.31 | $ 250,344,363.14 | $ 528,755,718.02 | $ 266,028,719.72 | $ 1,297,173,327.70 | $ 1,332,175.02 | $ 2,058,065,069.41 | $ 1,297,688,714.34 |
| 0 Total | 2024 | 2 Primary Care Spendin | $ 3,988,920,291.50 | $ 433,313,736.35 | $ 3,555,606,555.15 | $ 49,227,279.95 | $- | $ 480,304,915.18 | $ 34,861,370.06 | $ 37,599,301.63 | $ 2,504,494.44 | $ 1,136,060,515.94 | $ 433,041.93 | $ 573,679,396.64 | $ 1,240,936,239.38 |
| 0 Total | 2024 | 3 Primary Care % | 15.7% | 2.8% | 35.2% | 71.8% | 0.0% | 11.1% | 13.9% | 7.1% | 0.9% | 87.6% | 32.5% | 27.9% | 95.6% |
| 1 Commercial | 2024 | 1 Total Medical Spendi | $ 8,477,940,874.75 | $ 6,543,255,935.85 | $ 1,934,684,938.90 | $ 14,127,032.81 | $- | $ 456,636,261.32 | $ 183,212,732.22 | $ 148,420,816.31 | $ 29,352.24 | $ 53,634,230.75 | $ 1,271,175.45 | $ 1,073,716,298.04 | $ 3,637,039.76 |
| 1 Commercial | 2024 | 2 Primary Care Spendin | $ 661,316,464.62 | $ 263,127,507.23 | $ 398,188,957.39 | $ 7,475,907.50 | $- | $ 6,201,613.59 | $ 22,278,616.46 | $ 17,079,944.94 | $ - | $ 17,409.31 | $ 433,041.93 | $ 344,702,423.66 | $ - |
| 1 Commercial | 2024 | 3 Primary Care % | 7.8% | 4.0% | 20.6% | 52.9% | 0.0% | 1.4% | 12.2% | 11.5% | 0.0% | 0.0% | 34.1% | 32.1% | 0.0% |
| 2 Medicare Adv | 2024 | 1 Total Medical Spendi | $ 6,896,489,494.77 | $ 2,574,246,576.12 | $ 4,322,242,918.65 | $ 156,825.00 | $- | $ 1,525,289,597.03 | $ 33,713,720.49 | $ 380,334,901.71 | $ 165,596,929.47 | $ 1,606,717.59 | $ 60,999.57 | $ 974,544,073.41 | $ 1,240,939,154.38 |
| 2 Medicare Adv | 2024 | 2 Primary Care Spendin | $ 1,674,446,443.40 | $ 101,435,209.22 | $ 1,573,011,234.18 | $ - | $- | $ 83,981,705.19 | $ 2,110,197.03 | $ 20,519,356.69 | $ 2,504,494.44 | $ 19,521.37 | $ - | $ 222,939,720.08 | $ 1,240,936,239.38 |
| 2 Medicare Adv | 2024 | 3 Primary Care % | 24.3% | 3.9% | 36.4% | 0.0% | 0.0% | 5.5% | 6.3% | 5.4% | 1.5% | 1.2% | 0.0% | 22.9% | 100.0% |
| 3 Medicaid | 2024 | 1 Total Medical Spendi | $ 9,878,698,807.75 | $ 6,055,945,703.75 | $ 3,822,753,104.00 | $ 53,905,749.24 | $- | $ 2,340,046,989.92 | $ 33,417,910.43 | $ - | $ 100,402,438.01 | $ 1,241,867,496.20 | $ - | $ - | $ 53,112,520.20 |
| 3 Medicaid | 2024 | 2 Primary Care Spendin | $ 1,629,319,831.37 | $ 51,376,810.70 | $ 1,577,943,020.67 | $ 41,390,390.23 | $- | $ 390,121,371.77 | $ 10,472,556.57 | $ - | $ - | $ 1,135,958,702.10 | $ - | $ - | $ - |
| 3 Medicaid | 2024 | 3 Primary Care % | 16.5% | 0.8% | 41.3% | 76.8% | 0.0% | 16.7% | 31.3% | 0.0% | 0.0% | 91.5% | 0.0% | 0.0% | 0.0% |
| 4 CHP+ | 2024 | 1 Total Medical Spendi | $ 192,644,086.76 | $ 181,810,024.38 | $ 10,834,062.38 | $ 360,982.22 | $- | $ 603,499.04 | $ - | $ - | $ - | $ 64,883.16 | $ - | $ 9,804,697.96 | $ - |
| 4 CHP+ | 2024 | 2 Primary Care Spendin | $ 23,837,552.11 | $ 17,374,209.20 | $ 6,463,342.91 | $ 360,982.22 | $- | $ 224.63 | $ - | $ - | $ - | $ 64,883.16 | $ - | $ 6,037,252.90 | $ - |
| 4 CHP+ | 2024 | 3 Primary Care % | 12.4% | 9.6% | 59.7% | 100.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 100.0% | 0.0% | 61.6% | 0.0% |
| Unknown | 2024 | 1 Total Medical Spendi | $ - | $ - | $ - | $ - | $- | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Unknown | 2024 | 2 Primary Care Spendin | $ - | $ - | $ - | $ - | $- | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Unknown | 2024 | 3 Primary Care % | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |

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**TABLE 1a: ALTERNATIVE PAYMENT MODELS AS A PERCENTAGE OF PRIMARY CARE SPENDING, BY PAYER TYPE (2024)**

*Results for 2022-2024 are available in the accompanying Excel document*

**Table 1a: Alternative Payment Models as a Percentage of Primary Care Spending by Line of Business (2024)**

| Payer Type | Year | Metric | Total Spend | FFS | APM | 2A | 2B | 2C | 3A | 3B | 3N | 4A | 4B | 4C | 4N |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 Total | 2024 | 1 Primary Care Spending | $ 3,988,920,291.50 | $ 433,313,736.35 | $ 3,555,606,555.15 | $ 49,227,279.95 | $- | $ 480,304,915.18 | $ 34,861,370.06 | $ 37,599,301.63 | $ 2,504,494.44 | $ 1,136,060,515.94 | $ 433,041.93 | $ 573,679,396.64 | $ 1,240,936,239.38 |
| 0 Total | 2024 | 2 Primary Care % | 15.7% | 2.8% | 35.2% | 71.8% | 0.0% | 11.1% | 13.9% | 7.1% | 0.9% | 87.6% | 32.5% | 27.9% | 95.6% |
| 1 Commercial | 2024 | 1 Primary Care Spending | $ 661,316,464.62 | $ 263,127,507.23 | $ 398,188,957.39 | $ 7,475,907.50 | $- | $ 6,201,613.59 | $ 22,278,616.46 | $ 17,079,944.94 | $ - | $ 17,409.31 | $ 433,041.93 | $ 344,702,423.66 | $ - |
| 1 Commercial | 2024 | 2 Primary Care % | 7.8% | 4.0% | 20.6% | 52.9% | 0.0% | 1.4% | 12.2% | 11.5% | 0.0% | 0.0% | 34.1% | 32.1% | 0.0% |
| 2 Medicare Adva | 2024 | 1 Primary Care Spending | $ 1,674,446,443.40 | $ 101,435,209.22 | $ 1,573,011,234.18 | $ - | $- | $ 83,981,705.19 | $ 2,110,197.03 | $ 20,519,356.69 | $ 2,504,494.44 | $ 19,521.37 | $ - | $ 222,939,720.08 | $ 1,240,936,239.38 |
| 2 Medicare Adva | 2024 | 2 Primary Care % | 24.3% | 3.9% | 36.4% | 0.0% | 0.0% | 5.5% | 6.3% | 5.4% | 1.5% | 1.2% | 0.0% | 22.9% | 100.0% |
| 3 Medicaid | 2024 | 1 Primary Care Spending | $ 1,629,319,831.37 | $ 51,376,810.70 | $ 1,577,943,020.67 | $ 41,390,390.23 | $- | $ 390,121,371.77 | $ 10,472,556.57 | $ - | $ - | $ 1,135,958,702.10 | $ - | $ - | $ - |
| 3 Medicaid | 2024 | 2 Primary Care % | 16.5% | 0.8% | 41.3% | 76.8% | 0.0% | 16.7% | 31.3% | 0.0% | 0.0% | 91.5% | 0.0% | 0.0% | 0.0% |
| 4 CHP+ | 2024 | 1 Primary Care Spending | $ 23,837,552.11 | $ 17,374,209.20 | $ 6,463,342.91 | $ 360,982.22 | $- | $ 224.63 | $ - | $ - | $ - | $ 64,883.16 | $ - | $ 6,037,252.90 | $ - |
| 4 CHP+ | 2024 | 2 Primary Care % | 12.4% | 9.6% | 59.7% | 100.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 100.0% | 0.0% | 61.6% | 0.0% |
| Unknown | 2024 | 1 Primary Care Spending | $ - | $ - | $ - | $ - | $- | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Unknown | 2024 | 2 Primary Care % | | | | | | | | | | | | | |

