



California Department of Health Care Access and Information (HCAI)

Office of Health Care Affordability (OHCA)

# Total Health Care Expenditures Data Submission Guide

Version ~~4.1~~2.0

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## Version History

Version	Date	Summary of Changes
1.0	February 2024	
1.1	June 2024	<ul style="list-style-type: none"> <li>Added RR99 (Unspecified Region) code, added non-spatial Los Angeles ZIP codes, and corrected typographical errors in Appendix C: Regions</li> </ul>
<u>2.0</u>	<u>April 2025</u>	<ul style="list-style-type: none"> <li><u>Added requirement for health plans, health insurers, or other payers to submit separate registrations</u></li> <li><u>Added new Alternative Payment Model (APM) file (Section 5.8), associated payment allocation instructions (Section 4.8), and condition and procedure types (Appendix D)</u></li> <li><u>Added new Primary Care file (Section 5.9), associated allocation methodology (Section 4.9), and code sets (Appendix E)</u></li> <li><u>Added Section 4.3.1 Exclusions</u></li> <li><u>Updated dual eligibles descriptions in Section 4.4 Market Categories</u></li> <li><u>Revised attribution methodologies and instructions in Section 4.5 Member Attribution</u></li> <li><u>Removed Payment Arrangement field from Statewide TME file</u></li> <li><u>Added Taxpayer Identification Number and National Provider Identifier fields to Attributed TME file</u></li> <li><u>Split Member Responsibility field by claims and capitation payments on Statewide, Attributed, and Regional TME files</u></li> <li><u>Added fields to capture estimated benefit amounts for the Commercial (Partial Benefits) market category to the Submitter Questionnaire file</u></li> <li><u>Updated non-claims payment category descriptions and added subcategory descriptions to Appendix B: Expanded Non-Claims Payments Framework</u></li> <li><u>Removed Los Angeles Service Planning Areas (SPAs) from Appendix C: Regions</u></li> </ul>

## 1 Introduction

This Total Health Care Expenditures (THCE) Data Submission Guide (the “Guide”) is intended for use by payers and fully integrated delivery systems (“submitters”) when extracting and aggregating data for submission to the Office of Health Care Affordability (OHCA). This Guide provides technical specifications, file layouts, reporting schedules, and other instructions to ensure the submission of accurate THCE data in a standardized format. The submitter interactions described in this Guide will occur via the secure THCE Data Portal, which is the platform for submitter registration, data submission, and submission status information.

Payers and fully integrated delivery systems are required to submit data and other information necessary for OHCA to measure THCE and per capita THCE pursuant to Health and Safety Code section 127501.4 of the California Health Care Quality and Affordability Act (the “Act”) and its implementing regulations.<sup>1</sup> OHCA’s purpose and reporting responsibilities, including types of data collection and submitters, are broadly defined in the Act. OHCA actively maintains a website (<https://hcai.ca.gov/ohca/>) with information about OHCA’s mission, including background, links to state statutes and regulations, a link to this Guide and the THCE Data Portal, contact information, and other resources for submitters.

For additional detail on whether a payer or fully integrated delivery system meets OHCA’s criteria to submit THCE data on a mandatory basis (“required submitter”) versus a voluntary basis (“voluntary submitter”), refer to the Act’s implementing regulations, which incorporate this Guide by reference, in Article 2 of Chapter 11.5 of Division 7 of Title 22 of the California Code of Regulations, starting with Section 97445.

### 1.1 Contact Information

OHCA program and data management vendor staff are available to answer questions regarding the process and mechanics of data submission and technical issues regarding the covered population, contents of data files and elements, and reporting timeframes.

For program questions about OHCA, contact [ohca@hcai.ca.gov](mailto:ohca@hcai.ca.gov) or visit <https://hcai.ca.gov/ohca>.

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<sup>1</sup> California Health and Safety Code sections 127500 *et seq.* (Health Care Quality and Affordability Act).

For technical assistance or for questions related to data specifications, mapping, or submission results, contact OHCA's data management vendor, Onpoint, at [ohca-support@onpointhealthdata.org](mailto:ohca-support@onpointhealthdata.org) or 207-623-2555.

## 1.2 Data Submission Deadlines

~~OHCA's first public reporting of THCE data will be on baseline health care spending for covered health care benefits received by California residents during calendar years 2022 and 2023 (the "Baseline Report"). For purposes of the Baseline Report, payers and fully integrated delivery systems are required to submit THCE data by the statutory deadline of September 1, 2024. OHCA will release the Baseline Report by June 1, 2025. OHCA plans to release a supplementary report on implementation of the Health Care Quality and Affordability Act by June 1, 2026. For this supplementary report, payers and fully integrated delivery systems will be required to submit THCE data for reporting years 2023 and 2024 on or before September 1, 2025.~~ OHCA plans to release a report on health care spending for covered health care benefits received by California residents during calendar years 2023 and 2024 by June 1, 2026. For this report, payers and fully integrated delivery systems are required to submit THCE data on or before September 1, 2025.

On or before June 1, 2027, and annually thereafter, OHCA will prepare and publish annual reports concerning health care spending trends and underlying factors, including OHCA's policy recommendations to control costs and improve quality performance and equity of the health care system, while maintaining access to care and high-quality jobs and workforce stability.

For purposes of ongoing annual reporting, payers and fully integrated delivery systems will be required to submit THCE data on or before September 1st of each year. If an annual submission deadline falls on a weekend or state holiday, the due date is the next business day. Submitters will extract and submit data for the previous two calendar years with each annual submission.

Files may be submitted individually as they are ready; however, a submission will not be deemed complete until all required files are received.

## 1.3 Changes to this Guide

Consistent with Health and Safety Code section 127501.4(k), prior to making changes to this Guide, OHCA will engage with relevant stakeholders, hold a public meeting to solicit input, and provide a response to input received.

For notice of potential regulatory actions or public meetings, subscribe to OHCA's email listservs at <https://hcai.ca.gov/mailing-list/>.

## 2 Submitter Registration

~~All~~ Each year, all submitters must register to submit data to the THCE Data Portal, available from <https://hcai.ca.gov/login/>. This includes all required submitters and any approved voluntary submitters. Required submitters identified by OHCA will receive an email with a link to register in the THCE Data Portal. Any required submitters who do not receive a link to register and any entities who wish to request approval to submit on a voluntary basis must contact OHCA at [ohca@hcai.ca.gov](mailto:ohca@hcai.ca.gov).

~~In the first year of data collection, submitters shall submit a completed registration by April 30, 2024. In subsequent years,~~ Submitters shall complete separate registrations for each health plan, health insurer, or other payer as defined in 22 CCR 97445, for which they will report THCE data. Submitters shall complete registration annually by the ~~end~~ last business day of May.

During the registration process, all submitters will provide the following information:

1. Legal entity name and address
2. License Type and License Number
3. National Association of Insurance Commissioners (NAIC) Code(s),<sup>2</sup> if applicable, for any health insurers for which the submitter will be reporting THCE data
4. Parent company name
5. ~~2.~~ Market Category(ies) for which the submitter will report data. Refer to Market Categories for more information.
  - Commercial (Full Benefits)
  - Commercial (Partial Benefits)
  - Medi-Cal Managed Care<sup>23</sup>
  - Medicare Advantage
  - ~~Medi-Cal Expenses for~~ Dual Eligibles (Medi-Cal Expenses Only)<sup>34</sup>
  - ~~Medicare Expenses for~~ Dual Eligibles (Medicare Expenses Only)

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<sup>24</sup> Registrants shall use the NAIC code(s) required by the California Department of Insurance when filing pursuant to 10 CCR 2308.1.

<sup>32</sup> ~~Data for the Medi-Cal Managed Care market category will be collected beginning with the data submission due September 1, 2025. For the data submission due September 1, 2025, submitters are required to report data for the Medi-Cal Managed Care market category in the Alternative Payment Model (APM) and Primary Care files only. Refer to Required Files for more information.~~

<sup>43</sup> ~~Data for the Medi-Cal Expenses for Dual Eligibles market category will be collected beginning with the data submission due September 1, 2025. For the data submission due September 1, 2025, submitters are required to report data for the Dual Eligibles (Medi-Cal Expenses Only) market category in the APM and Primary Care files only. Refer to Required Files for more information.~~



- Dual Eligibles (Medi-Cal and Medicare Expenses) ~~Special Needs Plans (D-SNPs)~~
- 6. For each Market Category selected above, the number of members as of December 31st of the most recent reporting year
- 7. ~~3.~~ A regulatory contact (first and last name, phone, email, and mailing address)
- 8. ~~4.~~ A business contact for submission issues (first and last name, phone, email, and mailing address)
- 9. ~~5.~~ A technical contact for each data file type (first and last name, phone, email, and mailing address)
- ~~6. License Type(s) and License Number(s) for all licensed health plans for which the submitter will be reporting THCE data~~
- ~~7. National Association of Insurance Commissioners (NAIC) Code(s), if applicable, for any health insurers for which the submitter will be reporting THCE data~~
- ~~8. A list identifying the organizations on the OHCA Attribution Addendum and any other organizations for which the submitter can attribute total medical expenses for California members according to the Member Attribution instructions outlined in Section 4.5 of this Guide. The list shall also identify the Taxpayer Identification Numbers (TIN) that the submitter associates with each organization for payment purposes. The list shall include all organizations contracted for at least 1,000 member lives during the applicable reporting years (e.g., 2022 and 2023 for the 2024 submission). Newly identified organizations will be added to future iterations of the OHCA Attribution Addendum.~~

~~The organization list shall be submitted as a pipe (“|”) delimited text file (.txt) with one row per record in the following format:~~

Col. #	Field Name	Max	Description
1	Organization Code	4	Use this field to report the unique Organization Code provided by OHCA. Refer to the <u>OHCA Attribution Addendum</u> for valid values.  <b>Note:</b> To report records for other organizations with at least 1,000 attributed members, use code ‘7777’.
2	Organization Name	80	Use this field to report the full legal name of the organization or individual if applicable.
3	Taxpayer ID Number	9	Nine-digit Taxpayer Identification Number (TIN) associated with the

			organization for payment purposes. Do not include a hyphen.
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Upon approval of the registration, the registering entity will be notified and provided with a unique Submitter Code that will be used in data submission to identify data for which they are responsible. Data files that contain an invalid Submitter Code or no Submitter Code will not be accepted.

## 2.1 Test File Submission

Test files are not required, though submitters ~~may opt~~ are strongly encouraged to send test files to the THCE Data Portal at their discretion. In addition to confirming file layouts, test files are useful for ensuring file encryption protocols are working as expected. Test files must be indicated in the header record as described below (refer to the [Header Record](#) file layout for more information).

### 3 ~~General File~~ Intake Requirements ~~Specifications~~

The following ~~specifications shall~~ requirements apply to all files submitted to the THCE Data Portal. ~~A complete submission contains the following five files:~~

#### 3.1 Required Files

A complete submission contains the following seven files:

1. Statewide Total Medical Expenses (TME) – total medical expenses for covered health benefits during the reporting period broken out by market category, and where applicable, product type ~~contracting arrangement~~.
2. Attributed TME – total medical expenses for covered health benefits during the reporting period attributed to organizations and broken out by market category, age, and sex.
3. Regional TME – total medical expenses for covered health benefits during the reporting period broken out by geographic region and market category.
4. Pharmacy Rebates – statewide medical and retail pharmacy rebate data broken out by market category.
5. Submission Questionnaire – attestations and confirmation that instructions in the Guide were followed when preparing data for submission.
6. Alternative Payment Model (APM) – total medical expenses for covered health benefits during the reporting period broken out by Expanded Non-Claims Payments Framework category and subcategory.
7. Primary Care – primary care portions of total medical expenses for covered health benefits during the reporting period broken out by market category, and where applicable, product type.

Submitters reporting data for more than one health plan and/or health insurer shall complete separate file submissions for each registered entity. The total medical expenses reported for each registered entity shall be mutually exclusive.

For example, Payer A separately registers two entities: a health plan, licensed by the Department of Managed Health Care, and a health insurer, licensed by the Department of Insurance. Payer A receives a unique Submitter Code for each registered entity. Payer A submits a complete set of files reflecting total medical expenses for the health plan's lines of business using the health plan's Submitter Code. Payer A separately submits a complete set of files reflecting total medical expenses for the health insurer's lines of business using the health insurer's Submitter Code.

### 3.1.1 Special Requirements for Medi-Cal Data Submission in 2025

In 2025, submitters are required to report data for the Medi-Cal Managed Care and Dual Eligibles (Medi-Cal Expenses Only) market categories in the APM and Primary Care files; submission of Medi-Cal Managed Care data in TME files is voluntary (TME files are enumerated as 1 through 5 above). In 2026, OHCA plans to collect data for all market categories in all files.

The table below shows the required (R) and voluntary (v) files for each market category for the 2025 submission.

<u>Market Category</u>	<u>Statewide TME</u>	<u>Attributed TME</u>	<u>Regional TME</u>	<u>Pharmacy Rebates</u>	<u>Submission Questionnaire</u>	<u>Alternative Payment Model</u>	<u>Primary Care</u>
<u>Commercial (Full Benefits)</u>	R	R	R	R	R	R	R
<u>Commercial (Partial Benefits)</u>	R	R	R	R	R	R	R
<u>Medi-Cal Managed Care</u>	v	v	v	v	v	R	R
<u>Medicare Advantage</u>	R	R	R	R	R	R	R
<u>Dual Eligibles (Medi-Cal Expenses Only)</u>	v	v	v	v	v	R	R
<u>Dual Eligibles (Medicare Expenses Only)</u>	R	R	R	R	R	R	R
<u>Dual Eligibles (Medi-Cal and Medicare Expenses)</u>	R	R	R	R	R	R	R

### 3.2 Required Format

**Submission File format.** Data shall be submitted in a text (.txt) file that is pipe ("|") delimited with one row per record.

**Encryption.** Files must be encrypted prior to submission using the OpenPGP encryption standard<sup>5</sup>. After annual registration is approved, submitters and Onpoint must exchange public PGP keys. Submitters must encrypt the files using Onpoint's public PGP key with Onpoint identified as the recipient of the file. Submitters must also sign the encryption using the private key that pairs to the public PGP key associated to the submitter's Secure File Transfer Protocol (SFTP) account with the submitter identified as the sender of the file.

**No file naming convention requirements.** Data in the header record is used to identify key information about the file.

<sup>5</sup> For more information on OpenPGP encryption, refer to <https://openpgp.org>.

**Header and trailer records.** Each submission regardless of type (e.g., TME or pharmacy rebates) must begin with a header record and end with a trailer record.

**No empty rows.** There shall be no empty rows separating either the header or the trailer from the reported data.

**Submitting multiple years of data at once.** You may submit multiple complete years of data with one pair of header and trailer records by indicating the earliest reporting year in the Period Beginning Date field (HD004) and the latest year in the Period Ending Date field (HD005).

**Indicating missing data.** When indicating missing data, two or more pipes shall appear together showing there is no data for the field. The lack of data between the pipes indicates fields that are unavailable for reporting. There shall be no blank space left between the two pipes. Note: Any amount field with no reportable dollars shall be reported as 0 and not null or missing.

**Punctuation.** Punctuation shall not be included in the reporting of any names. Decimal points shall not be included in the reporting of financial fields. Amounts shall be rounded to the nearest whole dollar unless otherwise specified. Decimal points shall only be used when reporting standard deviation. Any negative values shall be entered with a hyphen (e.g., -100).

**Date formats.** Dates, unless otherwise specified, shall be reported using the 8-digit format of YYYYMMDD. For example, January 18, 2024, shall be reported as 20240118.

**All data fields shall be reported unless a Data Variance request has been approved by the Office.** Unless a Data Variance Request has been registered and accepted for a specific field, failure to provide a valid value in a required field will result in rejection of the submitted file (refer to [Data Variance Requests](#) for more information).

## 4 ~~General~~ Data Submission Information

### 4.1 Data Completeness

Submitters shall extract and submit data for the previous two calendar years with each annual submission following guidance in the THCE Data Submission Guide in effect at the time of submission. For each data submission, submitters shall not apply a “paid through date” or otherwise limit the claims run-out, even when reporting data with run-out periods longer than 180 days.