**TABLE 2: PRIMARY CARE SPENDING AND VALUE-BASED APM SPENDING, BY NAMED PAYER (2024)**

*The following tables report medical expenditures stratified by both named payer for 2024.*
*Payers with multiple lines of business appear more than once.*

# Primary Care Spending and Alternative Payment Model Use in Colorado

2022-2024

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**Table 2: Primary Care Spending and Value-based APM Spending by Named Payer (2024)**

| Data Source | LOB | Payer Name | Primary Care Percentage | VB APM Percentage | Primary Care Total | VB APM Total | Total Medical Spend | Prospective Payments | Prospective Percentage | Total Spend AM |
|---|---|---|---|---|---|---|---|---|---|---|
| APM | 1 Commercial | Aetna | 5.2% | 29.8% | $ 34,778,559.66 | $ 197,170,475.30 | $ 662,575,273.90 | $ - | 0.0% | $ 662,575,273.90 |
| APM | 1 Commercial | Anthem | 6.4% | 26.1% | $ 83,905,960.89 | $ 344,111,600.27 | $ 1,316,847,381.60 | $ 12,994,022.69 | 1.0% | $ 1,316,847,381.60 |
| APM | 1 Commercial | Cigna | 3.1% | 3.8% | $ 49,344,454.86 | $ 60,298,026.76 | $ 1,588,350,070.46 | $ 58,033,508.36 | 3.7% | $ 1,588,350,070.46 |
| APM | 1 Commercial | Denver Health | 3.0% | 0.0% | $ 2,910,529.86 | $ - | $ 97,981,676.48 | $ - | 0.0% | $ 97,981,676.48 |
| APM | 1 Commercial | Humana | 3.8% | 0.0% | $ 162,522.80 | $ - | $ 4,262,310.45 | $ - | 0.0% | $ 4,262,310.45 |
| APM | 1 Commercial | Kaiser Permanente | 16.8% | 62.2% | $ 356,137,463.75 | $ 1,321,875,328.78 | $ 2,123,772,096.76 | $ 1,082,156,473.52 | 50.6% | $ 2,137,541,742.67 |
| APM | 1 Commercial | UnitedHealthcare** | 5.0% | 0.3% | $ 123,451,973.05 | $ 7,563,115.79 | $ 2,468,094,134.59 | $ 7,486,055.26 | 0.3% | $ 2,468,093,978.17 |
| APCD | 1 Commercial | Allegiance Benefit Plan Management* | 5.3% | 0.0% | $ 1,278,861.99 | $ - | $ 24,285,525.71 | $ - | 0.0% | $ 24,285,525.71 |
| APCD | 1 Commercial | Ameriben* | 4.7% | 0.0% | $ 1,370,818.39 | $ - | $ 29,308,208.05 | $ - | 0.0% | $ 29,308,208.05 |
| APCD | 1 Commercial | American Enterprise* | 0.0% | 0.0% | $ - | $ - | $ 1,499,007.03 | $ - | 0.0% | $ 1,499,007.03 |
| APCD | 1 Commercial | Employee Benefit Management Services Inc.* | 4.4% | 0.0% | $ 1,040,696.48 | $ - | $ 23,408,819.45 | $ - | 0.0% | $ 23,408,819.45 |
| APCD | 1 Commercial | Friday Health Plans* | 0.0% | 0.0% | $ - | $ - | $ - | $ - | 0.0% | $ - |
| APCD | 1 Commercial | HealthSmart* | 4.7% | 0.0% | $ 11,072.89 | $ - | $ 237,745.99 | $ - | 0.0% | $ 237,745.99 |
| APCD | 1 Commercial | Kaiser Permanente* | 7.1% | 0.0% | $ 973,823.60 | $ - | $ 13,769,645.91 | $ 1,082,156,473.52 | 50.6% | $ 2,137,541,742.67 |
| APCD | 1 Commercial | Meritain Health* | 4.3% | 0.0% | $ 2,554,465.01 | $ - | $ 59,701,058.24 | $ - | 0.0% | $ 59,701,058.24 |
| APCD | 1 Commercial | Select Health* | 4.7% | 0.0% | $ 2,458,974.02 | $ - | $ 51,891,139.04 | $ - | 0.0% | $ 51,891,139.04 |
| APCD | 1 Commercial | UCHealth Plan* | 12.4% | 0.0% | $ 920,836.95 | $ - | $ 7,438,399.33 | $ - | 0.0% | $ - |
| APCD | 1 Commercial | USHEALTH Group* | 0.3% | 0.0% | $ 15,450.42 | $ - | $ 4,518,381.76 | $ - | 0.0% | $ 4,518,381.76 |
| APM | 2 Medicare Advantage | Aetna | 3.5% | 11.3% | $ 13,737,135.89 | $ 44,979,972.52 | $ 397,219,911.67 | $ - | 0.0% | $ 397,219,911.67 |
| APM | 2 Medicare Advantage | Anthem | 4.2% | 11.1% | $ 2,251,598.40 | $ 5,934,913.02 | $ 53,586,895.61 | $ 163,498.59 | 0.4% | $ 38,834,753.30 |
| APM | 2 Medicare Advantage | Denver Health | 1.2% | 0.0% | $ 1,058,561.82 | $ - | $ 92,015,876.97 | $ - | 0.0% | $ 92,015,876.97 |
| APM | 2 Medicare Advantage | Devoted Health | 7.6% | 5.4% | $ 6,132,319.17 | $ 4,312,346.23 | $ 80,389,633.70 | $ 2,884,545.67 | 5.6% | $ 51,493,176.45 |
| APM | 2 Medicare Advantage | Humana | 5.5% | 0.0% | $ 41,114,154.61 | $ - | $ 753,098,356.58 | $ - | 0.0% | $ 704,847,280.31 |
| APM | 2 Medicare Advantage | Kaiser Permanente | 14.5% | 77.9% | $ 226,188,372.03 | $ 1,210,695,970.99 | $ 1,554,691,001.29 | $ 1,011,066,198.94 | 65.0% | $ 1,554,691,001.29 |
| APM | 2 Medicare Advantage | UnitedHealthcare** | 37.0% | 44.6% | $ 1,367,604,502.60 | $ 1,649,783,632.04 | $ 3,696,008,985.95 | $ 1,240,936,239.38 | 33.6% | $ 3,696,008,985.95 |
| APCD | 2 Medicare Advantage | Cigna* | 3.9% | 0.0% | $ 274,086.28 | $ - | $ 7,100,986.97 | $ - | 0.0% | $ 7,100,986.97 |
| APCD | 2 Medicare Advantage | Humana* | 6.1% | 0.0% | $ 16,085,712.60 | $ - | $ 262,377,846.03 | $ - | 0.0% | $ 704,847,280.31 |
| APCD | 2 Medicare Advantage | Select Health* | 0.0% | 0.0% | $ - | $ - | $ - | $ - | 0.0% | $ - |
| APM | 3 Medicaid | 1 HCPF | 17.8% | 39.3% | $ 1,496,875,131.97 | $ 3,298,474,382.17 | $ 8,395,724,934.00 | $ 1,126,407,236.27 | 13.4% | $ 8,391,737,156.24 |
| APM | 3 Medicaid | 3 Carelon: RAEs 2 & 4 (Submitting on behalf of NHP and HCI) | 14.5% | 14.5% | $ 20,414,255.30 | $ 20,414,255.30 | $ 140,426,956.96 | $ 17,354,295.78 | 12.4% | $ 140,210,819.99 |
| APM | 3 Medicaid | 4 Colorado Access: RAEs 3 & 5 | 5.5% | 14.4% | $ 28,954,337.48 | $ 76,066,361.34 | $ 527,574,703.04 | $ 99,779,317.86 | 18.9% | $ 527,574,703.04 |
| APM | 3 Medicaid | 5 Colorado Community Health Alliance: RAEs 6 & 7 | 12.4% | 22.3% | $ 32,691,285.52 | $ 58,575,668.50 | $ 263,217,654.09 | $ 58,575,668.54 | 22.3% | $ 263,217,654.13 |
| APM | 3 Medicaid | 6 Denver Health: MCO | 14.1% | 52.2% | $ 30,993,787.78 | $ 114,445,548.02 | $ 219,234,757.24 | $ - | 0.0% | $ 219,234,757.24 |
| APM | 3 Medicaid | UnitedHealthcare** | 5.8% | 30.5% | $ 19,391,033.32 | $ 101,261,930.46 | $ 332,519,802.42 | $ 68,299,117.68 | 21.0% | $ 324,618,474.87 |
| APM | 4 CHP+ | Colorado Access | 10.8% | 0.3% | $ 14,616,787.87 | $ 360,982.22 | $ 135,064,409.53 | $ - | 0.0% | $ 135,064,409.53 |
| APM | 4 CHP+ | Denver Health | 12.9% | 0.0% | $ 1,788,061.82 | $ - | $ 13,891,321.79 | $ - | 0.0% | $ 13,891,321.79 |
| APM | 4 CHP+ | Kaiser Permanente | 27.3% | 45.6% | $ 6,240,190.13 | $ 10,408,197.00 | $ 22,842,649.04 | $ 9,804,950.31 | 42.9% | $ 22,842,649.04 |
| APM | 4 CHP+ | UnitedHealthcare** | 5.7% | 0.3% | $ 1,192,512.29 | $ 64,883.16 | $ 20,845,706.40 | $ 64,883.16 | 0.3% | $ 20,845,706.40 |
| APCD | Unknown | American Enterprise* | 0.0% | 0.0% | $ - | $ - | $ - | $ - | 0.0% | $ - |
| APCD | Unknown | Select Health* | 0.0% | 0.0% | $ - | $ - | $ - | $ - | 0.0% | $ - |