Submitters shall report allowed amounts for covered benefits. Allowed amounts include both the amount paid by the payer or fully integrated delivery system to the provider and the member’s financial responsibility owed directly to the provider, regardless of whether the member actually made a payment; this is also known as the negotiated rate, or the contracted rate. The allowed amount is not necessarily the sum of what the provider was paid.

#### 4.1.1 Claims Payments

Submitters shall allow for a claims run-out period of at least 180 days after December 31st of the most recent reporting year (*i.e.*, June 30, ~~2024~~ 2025 for ~~2022-and~~ 2023 and 2024 service dates) to allow for continued claims adjudication. Claims shall be included based on the incurred date or date of service, not the date paid or reconciled. Incurred but not reported (IBNR) or incurred but not paid (IBNP) factors shall not be applied. Refer to [Appendix A: Claims Service Category to Bill Code Mapping](#) for more information on claims service categories.

#### 4.1.2 Non-Claims Payments

Submitters shall allow for a non-claims reconciliation period of at least 180 days after December 31st of the most recent reporting year (*i.e.*, June 30, ~~2024~~ 2025 for ~~2022-and~~ 2023 and 2024 service dates) to reconcile non-claims payments ~~including incentives, capitation, risk settlements, and other non-claims-based payments~~. Submitters shall apply reasonable and appropriate estimations of non-claims liability for each provider (including payments expected to be made to providers not separately identified in the reporting) that are expected to be reconciled after the 180-day reconciliation period. Non-claims shall be reported based on the incurred date or date of service, not the date paid or reconciled. Refer to [Appendix B: Expanded Non-Claims Payments Framework](#) for more information on non-claims payment categories.

#### 4.1.3 Pharmacy Rebates

~~Pharmacy rebate data shall be reported based on actual amounts as of the time of submission without estimates.~~

Pharmacy rebates are payments, regardless of how categorized, paid by the pharmaceutical manufacturer or pharmacy benefits manager (PBM) to a payer or fully integrated delivery system.

For most members, pharmacy rebate data shall be reported based on actual amounts as of the time of submission without estimates. If pharmacy benefits are carved-out, submitters shall create a reasonable estimate of pharmacy rebates for members in the Commercial (Partial Benefits) market category. Refer to Market Categories for more information.

## 4.2 Data Variance Requests

Submitters that are unable to submit data files meeting the file intake specifications in this Guide may request a temporary variance to specific data submission requirements from OHCA pursuant to 22 CCR 97449(l).

OHCA will respond to temporary variance requests within 5 business days of the date the request was submitted. Data variance requests will be reviewed on a case-by-case basis. Data variance requests granted by OHCA will be limited in duration and will not carry over to future data submission years.

## 4.3 Included Population

Data must include all health care spending for covered benefits on behalf of, or by, California residents who are covered by Medicare, Medi-Cal, or commercial insurance, and receive care from any provider in or outside of California. ~~Claims paid for residents of states other than California who receive care from California providers shall not be included.~~ When reporting spending by geographic region, members shall be assigned to a region based on their residence address.

Data shall only be reported by the primary payer on the claim, as secondary coverage expenses would generally double count a portion of the allowed amount by the primary payer.

When calculating total medical expenses and member months, submitters shall include all members for whom the submitter is directly contracted with a group purchaser, individual subscriber, or public agency to arrange for the provision of health care services. ~~Total medical expenses and member months for members with whom the submitter is not directly contracted (i.e., members “from other plans”) shall not be included.~~

#### 4.3.1 Exclusions

Claims paid for residents of states other than California who receive care from California providers shall not be included. Total medical expenses and member months for members with whom the submitter is not directly contracted (i.e., members “from other plans”) shall not be included.

The following lines of business shall be excluded from data submissions:

- |  |   |
|--|---|
| • <u>Accident policies</u>                         | • <u>Specific disease policies</u>  |
| • <u>Acupuncture-only insurance</u>                | • <u>Stand-alone prescription drug plans</u>                                  |
| • <u>Chiropractic-only insurance</u>               | • <u>Stop-loss plans</u>  |
| • <u>Dental-only insurance</u>                     | • <u>Supplemental insurance that pays deductibles, copays, or coinsurance</u> |
| • <u>Disability policies</u>                       | • <u>Vision-only insurance</u>  |
| • <u>Hospital indemnity policies</u>               | • <u>Workers’ compensation</u>  |
| • <u>Long-term care insurance</u>                  |   |
| • <u>Medicare supplemental insurance (Medigap)</u> |   |

Submitters shall also exclude the following items from data submissions:

- Reinsurance recoveries or premiums
- CMS reconciliation payments, such as Medicare sweep or Part D
- Premiums
- Affordable Care Act (ACA) risk transfer payments

#### 4.4 Market Categories

Market categories are a segment within the public or private health insurance market for the purposes of reporting total medical expenses. The seven market categories are:

1. Commercial (Full Benefits) – The Commercial (Full Benefits) market category shall be used when a submitter is able to report information on all claims and/or capitation paid on behalf of a member and the submitter is responsible for all covered benefits including pharmacy. In this scenario, the submitter has a complete picture of the member’s total medical expenses, even in the case where a capitated, delegated organization pays downstream claims.
2. Commercial (Partial Benefits) – If the submitter does not have all of the information on claims and/or capitation paid on behalf of the member (e.g., self-funded pharmacy), the submitter shall use their Commercial (Full Benefits) population spend to create an estimate of expenses for those members on a



PMPM basis. The estimate will be added to the spending for members for whom certain benefits are carved out (e.g., pharmacy). The total medical expenses for these members shall be reported in the Commercial (Partial Benefits) market category to indicate a portion of spending has been estimated, and the estimated amounts must be reported in the Submission Questionnaire file.

**Note for the Commercial (Full Benefits) and Commercial (Partial Benefits) categories:**

Within the Statewide TME ~~File~~, APM, and Primary Care files,

spending shall be further disaggregated by product type ~~and payment arrangement (capitated/delegated or non-capitated/direct).~~

Product types include:

- Health maintenance organization (HMO) or point of service (POS) products, which require a primary care provider to manage the member's care.
- Preferred provider organization (PPO) or exclusive provider organization (EPO) products, which allow members to schedule visits without a referral.
- Other products, which do not fit the descriptions above.

3. Medi-Cal Managed Care<sup>5</sup>
4. Medicare Advantage
5. ~~Medi-Cal Expenses for~~ Dual Eligibles<sup>6</sup> (Medi-Cal Expenses Only) – ~~The portion of dual eligibles' expenses that are assigned to Medi-Cal~~ Use this market category to report total medical expenses for dual eligible members when the submitter is only administering Medi-Cal benefits.
6. ~~Medicare Expenses for~~ Dual Eligibles (Medicare Expenses Only) – ~~The portion of dual eligibles' expenses that are assigned to Medicare~~ Use this market category to report total medical expenses for dual eligible members when the submitter is only administering Medicare benefits.

**~~Note for Medi-Cal Expenses for Dual Eligibles and Medicare Expenses for Dual Eligibles categories:~~**

~~Dual Eligibles are members who are enrolled in both Medicare and Medi-Cal, for whom Medicare is the primary payer for acute and post-acute care services while Medi-Cal provides assistance with Medicare premiums and cost sharing and covers some services that Medicare does not. If a submitter cannot directly assign dual eligibles' expenses to either Medi-Cal or Medicare, the claims shall be assigned as follows: Claims for Long-Term Care to Medi-Cal, claims for all other categories to Medicare.~~

<sup>5</sup> ~~Data for the Medi-Cal Managed Care market category will be collected beginning with the data submission due September 1, 2025.~~

<sup>6</sup> ~~Data for the Medi-Cal Expenses for Dual Eligibles market category will be collected beginning with the data submission due September 1, 2025.~~

7. ~~Dual Eligible Special Needs Plans (D-SNPs) — Medicare Advantage health plans which provide specialized care and wrap-around services for dual eligible beneficiaries (eligible for both Medicare and Medi-Cal).~~ Dual Eligibles (Medi-Cal and Medicare Expenses) – Use this market category to report total medical expenses for dual eligible members when the submitter is administering both Medicare and Medi-Cal benefits (e.g., Medicare Medi-Cal (Medi-Medi) Plans).

**Note for Dual Eligibles market categories:** Member months for dual eligibles should be mutually exclusive across the three market categories. A member's total medical expenses shall only be reported in one market category for any given month based on the benefits administered by the submitter.

#### 4.5 Member Attribution

Submitters shall attribute member-level expenses to organizations listed on the [OHCA Attribution Addendum](#) (incorporated at 22 CCR 97445) according to the methods described below. Attribution shall be calculated on a monthly basis and reported in terms of member months.

Members must only be attributed to one organization for any given month. If a member is attributed to more than one organization during a reporting year, their total medical expenses shall be allocated to each organization on a mutually exclusive basis (*i.e.*, expenses shall be allocated based on the respective member months allocated to each organization).

Data reported for each organization must include the total medical expenses for the attributed members, including spending on care from providers outside of the attributed organization.

In addition, submitters shall report the identifier(s) (*i.e.*, Taxpayer Identification Number (TIN) and/or National Provider Identifier (NPI)) used to identify the organization on the OHCA Attribution Addendum within their data.

Member attribution shall be performed in the following order:

1. First, identify members for whom utilization management and claims payment functions have been delegated to an organization listed on the [OHCA Attribution Addendum](#) through a capitated payment arrangement. Report data for these members using the **Capitated, Delegated Arrangement** attribution method.
2. Next, attribute remaining members to a total cost of care Accountable Care Organization (ACO) arrangement that includes an organization listed on the [OHCA Attribution Addendum](#). Report data for these members using the **ACO Arrangement** attribution method.

- ~~3. The list of organizations in the OHCA Attribution Addendum is not comprehensive. Data for members who can be attributed using the above steps to an organization **not** listed on the OHCA Attribution Addendum shall be reported using the **Attributed to Other Organizations** attribution method.~~
- ~~a. Report data in separate records for any organization with at least 1,000 attributed members. Include the full legal name in the Organization Name field and use the Organization Code '7777'.~~
  - ~~b. Report data for all organizations with 1-999 attributed members in a single record leaving the Organization Name field blank and using the Organization Code '8888'.~~

~~After attributing members using the methods above, attribute total medical expenses for remaining members using the following:~~

- ~~3.~~ 4. Any members who **cannot** be attributed using one of the above methods may be attributed to an organization listed on the OHCA Attribution Addendum ~~or other organization~~ using a submitter-developed, rules-based approach for assigning total medical expenses. Report data for these members using the attribution method **Payer-Developed Attribution**.

**Note:** The list of organizations in the OHCA Attribution Addendum is not comprehensive. Data for members who can be attributed using the above steps to an organization **not** listed on the OHCA Attribution Addendum shall be reported with '7777' in the Organization Code field (ATT003). Report data in separate records for each organization with at least 1,000 attributed members. Include the full legal name in the Organization Name field (ATT004).

- ~~a. Report data in separate records for any organization not listed on the OHCA Attribution Addendum with at least 1,000 attributed members. Include the full legal name in the Organization Name field and use the Organization Code '7777'.~~
  - ~~b. Report data for all organizations not listed on the OHCA Attribution Addendum with 1-999 attributed members in a single record leaving the Organization Name field blank and using the Organization Code '8888'.~~
- ~~4.~~ 5. Not all members will be attributed. Data for members who cannot be attributed to any organization using any of the attribution methods shall be reported using the **Not Attributed** attribution method ~~and the Organization Code~~ with '9999' in the Organization Code field (ATT003).

## 4.6 Self-Insured Plans

For self-insured lines of business, the administrative costs and profits portion of THCE is calculated using additional payer-submitted data ~~submitted by self-insured payers~~ on the income from fees from any self-insured accounts.

OHCA requests submitters with self-insured lines of business report aggregate information on the fees earned from their self-insured accounts (e.g., “fees from uninsured plans”) as part of the THCE data submission. Submitters shall follow the instructions for Part 1, Line 12 on the NAIC Supplemental Health Care Exhibit (SHCE) for their California-situs self-insured accounts. The amount shall be entered on the Submission Questionnaire file in the Administrative Costs and Profits for Self-Insured Plans Business field (SQS0243).

## 4.7 Standard Deviation

Standard deviation shall be calculated for all members, including those with no utilization, and reported as a PMPM value. Standard deviation must be calculated for the applicable market category and reporting year on the Statewide TME File, and for the applicable market category, ~~and~~ organization, and reporting year on the Attributed TME File. Standard deviation shall be based on PMPM spending and calculated after any estimates for ~~specialty~~ specialized or carved-out services have been applied. Non-claims expenses shall be excluded from the calculation of standard deviation.

### 4.7.1 Statewide TME File

The following steps detail how submitters can calculate standard deviation values for each reporting year on the Statewide TME File data submission.

- **Step 1:** For each market category, the submitter must calculate the average monthly spending amount for each member using claims-based allowed amounts. Submitters shall calculate the average claims-based allowed amount after partial claims adjustments. Non-claims expenses shall be excluded from this average.

**Note:** The unit of analysis is member months, not individual members. This ensures that the weight of monthly spending for each member is accurately reflected in the average.

- **Step 2:** For each market category, divide Claims: Total amount by total member months (across all members) to produce a PMPM dollar amount specific to that market category.

- **Step 3:** With the average claims expenses value for each market category, submitters can now calculate the standard deviation. The formula is:

$$SD = \sqrt{\frac{\sum (x_i - \bar{x})^2}{N}}$$

Where:

$x_i$  = value of the one observation

$\bar{x}$  = mean value of all observations

N = number of observations (count of members)

Validating results: Using the Microsoft Excel function STDEV.P() or other standard deviation commands in any other statistical software program, submitters can calculate the standard deviation of the PMPM costs for a given market category.

Note that when calculating standard deviation, submitters shall use the formula for population standard deviation (divided by N). Submitters shall NOT use the formula for sample standard deviation (divided by N-1).

- **Step 4:** Report the standard deviation value in the Standard Deviation field within the Statewide TME File. Each row shall correspond to a specific market category [and reporting year](#).

#### 4.7.2 Attributed TME File

The following steps detail how submitters can calculate standard deviation values for [each reporting year on](#) the Attributed TME File data submission.

- **Step 1:** Attribute members to the appropriate organization for a specific market category.
- **Step 2:** For each market category, for each organization, the submitter must calculate the average monthly spending amount for each member using claims-based allowed amounts. Submitters shall calculate the average claims-based allowed amount after partial claims adjustments. Non-claims expenses shall be excluded from this average.

**Note:** The unit of analysis is member months, not individual members. This

ensures that the weight of monthly spending for each member is accurately reflected in the average.

- **Step 3:** For each market category, for each organization, divide Claims: Total amount by total member months (across all members) to produce a PMPM dollar amount specific to that given market category and organization.
- **Step 4:** With the average claims expenses value for each organization, submitters can now calculate the standard deviation. The formula is:

$$SD = \sqrt{\frac{\sum (x_i - \bar{x})^2}{N}}$$

Where:

$x_i$  = value of the one observation

$\bar{x}$  = mean value of all observations

N = number of observations (count of members)

Validating results: Using the Microsoft Excel function STDEV.P() or other standard deviation commands in any other statistical software program, submitters can calculate the standard deviation of the PMPM costs for a given market category.

Note that when calculating standard deviation, submitters shall use the formula for population standard deviation (divided by N). Submitters shall NOT use the formula for sample standard deviation (divided by N-1).

- **Step 5:** Report the standard deviation value in the Standard Deviation field within the Attributed TME File. Each row shall correspond to an organization, ~~and~~ market category, and reporting year.

#### 4.8 APM File Payment Allocation

The APM File collects payment data for members based on the type of non-claims payments paid for the member. Data shall be reported in aggregate at the payer or fully integrated delivery system level by market category and product type. A distinct entry shall be made for each payment subcategory for arrangements that are linked to quality and those that are not linked to quality using the Quality Indicator (APM007). Payments and member months shall be allocated to each payment subcategory on a mutually

exclusive basis. Total medical expenses and member months for the member shall be reported in the payment subcategory furthest along the continuum of provider clinical and financial risk (i.e., claims and non-claims payments for the member shall be allocated based on the subcategory where the provider is most at risk for some or all of the payment made on behalf of the member). Refer to Appendix B: Expanded Non-Claims Payments Framework for more information and Figure 1 for the hierarchy of payment subcategories. Provider clinical and financial risk increases moving across the categories from A to D and as you move down subcategories within categories B-D as demonstrated in Figure 1. For the purposes of assigning members to subcategories, for all subcategories data submitters should first identify the category farthest along the continuum (A-D) and then identify the subcategory moving from the lowest number to the highest.

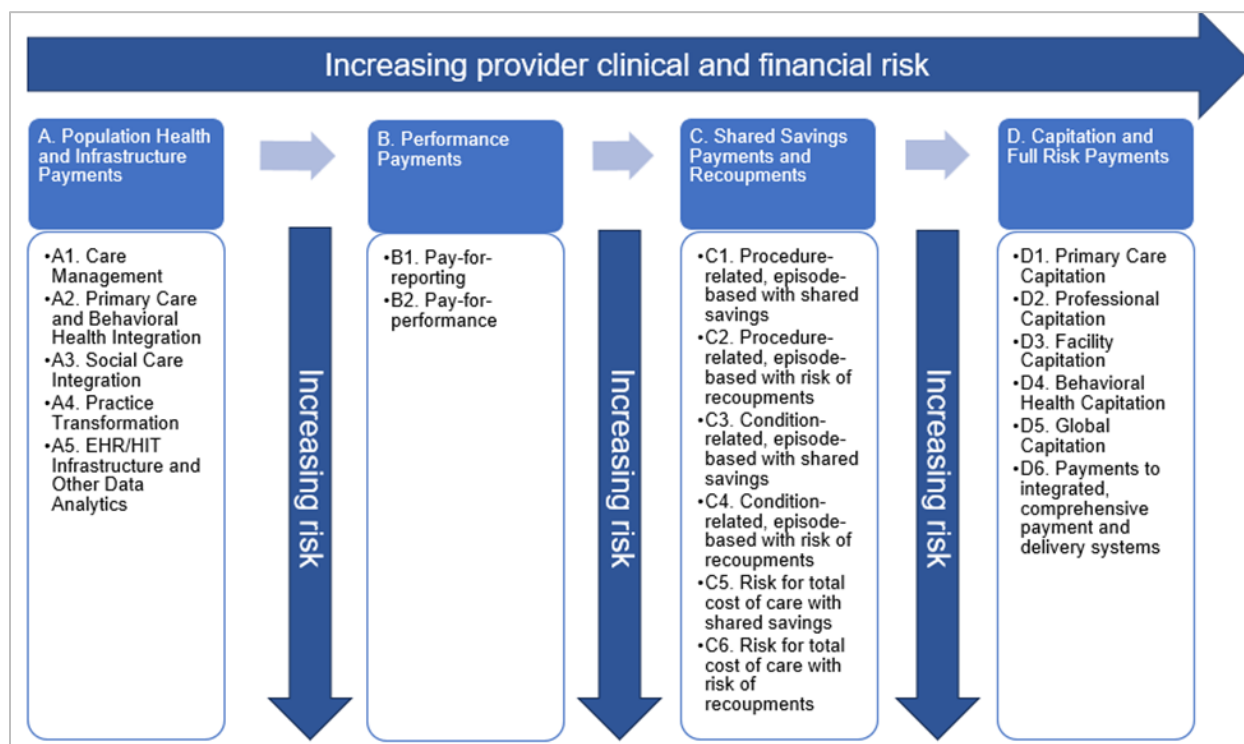


Figure 1. Continuum of Provider Clinical and Financial Risk in APM File

**Note:** A member whose care is included in the determination of a pay-for-performance payment (payment subcategory B2) to a provider and who is included in a total cost of care shared savings arrangement (payment subcategory C5) would have all of their claims and non-claims payments and member months in the total cost of care shared savings arrangement line and none in the pay-for-performance line.



**Note:** Data for payment arrangements linked to quality and those that are not linked to quality will be reported distinctly. A payment arrangement is “linked to quality” if any component of the provider’s payment was adjusted based on specific predefined goals for quality. For example, if the provider received a pay-for-performance payment (payment subcategory B2) in recognition of quality performance in addition to a professional capitation payment (payment subcategory D2), then the capitation payment is considered “linked to quality”. Submitters will indicate a payment is “linked to quality” with a ‘1’ in the Quality Indicator field (APM007). If the provider’s professional capitation payment (payment subcategory D2) was not adjusted based on specific predefined goals for quality, then the capitation payment is not considered “linked to quality”. Submitters will indicate a payment is not “linked to quality” with a ‘0’ in the Quality Indicator field (APM007).

#### 4.8.1 Payment Allocation for Payment Arrangements

The following steps detail how submitters shall allocate payments and member months for members in the Total Amount Allowed field (APM008) and the Member Months field (APM009) for Payment Subcategory fields (APM006) A1-E1 for each reporting year on the APM File data submission.

- **Step 1:** Attribute members to the appropriate payment subcategory based on the payment furthest along the continuum of clinical and financial risk.
- **Step 2:** The total medical expenses for the member should be reported in Total Amount Allowed (APM008), including all claims, non-claims payments, and the member’s financial responsibility. Payments shall not be capped, truncated, or risk-adjusted. Reported payments should match what the data submitter has paid the provider and without any subsequent risk adjustment. Capitation payments developed based on risk-adjusted revenue should be reported as developed and paid to the provider and not include any further adjustments.
- **Step 3:** The total member months for the member in the reporting year should be reported in Member Months (APM009).

#### 4.9 Primary Care Allocation Methodology

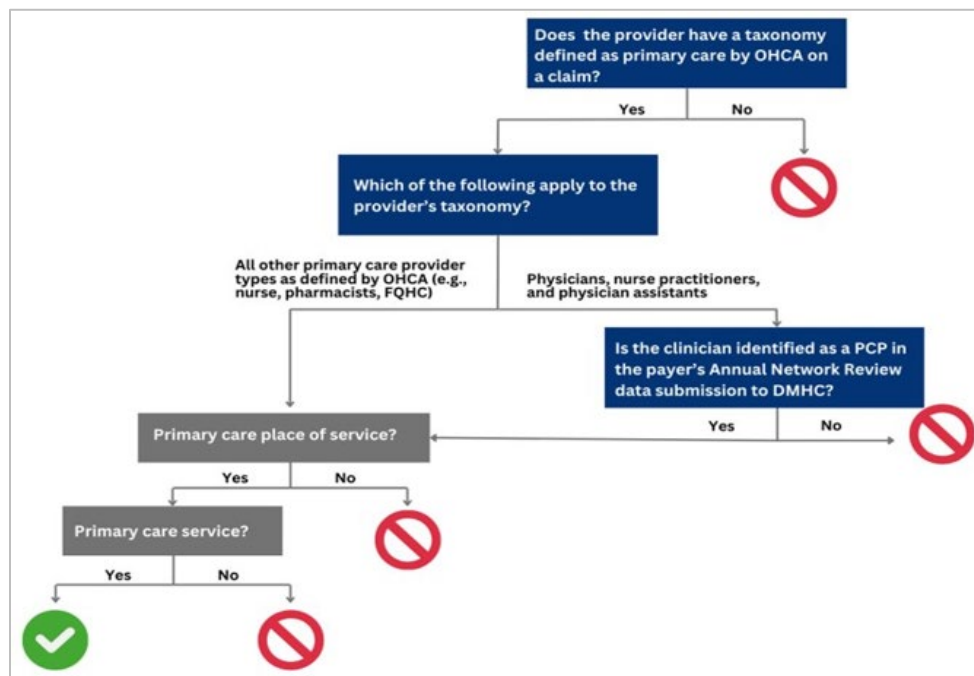
The Primary Care File shall contain the primary care claims and non-claims portion of total medical expenses using the methodology outlined in this section.

##### 4.9.1 Primary Care Paid via Claims

Primary care claims payments are a subset of all professional claims (i.e., the subset of professional claims that meet OHCA’s primary care definition). The code set defines



what spending should be identified as primary care based on the provider taxonomy, place of service, and service codes included on the claim. Figure 2 below shows the order for identifying primary care paid via claims.



*Figure 2. Identifying Primary Care Paid via Claims*

- **Step 1:** The first step is to determine whether the claim was rendered by a provider with a taxonomy defined as primary care by OHCA (see Primary Care Providers Taxonomy List). If the claim was not rendered by a provider with a taxonomy on the Primary Care Providers Taxonomy List, then the claim should not be included as primary care spending. If the rendering provider has a taxonomy included in the list, proceed to the second step. Note: If rendering provider field is incomplete, use billing provider's taxonomy.
- **Step 2:** The second step is based on the provider's taxonomy identified in Step 1:
  - For physicians, nurse practitioners, and physician assistants (these taxonomies are marked with an asterisk (\*) in the Primary Care Providers Taxonomy List), crosswalk the provider from the claim with the payer's Annual Network Review data submission to the California Department of Managed Health Care (DMHC) for the respective market (e.g., Medicare, Commercial, Medi-Cal) and product type (e.g., PPO, HMO).

- If the payer does not have an Annual Network Review submission to DMHC, proceed to Step 3.
- If the provider on the claim is identified as a primary care physician or primary care non-physician medical practitioner (NPMP) in the Annual Network Review data submission, proceed to Step 3.
- If the provider on the claim is not identified as a primary care physician or practitioner, the claim should not be included as primary care spending.
- For all other primary care provider types as defined by OHCA (e.g., nurses, pharmacists, Federally Qualified Health Center), proceed to Step 3.
- **Step 3:** The third step is to determine whether the claim represents a service provided at a care setting that OHCA defines as primary care. The list of Centers for Medicare and Medicaid (CMS) Place of Service codes that OHCA defines as primary care settings can be found in Primary Care CMS Places of Service. If the place of service code is on the list, proceed to the fourth and final step. If the place of service code is not on the list, the claim should not be included as primary care spending.
- **Step 4:** The final decision confirms whether the service on the claim provided by a primary care provider at a primary care place of service is for a primary care service as defined by OHCA. If the Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code on the claim is included in the list of service codes in HCPCS/CPT Primary Care Services, the claim should be included in Amount Paid for Primary Care (PRC008). If the claim has a service not included in the list, then the claim should not be included in Amount Paid for Primary Care (PRC008). **Note:** UB-04 payments with the facility type code 73 (Freestanding Clinic) that meet the primary care provider taxonomy and HCPCS/CPT service code requirements should be included in Amount Paid for Primary Care (PRC008).

#### 4.9.2 Primary Care Paid via Non-Claims

The following steps detail how submitters shall identify the primary care portion of non-claims payments by category and subcategory. Refer to Appendix B: Expanded Non-Claims Payments Framework for more information. Categorize primary care non-claims payments based on the purpose of the payment outlined in data submitter and provider organization contracts and the subcategory description.

## Category A. Population Health and Practice Infrastructure Payments

### Subcategory A1. Care management/care coordination/population health/medication reconciliation and Subcategory A3. Social care integration

- Identify payments with 'A' in Payment Category (PRC005) and 'A1' or 'A3' in Payment Subcategory (PRC006), respectively.
  - Include these payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to a primary care provider, care team, or provider organization.
  - Only include subcategory A1 and A3 payments to multi-specialty practices and health systems as primary care spending in Amount Paid for Primary Care (PRC008) if paid for a primary care program as identified by the payer.

### Subcategory A2. Primary care and behavioral health integration

- Identify payments with 'A' in Payment Category (PRC005) and 'A2' in Payment Subcategory (PRC006).
  - Allocate all subcategory A2 payments as primary care spending in Amount Paid for Primary Care (PRC008).

### Subcategory A4. Practice transformation payments

- Identify payments with 'A' in Payment Category (PRC005) and 'A4' in Payment Subcategory (PRC006).
  - Include all subcategory A4 payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to a primary care provider, care team, or provider organization.
  - Allocate only a portion of these payments when paid to multi-specialty practices and health systems as primary care spending in Amount Paid for Primary Care (PRC008). Determine the portion of these payments paid in support of primary care and limit the portion of practice transformation payments allocated to primary care to a maximum of 1% of total medical expenses as determined by adding all Total Amount Allowed (PRC007) in the submission.

### Subcategory A5. EHR/HIT infrastructure and other data analytics payments

- Identify payments with 'A' in Payment Category (PRC005) and 'A5' in Payment Subcategory (PRC006).
  - Include all subcategory A5 payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to a primary care provider, care team, or provider organization.
  - Allocate only a portion of these payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to multi-specialty

practices and health systems. Estimate the portion of these payments to primary care and limit the portion of EHR/HIT infrastructure and other data analytics payments allocated to primary care to a maximum of 1% of total medical expenses as determined by adding all Total Amount Allowed (PRC007) in the submission.

## Category B. Performance Payments

### *Subcategory B1. Retrospective/prospective incentive payments: pay-for-reporting*

- Identify payments with 'B' in Payment Category (PRC005) and 'B1' in Payment Subcategory (PRC006).
  - Include all subcategory B1 payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to a primary care provider, care team, or provider organization.
  - Allocate only a portion of these payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to multi-specialty practices and health systems. Limit the portion of pay-for-reporting payments included to only those for patients attributed to primary care providers.

### *Subcategory B2. Retrospective/prospective incentive payments: pay-for-performance*

- Identify payments with 'B' in Payment Category (PRC005) and 'B2' in Payment Subcategory (PRC006).
  - Include all subcategory B2 payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to a primary care provider, care team, or provider organization.
  - Allocate only a portion of these payments as primary care spending in Amount Paid for Primary Care (PRC008) when paid to multi-specialty practices and health systems. Limit the portion of pay-for-performance payments included to only those for patients attributed to primary care providers.

## Category C. Shared Savings Payments and Recoupments

### *Subcategory C1. Procedure-related, episode-based payments with shared savings and Subcategory C2. Procedure-related, episode-based payments with risk of recoupments*

- Do not allocate payments in subcategories C1 or C2 to primary care spending.

Subcategory C3. Condition-related, episode-based payments with shared savings, Subcategory C4. Condition-related, episode-based payments with risk of recoupments, Subcategory C5. Risk for total cost of care (e.g., ACO) with shared savings, and Subcategory C6. Risk for total cost of care (e.g., ACO) with risk of recoupments

- Identify payments with 'C' in Payment Category (PRC005) and 'C3', 'C4', 'C5', or 'C6' in Payment Subcategory (PRC006).
  - Allocate only a portion of these payments as primary care spending in Amount Paid for Primary Care (PRC008). Limit the portion of the shared savings (or recoupment) to the ratio of Claims: Professional to the sum of Claims: Professional, Claims: Hospital Inpatient, and Claims: Hospital Outpatient multiplied by the shared savings payment as shown in Figure 3 below.

<p>Subcategories C3-C6</p> <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <math>\Sigma</math> Shared Savings Payments         </div>	$\times$	<div style="border: 1px solid black; padding: 10px; display: inline-block;"> <p>Claims: Professional</p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <p>Claims: Professional + Claims: Hospital Inpatient + Claims: Hospital Outpatient</p> </div>	$=$	<div style="border: 1px solid black; padding: 10px; display: inline-block;"> <p>Category C Primary Care Spend via Non-Claims</p> </div>
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Figure 3. Equation for Allocating Shared Savings and Recoupments to Primary Care

#### Category D. Capitation and Full Risk Payments

There are two amounts that are added together to calculate primary care spending within capitation:

1. All payments for subcategory D1. Primary Care Capitation
2. A portion of payments for subcategories D2. Professional Capitation, D5. Global Capitation, and D6. Payments to Integrated, Comprehensive Payment and Delivery Systems.

#### Subcategory D1. Primary Care Capitation

- Identify payments with 'D' in Payment Category (PRC005) and 'D1' in Payment Subcategory (PRC006).
  - Allocate all subcategory D1 payments as primary care spending in Amount Paid for Primary Care (PRC008).