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## TABLE 2a: PRIMARY CARE SPENDING AND VALUE-BASED APM SPENDING, Medicaid Payers by RAE (2024)

| Table 2a: Primary Care Spending and Value-based APM Spending, Medicaid Payers by RAE (2024) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Data Source | LOB | Payer Name | Primary Care Percentage | VB APM Per | Primary Care Total | VB APM Total | Total Medical Spend | Prospective Payments | Prospective Percentage | Total Spend AM |
| APM | 3 Medicaid | 1a HCPF: RAE 1 | 100.0% | 100.0% | $ 172,438,007.12 | $ 172,438,007.12 | $ 172,438,007.12 | $ 172,438,568.36 | 100.0% | $ 172,438,568.36 |
| APM | 3 Medicaid | 2a HCPF: RAE 2 | 100.0% | 100.0% | $ 58,727,191.53 | $ 58,727,191.53 | $ 58,727,191.53 | $ 58,727,587.53 | 100.0% | $ 58,727,587.53 |
| APM | 3 Medicaid | 2b Carelon: RAE 2 | 39.0% | 39.0% | $ 9,279,888.53 | $ 9,279,888.53 | $ 23,816,623.74 | $ 17,354,295.78 | 72.9% | $ 23,790,391.35 |
| APM | 3 Medicaid | 3a HCPF: RAE 3 | 100.0% | 100.0% | $ 261,074,284.13 | $ 261,074,284.13 | $ 261,074,284.13 | $ 261,075,370.43 | 100.0% | $ 261,075,370.43 |
| APM | 3 Medicaid | 3b Colorado Access: RAE 3 | 6.1% | 16.6% | $ 17,466,180.72 | $ 47,817,754.94 | $ 287,820,576.57 | $ 52,549,279.40 | 18.3% | $ 287,820,576.57 |
| APM | 3 Medicaid | 4a HCPF: RAE 4 | 100.0% | 100.0% | $ 106,608,438.54 | $ 106,608,438.54 | $ 106,608,438.54 | $ 106,608,438.54 | 100.0% | $ 106,608,438.54 |
| APM | 3 Medicaid | 4b Carelon: RAE 4 | 9.5% | 9.5% | $ 11,134,366.77 | $ 11,134,366.77 | $ 116,610,333.22 | $ - | 0.0% | $ 116,420,428.64 |
| APM | 3 Medicaid | 5a HCPF: RAE 5 | 100.0% | 100.0% | $ 155,456,581.03 | $ 155,456,581.03 | $ 155,456,581.03 | $ 155,456,581.03 | 100.0% | $ 155,456,581.03 |
| APM | 3 Medicaid | 5b Colorado Access: RAE 5 | 6.2% | 14.8% | $ 10,464,268.73 | $ 24,994,296.68 | $ 168,543,427.03 | $ 31,801,432.02 | 18.9% | $ 168,543,427.03 |
| APM | 3 Medicaid | 6a HCPF: RAE 6 | 100.0% | 100.0% | $ 134,885,895.76 | $ 134,885,895.76 | $ 134,885,895.76 | $ 134,885,895.76 | 100.0% | $ 134,885,895.76 |
| APM | 3 Medicaid | 6b Colorado Community Health Alliance: RAE 6 | 11.1% | 25.0% | $ 14,701,579.94 | $ 33,260,976.60 | $ 132,871,010.63 | $ 33,260,976.67 | 25.0% | $ 132,871,010.70 |
| APM | 3 Medicaid | 7a HCPF: RAE 7 | 100.0% | 100.0% | $ 114,669,782.70 | $ 114,669,782.70 | $ 114,669,782.70 | $ 114,670,069.11 | 100.0% | $ 114,670,069.11 |
| APM | 3 Medicaid | 7b Colorado Community Health Alliance: RAE 7 | 13.8% | 19.4% | $ 17,989,705.58 | $ 25,314,691.90 | $ 130,346,643.46 | $ 25,314,691.87 | 19.4% | $ 130,346,643.43 |
| APM | 3 Medicaid | Colorado Access RAE 8 | 1.4% | 4.6% | $ 1,023,888.03 | $ 3,254,309.72 | $ 71,210,699.44 | $ 15,428,606.44 | 21.7% | $ 71,210,699.44 |
| APM | 3 Medicaid | Denver Health | 14.1% | 52.2% | $ 30,993,787.78 | $ 114,445,548.02 | $ 219,234,757.24 | $ - | 0.0% | $ 219,234,757.24 |
| APM | 3 Medicaid | HCPF | 5.7% | 30.4% | $ 420,460,156.76 | $ 2,222,059,406.96 | $ 7,319,309,958.79 | $ 49,989,931.11 | 0.7% | $ 7,315,319,851.08 |
| APM | 3 Medicaid | HCPF Rae 8 | 100.0% | 100.0% | $ 72,554,794.40 | $ 72,554,794.40 | $ 72,554,794.40 | $ 72,554,794.40 | 100.0% | $ 72,554,794.40 |
| APM | 3 Medicaid | UnitedHealthcare | 5.8% | 30.5% | $ 19,391,033.32 | $ 101,261,930.46 | $ 332,519,802.42 | $ 68,299,117.68 | 21.0% | $ 324,618,474.87 |

## 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[1].
- 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.
- Continue working with carrier representatives to ensure accurate reporting

[1] Carelon has only submitted non claims behavioral health expenditures in their APM files since 2019, all of which have been categorized as primary care. Since Carelon is offboarding from the CO APCD next year, CIVHC decided to leave this data as is, rather than add in their primary care spending from the APCD in addition to their APM spending.