Subcategory D2. Professional Capitation, Subcategory D5. Global Capitation, and Subcategory D6. Payments to Integrated, Comprehensive Payment and Delivery Systems

- Identify payments with 'D' in Payment Category (PRC005) and 'D2', 'D5', or 'D6' in Payment Subcategory (PRC006).
  - For subcategories D2, D5, and D6, allocate only a portion of these payments as primary care spending in Amount Paid for Primary Care (PRC008). Take the ratio of (a) the sum of primary care encounters multiplied by their fee-for-service equivalent fee over (b) the sum of all encounters multiplied by their fee-for-service equivalent fee.
    - Encounters included in the numerator sum are those that include a HCPCS/CPT service code from the primary care definition, are provided by a primary care provider taxonomy, and include a primary care CMS Place of Service code as defined by OHCA (see Appendix E: Primary Care Code Sets).
    - The fee-for-service equivalents should also be for primary care services, delivered by a primary care provider in a primary care place of service, using OHCA's definition.
    - The fee-for-service equivalent fee should be determined by the submitter and vary by year, payer type, and geography (as indicated by "segment" in Figure 4), if appropriate. If the submitter does not have an associated fee-for-service equivalent fee, then they may use the Medicare Physician Fee Schedule if available.<sup>6</sup> If the Medicare Physician Fee Schedule does not have a fee for the HCPCS/CPT service code, then submitters should use fees for the codes based on Medi-Cal rates.<sup>7</sup>
  - Next, the ratio should be multiplied by the capitation amount for each respective type of capitation arrangement as shown in Figure 4 below.

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<sup>6</sup> Medicare Physician Fee Schedule can be found at <https://www.cms.gov/medicare/physician-fee-schedule/search>

<sup>7</sup> Medi-Cal rates can be found at <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/rates>

$$\begin{array}{c}
 \text{Subcategories D2, D5, D6} \\
 \left[ \begin{array}{l}
 \text{All payments for Subcategory D1 (Primary Care Capitation)} \\
 + \\
 \left[ \begin{array}{l}
 \Sigma (\# \text{ of PC Encounters} \times \text{FFS-equivalent Fee})_{\text{segment}^*} \\
 \Sigma (\# \text{ of All Encounters} \times \text{FFS-equivalent Fee})_{\text{segment}}
 \end{array} \right] \times \text{Capitation}
 \end{array} \right] \\
 = \\
 \text{Primary Care spend paid via capitation}
 \end{array}$$

\*Segment is the combination of the year, payer type, and geographic region for the service.

Figure 4. Equation for Allocating Capitation and Full Risk Payments to Primary Care

Subcategory D3. Facility Capitation and Subcategory D4. Behavioral Health Capitation

- Do not allocate payments in Subcategory D3 or D4 to primary care spending.

Category E. Other Non-Claims Payments

Do not allocate payments in Category E to primary care spending.



## 5 File Layouts and Field Specifications

### 5.1 Header Record

Col. #	Field ID	Field Name	Type	Max	Description
1	HD001	Record Type	Text	2	This field must be coded 'HD' to indicate the start of the header record.
2	HD002	<del>Data</del> Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
3	HD003	File Type	Text	3	Use this field to report the code that indicates the type of data being submitted. The only valid codes for this field are: <ul style="list-style-type: none"><li>• SWT = Statewide TME</li><li>• ATT = Attributed TME</li><li>• RET = Regional TME</li><li>• RXR = Pharmacy Rebates</li><li>• SQS = Submission Questionnaire</li><li>• <u>APM = Alternative Payment Model</u></li><li>• <u>PRC = Primary Care</u></li></ul>
4	HD004	Period Beginning Date	Integer	6	Use this field to report the earliest reporting year year/month included in the submission in YYYYMM format.
5	HD005	Period Ending Date	Integer	6	Use this field to report the latest reporting year year/month included in the submission in YYYYMM format.
6	HD006	Test File Flag	Text	1	Use this field to report whether this submission is a test or production submission. The only valid codes for this field are: <ul style="list-style-type: none"><li>• T = Test</li><li>• P = Production</li></ul>
7	HD007	Comments	Text	50	This field may be used by the submitter to document a file name, system source, or other administrative device to assist with their internal tracking of the submission.
8	HD008	Guide Version Number	Text	8	This field is used to report the THCE Data Submission Guide version used for reporting data. The version number is found on the title page of the document.



5.2 Trailer Record

Col. #	Field ID	Field Name	Type	Max	Description
1	TR001	Record Type	Text	2	This field must be coded 'TR' to indicate the start of the trailer record.
2	TR002	<del>Data</del> Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
3	TR003	File Type	Text	3	Use this field to report the code that indicates the type of data being submitted. The only valid codes for this field are: <ul style="list-style-type: none"><li>• SWT = Statewide TME</li><li>• ATT = Attributed TME</li><li>• RET = Regional TME</li><li>• RXR = Pharmacy Rebates</li><li>• SQS = Submission Questionnaire</li><li>• <u>APM = Alternative Payment Model</u></li><li>• <u>PRC = Primary Care</u></li></ul>
4	TR004	Extraction Date	Date	8	Use this field to report the date on which the file was created in YYYYMMDD format.
5	TR005	Record Count	Integer	10	Report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters. If the number of records within the submission does not equal the number reported in this field, the submission will fail. The record count shall not include the header and trailer records.

5.3 Statewide TME File

Col. #	Field ID	Field Name	Type	Max	Description
1	SWT001	<del>Data</del> Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	SWT002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	SWT003	Market Category	Integer	1	Use this field to report the market category code. Refer to <a href="#">Market Categories</a> for more information. Valid values include: <ul style="list-style-type: none"><li>• 1 = Commercial (Full Benefits)</li></ul>

Col. #	Field ID	Field Name	Type	Max	Description
					<ul style="list-style-type: none"><li>• 2 = Commercial (Partial Benefits)</li><li>• 3 = Medi-Cal Managed Care</li><li>• 4 = Medicare Advantage</li><li>• 5 = <del>Medi-Cal Expenses for</del> Dual Eligibles (<a href="#">Medi-Cal Expenses Only</a>)</li><li>• 6 = <del>Medicare Expenses for</del> Dual Eligibles (<a href="#">Medicare Expenses Only</a>)</li><li>• 7 = Dual Eligibles (<a href="#">Medi-Cal and Medicare Expenses</a>) <del>Special Needs Plans (D-SNPs)</del></li></ul>
4	SWT004	Product Type	Integer	1	<p>Use this field to designate the product type. Refer to <a href="#">Market Categories</a> for more information. For Commercial (Full Benefits) and Commercial (Partial Benefits) (Market Category = 1 or 2), valid values include:</p> <ul style="list-style-type: none"><li>• 1 = HMO/POS</li><li>• 2 = PPO/EPO</li><li>• 3 = Other</li></ul> <p>For other Market Categories, valid value includes:</p> <ul style="list-style-type: none"><li>• 0 = Not applicable</li></ul>
<del>5</del>	<del>SWT005</del>	<del>Payment Arrangement</del>	<del>Integer</del>	<del>4</del>	<p><del>Use this field to designate the payment arrangement. For Commercial (Full Benefits) and Commercial (Partial Benefits) (Market Category = 1 or 2), valid values include:</del></p> <ul style="list-style-type: none"><li><del>• 1 = Capitated / Delegated</del></li><li><del>• 2 = Non-capitated / Direct</del></li></ul> <p><del>For other Market Categories, valid value includes:</del></p> <ul style="list-style-type: none"><li><del>• 0 = Not applicable</del></li></ul>
<del>6</del> 5	SWT00 <del>6</del> 5	Member Months	Integer	12	<p>Report the total number of months of coverage for all members. All months where a member had at least 1 day of coverage are counted. <a href="#">Member months shall be mutually exclusive across all rows.</a></p> <p><b>Note:</b> This field reported as an integer.</p>

Col. #	Field ID	Field Name	Type	Max	Description
<del>7</del> 6	SWT00 <del>7</del> 6	Claims: Hospital Inpatient	Integer	12	<p>Report the total allowed amount for hospital inpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (<i>i.e.</i>, copay, coinsurance, and deductible).</p> <p>This category includes facility payments for inpatient services from claims. Includes all room and board and ancillary payments, emergency department visits that result in a hospital stay, and hospitalizations regardless of diagnosis (<i>e.g.</i>, behavioral). This does not include physician services during the hospitalization that were billed on a professional claim, nor inpatient services at non-hospital facilities.</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
<del>8</del> 7	SWT00 <del>8</del> 7	Claims: Hospital Outpatient	Integer	12	<p>Report the total allowed amount for hospital outpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (<i>i.e.</i>, copay, coinsurance, and deductible).</p> <p>This category includes facility payments for outpatient services from claims. Includes all hospital types and hospital-licensed satellite clinics, emergency department visits that do not result in a hospital stay, and does not include payments made for physician services during the outpatient service that were billed on a professional claim.</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
<del>9</del> 8	SWT00 <del>9</del> 8	Claims: Professional	Integer	12	<p>Report the total allowed amount for professional services for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (<i>i.e.</i>, copay, coinsurance, and deductible).</p> <p>This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a community health center, freestanding</p>

Col. #	Field ID	Field Name	Type	Max	Description
					ambulatory surgical center, licensed physician and surgeon, nurse practitioner, physician assistant, physical therapist, occupational therapist, speech therapist, psychologist, licensed clinical social worker, dietician, dentist, and chiropractor.  <b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
<del>40</del> 9	SWT0 <del>40</del> 9	Claims: Long-Term Care	Integer	12	Report the total allowed amount for long-term care claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts ( <i>i.e.</i> , copay, coinsurance, and deductible).  This category includes payments for long-term care services from claims. Includes skilled nursing facilities, nursing homes, intermediate care facilities, assisted living facilities, residential facilities, and providers of home- and community-based services ( <i>e.g.</i> , personal care, home-delivered meal program, home health services, adult daycare), and programs designed to assist individuals with long-term care needs who receive care in their home and community.  <b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
<del>14</del> 0	SWT01 <del>14</del> 0	Claims: Retail Pharmacy	Integer	12	Report the total allowed amount for retail pharmacy claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts ( <i>i.e.</i> , copay, coinsurance, and deductible). This amount excludes pharmacy rebates.  This category includes payments from claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit net of any coverage gap discount. This does not include any prescription drugs covered under a medical benefit ( <i>e.g.</i> , administered in a hospital setting).

Col. #	Field ID	Field Name	Type	Max	Description
					<b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
<del>12</del> 1	SWT01 <del>2</del> 1	Claims: Other	Integer	12	<p>Report the total allowed amount for all claims not included in other claims categories (e.g., durable medical equipment, optical services, transportation, hospice) for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (i.e., copay, coinsurance, and deductible).</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
<del>13</del> 2	SWT01 <del>3</del> 2	Claims: Total	Integer	12	<p>Report the total allowed amount for all claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (i.e., copay, coinsurance, and deductible). This total shall equal the sum of the individual claims categories (SWT00<del>7</del>6 through SWT01<del>2</del>1).</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
<u>13</u>	<u>SWT013</u>	<u>Member Responsibility (Claims)</u>	<u>Integer</u>	<u>12</u>	<p><u>Report the total member responsibility portion (i.e., copay, coinsurance, and deductible) of claims for all members for the reporting year. Include all amounts not paid by the primary payer. Include member responsibility amounts from claims across all categories (SWT006 through SWT011).</u></p> <p><u><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</u></p>
14	SWT014	Capitation and Full Risk Payments	Integer	12	<p>Report the total per capita, non-claims payments paid to health care providers <del>and</del> <u>or</u> organizations to provide a defined set of services to a designated population of patients for the reporting year.</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>

Col. #	Field ID	Field Name	Type	Max	Description
15	SWT015	Member Responsibility (Capitation)	Integer	12	<p>Report the total member responsibility amount (i.e., copay, coinsurance, and deductible) for all members <u>covered by capitation payments</u> for the reporting year. Include all amounts not paid by the primary payer. <del>Include member responsibility amounts from claims across all categories (SWT007 through SWT012) as well as capitation payments (SWT014).</del></p> <p><b>Note:</b> <u>The member responsibility amount should not have been included in the amount reported in Capitation and Full Risk Payments (SWT014).</u> This is a money field reported in whole dollars. This field may contain a negative value.</p>
16	SWT016	Non-Claims: Population Health and Practice Infrastructure Payments	Integer	12	<p>Report the total amount of prospective, non-claims payments paid to health care providers and organizations to support care delivery goals; not tied to specific performance metrics. Do not include costs associated with payer personnel, payer information technology systems, or other internal payer expenses.</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
17	SWT017	Non-Claims: Performance Payments	Integer	12	<p>Report the total amount of non-claims bonus payments paid to health care providers <del>and</del> <u>or</u> organizations for reporting data or achieving specific <del>predefined</del> goals for quality, cost reduction, equity, or another performance achievement domain.</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
18	SWT018	Non-Claims: <del>Payments with</del> Shared Savings <u>Payments</u> and Recoupments	Integer	12	<p>Report the net total amount of non-claims payments <del>made</del> to health care providers <del>and</del> <u>or</u> organizations (or recouped from health care providers <del>and</del> <u>or</u> 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. <u>Dollars reported in this category should reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component.</u></p>

Col. #	Field ID	Field Name	Type	Max	Description
					<b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
19	SWT019	Non-Claims: Other	Integer	12	Report <del>the total other non-claims-based payments paid for the reporting year</del> <u>any other payments to a health care 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.</u>  <b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
20	SWT020	Standard Deviation	Decimal	<del>7</del> 12,5	Report the standard deviation of the total claims spending for the members included in this record for the reporting year. Report up to 5 decimal places (e.g., 12 <u>34</u> . <del>4234</del> <u>56789</u> ). Refer to the <a href="#">Standard Deviation</a> instructions for more information.  <u><b>Note:</b> The same value should be reported for all rows with the same Reporting Year (SWT002) and Market Category (SWT003) combination.</u>
<del>21</del> <u>24</u>	<u>SWT021</u>	<u>Submission Year</u>	<u>Integer</u>	<u>4</u>	<u>Use this field to report the data submission year in YYYY format.</u>
<del>24</del> <u>2</u>	SWT899	Record Type	Text	3	Use this field to report the value of 'SWT' to indicate TME reporting at the statewide level.

5.4 Attributed TME File

Col. #	Field ID	Field Name	Type	Max	Description
1	ATT001	<del>Data</del> Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	ATT002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	ATT003	Organization Code	Text	4	Use this field to report the unique Organization Code provided by OHCA. Refer to the <a href="#">OHCA Attribution Addendum</a> for valid values.