- Use various payer forums to discuss 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.

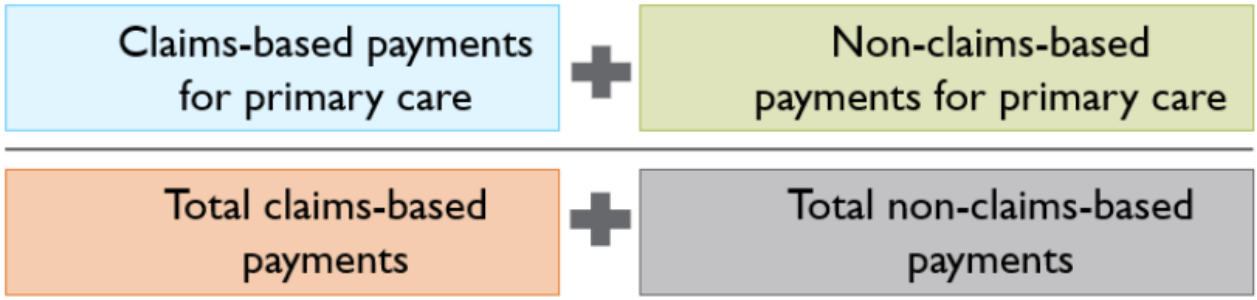
Below is the list of medical submitters that only reimburse providers on a FFS basis or only submit Medicare Supplemental data:

| Payer | Exemption Reason |
|---|---|
| Allegiance Benefit Plan Management | FFS only |
| AmeriBen | FFS only |
| American Enterprise | FFS only |
| Employee Benefits Management Services Inc | FFS only |
| Friday Health Plans | FFS only |
| Harrington Kaiser Permanente | FFS only |
| HealthSmart | FFS only |
| Humana | FFS only |
| Meritain Health | FFS only |
| UCHealth Plan | FFS only |
| UMR | FFS only |
| United Health Care | FFS only |
| USHEALTH Group | FFS only |

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

## Primary Care Calculation

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




**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**:

**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.

**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 *Table 5* below) | + | Primary Care (defined by taxonomies in *Table 3* below) | + | None |
| B | Primary Care (defined by CPT-4 codes in *Table 5* below) | | Other Primary Care (defined by taxonomies in *Table 4* below) | | Primary Care (defined by taxonomies in *Table 3* below) |

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

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

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

## TABLE 3: PRIMARY CARE PROVIDER TAXONOMIES

| Taxonomy Code | Description | Taxonomy Type |
|---|---|---|
| 261QF0400X | Federally Qualified Health Center | Organization |
| 261QP2300X | Primary care clinic | Organization |
| 261QR1300X | Rural Health Center | Organization |

| | | |
|---|---|---|
| 261QC1500X | Community Health | Organization |
| 261QM1000X | Migrant Health | Organization |
| 261QP0904X | Public Health, Federal | Organization |
| 261QS1000X | Student Health | Organization |
| 207Q00000X | Physician, family medicine | Individual |
| 207R00000X | Physician, general internal medicine | Individual |
| 208000000X | Physician, pediatrics | Individual |
| 208D00000X | Physician, general practice | Individual |
| 363LA2200X | Nurse practitioner, adult health | Individual |
| 363LF0000X | Nurse practitioner, family | Individual |
| 363LP0200X | Nurse practitioner, pediatrics | Individual |
| 363LP2300X | Nurse practitioner, primary care | Individual |
| 363LW0102X | Nurse practitioner, women's health | Individual |
| 363AM0700X | Physician's assistant, medical | Individual |
| 207RG0300X | Physician, geriatric medicine, internal medicine | Individual |
| 2083P0500X | Physician, preventive medicine | Individual |
| 364S00000X | Certified clinical nurse specialist | Individual |
| 163W00000X | Nurse, non-practitioner | Individual |
| 207QG0300X | Allopathic & Osteopathic Physicians/Family Medicine, Geriatric Medicine | Individual |
| 207QA0000X | Family Medicine - Adolescent Medicine | Individual |
| 207QA0505X | Family Medicine - Adult Medicine | Individual |

| | | |
|---|---|---|
| 207QB0002X | Family Medicine - Obesity Medicine | Individual |
| 207QG0300X | Family Medicine - Geriatric Medicine | Individual |
| 207QS0010X | Family Medicine - Sports Medicine | Individual |
| 207RA0000X | Internal Medicine - Adolescent Medicine | Individual |
| 207RB0002X | Internal Medicine - Obesity Medicine | Individual |
| 207RS0010X | Internal Medicine - Sports Medicine | Individual |
| 2080A0000X | Pediatrics - Adolescent Medicine | Individual |
| 2080B0002X | Pediatrics - Obesity Medicine | Individual |
| 2080S0010X | Pediatrics - Sports Medicine | Individual |
| 363LC1500X | Nurse Practitioner - Community Health | Individual |
| 363LG0600X | Nurse Practitioner - Gerontology | Individual |
| 363LS0200X | Nurse Practitioner - School | Individual |
| 364SA2200X | Clinical Nurse Specialist - Adult Health | Individual |
| 364SC1501X | Clinical Nurse Specialist - Community Health/Public Health | Individual |
| 364SC2300X | Clinical Nurse Specialist - Chronic Health | Individual |
| 364SF0001X | Clinical Nurse Specialist - Family Health | Individual |
| 364SG0600X | Clinical Nurse Specialist - Gerontology | Individual |
| 364SH1100X | Clinical Nurse Specialist - Holistic | Individual |
| 364SP0200X | Clinical Nurse Specialist - Pediatrics | Individual |
| 364SS0200X | Clinical Nurse Specialist - School | Individual |
| 364SW0102X | Clinical Nurse Specialist - Women's Health | Individual |

| | | |
|---|---|---|
| 207V00000X | Physician, obstetrics and gynecology | OB/GYN |
| 207VG0400X | Physician, gynecology | OB/GYN |
| 363LX0001X | Nurse practitioner, obstetrics and gynecology | OB/GYN |
| 367A00000X | Physician Assistants & Advanced Practice Nursing Providers/Midwife, Certified Nurse | OB/GYN |
| 207VX0000X | OB/GYN- Obstetrics | OB/GYN |

## TABLE 4: OTHER PRIMARY CARE PROVIDER TAXONOMIES

| Taxonomy Code | Description | Taxonomy Type |
|---|---|---|
| 363L00000X | Nurse practitioner | Nurse Practitioner |
| 363A00000X | Physician's assistant | Physician's Assistant |
| 2084P0800X | Physician, general psychiatry | Behavioral Health |
| 2084P0804X | Physician, child and adolescent psychiatry | Behavioral Health |
| 363LP0808X | Nurse practitioner, psychiatric | Behavioral Health |
| 1041C0700X | Behavioral Health & Social Service Providers/Social Worker, Clinical | Behavioral Health |
| 2084P0805X | Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Geriatric Psychiatry | Behavioral Health |
| 2084H0002X | Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Hospice & Palliative Medicine | Behavioral Health |
| 261QM0801X | Ambulatory Health Care Facilities/Clinic/Center, Mental Health- CMHC | Behavioral Health |
| 101Y00000X | Counselor | Behavioral Health |
| 101YA0400X | Counselor - Addiction (SUD) | Behavioral Health |