Col. #	Field ID	Field Name	Type	Max	Description
					<b>Note:</b> To report records for other organizations with at least 1,000 attributed members, use code '7777'. <del>To report records for organizations with 1-999 attributed members, use code '8888'.</del> To report records for members that cannot be attributed, use code '9999'.
4	ATT004	Organization Name	Text	80	Use this field to report the full legal name of the organization or individual if applicable.  <b>Note:</b> Leave blank if Organization Code (ATT003) is <del>'8888'</del> or '9999'.
<del>5</del>	<del>ATT005</del>	<del>Organization Taxpayer Identification Number</del>	<del>Integer</del>	<del>9</del>	<del>Use this field to report the nine-digit Taxpayer Identification Number (TIN) associated with the organization identified in Organization Name (ATT004). Do not include a hyphen.</del>  <b>Note:</b> Leave blank if Organization Code (ATT003) is '9999'.
<del>6</del>	<del>ATT006</del>	<del>Organization National Provider Identifier</del>	<del>Integer</del>	<del>10</del>	<del>Use this field to report the ten-digit National Provider Identifier (NPI) associated with the organization identified in Organization Name (ATT004).</del>  <b>Note:</b> Leave blank if Organization Code (ATT003) is '9999'.
<del>57</del>	<del>ATT0057</del>	Attribution Method	Integer	1	Use this field to report the method as to how these members were attributed. Valid values include: <ul style="list-style-type: none"><li>1 = Capitated, Delegated Arrangement</li><li>2 = ACO Arrangement</li><li><del>3 = Attributed to Other Organizations</del></li><li>43 = Payer-Developed Attribution</li><li>54 = Not Attributed</li></ul> <b>Note:</b> <del>When Organization Code (ATT003) is reported as '7777' or '8888' this field shall be reported as '3' (Attributed to Other Organizations) or '4' (Payer-Developed Attribution).</del> When Organization Code (ATT003) is reported as '9999' this field shall be reported as '54' (Not Attributed). Refer to the <a href="#">Member Attribution</a> instructions for more information.
<del>68</del>	<del>ATT0068</del>	Market Category	Integer	1	Use this field to report the market category code. Refer to <a href="#">Market Categories</a> for more information. Valid values include:



Col. #	Field ID	Field Name	Type	Max	Description
					<ul style="list-style-type: none"><li>• 1 = Commercial (Full Benefits)</li><li>• 2 = Commercial (Partial Benefits)</li><li>• 3 = Medi-Cal Managed Care</li><li>• 4 = Medicare Advantage</li><li>• 5 = <del>Medi-Cal Expenses for</del> Dual Eligibles (<a href="#">Medi-Cal Expenses Only</a>)</li><li>• 6 = <del>Medicare Expenses for</del> Dual Eligibles (<a href="#">Medicare Expenses Only</a>)</li><li>• 7 = Dual Eligibles (<a href="#">Medi-Cal and Medicare Expenses</a>) <del>Special Needs Plans (D-SNPs)</del></li></ul>
<del>7</del> 9	ATT00 <del>7</del> 9	Age Band (in Years)	Integer	1	<p>Use this field to report the appropriate age band (in years) of the members. Age band is assigned based on the age of the member on the last day of the reporting year (December 31st). Valid values include:</p> <ul style="list-style-type: none"><li>• 1 = 0-1</li><li>• 2 = 2-18</li><li>• 3 = 19-39</li><li>• 4 = 40-54</li><li>• 5 = 55-64</li><li>• 6 = 65-74</li><li>• 7 = 75-84</li><li>• 8 = 85+</li></ul> <p><u>In very rare circumstances, a submitter may not have access to the member's age. In that scenario, report claims and/or capitation payments using Age Band '9' (Unknown) and enter a response to the Unknown Age Band question in the Submission Questionnaire file.</u></p> <p>For reporting non-claims payments (ATT0<del>19</del>22 through ATT02<del>25</del>), valid value includes:</p> <ul style="list-style-type: none"><li>• 0 = Not applicable</li></ul>
<del>8</del> 10	ATT00 <del>8</del> 10	Sex	Text	1	<p>Use this field to report the member's sex as reported by the member. Valid values include:</p> <ul style="list-style-type: none"><li>• F = Female</li><li>• M = Male</li></ul>

Col. #	Field ID	Field Name	Type	Max	Description
					<ul style="list-style-type: none"><li>U = Unknown <u>or Other</u></li></ul> <p>For reporting non-claims payments (ATT0<del>19</del><u>22</u> through ATT02<del>25</del>), valid value includes:</p> <ul style="list-style-type: none"><li>X = Not applicable</li></ul>
<del>9</del> <u>11</u>	ATT00 <del>9</del> <u>11</u>	Member Months	Integer	12	<p>Report the total number of months of coverage for all members. All months where a member had at least 1 day of coverage are counted. <u>Member months shall be mutually exclusive across all rows.</u></p> <p><b>Note:</b> This field reported as an integer. <u>When Age Band (in Years) (ATT009) is '0' and Sex (ATT010) is 'X', Member Months should be 0.</u></p>
<del>10</del> <u>2</u>	ATT01 <del>0</del> <u>2</u>	Claims: Hospital Inpatient	Integer	12	<p>Report the total allowed amount for hospital inpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (<i>i.e.</i>, copay, coinsurance, and deductible).</p> <p>This category includes facility payments for inpatient services from claims. Includes all room and board and ancillary payments, emergency department visits that result in a hospital stay, and hospitalizations regardless of diagnosis (<i>e.g.</i>, behavioral). This does not include physician services during the hospitalization that were billed on a professional claim, nor inpatient services at non-hospital facilities.</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
<del>14</del> <u>3</u>	ATT01 <del>4</del> <u>3</u>	Claims: Hospital Outpatient	Integer	12	<p>Report the total allowed amount for hospital outpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (<i>i.e.</i>, copay, coinsurance, and deductible).</p> <p>This category includes facility payments for outpatient services from claims. Includes all hospital types and hospital-licensed satellite clinics, emergency department visits that do not</p>

Col. #	Field ID	Field Name	Type	Max	Description
					result in a hospital stay, and does not include payments made for physician services during the outpatient service that were billed on a professional claim.  <b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
<del>12</del> 4	ATT01 <del>2</del> 4	Claims: Professional	Integer	12	Report the total allowed amount for professional services for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts ( <i>i.e.</i> , copay, coinsurance, and deductible).  This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a community health center, freestanding ambulatory surgical center, licensed physician and surgeon, nurse practitioner, physician assistant, physical therapist, occupational therapist, speech therapist, psychologist, licensed clinical social worker, dietician, dentist, and chiropractor.  <b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
<del>13</del> 5	ATT01 <del>3</del> 5	Claims: Long-Term Care	Integer	12	Report the total allowed amount for long-term care claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts ( <i>i.e.</i> , copay, coinsurance, and deductible).  This category includes payments for long-term care services from claims. Includes skilled nursing facilities, nursing homes, intermediate care facilities, assisted living facilities, residential facilities, and providers of home- and community-based services ( <i>e.g.</i> , personal care, home-delivered meal program, home health services, adult daycare), and programs designed to assist individuals with long-term care needs who receive care in their home and community.

Col. #	Field ID	Field Name	Type	Max	Description
					<b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
14 <del>6</del>	ATT014 <del>6</del>	Claims: Retail Pharmacy	Integer	12	<p>Report the total allowed amount for retail pharmacy claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (<i>i.e.</i>, copay, coinsurance, and deductible). This amount excludes pharmacy rebates.</p> <p>This category includes payments from claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit net of any coverage gap discount. This does not include any prescription drugs covered under a medical benefit (<i>e.g.</i>, administered in a hospital setting).</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
15 <del>7</del>	ATT015 <del>7</del>	Claims: Other	Integer	12	<p>Report the total allowed amount for all claims not included in other claims categories (<i>e.g.</i>, durable medical equipment, optical services, transportation, hospice) for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (<i>i.e.</i>, copay, coinsurance, and deductible).</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
16 <del>8</del>	ATT016 <del>8</del>	Claims: Total	Integer	12	<p>Report the total allowed amount for all claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (<i>i.e.</i>, copay, coinsurance, and deductible). This total shall equal the sum of the individual claims categories (ATT010<del>2</del> through ATT015<del>7</del>).</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value. <u>When Age Band (in Years) (ATT009) is '0' and Sex (ATT010) is 'X', Claims: Total should be 0.</u></p>

Col. #	Field ID	Field Name	Type	Max	Description
<u>19</u>	<u>ATT019</u>	<u>Member Responsibility (Claims)</u>	<u>Integer</u>	<u>12</u>	<u>Report the total member responsibility portion (i.e., copay, coinsurance, and deductible) of claims for all members for the reporting year. Include all amounts not paid by the primary payer. Include member responsibility amounts from claims across all categories (ATT012 through ATT017).</u>  <u><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</u>
<del>17</del> <u>20</u>	<del>ATT017</del> <u>20</u>	Capitation and Full Risk Payments	Integer	12	Report the total per capita, non-claims payments paid to health care providers <del>and</del> <u>or</u> organizations to provide a defined set of services to a designated population of patients for the reporting year.  <b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
<del>18</del> <u>21</u>	<del>ATT018</del> <u>21</u>	<u>Member Responsibility (Capitation)</u>	Integer	12	Report the total member responsibility amount (i.e., copay, coinsurance, and deductible) for all members <u>covered by capitation payments</u> for the reporting year. Include all amounts not paid by the primary payer. <del>Include member responsibility amounts from claims across all categories (ATT010 through ATT015) as well as capitation payments (ATT017).</del>  <b>Note:</b> <u>The member responsibility amount should not have been included in the amount reported in Capitation and Full Risk Payments (ATT020).</u> This is a money field reported in whole dollars. This field may contain a negative value.
<del>19</del> <u>22</u>	<del>ATT019</del> <u>22</u>	Non-Claims: Population Health and Practice Infrastructure Payments	Integer	12	Report the total amount of prospective, non-claims payments paid to health care providers and organizations to support care delivery goals; not tied to specific performance metrics. Do not include costs associated with payer personnel, payer information technology systems, or other internal payer expenses.  <b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.

Col. #	Field ID	Field Name	Type	Max	Description
<del>20</del> 3	ATT02 <del>0</del> 3	Non-Claims: Performance Payments	Integer	12	<p>Report the total amount of non-claims bonus payments paid to health care providers <del>and</del> <u>or</u> organizations for reporting data or achieving specific <del>predefined</del> goals for quality, cost reduction, equity, or another performance achievement domain.</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
<del>21</del> 4	ATT02 <del>1</del> 4	Non-Claims: <del>Payments</del> <del>with</del> Shared Savings <u>Payments</u> and Recoupments	Integer	12	<p>Report the net total amount of non-claims payments <del>made</del> to health care providers <del>and</del> <u>or</u> organizations (or recouped from health care providers and 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. <u>Dollars reported in this category should reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component.</u></p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
<del>22</del> 5	ATT02 <del>2</del> 5	Non-Claims: Other	Integer	12	<p>Report <del>the total other non-claims-based payments paid for the reporting year</del> <u>any other payments to a health care 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.</u></p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
<del>23</del> 6	ATT02 <del>3</del> 6	Standard Deviation	Decimal	<del>7</del> 12,5	<p>Report the standard deviation of the total claims spending for the members included in this record for the reporting year. Report up to 5 decimal places (e.g., 1234.<del>1234</del><u>56789</u>). Refer to the <a href="#">Standard Deviation</a> instructions for more information.</p> <p><u><b>Note:</b> The same value should be reported for all rows with the same Reporting Year (ATT002), Organization Code (ATT003), and Market Category (ATT008) combination. Use this field to report the data submission year in YYYY format.</u></p>
<u>27</u>	<u>ATT027</u>	<u>Submission Year</u>	<u>Integer</u>	<u>4</u>	

Col. #	Field ID	Field Name	Type	Max	Description
248	ATT899	Record Type	Text	3	Use this field to report the value of 'ATT' to indicate TME reporting at the attributed organization level.

5.5 Regional TME File

Col. #	Field ID	Field Name	Type	Max	Description
1	RET001	<del>Data</del> Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	RET002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	RET003	Region	Text	4	Use this field to report <del>either</del> the Rating Region <del>or the Service Planning Area (for Los Angeles County)</del> of the member's residence address. Refer to <a href="#">Appendix C: Regions</a> for a list of valid values.  <u>Note: Report TME for any members whose residence address cannot be assigned to a region using 'RR99' (Unspecified Region).</u>
4	RET004	Market Category	Integer	1	Use this field to report the market category code. Refer to <a href="#">Market Categories</a> for more information. Valid values include: <ul style="list-style-type: none"><li>1 = Commercial (Full Benefits)</li><li>2 = Commercial (Partial Benefits)</li><li>3 = Medi-Cal Managed Care</li><li>4 = Medicare Advantage</li><li>5 = <del>Medi-Cal Expenses for</del> Dual Eligibles <a href="#">(Medi-Cal Expenses Only)</a></li><li>6 = <del>Medicare Expenses for</del> Dual Eligibles <a href="#">(Medicare Expenses Only)</a></li><li>7 = Dual Eligibles <a href="#">(Medi-Cal and Medicare Expenses)</a> <del>Special Needs Plans (D-SNPs)</del></li></ul>
5	RET005	Member Months	Integer	12	Report the total number of months of coverage for all members. All months where a member had at least 1 day of coverage are counted. <u>Member months shall be mutually exclusive across all rows.</u>

Col. #	Field ID	Field Name	Type	Max	Description
					<b>Note:</b> This field reported as an integer.
6	RET006	Claims: Hospital Inpatient	Integer	12	<p>Report the total allowed amount for hospital inpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (<i>i.e.</i>, copay, coinsurance, and deductible).</p> <p>This category includes facility payments for inpatient services from claims. Includes all room and board and ancillary payments, emergency department visits that result in a hospital stay, and hospitalizations regardless of diagnosis (<i>e.g.</i>, behavioral). This does not include physician services during the hospitalization that were billed on a professional claim, nor inpatient services at non-hospital facilities.</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
7	RET007	Claims: Hospital Outpatient	Integer	12	<p>Report the total allowed amount for hospital outpatient claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (<i>i.e.</i>, copay, coinsurance, and deductible).</p> <p>This category includes facility payments for outpatient services from claims. Includes all hospital types and hospital-licensed satellite clinics, emergency department visits that do not result in a hospital stay, and does not include payments made for physician services during the outpatient service that were billed on a professional claim.</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
8	RET008	Claims: Professional	Integer	12	<p>Report the total allowed amount for professional services for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (<i>i.e.</i>, copay, coinsurance, and deductible).</p> <p>This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a community health center, freestanding ambulatory surgical center, licensed physician and surgeon, nurse practitioner, physician</p>



Col. #	Field ID	Field Name	Type	Max	Description
					assistant, physical therapist, occupational therapist, speech therapist, psychologist, licensed clinical social worker, dietician, dentist, and chiropractor.  <b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
9	RET009	Claims: Long-Term Care	Integer	12	Report the total allowed amount for long-term care claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts ( <i>i.e.</i> , copay, coinsurance, and deductible).  This category includes payments for long-term care services from claims. Includes skilled nursing facilities, nursing homes, intermediate care facilities, assisted living facilities, residential facilities, and providers of home- and community-based services ( <i>e.g.</i> , personal care, home-delivered meal program, home health services, adult daycare), and programs designed to assist individuals with long-term care needs who receive care in their home and community.  <b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
10	RET010	Claims: Retail Pharmacy	Integer	12	Report the total allowed amount for retail pharmacy claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts ( <i>i.e.</i> , copay, coinsurance, and deductible). This amount excludes pharmacy rebates.  This category includes payments from claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit net of any coverage gap discount. This does not include any prescription drugs covered under a medical benefit ( <i>e.g.</i> , administered in a hospital setting).  <b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
11	RET011	Claims: Other	Integer	12	Report the total allowed amount for all claims not included in other claims categories ( <i>e.g.</i> , durable medical equipment, optical services, transportation, hospice) for the reporting year.

Col. #	Field ID	Field Name	Type	Max	Description
					Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts ( <i>i.e.</i> , copay, coinsurance, and deductible).  <b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
12	RET012	Claims: Total	Integer	12	Report the total allowed amount for all claims for the reporting year. Include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts ( <i>i.e.</i> , copay, coinsurance, and deductible). This total shall equal the sum of the individual claims categories (RET006 through RET011).  <b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
<u>13</u>	<u>RET013</u>	<u>Member Responsibility (Claims)</u>	<u>Integer</u>	<u>12</u>	<u>Report the total member responsibility portion (<i>i.e.</i>, copay, coinsurance, and deductible) of claims for all members for the reporting year. Include all amounts not paid by the primary payer. Include member responsibility amounts from claims across all categories (RET006 through RET011).</u>  <u><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</u>
<del>13</del> <u>4</u>	<del>RET013</del> <u>4</u>	Capitation and Full Risk Payments	Integer	12	Report the total per capita, non-claims payments paid to health care providers <del>and</del> <u>or</u> organizations to provide a defined set of services to a designated population of patients for the reporting year.  <b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
<del>14</del> <u>5</u>	<del>RET014</del> <u>5</u>	Member Responsibility ( <u>Capitation</u> )	Integer	12	Report the total member responsibility amount ( <i>i.e.</i> , copay, coinsurance, and deductible) for all members <u>covered by capitation payments</u> for the reporting year. Include all amounts not paid by the primary payer. <del>Include member responsibility amounts from claims across all categories (RET006 through RET011) as well as capitation payments (RET013).</del>  <b>Note:</b> <u>The member responsibility amount should not have been included in the amount reported in Capitation and Full Risk Payments (RET014).</u> This is a money field reported in whole dollars. This field may contain a negative value.

Col. #	Field ID	Field Name	Type	Max	Description
<del>15</del> 16	<del>RET899</del> RET016	<del>Record Type</del> Submission Year	<del>Text</del> Integer	<del>3</del> 4	<del>Use this field to report the value of 'RET' to indicate TME reporting at the regional level.</del> Use this field to report the data submission year in YYYY format.

5.6 Pharmacy Rebates File

Col. #	Field ID	Field Name	Type	Max	Description
1	RXR001	<del>Data</del> Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	RXR002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
3	RXR003	Market Category	Integer	1	Use this field to report the market category code. Valid values include: <ul style="list-style-type: none"><li>1 = Commercial (Full Benefits)</li><li>2 = Commercial (Partial Benefits)</li><li>3 = Medi-Cal Managed Care</li><li>4 = Medicare Advantage</li><li>5 = <del>Medi-Cal Expenses for</del> Dual Eligibles (Medi-Cal Expenses Only)</li><li>6 = <del>Medicare Expenses for</del> Dual Eligibles (Medicare Expenses Only)</li><li>7 = Dual Eligibles (Medi-Cal and Medicare Expenses) <del>Special Needs Plans (D-SNPs)</del></li></ul>
4	RXR004	Medical Pharmacy Rebate Amount	Integer	12	Report the total amount of rebates for drugs covered under the members' medical benefit for the reporting year. Report only actual amounts; do not include estimates. <u>Report pharmacy rebates as a positive number.</u>  <b>Note:</b> This is a money field reported in whole dollars.
5	RXR005	Retail Pharmacy Rebate Amount	Integer	12	Report the total amount of rebates for drugs covered under the members' retail pharmacy benefit for the reporting year. Report only actual amounts; do not include estimates. <u>Report pharmacy rebates as a positive number.</u>  <b>Note:</b> This is a money field reported in whole dollars.

Col. #	Field ID	Field Name	Type	Max	Description
6	RXR006	Total Pharmacy Rebate Amount	Integer	12	Report the total amount of pharmacy rebates for the reporting year. Report only actual amounts; do not include estimates. This amount shall equal the sum of all reported rebate amounts (RXR004 through RXR005).  <b>Note:</b> This is a money field reported in whole dollars.
<del>7</del>	<del>RXR007</del>	<del>Submission Year</del>	<del>Integer</del>	<del>4</del>	<del>Use this field to report the data submission year in YYYY format.</del>
<del>7</del> 8	RXR899	Record Type	Text	3	Use this field to report the value of 'RXR' to indicate reporting pharmacy rebates.

5.7 Submission Questionnaire File

Col. #	Field ID	Field Name	Type	Max	Description
1	SQS001	<del>Data</del> Submitter Code	Text	8	This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.
2	SQS002	Reporting Year	Integer	4	Use this field to report the reporting year in YYYY format.
<del>3</del>	<del>SQS003</del>	<del>Valid Values</del>	<del>Text</del>	<del>4</del>	<del>Is spending reported in a manner consistent with the instructions in Version 1.0 of the THCE Data Submission Guide? Valid values include:</del> <del>• Y = Yes</del> <del>• N = No</del>
<del>4</del> 3	SQS00 <del>4</del> 3	CA Residents Only	Text	1	Does the spending data include California residents only? Valid values include: • Y = Yes • N = No
<del>5</del> 4	SQS00 <del>5</del> 4	Members	Text	1	Does the spending data represent members in a full-service health care service plan, specialized mental health care service plan, health insurance plan, or specialized behavioral health-only policy? Valid values include: • Y = Yes • N = No
<del>6</del> 5	SQS00 <del>6</del> 5	Primary Payer	Text	1	Does the spending data only include members for whom the payer or fully integrated delivery system is primary payer on the claim? Valid values include:

Col. #	Field ID	Field Name	Type	Max	Description
					<ul style="list-style-type: none"> <li>• Y = Yes</li> <li>• N = No</li> </ul>
<del>7</del> 6	SQS00 <del>7</del> 6	Allowed Amounts	Text	1	Does the <u>claims</u> spending data include allowed amounts? Valid values include: <ul style="list-style-type: none"> <li>• Y = Yes</li> <li>• N = No</li> </ul>
<del>8</del> 7	SQS00 <del>8</del> 7	Attribution	Text	1	Does the spending data include all data for all attributed members for each month a member was attributed? Valid values include: <ul style="list-style-type: none"> <li>• Y = Yes</li> <li>• N = No</li> </ul>
<del>9</del> 8	SQS00 <del>9</del> 8	Attribution Methodology	Text	500	Briefly describe the approach used to attribute members in the Payer-Developed Attribution method.
<del>40</del> 9	SQS0 <del>40</del> 9	Date Incurred or Served	Text	1	Are spending data submitted based on the incurred date or date of service? Valid values include: <ul style="list-style-type: none"> <li>• Y = Yes</li> <li>• N = No</li> </ul>
<del>41</del> 0	SQS0 <del>41</del> 0	Claims Runout	Date	8	For claims runout, what is the maximum payment date for claims payments? Format = YYYYMMDD
<del>12</del> 1	SQS01 <del>2</del> 1	Non-Claims Runout	Date	8	For non-claims runout, what is the maximum payment date for non-claims payments? Format = YYYYMMDD
<del>13</del> 2	SQS01 <del>3</del> 2	IBNR IBNP	Text	1	Are spending data reported without IBNR/IBNP factors applied? Valid values include: <ul style="list-style-type: none"> <li>• Y = Yes</li> <li>• N = No</li> </ul>
<del>14</del> 3	SQS01 <del>4</del> 3	Pharmacy Rebates	Text	1	Are pharmacy rebate data actuals, without estimates? <u>This question does not apply to data submitted in the Commercial (Partial Benefits) market category.</u> Valid values include: <ul style="list-style-type: none"> <li>• Y = Yes</li> <li>• N = No</li> </ul>
<del>15</del> 4	SQS01 <del>5</del> 4	Standard Deviation	Text	1	Is the standard deviation calculated using the formula for population standard deviation? Valid values include:

Col. #	Field ID	Field Name	Type	Max	Description
					<ul style="list-style-type: none"> <li>• Y = Yes</li> <li>• N = No</li> </ul>
<del>16</del> 5	SQS01 <del>6</del> 5	Standard Deviation Members	Text	1	<p>In calculating standard deviation, is spending included for every month the member was attributed, regardless of whether the member has paid claims? Valid values include:</p> <ul style="list-style-type: none"> <li>• Y = Yes</li> <li>• N = No</li> </ul>
<del>17</del> 6	SQS01 <del>7</del> 6	Standard Deviation Non-Claims Excluded	Text	1	<p>Does the standard deviation data exclude non-claims spending? Valid values include:</p> <ul style="list-style-type: none"> <li>• Y = Yes</li> <li>• N = No</li> </ul>
<del>18</del>	<del>SQS018</del>	<del>Standard Deviation Age/Sex</del>	<del>Text</del>	<del>1</del>	<p><del>Is standard deviation calculated by Age/Sex band? Valid values include:</del></p> <ul style="list-style-type: none"> <li><del>• Y = Yes</del></li> <li><del>• N = No</del></li> </ul>
<u>17</u>	<u>SQS017</u>	<u>Unknown Age Band</u>	<u>Text</u>	<u>500</u>	<p><u>Briefly describe why you do not have access to the member age. This field is required when the value in Age Band (in Years) (ATT009) is '9'.</u></p>
<u>18</u>	<u>SQS018</u>	<u>Estimated Pharmacy Spending</u>	<u>Integer</u>	<u>12</u>	<p><u>Report the total estimated amount for carved-out pharmacy spending within the Commercial (Partial Benefits) market category.</u></p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
<u>19</u>	<u>SQS019</u>	<u>Estimated Behavioral Health Spending</u>	<u>Integer</u>	<u>12</u>	<p><u>Report the total estimated amount for carved-out behavioral health spending within the Commercial (Partial Benefits) market category.</u></p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
<u>20</u>	<u>SQS020</u>	<u>Estimated Other Spending</u>	<u>Integer</u>	<u>12</u>	<p><u>Report the total estimated amount for other (non-pharmacy and non-behavioral health) carved-out benefits within the Commercial (Partial Benefits) market category. Describe the benefits that have been estimated in your response to Estimate Methodology (SQS021).</u></p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>

Col. #	Field ID	Field Name	Type	Max	Description
<del>21</del> 9	SQS0 <del>21</del> 9	Estimate Methodology	Text	500	Briefly describe the methodology used to estimate spend in the Commercial (Partial Benefits) market category.
<del>20</del> 2	SQS02 <del>02</del>	Self-Insured Plans	Text	1	Does the submission include spending data from self-insured accounts? Valid values include: <ul style="list-style-type: none"><li>Y = Yes</li><li>N = No</li></ul>
<del>24</del> 3	SQS02 <del>43</del>	Administrative Costs and Profits for Self-Insured Plans	Integer	12	Report aggregate information on the fees earned from self-insured accounts (e.g., “fees from uninsured plans”). Submitters shall follow the instructions for Part 1, Line 12 on the NAIC SHCE for their California-situs self-insured accounts. This field is required when the value in Self-Insured Plans (SQS02 <del>02</del> ) is ‘Y’.  <b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.
<u>24</u>	<u>SQS024</u>	<u>Procedure and Condition-Specific Episode-based Payment Arrangements</u>	<u>Text</u>	<u>500</u>	<u>List the types of procedure and condition-specific episode-based payment arrangements in place with providers during the reporting year. Use Appendix D: Condition and Procedure Types as a reference to categorize and describe the type of arrangement.</u>
<u>25</u>	<u>SQS025</u>	<u>Submission Year</u>	<u>Integer</u>	<u>4</u>	<u>Use this field to report the data submission year in YYYY format.</u>
<del>22</del> 6	SQS899	Record Type	Text	3	Use this field to report the value of 'SQS' to indicate submission questionnaire responses.

5.8 Alternative Payment Model (APM) File

Col. #	Field ID	Field Name	Type	Max	Description
<u>1</u>	<u>APM001</u>	<u>Submitter Code</u>	<u>Text</u>	<u>8</u>	<u>This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.</u>
<u>2</u>	<u>APM002</u>	<u>Reporting Year</u>	<u>Integer</u>	<u>4</u>	<u>Use this field to report the reporting year in YYYY format.</u>
<u>3</u>	<u>APM003</u>	<u>Market Category</u>	<u>Integer</u>	<u>1</u>	<u>Use this field to report the market category code. Refer to Market Categories for more information. Valid values include:</u> <ul style="list-style-type: none"><li><u>1 = Commercial (Full Benefits)</u></li></ul>

Col. #	Field ID	Field Name	Type	Max	Description
					<ul style="list-style-type: none"><li>• <u>2 = Commercial (Partial Benefits)</u></li><li>• <u>3 = Medi-Cal Managed Care</u></li><li>• <u>4 = Medicare Advantage</u></li><li>• <u>5 = Dual Eligibles (Medi-Cal Expenses Only)</u></li><li>• <u>6 = Dual Eligibles (Medicare Expenses Only)</u></li><li>• <u>7 = Dual Eligibles (Medi-Cal and Medicare Expenses)</u></li></ul>
<u>4</u>	<u>APM004</u>	<u>Product Type</u>	<u>Integer</u>	<u>1</u>	<p><u>Use this field to designate the product type. Refer to Market Categories for more information. For Commercial (Full Benefits) and Commercial (Partial Benefits) (Market Category = 1 or 2), valid values include:</u></p> <ul style="list-style-type: none"><li>• <u>1 = HMO/POS</u></li><li>• <u>2 = PPO/EPO</u></li><li>• <u>3 = Other</u></li></ul> <p><u>For other Market Categories, valid value includes:</u></p> <ul style="list-style-type: none"><li>• <u>0 = Not applicable</u></li></ul>
<u>5</u>	<u>APM005</u>	<u>Payment Category</u>	<u>Text</u>	<u>1</u>	<p><u>Use this field to report the payment category. Refer to Appendix B: Expanded Non-Claims Payments Framework for more information. Valid values include:</u></p> <ul style="list-style-type: none"><li>• <u>A = Population health and practice infrastructure payments</u></li><li>• <u>B = Performance payments</u></li><li>• <u>C = Shared savings payments and recoupments</u></li><li>• <u>D = Capitation and full risk payments</u></li><li>• <u>E = Other non-claims payments</u></li><li>• <u>X = Fee-for-service</u></li></ul> <p><u><b>Note:</b> This field shall correspond to a Payment Subcategory (APM006) that begins with the same character.</u></p>



Col. #	Field ID	Field Name	Type	Max	Description
<u>6</u>	<u>APM006</u>	<u>Payment Subcategory</u>	<u>Text</u>	<u>2</u>	<p>Use this field to report the payment subcategory based on the initial character in Payment Category (APM005). Refer to Appendix B: Expanded Non-Claims Payments Framework for more information. Valid values include:</p> <ul style="list-style-type: none"><li>• <u>A1 = Care management/care coordination/population health/medication reconciliation</u></li><li>• <u>A2 = Primary care and behavioral health integration</u></li><li>• <u>A3 = Social care integration</u></li><li>• <u>A4 = Practice transformation payments</u></li><li>• <u>A5 = EHR/HIT infrastructure payments</u></li><li>• <u>B1 = Retrospective/prospective incentive payments: pay-for-reporting</u></li><li>• <u>B2 = Retrospective/prospective incentive payments: pay-for-performance</u></li><li>• <u>C1 = Procedure-related, episode-based payments with shared savings</u></li><li>• <u>C2 = Procedure-related, episode-based payments with risk of recoupments</u></li><li>• <u>C3 = Condition-related, episode-based payments with shared savings</u></li><li>• <u>C4 = Condition-related, episode-based payments with risk of recoupments</u></li><li>• <u>C5 = Risk for total cost of care (e.g., ACO) with shared savings</u></li><li>• <u>C6 = Risk for total cost of care (e.g., ACO) with risk of recoupments</u></li><li>• <u>D1 = Primary care capitation</u></li><li>• <u>D2 = Professional capitation</u></li><li>• <u>D3 = Facility capitation</u></li><li>• <u>D4 = Behavioral health capitation</u></li><li>• <u>D5 = Global capitation</u></li><li>• <u>D6 = Payment to integrated, comprehensive payment and delivery systems</u></li><li>• <u>E1 = Other non-claims payments</u></li><li>• <u>X9 = Claims: Total</u></li></ul>
<u>7</u>	<u>APM007</u>	<u>Quality Indicator</u>	<u>Integer</u>	<u>1</u>	<p><u>This field indicates when a payment arrangement is linked to quality. Submitters will provide data on arrangements linked to quality and those that are not for each Payment Subcategory in APM006.</u></p>

Col. #	Field ID	Field Name	Type	Max	Description
					<p>A payment arrangement is “linked to quality” if any 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 or capitation payment, then the payment would be considered “linked to quality”. Refer to APM File Payment Allocation for more information.</p> <p>Valid values are:</p> <ul style="list-style-type: none"><li>• 0 = No</li><li>• 1 = Yes</li></ul>
<u>8</u>	<u>APM008</u>	<u>Total Amount Allowed</u>	<u>Integer</u>	<u>12</u>	<p>Report the total of all payments made across providers during the reporting year. For non-claims payments, this is the amount paid by the payer or fully integrated delivery system across providers. For fee-for-service claims, include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (<i>i.e.</i>, copay, coinsurance, and deductible). For capitation, include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (<i>i.e.</i>, copay, coinsurance, and deductible). Refer to APM File Payment Allocation for more information.</p> <p><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</p>
<u>9</u>	<u>APM009</u>	<u>Member Months</u>	<u>Integer</u>	<u>12</u>	<p>Report the total number of months of coverage for members in the arrangement indicated in Payment Category (APM005) and Payment Subcategory (APM006). All months where a member had at least 1 day of coverage are counted. Member months shall be mutually exclusive across all rows.</p> <p><b>Note:</b> This field reported as an integer. When Payment Subcategory (APM006) is ‘A4’, ‘A5’, or ‘E1’, Member Months should be 0.</p>
<u>10</u>	<u>APM010</u>	<u>Submission Year</u>	<u>Integer</u>	<u>4</u>	<p>Use this field to report the data submission year in YYYY format.</p>
<u>11</u>	<u>APM899</u>	<u>Record Type</u>	<u>Text</u>	<u>3</u>	<p>Use this field to report the value of ‘APM’ to indicate APM reporting at the submitter level.</p>