| | | |
|---|---|---|
| 101YM0800X | Counselor - Mental Health (Note: Counselor working in MAT programs in FQHC) | Behavioral Health |
| 101YP1600X | Counselor - Pastoral | Behavioral Health |
| 101YP2500X | Counselor - Professional (Note: Counselor in FQHC) | Behavioral Health |
| 101YS0200X | Counselor – School | Behavioral Health |
| 102L00000X | Psychoanalyst | Behavioral Health |
| 103T00000X | Psychologist (Note: Clinical Psychologist in FQHC) | Behavioral Health |
| 103TA0400X | Psychologist - Addiction | Behavioral Health |
| 103TA0700X | Psychologist - Adult Development and Aging (Note: Clinical Psychologist in FQHC) | Behavioral Health |
| 103TB0200X | Psychologist - Cognitive and Behavioral | Behavioral Health |
| 103TC0700X | Psychologist - Clinical | Behavioral Health |
| 103TC1900X | Psychologist - Counseling | Behavioral Health |
| 103TC2200X | Psychologist - Clinical Child & Adolescent | Behavioral Health |
| 103TE1000X | Psychologist - Educational | Behavioral Health |
| 103TE1100X | Psychologist - Exercise & Sports | Behavioral Health |
| 103TF0000X | Psychologist - Family | Behavioral Health |
| 103TH0004X | Psychologist - Health | Behavioral Health |
| 103TH0100X | Psychologist - Health Service | Behavioral Health |
| 103TM1700X | Psychologist - Men & Masculinity | Behavioral Health |
| 103TM1800X | Psychologist - Mental Retardation & Developmental Disabilities | Behavioral Health |
| 103TP0016X | Psychologist - Prescribing (Medical) | Behavioral Health |

| | | |
|---|---|---|
| 103TP0814X | Psychologist - Psychoanalysis | Behavioral Health |
| 103TP2700X | Psychologist - Psychotherapy | Behavioral Health |
| 103TP2701X | Psychologist - Group Psychotherapy | Behavioral Health |
| 103TR0400X | Psychologist - Rehabilitation | Behavioral Health |
| 103TS0200X | Psychologist - School | Behavioral Health |
| 103TW0100X | Psychologist - Women | Behavioral Health |
| 104100000X | Social Worker | Behavioral Health |
| 1041S0200X | Social Worker - School | Behavioral Health |
| 106H00000X | Marriage & Family Therapist (Note: Psychotherapist in FQHC) | Behavioral Health |

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

| Procedure Code | Description |
|---|---|
| 10060 | DRAINAGE OF SKIN ABSCESS |
| 10061 | DRAINAGE OF SKIN ABSCESS |
| 10080 | DRAINAGE OF PILONIDAL CYST |
| 10120 | REMOVE FOREIGN BODY |
| 10121 | REMOVE FOREIGN BODY |
| 10160 | PUNCTURE DRAINAGE OF LESION |
| 11000 | DEBRIDE INFECTED SKIN |
| 11055 | TRIM SKIN LESION |
| 11056 | TRIM SKIN LESIONS 2 TO 4 |

| | |
|---|---|
| 11100 | BIOPSY SKIN LESION |
| 11101 | BIOPSY SKIN ADD-ON |
| 11200 | REMOVAL OF SKIN TAGS <W/15 |
| 11201 | REMOVE SKIN TAGS ADD-ON |
| 11300 | SHAVE SKIN LESION 0.5 CM/< |
| 11301 | SHAVE SKIN LESION 0.6-1.0 CM |
| 11302 | SHAVE SKIN LESION 1.1-2.0 CM |
| 11303 | SHAVE SKIN LESION >2.0 CM |
| 11305 | SHAVE SKIN LESION 0.5 CM/< |
| 11306 | SHAVE SKIN LESION 0.6-1.0 CM |
| 11307 | SHAVE SKIN LESION 1.1-2.0 CM |
| 11310 | SHAVE SKIN LESION 0.5 CM/< |
| 11311 | SHAVE SKIN LESION 0.6-1.0 CM |
| 11400 | EXC TR-EXT B9+MARG 0.5 CM< |
| 11401 | EXC TR-EXT B9+MARG 0.6-1 CM |
| 11402 | EXC TR-EXT B9+MARG 1.1-2 CM |
| 11403 | EXC TR-EXT B9+MARG 2.1-3CM |
| 11420 | EXC H-F-NK-SP B9+MARG 0.5/< |
| 11421 | EXC H-F-NK-SP B9+MARG 0.6-1 |
| 11422 | EXC H-F-NK-SP B9+MARG 1.1-2 |
| 11423 | EXC H-F-NK-SP B9+MARG 2.1-3 |
| 11720 | DEBRIDE NAIL 1-5 |

| | |
|---|---|
| 11730 | REMOVAL OF NAIL PLATE |
| 11750 | REMOVAL OF NAIL BED |
| 11765 | EXCISION OF NAIL FOLD TOE |
| 11900 | INJECT SKIN LESIONS </W 7 |
| 11976 | REMOVE CONTRACEPTIVE CAPSULE |
| 11980 | IMPLANT HORMONE PELLET(S) |
| 11981 | INSERT DRUG IMPLANT DEVICE |
| 11982 | REMOVE DRUG IMPLANT DEVICE |
| 11983 | REMOVE/INSERT DRUG IMPLANT |
| 12001 | RPR S/N/AX/GEN/TRNK 2.5CM/< |
| 12042 | INTMD RPR N-HF/GENIT2.6-7.5 |
| 15839 | EXCISE EXCESS SKIN & TISSUE |
| 17000 | DESTRUCT PREMALG LESION |
| 17003 | DESTRUCT PREMALG LES 2-14 |
| 17004 | DESTROY PREMAL LESIONS 15/> |
| 17110 | DESTRUCT B9 LESION 1-14 |
| 17111 | DESTRUCT LESION 15 OR MORE |
| 17250 | CHEM CAUT OF GRANLTJ TISSUE |
| 17281 | DESTRUCTION OF SKIN LESIONS |
| 17340 | CRYOTHERAPY OF SKIN |
| 19000 | DRAINAGE OF BREAST LESION |
| 20005 | I&D ABSCESS SUBFASCIAL |

| | |
|---|---|
| 20520 | REMOVAL OF FOREIGN BODY |
| 20550 | INJ TENDON SHEATH/LIGAMENT |
| 20551 | INJ TENDON ORIGIN/INSERTION |
| 20552 | INJ TRIGGER POINT 1/2 MUSCL |
| 20553 | INJECT TRIGGER POINTS 3/> |
| 20600 | DRAIN/INJ JOINT/BURSA W/O US |
| 20605 | DRAIN/INJ JOINT/BURSA W/O US |
| 20610 | DRAIN/INJ JOINT/BURSA W/O US |
| 20612 | ASPIRATE/INJ GANGLION CYST |
| 36415 | ROUTINE VENIPUNCTURE |
| 36416 | CAPILLARY BLOOD DRAW |
| 54050 | DESTRUCTION PENIS LESION(S) |
| 54056 | CRYOSURGERY PENIS LESION(S) |
| 55250 | REMOVAL OF SPERM DUCT(S) |
| 56405 | I & D OF VULVA/PERINEUM |
| 56420 | DRAINAGE OF GLAND ABSCESS |
| 56501 | DESTROY VULVA LESIONS SIM |
| 56515 | DESTROY VULVA LESION/S COMPL |
| 56605 | BIOPSY OF VULVA/PERINEUM |
| 56606 | BIOPSY OF VULVA/PERINEUM |
| 56820 | EXAM OF VULVA W/SCOPE |
| 56821 | EXAM/BIOPSY OF VULVA W/SCOPE |

| | |
|---|---|
| 57061 | DESTROY VAG LESIONS SIMPLE |
| 57100 | BIOPSY OF VAGINA |
| 57105 | BIOPSY OF VAGINA |
| 57135 | REMOVE VAGINA LESION |
| 57150 | TREAT VAGINA INFECTION |
| 57170 | FITTING OF DIAPHRAGM/CAP |
| 57410 | PELVIC EXAMINATION |
| 57420 | EXAM OF VAGINA W/SCOPE |
| 57421 | EXAM/BIOPSY OF VAG W/SCOPE |
| 57452 | EXAM OF CERVIX W/SCOPE |
| 57454 | BX/CURETT OF CERVIX W/SCOPE |
| 57455 | BIOPSY OF CERVIX W/SCOPE |
| 57456 | ENDOCERV CURETTAGE W/SCOPE |
| 57500 | BIOPSY OF CERVIX |
| 57505 | ENDOCERVICAL CURETTAGE |
| 58100 | BIOPSY OF UTERUS LINING |
| 58110 | BX DONE W/COLPOSCOPY ADD-ON |
| 58120 | DILATION AND CURETTAGE |
| 58300 | INSERT INTRAUTERINE DEVICE |
| 58301 | REMOVE INTRAUTERINE DEVICE |
| 59025 | FETAL NON-STRESS TEST |
| 59200 | INSERT CERVICAL DILATOR |