5.9 Primary Care File

Col. #	Field ID	Field Name	Type	Max	Description
<u>1</u>	<u>PRC001</u>	<u>Submitter Code</u>	<u>Text</u>	<u>8</u>	<u>This field must contain the Submitter Code assigned to you by OHCA or Onpoint Health Data.</u>
<u>2</u>	<u>PRC002</u>	<u>Reporting Year</u>	<u>Integer</u>	<u>4</u>	<u>Use this field to report the reporting year in YYYY format.</u>
<u>3</u>	<u>PRC003</u>	<u>Market Category</u>	<u>Integer</u>	<u>1</u>	<u>Use this field to report the market category code. Refer to Market Categories for more information. Valid values include:</u> <ul style="list-style-type: none"><li><u>1 = Commercial (Full Benefits)</u></li><li><u>2 = Commercial (Partial Benefits)</u></li><li><u>3 = Medi-Cal Managed Care</u></li><li><u>4 = Medicare Advantage</u></li><li><u>5 = Dual Eligibles (Medi-Cal Expenses Only)</u></li><li><u>6 = Dual Eligibles (Medicare Expenses Only)</u></li><li><u>7 = Dual Eligibles (Medi-Cal and Medicare Expenses)</u></li></ul>
<u>4</u>	<u>PRC004</u>	<u>Product Type</u>	<u>Integer</u>	<u>1</u>	<u>Use this field to designate the product type. Refer to Market Categories for more information. For Commercial (Full Benefits) and Commercial (Partial Benefits) (Market Category = 1 or 2), valid values include:</u> <ul style="list-style-type: none"><li><u>1 = HMO/POS</u></li><li><u>2 = PPO/EPO</u></li><li><u>3 = Other</u></li></ul> <u>For other Market Categories, valid value includes:</u> <ul style="list-style-type: none"><li><u>0 = Not applicable</u></li></ul>
<u>5</u>	<u>PRC005</u>	<u>Payment Category</u>	<u>Text</u>	<u>1</u>	<u>Use this field to report the payment category. Refer to Appendix B: Expanded Non-Claims Payments Framework for more information. Valid values include:</u>

Col. #	Field ID	Field Name	Type	Max	Description
					<ul style="list-style-type: none"><li>• <u>A = Population health and practice infrastructure payments</u></li><li>• <u>B = Performance payments</u></li><li>• <u>C = Shared savings payments and recoupments</u></li><li>• <u>D = Capitation and full risk payments</u></li><li>• <u>E = Other non-claims payments</u></li><li>• <u>X = Fee-for-service</u></li></ul> <p><u>Note: This field shall correspond to a Payment Subcategory (PRC006) that begins with the same character.</u></p>
<u>6</u>	<u>PRC006</u>	<u>Payment Subcategory</u>	<u>Text</u>	<u>2</u>	<p><u>Use this field to report the payment subcategory based on the initial character in the Payment Category (PRC005). Refer to Appendix B: Expanded Non-Claims Payments Framework for more information. Valid values include:</u></p> <ul style="list-style-type: none"><li>• <u>A1 = Care management/care coordination/population health/medication reconciliation</u></li><li>• <u>A2 = Primary care and behavioral health integration</u></li><li>• <u>A3 = Social care integration</u></li><li>• <u>A4 = Practice transformation payments</u></li><li>• <u>A5 = EHR/HIT infrastructure payments</u></li><li>• <u>B1 = Retrospective/prospective incentive payments: pay-for-reporting</u></li><li>• <u>B2 = Retrospective/prospective incentive payments: pay-for-performance</u></li><li>• <u>C1 = Procedure-related, episode-based payments with shared savings</u></li><li>• <u>C2 = Procedure-related, episode-based payments with risk of recoupments</u></li><li>• <u>C3 = Condition-related, episode-based payments with shared savings</u></li><li>• <u>C4 = Condition-related, episode-based payments with risk of recoupments</u></li><li>• <u>C5 = Risk for total cost of care (e.g., ACO) with shared savings</u></li><li>• <u>C6 = Risk for total cost of care (e.g., ACO) with risk of recoupments</u></li><li>• <u>D1 = Primary care capitation</u></li><li>• <u>D2 = Professional capitation</u></li></ul>

Col. #	Field ID	Field Name	Type	Max	Description
					<ul style="list-style-type: none"><li>• <u>D3 = Facility capitation</u></li><li>• <u>D4 = Behavioral health capitation</u></li><li>• <u>D5 = Global capitation</u></li><li>• <u>D6 = Payment to integrated, comprehensive payment and delivery systems</u></li><li>• <u>E1 = Other non-claims payments</u></li><li>• <u>X9 = Claims: Total</u></li></ul>
<u>7</u>	<u>PRC007</u>	<u>Total Amount Allowed</u>	<u>Integer</u>	<u>12</u>	<p><u>Report the total of all payments made across providers during the reporting year. For non-claims payments, this is the amount paid by the payer or fully integrated delivery system across providers. For fee-for-service claims, include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (i.e., copay, coinsurance, and deductible). For capitation, include amounts paid by the payer or fully integrated delivery system and any member responsibility amounts (i.e., copay, coinsurance, and deductible).</u></p> <p><u><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value.</u></p>
<u>8</u>	<u>PRC008</u>	<u>Amount Paid for Primary Care</u>	<u>Integer</u>	<u>12</u>	<p><u>Report the total of all payments made across providers for primary care during the reporting year. For fee-for-service payments follow the instructions in Primary Care Paid via Claims to determine the portion allocated to primary care. For non-claims payments follow the instructions specific to each payment subcategory outlined in Primary Care Paid via Non-Claims.</u></p> <p><u><b>Note:</b> This is a money field reported in whole dollars. This field may contain a negative value. When Payment Subcategory (PRC006) is 'C1', 'C2', 'D3', 'D4', or 'E1', Amount Paid for Primary Care should be 0.</u></p>
<u>9</u>	<u>PRC009</u>	<u>Member Months</u>	<u>Integer</u>	<u>12</u>	<p><u>Report the total number of months of coverage for members in the payment reported in Total Amount Allowed (PRC007). All months where a member had at least 1 day of coverage are counted. Member months shall <b>not</b> be mutually exclusive across all rows.</u></p>

Col. #	Field ID	Field Name	Type	Max	Description
					<b>Note:</b> This field reported as an integer. When Payment Subcategory (PRC006) is 'A4', 'A5', or 'E1', Member Months should be 0.
<u>10</u>	<u>PRC010</u>	<u>Submission Year</u>	<u>Integer</u>	<u>4</u>	<u>Use this field to report the data submission year in YYYY format.</u>
<u>11</u>	<u>PRC899</u>	<u>Record Type</u>	<u>Text</u>	<u>3</u>	<u>Use this field to report the value of 'PRC' to indicate primary care reporting at the submitter level.</u>

## Appendix A: Claims Service Category to Bill Code Mapping

The table below provides guidance on mapping claims service categories to bill codes for the purpose of reporting total medical expenses. The codes listed are provided as examples but not meant to be an exhaustive list.

Claims Service Category	Description	Code Sets
Hospital Inpatient	This category includes facility payments for inpatient services from claims. Includes all room and board and ancillary payments, emergency department visits that result in a hospital stay, and hospitalizations regardless of diagnosis (e.g., behavioral). This does not include physician services during the hospitalization that were billed on a professional claim, nor inpatient services at non-hospital facilities.	Type of bill codes: <ul style="list-style-type: none"> <li>Hospital: 011X</li> <li>Hospital Swing Bed: 018X</li> <li>Religious Nonmedical Hospital: 041X</li> </ul>
Hospital Outpatient	This category includes facility payments for outpatient services from claims. Includes all hospital types and hospital-licensed satellite clinics, emergency department visits that do not result in a hospital stay, and does not include payments made for physician services during the outpatient service that were billed on a professional claim.	Type of bill codes: <ul style="list-style-type: none"> <li>Hospital Inpatient, Part B only: 012X</li> <li>Hospital Outpatient: 013X</li> <li>Hospital Other Part B: 014X</li> <li>Religious Nonmedical Hospital: 043X</li> </ul>
Professional	This category includes payments for services provided by a licensed practitioner. This includes but is not limited to services provided by a community health center, freestanding ambulatory surgical center, licensed physician and surgeon, nurse practitioner, physician assistant, physical therapist, occupational therapist, speech therapist, psychologist, licensed	All professional claims (CSM-1500) <i>excluding</i> : <ul style="list-style-type: none"> <li>Ambulance/transportation services (Place of service codes: 41, 42)</li> <li>Durable Medical Equipment</li> <li>Independent Labs (Place of service code: 81)</li> </ul>

Claims Service Category	Description	Code Sets
	clinical social worker, dietician, dentist, and chiropractor.	<ul style="list-style-type: none"> <li>Optical services (<a href="#">HCPCS codes V2020-2799</a>)</li> <li>Medical services provided at a pharmacy (Place of service code: 01)</li> </ul>
Long-Term Care	This category includes payments for long-term care services from claims. Includes skilled nursing facilities, nursing homes, intermediate care facilities, assisted living facilities, and providers of home- and community-based services (e.g., personal care, home-delivered meal program, home health services, adult daycare), and programs designed to assist individuals with long-term care needs who receive care in their home and community.	Type of bill codes: <ul style="list-style-type: none"> <li>SNF: 021X</li> <li>SNF Part B: 022X</li> <li>SNF Outpatient: 023X</li> <li>SNF Swing Bed: 028X</li> <li>ICF: 065X, 066X</li> <li>Home Health: 032X, 033X</li> <li>Home Health Part B: 034X</li> <li>Residential Facilities: 086X</li> </ul>
Retail Pharmacy	This category includes payments from claims for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit net of any coverage gap discount. This does not include any prescription drugs covered under a medical benefit (e.g., administered in a hospital setting).	
Other	Claims not included in other claims categories (e.g., durable medical equipment, optical services, transportation, hospice) for the reporting year.	Examples of claims to include: <ul style="list-style-type: none"> <li>Ambulance services (Place of service codes: 41, 42)</li> <li>Durable Medical Equipment</li> <li>Independent Labs (Place of service code: 81)</li> </ul>



Claims Service Category	Description	Code Sets
		<ul style="list-style-type: none"> <li>Optical services (<a href="#">HCPCS codes V2020-2799</a>)</li> <li>Medical services provided at a pharmacy (Place of service code: 01)</li> </ul> <p>Institutional Claims Type of Bill Codes:</p> <ul style="list-style-type: none"> <li>Clinic: Rural Health: 071X</li> <li>Clinic: ESRD: 072X</li> <li>Clinic: Free Standing: 073X</li> <li>Clinic: Outpatient Rehabilitation Facility (ORF): 074X</li> <li>Clinic: Comprehensive Outpatient Rehabilitation Facility (CORF): 075X</li> <li>Clinic: Community Mental Health Center: 076X</li> <li>Federally Qualified Health Center (FQHC): 077X</li> <li>Clinic: Other 079X</li> <li>Hospice: 081X, 082X</li> <li>Ambulatory Surgical Clinic Non-professional services: 083X</li> <li>Freestanding birth center: 084X</li> <li>Freestanding Non-residential Opioid Treatment Program: 087X</li> <li>Special Facility – Other: 089X</li> </ul>

## Appendix B: Expanded Non-Claims Payments Framework

The table below provides guidance to submitters on mapping payment types to non-claims payment categories and subcategories used for data submission.

Non-Claims Payment Category	Payment Types	Corresponding HCP-LAN Category <sup>7</sup>
Population Health and Practice Infrastructure Payments	Care management/care coordination/population health/medication reconciliation	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
	Primary care and behavioral health integration	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
	Social care integration	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
	Practice transformation payments	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
	EHR/HIT infrastructure and other data analytics payments	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments

<sup>7</sup> For submitters familiar with the Health Care Payment Learning and Action Network (HCP-LAN)'s Alternative Payment Models (APM) Framework, payment types are also mapped to the corresponding HCP-LAN APM Framework category. See HCP-LAN APM Framework website, located at: <https://hcp-lan.org/apm-framework/>.

Non-Claims Payment Category	Payment Types	Corresponding HCP-LAN Category <sup>7</sup>
Performance Payments	Retrospective/prospective incentive payments: pay-for-reporting	2B: Pay for Reporting: Bonuses for reporting data or penalties for not reporting data
	Retrospective/prospective incentive payments: pay-for-performance	2C: Pay for Performance: Bonuses for quality performance
Payments with Shared Savings and Recoupments	Procedure-related, episode-based payments with shared savings	3A: Shared Savings: Shared savings with upside risk only
	Procedure-related, episode-based payments with risk of recoupments	3B: Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk
	Condition-related, episode-based payments with shared savings	3A: Shared Savings: Shared savings with upside risk only
	Condition-related, episode-based payments with risk of recoupments	3B: Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk
	Risk for total cost of care (e.g., AGO) with shared savings	3A: Shared Savings: Shared savings with upside risk only
	Risk for total cost of care (e.g., AGO) with risk of recoupments	3B: Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk
Capitation and Full Risk Payments	Primary Care capitation	4A: Condition-specific Population-based Payment: Per member per

Non-Claims Payment Category	Payment Types	Corresponding HCP-LAN Category <sup>7</sup>
		month payments, payments for specialty services, such as oncology or mental health
	Professional capitation	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health
	Facility capitation	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health
	Behavioral Health capitation	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health
	Global capitation	4B: Comprehensive Population-based Payment: Global budgets or full/percent of premium payments
	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C: Integrated Finance and Delivery Systems: Global budgets or full/percent of premium payments in integrated systems

#	Non-Claims Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
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.	
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 member (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.	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
A2	Primary care and behavioral health integration	Prospective, non-claims payments paid to healthcare providers or organizations to fund 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 behavior 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.	2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
A3	Social care integration	Prospective, non-claims payments paid to healthcare providers or organizations to support screening for health-	2A: Foundational Payments for

#	Non-Claims Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
		<u>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.</u>	<u>Infrastructure and Operations: Care coordination fees, payments for HIT investments</u>
<u>A4</u>	<u>Practice transformation payments</u>	<u>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.</u>	<u>2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments</u>
<u>A5</u>	<u>EHR/HIT infrastructure and other data analytics payments</u>	<u>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 information exchanges, software that enables practices to analyze quality and/or costs, and/or the cost of a data analyst to support practices.</u>	<u>2A: Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments</u>
<u>B</u>	<u>Performance Payments</u>	<u>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.</u>	
<u>B1</u>	<u>Pay-for-reporting payment</u>	<u>Non-claims bonus payments paid to healthcare providers or organizations for reporting data related to quality, cost reduction, equity, or another performance achievement domain.</u>	<u>2B: Pay for Reporting: Bonuses for reporting data or penalties for not reporting data</u>

#	Non-Claims Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
<u>B2</u>	<u>Pay-for-performance payments</u>	<u>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.</u>	<u>2C: Pay for Performance: Bonuses for quality performance</u>
<u>C</u>	<u>Shared Savings Payments and Recoupments</u>	<u>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 may be 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.” Payments in this category may not be “linked to quality”.</u>	
<u>C1</u>	<u>Procedure-related, episode-based payments with shared savings</u>	<u>Non-claims payments to 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</u>	<u>3A: Shared Savings: Shared savings with upside risk only; 3N:</u>