| | |
|---|---|
| 59300 | EPISIOTOMY OR VAGINAL REPAIR |
| 59400 | OBSTETRICAL CARE |
| 59409 | OBSTETRICAL CARE |
| 59410 | OBSTETRICAL CARE |
| 59412 | Vaginal Delivery, Antepartum and Postpartum Care Procedures * 60% of payment |
| 59414 | Under Vaginal Delivery, Antepartum and Postpartum Care Procedures * 60% of payment |
| 59425 | ANTEPARTUM CARE ONLY |
| 59426 | ANTEPARTUM CARE ONLY |
| 59430 | CARE AFTER DELIVERY |
| 59510 | CESAREAN DELIVERY |
| 59514 | CESAREAN DELIVERY ONLY |
| 59515 | CESAREAN DELIVERY |
| 59515 | Cesarean delivery only * 60% of payment |
| 59610 | Routine obstetric care incl. VBAC delivery * 60% of payment |
| 59612 | Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps) * 60% of payment |
| 59614 | Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care * 60% of payment |
| 59618 | ATTEMPTED VBAC DELIVERY |
| 59620 | Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery * 60% of payment |
| 59622 | Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care * 60% of payment |

| | |
|---|---|
| 59820 | CARE OF MISCARRIAGE |
| 69200 | CLEAR OUTER EAR CANAL |
| 69209 | REMOVE IMPACTED EAR WAX UNI |
| 69210 | REMOVE IMPACTED EAR WAX UNI |
| 76801 | OB US < 14 WKS SINGLE FETUS |
| 76802 | OB US < 14 WKS ADDL FETUS |
| 76805 | OB US >= 14 WKS SNGL FETUS |
| 76810 | OB US >= 14 WKS ADDL FETUS |
| 76811 | OB US DETAILED SNGL FETUS |
| 76812 | OB US DETAILED ADDL FETUS |
| 76813 | OB US NUCHAL MEAS 1 GEST |
| 76814 | OB US NUCHAL MEAS ADD-ON |
| 76815 | OB US LIMITED FETUS(S) |
| 76816 | OB US FOLLOW-UP PER FETUS |
| 76817 | TRANSVAGINAL US OBSTETRIC |
| 76818 | FETAL BIOPHYS PROFILE W/NST |
| 76819 | FETAL BIOPHYS PROFIL W/O NST |
| 90460 | IM ADMIN 1ST/ONLY COMPONENT |
| 90461 | IM ADMIN EACH ADDL COMPONENT |
| 90471 | IMMUNIZATION ADMIN |
| 90472 | IMMUNIZATION ADMIN EACH ADD |
| 90473 | IMMUNE ADMIN ORAL/NASAL |

| | |
|---|---|
| 90474 | IMMUNE ADMIN ORAL/NASAL ADDL |
| 90785 | PSYTX COMPLEX INTERACTIVE |
| 90791 | PSYCH DIAGNOSTIC EVALUATION |
| 90792 | PSYCH DIAG EVAL W/MED SRVCS |
| 90832 | PSYTX W PT 30 MINUTES |
| 90833 | PSYTX W PT W E/M 30 MIN |
| 90834 | PSYTX W PT 45 MINUTES |
| 90837 | PSYTX W PT 60 MINUTES |
| 90846 | FAMILY PSYTX W/O PT 50 MIN |
| 90847 | FAMILY PSYTX W/PT 50 MIN |
| 92551 | PURE TONE HEARING TEST AIR |
| 92552 | PURE TONE AUDIOMETRY AIR |
| 92558 | EVOKED AUDITORY TEST QUAL |
| 92567 | TYMPANOMETRY |
| 92585 | AUDITOR EVOKE POTENT COMPRE |
| 92587 | EVOKED AUDITORY TEST LIMITED |
| 92588 | EVOKED AUDITORY TST COMPLETE |
| 94010 | BREATHING CAPACITY TEST |
| 94014 | PATIENT RECORDED SPIROMETRY |
| 94015 | PATIENT RECORDED SPIROMETRY |
| 94016 | REVIEW PATIENT SPIROMETRY |
| 94060 | EVALUATION OF WHEEZING |

| | |
|---|---|
| 94070 | EVALUATION OF WHEEZING |
| 94375 | RESPIRATORY FLOW VOLUME LOOP |
| 96101 | PSYCHO TESTING BY PSYCH/PHYS |
| 96102 | PSYCHO TESTING BY TECHNICIAN |
| 96103 | PSYCHO TESTING ADMIN BY COMP |
| 96110 | DEVELOPMENTAL SCREEN W/SCORE |
| 96111 | DEVELOPMENTAL TEST EXTEND |
| 96127 | BRIEF EMOTIONAL/BEHAV ASSMT |
| 96150 | ASSESS HLTH/BEHAVE INIT |
| 96151 | ASSESS HLTH/BEHAVE SUBSEQ |
| 96156 | Health behavior assessment or re-assessment |
| 96160 | PT-FOCUSED HLTH RISK ASSMT |
| 96161 | CAREGIVER HEALTH RISK ASSMT |
| 96372 | THER/PROPH/DIAG INJ SC/IM |
| 97802 | MEDICAL NUTRITION INDIV IN |
| 97803 | MED NUTRITION INDIV SUBSEQ |
| 97804 | MEDICAL NUTRITION GROUP |
| 98925 | OSTEOPATH MANJ 1-2 REGIONS |
| 98926 | OSTEOPATH MANJ 3-4 REGIONS |
| 98927 | OSTEOPATH MANJ 5-6 REGIONS |
| 98928 | OSTEOPATH MANJ 7-8 REGIONS |
| 98929 | OSTEOPATH MANJ 9-10 REGIONS |

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

| | |
|---|---|
| 99204 | OFFICE/OUTPATIENT VISIT NEW |
| 99205 | OFFICE/OUTPATIENT VISIT NEW |
| 99211 | OFFICE/OUTPATIENT VISIT EST |
| 99212 | OFFICE/OUTPATIENT VISIT EST |
| 99213 | OFFICE/OUTPATIENT VISIT EST |
| 99214 | OFFICE/OUTPATIENT VISIT EST |
| 99215 | OFFICE/OUTPATIENT VISIT EST |
| 99334 | DOMICIL/R-HOME VISIT EST PAT |
| 99336 | DOMICIL/R-HOME VISIT EST PAT |
| 99337 | DOMICIL/R-HOME VISIT EST PAT |
| 99339 | Individual physician supervision of a patient requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian), and/or key caregiver(s) involved in patient's care; integration of new information into the medical treatment plan; and/or adjustment of medical therapy, within a calendar month; 15-29 minutes |
| 99340 | 30 minutes or more |
| 99341 | HOME VISIT NEW PATIENT |
| 99342 | HOME VISIT NEW PATIENT |
| 99343 | HOME VISIT NEW PATIENT |
| 99344 | HOME VISIT NEW PATIENT |
| 99345 | HOME VISIT NEW PATIENT |

| | |
|---|---|
| 99347 | HOME VISIT EST PATIENT |
| 99348 | HOME VISIT EST PATIENT |
| 99349 | HOME VISIT EST PATIENT |
| 99350 | HOME VISIT EST PATIENT |
| 99354 | PROLONG E&M/PSYCTX SERV O/P |
| 99355 | PROLONG E&M/PSYCTX SERV O/P |
| 99358 | PROLONG SERVICE W/O CONTACT |
| 99359 | PROLONG SERV W/O CONTACT ADD |
| 99366 | TEAM CONF W/PAT BY HC PROF |
| 99367 | With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician |
| 99368 | With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional |
| 99381 | INIT PM E/M NEW PAT INFANT |
| 99382 | INIT PM E/M NEW PAT 1-4 YRS |
| 99383 | PREV VISIT NEW AGE 5-11 |
| 99384 | PREV VISIT NEW AGE 12-17 |
| 99385 | PREV VISIT NEW AGE 18-39 |
| 99386 | PREV VISIT NEW AGE 40-64 |
| 99387 | INIT PM E/M NEW PAT 65+ YRS |
| 99391 | PER PM REEVAL EST PAT INFANT |
| 99392 | PREV VISIT EST AGE 1-4 |

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

| | |
|---|---|
| 99441 | PHONE E/M PHYS/QHP 5-10 MIN |
| 99442 | PHONE E/M PHYS/QHP 11-20 MIN |
| 99443 | PHONE E/M PHYS/QHP 21-30 MIN |
| 99444 | ONLINE E/M BY PHYS/QHP |
| 99451 | Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time |
| 99452 | Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, > 16 minutes |
| 99455 | WORK RELATED DISABILITY EXAM |
| 99456 | DISABILITY EXAMINATION |
| 99457 | Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes |
| 99458 | each additional 20 minutes (List separately in addition to code for primary procedure |
| 99461 | INIT NB EM PER DAY NON-FAC |
| 99473 | Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration |
| 99474 | separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient |
| 99484 | CARE MGMT SVC BHVL HLTH COND |

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| 99487 | CMPLX CHRON CARE W/O PT VSIT |
| 99489 | CMPLX CHRON CARE ADDL 30 MIN |
| 99490 | CHRON CARE MGMT SRVC 20 MIN |
| 99491 | Chronic care management services at least 30 minutes |
| 99492 | 1ST PSYC COLLAB CARE MGMT |
| 99493 | SBSQ PSYC COLLAB CARE MGMT |
| 99494 | 1ST/SBSQ PSYC COLLAB CARE |
| 99495 | TRANS CARE MGMT 14 DAY DISCH |
| 99496 | TRANS CARE MGMT 7 DAY DISCH |
| 99497 | ADVNCD CARE PLAN 30 MIN |
| 99498 | ADVNCD CARE PLAN ADDL 30 MIN |
| 0500F | INITIAL PRENATAL CARE VISIT |
| 0501F | PRENATAL FLOW SHEET |
| 0502F | SUBSEQUENT PRENATAL CARE |
| 0503F | POSTPARTUM CARE VISIT |
| 1000F | TOBACCO USE ASSESSED |
| 1031F | SMOKING & 2ND HAND ASSESSED |
| 1032F | PT received Tobacco Cessation Information |
| 1033F | TOBACCO NONSMOKER NOR 2NDHND |
| 1034F | CURRENT TOBACCO SMOKER |
| 1035F | SMOKELESS TOBACCO USER |
| 1036F | TOBACCO NON-USER |

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| 1111F | DSCHRG MED/CURRENT MED MERGE |
| 1220F | PT SCREENED FOR DEPRESSION |
| 3016F | PT SCRND UNHLTHY OH USE |
| 3085F | SUICIDE RISK ASSESSED |
| 3351F | NEG SCRN DEP SYMP BY DEPTOOL |
| 3352F | NO SIG DEP SYMP BY DEP TOOL |
| 3353F | MILD-MOD DEP SYMP BY DEPTOOL |
| 3354F | CLIN SIG DEP SYM BY DEP TOOL |
| 3355F | CLIN SIG DEP SYM BY DEP TOOL |
| 4000F | TOBACCO USE TXMNT COUNSELING |
| 4001F | TOBACCO USE TXMNT PHARMACOL |
| 4004F | PT TOBACCO SCREEN RCVD TLK |
| 4290F | Alcohol and/or drug assessment or screening |
| 4293F | Pt screened for high risk sexual behavior |
| 4306F | Alcohol and/or Drug use counseling services |
| 4320F | Alcohol and/or Drug use counseling services |
| 90848-90899 | Services to patients for evaluation and treatment of mental illnesses that require psychiatric services |
| 96158-96159 | Health behavior intervention, individual face-to-face |
| 96164-96165 | Health behavior intervention, group (two or more patients), face-to-face |
| 96167-96168 | Health behavior intervention, family (with the patient present), face-to-face |

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| 96170-96171 | Health behavior intervention, family (without the patient present), face-to-face |
| 97151-97158 | Behavior Identification Assessment, administered by QHP, each 15 minutes of QHP's time face-to-face with patient and/or guardian(s)/caregivers(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan |
| 98967-98968 | Non-physician telephone services |
| G0008 | ADMIN INFLUENZA VIRUS VAC |
| G0009 | ADMIN PNEUMOCOCCAL VACCINE |
| G0010 | ADMIN HEPATITIS B VACCINE |
| G0101 | CA SCREEN; PELVIC/BREAST EXAM |
| G0123 | SCREEN CERV/VAG THIN LAYER |
| G0179 | MD RECERTIFICATION HHA PT |
| G0180 | MD CERTIFICATION HHA PATIENT |
| G0270 | Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes |
| G0271 | Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes |
| G0396 | ALCOHOL/SUBS INTERV 15-30MN |
| G0397 | Alcohol or substance abuse assessment |
| G0402 | INITIAL PREVENTIVE EXAM |

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| G0403 | EKG FOR INITIAL PREVENT EXAM |
| G0404 | EKG TRACING FOR INITIAL PREV |
| G0405 | EKG INTERPRET & REPORT PREVE |
| G0438 | PPPS, INITIAL VISIT |
| G0439 | PPPS, SUBSEQ VISIT |
| G0442 | ANNUAL ALCOHOL SCREEN 15 MIN |
| G0443 | BRIEF ALCOHOL MISUSE COUNSEL |
| G0444 | DEPRESSION SCREEN ANNUAL |
| G0445 | HIGH INTEN BEH COUNS STD 30M |
| G0447 | BEHAVIOR COUNSEL OBESITY 15M |
| G0463 | HOSPITAL OUTPT CLINIC VISIT |
| G0476 | HPV COMBO ASSAY CA SCREEN |
| G0502 | Initial psychiatric collaborative care management |
| G0503 | Subsequent psychiatric collaborative care management |
| G0504 | Initial or subsequent psychiatric collaborative care management |
| G0505 | Cognition and functional assessment |
| G0506 | COMP ASSES CARE PLAN CCM SVC |
| G0507 | Care management services for behavioral health conditions |
| G0513 | PROLONG PREV SVCS, FIRST 30M |
| G0514 | Prolonged preventive service |
| G2058 | Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month; |

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| G2064-G2065 | Comprehensive care management services for a single high-risk disease |
| H0002 | ALCOHOL AND/OR DRUG SCREENIN |
| H0031 | MH HEALTH ASSESS BY NON-MD |
| H0049 | ALCOHOL/DRUG SCREENING |
| H1000 | PRENATAL CARE ATRISK ASSESSM |
| H1001 | ANTEPARTUM MANAGEMENT |
| Q0091 | OBTAINING SCREEN PAP SMEAR |
| S0610 | ANNUAL GYNECOLOGICAL EXAMINA |
| S0612 | ANNUAL GYNECOLOGICAL EXAMINA |
| S0613 | ANN BREAST EXAM |
| S0622 | PHYS EXAM FOR COLLEGE |
| S9444 | Parenting Classes, non-physician provider, per session |
| S9445 | PT EDUCATION NOC INDIVID |
| S9446 | PT EDUCATION NOC GROUP |
| S9447 | Infant safety (including cardiopulmonary resuscitation classes nonphysician provider, per session) |
| S9449 | WEIGHT MGMT CLASS |
| S9451 | EXERCISE CLASS |
| S9452 | Nutrition classes non-physician provider per session |
| S9454 | Stress management classes non-physician provider per session |
| S9470 | NUTRITIONAL COUNSELING, DIET |
| T1015 | CLINIC SERVICE |

## Appendix 3. Payment Arrangement Categories[6]

| 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 | Payments representing a share of savings generated when a cost or utilization target is met and no quality targets |

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| | Linked to Quality | exist (e.g., episode-based payments for procedures without quality measures and targets). |
| 4A | Condition-Specific Population-Based Payment | Payments for the comprehensive treatment of specific conditions (e.g., payments for specialty services, such as oncology or mental health). Bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering only chemotherapy payments. Also, payments that are prospective and population-based and cover all care delivered by particular types of clinicians (e.g., orthopedics). |
| 4B | Comprehensive Population-Based Payment | Payments that are prospective and population-based, and cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct, (e.g. global budgets or full/percent of premium payments). |
| 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. |

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

## Appendix 4. Expanded Framework Categories and HCP-LAN Categories

| Expanded Framework Category | Non-claims-based payment categories and subcategories | Corresponding HCP-LAN Category |
|---|---|---|
| A | Population Health and Infrastructure Payments | |
| A1 | Care management/care coordination/population health/medication reconciliation | 2A |
| A2 | Primary care and behavioral health integration | 2A |
| A3 | Social care integration | 2A |
| A4 | Practice transformation payments | 2A |
| A5 | EHR/HIT infrastructure and other data analytics payments | 2A |
| B | Performance Payments | |
| B1 | Pay-for-reporting payment | 2B |
| B2 | Pay-for-performance payments | 2C |
| C | Shared Savings Payments and Recoupments | |
| C1 | Procedure-related, episode-based payments with shared savings | 3A, 3N |
| C2 | Procedure-related, episode-based payments with risk of recoupments | 3B, 3N |
| C3 | Condition-related, episode-based payments with shared savings | 3A, 3N |
| C4 | Condition-related, episode-based payments with risk of recoupments | 3B, 3N |

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| C5 | Risk for total cost of care (e.g., ACO) with shared savings | 3A, 3N |
| C6 | Risk for total cost of care (e.g., ACO) with risk of recoupments | 3B, 3N |
| D | Capitation and Full Risk Payments | |
| D1 | Primary Care Capitation | 4A, 4N |
| D2 | Professional Capitation | 4A, 4N |
| D3 | Facility Capitation | 4A, 4N |
| D4 | Behavioral Health Capitation | 4A, 4N |
| D5 | Global Capitation | 4B, 4N |
| D6 | Payments to Integrated, Comprehensive Payment and Delivery Systems | 4C, 4N |
| E | Other Non-Claims Payments | |
| X | Fee for Service | |
| X9 | Fee for Service | 01 |
| Z | Member Count | |

## Appendix 5. Expanded Framework Categories Definitions

| Category Code | Non-claims-based payment categories and subcategories | Definition |
|---|---|---|
| A | Population Health and Infrastructure Payments | Prospective, non-claims payments paid to healthcare providers or organizations to support specific care delivery goals; not tied to performance metrics. Does not include costs associated with payer personnel, payer information technology systems or other internal payer expenses. |

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| A1 | Care management/care coordination/population health/medication reconciliation | Prospective, non-claims payments paid to healthcare providers or organizations to fund a care manager, care coordinator, or other traditionally non-billing practice team members (e.g., practice coach, patient educator, patient navigator, pharmacist, or nurse care manager) who helps providers organize clinics to function better and helps patients take charge of their health. |
| A2 | Primary care and behavioral health integration | Prospective, non-claims payments paid to healthcare providers or organizations to fund the integration of primary care and behavioral health and related services that are not typically reimbursed through claims (e.g., funding behavioral health services not traditionally covered with a fee-for-service payment when provided in a primary care setting). Examples of these services include a) substance use disorder or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, c) supporting health behavioral change, such as diet and exercise for managing pre-diabetes risk, d) brief interventions with a social worker or other behavioral health clinician not reimbursed via claims. |
| A3 | Social care integration | Prospective, non-claims payments paid to healthcare providers or organizations to support screening for health-related social needs, connections to social services and other interventions to address patients' social needs, such as housing or food insecurity, that are not typically reimbursed through claims. |
| A4 | Practice transformation payments | Prospective, non-claims payments paid to healthcare providers or organizations to support practice transformation which may include care team members not typically reimbursed by claims, technical assistance and training, and analytics. |
| A5 | EHR/HIT infrastructure and other data analytics payments | Prospective, non-claims payments paid to healthcare providers or organizations to support providers in adopting and utilizing health information technology, such as electronic medical records and health |

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| | | information exchanges, software that enables practices to analyze quality and/or costs, and/or the cost of a data analyst to support practices. |
| B | Performance Payments | Non-claims bonus payments paid to healthcare providers or organizations for reporting data or achieving specific goals for quality, cost reduction, equity, or another performance achievement domain. |
| B1 | Pay-for-reporting payment | Non-claims bonus payments paid to healthcare providers or organizations for reporting data related to quality, cost reduction, equity, or another performance achievement domain. |
| B2 | Pay-for-performance payments | Non-claims bonus payments paid to healthcare providers or organizations for achieving specific, predefined goals for quality, cost reduction, equity, or another performance achievement domain. |
| C | Shared Savings Payments and Recoupments | Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. Dollars reported in this category should reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component. Recouped dollars should be reported as a negative value. Payments in this category are considered "linked to quality" if the shared savings payment or any other component of the provider's payment was adjusted based on specific predefined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the shared savings payment, then the shared savings payment would be considered "linked to quality." |
| C1 | Procedure-related, episode-based | Non-claims payments to healthcare providers or organizations for a procedure-based episode (e.g., |

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| | payments with shared savings | joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for- service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. |
| C2 | Procedure-related, episode-based payments with risk of recoupments | Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a procedure- based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. |
| C3 | Condition-related, episode-based payments with shared savings | Non-claims payments to healthcare providers or organizations for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for- service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. |

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| C4 | Condition-related, episode-based payments with risk of recoupments | Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. |
| C5 | Risk for total cost of care (e.g., ACO) with shared savings | Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for- service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 40% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.” Providers that would be classified by CMS as “low revenue” may be eligible for shared savings at a lower rate of 20% if they do not meet minimum savings requirements. |
| C6 | Risk for total cost of care (e.g., ACO) with risk of recoupments | Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for- service payment. Payment models in this subcategory should be based |

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| | | on fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer<br><br>providers with a minimum of 50% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.” Providers that would be classified by CMS as “low revenue” may be eligible for shared savings at a lower rate of 25% if they do not meet minimum shared savings requirements. These models also must put providers at risk for at least 30% losses. Models offering less than this degree of risk are classified as “Risk for total cost of care with shared savings.” |
| D | Capitation and Full Risk Payments | Per capita, non-claims payments paid to healthcare providers or organizations to provide a defined set of services to a designated population of patients over a defined period of time. Payments in this category are considered “linked to quality” if the capitation payment or any other component of the provider’s payment was adjusted based on specific, pre-defined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the capitation payment, then the capitation payment would be considered “linked to quality.” |
| D1 | Primary Care Capitation | Per capita, non-claims payments paid to healthcare organizations or providers to provide primary care services to a designated patient population over a defined period of time. Services are restricted to primary care services performed by primary care teams. |
| D2 | Professional Capitation | Per capita, non-claims payments paid to healthcare organizations or providers to provide professional services to a designated patient population over a defined period of time. Services typically include primary care clinician, specialty care physician |

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| | | services, and other professional and ancillary services. |
| D3 | Facility Capitation | Per capita, non-claims payments paid to healthcare organizations or providers to provide inpatient and outpatient facility services to a designated patient population over a defined period of time. |
| D4 | Behavioral Health Capitation | Per capita, non-claims payments paid to healthcare organizations or providers to provide behavioral health services to a designated patient population over a defined period of time. May include professional, facility, and/or residential services. |
| D5 | Global Capitation | Per capita, non-claims payments paid to healthcare organizations or providers to provide comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital, and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out. |
| D6 | Payments to Integrated, Comprehensive Payment and Delivery Systems | Per capita, non-claims payments paid to healthcare organizations and providers to provide a comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out. This category differs from the global capitation category because the provider organization and the payer organization are a single, integrated entity. |
| E | Other Non-Claims Payments | Any other payments to a healthcare provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit. It also includes |

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| | | governmental payer grants and shortfall payments to providers (e.g., Disproportionate Share Hospital payments and FQHC wraparound payments). |
| X9 | Fee for Service | |
| Z9 | Member Count | |

For additional information regarding the Expanded Framework, please see:

https://www.milbank.org/2024/03/a-new-standard-for-categorizing-and-collecting-non-claims-payment-data/

https://hcai.ca.gov/affordability/ohca/expanded-non-claims-payments-framework/