#	Non-Claims Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
		<u>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.</u>	<u>Risk based payments not linked to quality</u>
<u>C2</u>	<u>Procedure-related, episode-based payments with risk of recoupments</u>	<u>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 a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.</u>	<u>3B: Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk; 3N: Risk based payments not linked to quality</u>
<u>C3</u>	<u>Condition-related, episode-based payments with shared savings</u>	<u>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-</u>	<u>3A: Shared Savings: Shared savings with upside risk only; 3N: Risk based payments not linked to quality</u>



#	Non-Claims Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
		<u>service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.</u>	
<u>C4</u>	<u>Condition-related, episode-based payments with risk of recoupments</u>	<u>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 a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.</u>	<u>3B: Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk; 3N: Risk based payments not linked to quality</u>
<u>C5</u>	<u>Risk for total cost of care (e.g., ACO) with shared savings</u>	<u>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.</u>	<u>3A: Shared Savings: Shared savings with upside risk only; 3N: Risk based payments not linked to quality</u>

#	Non-Claims Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
		<u>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.</u>	
<u>C6</u>	<u>Risk for total cost of care (e.g., ACO) with risk of recoupments</u>	<u>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 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 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% of losses. Models offering less than this degree of risk are classified as “Risk for total cost of care with shared savings.”</u>	<u>3B: Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk;</u> <u>3N: Risk based payments not linked to quality</u>
<u>D</u>	<u>Capitation and Full Risk Payments</u>	<u>Per capita, non-claims payments paid to healthcare providers or organizations to provide a defined set of</u>	

#	Non-Claims Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
		<u>services to a designated population of patients over a defined period of time. Payments in this category may be 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.” Payments in this category may not be “linked to quality”.</u>	
<u>D1</u>	<u>Primary care capitation</u>	<u>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.</u>	<u>4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health; 4N: Capitated payments not linked to quality</u>
<u>D2</u>	<u>Professional capitation</u>	<u>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 services, and other professional and ancillary services.</u>	<u>4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or</u>

#	Non-Claims Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
			mental health; 4N: Capitated payments not linked to quality
<u>D3</u>	<u>Facility capitation</u>	<u>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.</u>	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health; 4N: Capitated payments not linked to quality
<u>D4</u>	<u>Behavioral health capitation</u>	<u>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.</u>	4A: Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health; 4N: Capitated payments not linked to quality
<u>D5</u>	<u>Global capitation</u>	<u>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,</u>	4B: Comprehensive Population-based Payment: Global budgets or full/percent

#	Non-Claims Payment Category and Subcategory	Description	Corresponding HCP-LAN Category
		<u>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.</u>	<u>of premium payments;</u> <u>4N: Capitated payments not linked to quality</u>
<u>D6</u>	<u>Payments to integrated, comprehensive payment and delivery systems</u>	<u>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.</u>	<u>4C: Integrated Finance and Delivery Systems: Global budgets or full/percent of premium payments in integrated systems;</u> <u>4N: Capitated payments not linked to quality</u>
<u>E</u>	<u>Other Non-Claims Payments</u>	<u>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.</u>	
<u>F</u>	<u>Pharmacy Rebates</u>	<u>Payments, regardless of how categorized, paid by the pharmaceutical manufacturer or pharmacy benefits manager (PBM) to a payer or fully integrated delivery system.</u>	

## Appendix C: Regions

Total medical expenses shall be reported by region based on the member's residence address. Use the table below to determine which Rating Region ~~or Service Planning Area (Los Angeles County only)~~ to use in the Region field (RET003) on the [Regional TME](#) file.

Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
RR01	Alpine	
RR01	Amador	
RR01	Butte	
RR01	Calaveras	
RR01	Colusa	
RR01	Del Norte	
RR01	Glenn	
RR01	Humboldt	
RR01	Lake	
RR01	Lassen	
RR01	Mendocino	
RR01	Modoc	
RR01	Nevada	
RR01	Plumas	
RR01	Shasta	
RR01	Sierra	
RR01	Siskiyou	
RR01	Sutter	
RR01	Tehama	
RR01	Trinity	
RR01	Tuolumne	
RR01	Yuba	
RR02	Marin	
RR02	Napa	
RR02	Solano	
RR02	Sonoma	
RR03	El Dorado	
RR03	Placer	
RR03	Sacramento	
RR03	Yolo	
RR04	San Francisco	
RR05	Contra Costa	
RR06	Alameda	

Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
RR07	Santa Clara	
RR08	San Mateo	
RR09	Monterey	
RR09	San Benito	
RR09	Santa Cruz	
RR10	Mariposa	
RR10	Merced	
RR10	San Joaquin	
RR10	Stanislaus	
RR10	Tulare	
RR11	Fresno	
RR11	Kings	
RR11	Madera	
RR12	San Luis Obispo	
RR12	Santa Barbara	
RR12	Ventura	
RR13	Imperial	
RR13	Inyo	
RR13	Mono	
RR14	Kern	
<u>RR15</u>	<u>Los Angeles (East)</u>	<u>906</u>
		<u>907</u>
		<u>908</u>
		<u>910</u>
		<u>911</u>
		<u>912</u>
		<u>915</u>
		<u>917</u>
		<u>918</u>
		<u>935</u>
<u>RR16</u>	<u>Los Angeles (West)</u>	<u>900</u>
		<u>901</u>
		<u>902</u>
		<u>903</u>
		<u>904</u>
		<u>905</u>
		<u>913</u>
		<u>914</u>
		<u>916</u>
		<u>932</u>

Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
RR17	Riverside	
RR17	San Bernardino	
RR18	Orange	
RR19	San Diego	
RR99	Unspecified Region	
SPA1	<del>Los Angeles – Gorman</del>	93243
SPA1	<del>Los Angeles – Acton</del>	93510
SPA1	<del>Los Angeles – Edwards AFB</del>	93523
SPA1	<del>Los Angeles – Lancaster</del>	93534
SPA1	<del>Los Angeles – Lancaster</del>	93535
SPA1	<del>Los Angeles – Lancaster</del>	93536
SPA1	<del>Los Angeles – Lancaster</del>	93539
SPA1	<del>Los Angeles – Littlerock</del>	93543
SPA1	<del>Los Angeles – Crystalair, Llano</del>	93544
SPA1	<del>Los Angeles – Palmdale</del>	93550
SPA1	<del>Los Angeles – Palmdale</del>	93551
SPA1	<del>Los Angeles – Palmdale</del>	93552
SPA1	<del>Los Angeles – Lancaster</del>	93584
SPA1	<del>Los Angeles – Lancaster, Quartz Hill</del>	93586
SPA1	<del>Los Angeles – Palmdale</del>	93590
SPA1	<del>Los Angeles – Lake Los Angeles</del>	93591
SPA1	<del>Los Angeles – Palmdale</del>	93599
SPA2	<del>Los Angeles – Calabasas</del>	90290
SPA2	<del>Los Angeles – La Cañada Flintridge</del>	91012
SPA2	<del>Los Angeles – La Crescenta</del>	91020
SPA2	<del>Los Angeles – Montrose</del>	91021
SPA2	<del>Los Angeles – Sunland LA</del>	91040
SPA2	<del>Los Angeles – Sunland</del>	91041
SPA2	<del>Los Angeles – Tujunga</del>	91043
SPA2	<del>Los Angeles – Glendale</del>	91046
SPA2	<del>Los Angeles – Glendale</del>	91201
SPA2	<del>Los Angeles – Glendale</del>	91202
SPA2	<del>Los Angeles – Glendale</del>	91203
SPA2	<del>Los Angeles – Glendale</del>	91204
SPA2	<del>Los Angeles – Glendale</del>	91205
SPA2	<del>Los Angeles – Glendale</del>	91206
SPA2	<del>Los Angeles – Glendale</del>	91207
SPA2	<del>Los Angeles – Glendale</del>	91208



Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
SPA2	Los Angeles—Glendale—	91209
SPA2	Los Angeles—Glendale—	91210
SPA2	Los Angeles—La Crescenta	91214
SPA2	Los Angeles—Glendale—	91221
SPA2	Los Angeles—Glendale—	91222
SPA2	Los Angeles—Glendale, La Crescenta—	91224
SPA2	Los Angeles—Glendale—	91225
SPA2	Los Angeles—Glendale—	91226
SPA2	Los Angeles—Calabasas	91301
SPA2	Los Angeles—Calabasas	91302
SPA2	Los Angeles—Mid-SFV LA	91303
SPA2	Los Angeles—Canoga Park LA	91304
SPA2	Los Angeles—Canoga Park	91305
SPA2	Los Angeles—Mid-SFV LA	91306
SPA2	Los Angeles—Canoga Park LA	91307
SPA2	Los Angeles—Canoga Park	91308
SPA2	Los Angeles—Canoga Park	91309
SPA2	Los Angeles—Castaic—	91310
SPA2	Los Angeles—Northwest SFV LA	91311
SPA2	Los Angeles—Chatsworth	91313
SPA2	Los Angeles—Encino LA	91316
SPA2	Los Angeles—Santa Clarita	91321
SPA2	Los Angeles—Santa Clarita—	91322
SPA2	Los Angeles—Northridge LA	91324
SPA2	Los Angeles—Northridge LA	91325
SPA2	Los Angeles—Northwest SFV LA	91326
SPA2	Los Angeles—Northridge	91327
SPA2	Los Angeles—Northridge	91328
SPA2	Los Angeles—Northridge	91329
SPA2	Los Angeles—California State Univ Northridge	91330
SPA2	Los Angeles—Pacoima LA	91331
SPA2	Los Angeles—Pacoima	91333
SPA2	Los Angeles—Pacoima	91334
SPA2	Los Angeles—Mid-SFV LA	91335
SPA2	Los Angeles—Reseda	91337
SPA2	Los Angeles—San Fernando	91340
SPA2	Los Angeles—San Fernando—	91341
SPA2	Los Angeles—North Hills LA	91343

Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
SPA2	Los Angeles—Northwest SFV LA	91344
SPA2	Los Angeles—North Hills LA	91345
SPA2	Los Angeles—Mission Hills	91346
SPA2	Los Angeles—Santa Clarita	91350
SPA2	Los Angeles—Santa Clarita	91351
SPA2	Los Angeles—Sunland LA	91352
SPA2	Los Angeles—Sun Valley	91353
SPA2	Los Angeles—Santa Clarita	91354
SPA2	Los Angeles—Santa Clarita	91355
SPA2	Los Angeles—Encino LA	91356
SPA2	Los Angeles—Tarzana	91357
SPA2	Los Angeles—Westlake Village	91361
SPA2	Los Angeles—Thousand Oaks	91362
SPA2	Los Angeles—Woodland Hills LA	91364
SPA2	Los Angeles—Woodland Hills	91365
SPA2	Los Angeles—Woodland Hills LA	91367
SPA2	Los Angeles—Pierce College	91371
SPA2	Los Angeles—Woodland Hills	91372
SPA2	Los Angeles—Agoura Hills	91376
SPA2	Los Angeles—Santa Clarita	91380
SPA2	Los Angeles—Santa Clarita	91381
SPA2	Los Angeles—Santa Clarita	91382
SPA2	Los Angeles—Castaic Valley	91383
SPA2	Los Angeles—Santa Clarita	91384
SPA2	Los Angeles—Santa Clarita	91385
SPA2	Los Angeles—Santa Clarita	91386
SPA2	Los Angeles—Santa Clarita	91387
SPA2	Los Angeles—Agua Dulce, Green Valley, Santa Clarita	91390
SPA2	Los Angeles—Sylmar	91392
SPA2	Los Angeles—North Hills	91393
SPA2	Los Angeles—Granada Hills	91394
SPA2	Los Angeles—Mission Hills	91395
SPA2	Los Angeles—Winnetka	91396
SPA2	Los Angeles—Van Nuys LA	91401
SPA2	Los Angeles—Van Nuys LA	91402
SPA2	Los Angeles—Sherman Oaks LA	91403
SPA2	Los Angeles—Van Nuys	91404
SPA2	Los Angeles—Van Nuys LA	91405
SPA2	Los Angeles—Mid-SFV LA	91406

Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
SPA2	<del>Los Angeles – Van Nuys</del>	91407
SPA2	<del>Los Angeles – Van Nuys</del>	91408
SPA2	<del>Los Angeles – Van Nuys</del>	91409
SPA2	<del>Los Angeles – Van Nuys</del>	91410
SPA2	<del>Los Angeles – Van Nuys LA</del>	91411
SPA2	<del>Los Angeles – Panorama City</del>	91412
SPA2	<del>Los Angeles – Sherman Oaks, Van Nuys</del>	91413
SPA2	<del>Los Angeles – Encino</del>	91416
SPA2	<del>Los Angeles – Sherman Oaks LA</del>	91423
SPA2	<del>Los Angeles – Encino</del>	91426
SPA2	<del>Los Angeles – Encino LA</del>	91436
SPA2	<del>Los Angeles – Van Nuys</del>	91470
SPA2	<del>Los Angeles – Van Nuys</del>	91482
SPA2	<del>Los Angeles – Van Nuys</del>	91495
SPA2	<del>Los Angeles – Van Nuys</del>	91496
SPA2	<del>Los Angeles – Van Nuys</del>	91499
SPA2	<del>Los Angeles – Burbank</del>	91501
SPA2	<del>Los Angeles – Burbank</del>	91502
SPA2	<del>Los Angeles – Burbank</del>	91503
SPA2	<del>Los Angeles – Burbank</del>	91504
SPA2	<del>Los Angeles – Burbank</del>	91505
SPA2	<del>Los Angeles – Burbank</del>	91506
SPA2	<del>Los Angeles – Burbank</del>	91507
SPA2	<del>Los Angeles – Burbank</del>	91508
SPA2	<del>Los Angeles – Burbank</del>	91510
SPA2	<del>Los Angeles – Burbank</del>	91521
SPA2	<del>Los Angeles – Burbank</del>	91522
SPA2	<del>Los Angeles – Burbank</del>	91523
SPA2	<del>Los Angeles – Burbank</del>	91526
SPA2	<del>Los Angeles – North Hollywood LA</del>	91601
SPA2	<del>Los Angeles – Studio City LA</del>	91602
SPA2	<del>Los Angeles – North Hollywood</del>	91603
SPA2	<del>Los Angeles – Studio City LA</del>	91604
SPA2	<del>Los Angeles – North Hollywood LA</del>	91605
SPA2	<del>Los Angeles – North Hollywood LA</del>	91606

Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
SPA2	Los Angeles—North Hollywood LA	91607
SPA2	Los Angeles—Studio City	91608
SPA2	Los Angeles—North Hollywood	91609
SPA2	Los Angeles—North Hollywood, Toluca Lake	91610
SPA2	Los Angeles—North Hollywood	91611
SPA2	Los Angeles—North Hollywood	91612
SPA2	Los Angeles—North Hollywood	91614
SPA2	Los Angeles—North Hollywood	91615
SPA2	Los Angeles—North Hollywood	91616
SPA2	Los Angeles—Valley Village	91617
SPA2	Los Angeles—Lake Hughes	93532
SPA3	Los Angeles—Altadena	91001
SPA3	Los Angeles—Altadena	91003
SPA3	Los Angeles—Arcadia	91006
SPA3	Los Angeles—Arcadia	91007
SPA3	Los Angeles—Bradbury	91008
SPA3	Los Angeles—Duarte	91009
SPA3	Los Angeles—Duarte	91010
SPA3	Los Angeles—La Canada	91011
SPA3	Los Angeles—Monrovia	91016
SPA3	Los Angeles—Monrovia	91017
SPA3	Los Angeles—Mt. Wilson	91023
SPA3	Los Angeles—Sierra Madre	91024
SPA3	Los Angeles—Sierra Madre	91025
SPA3	Los Angeles—South Pasadena	91030
SPA3	Los Angeles—South Pasadena	91031
SPA3	Los Angeles—Tujunga LA	91042
SPA3	Los Angeles—Arcadia	91066
SPA3	Los Angeles—Arcadia	91077
SPA3	Los Angeles—Pasadena	91101
SPA3	Los Angeles—Pasadena	91102
SPA3	Los Angeles—Pasadena	91103
SPA3	Los Angeles—Pasadena	91104
SPA3	Los Angeles—Pasadena	91105
SPA3	Los Angeles—Pasadena	91106
SPA3	Los Angeles—Pasadena	91107
SPA3	Los Angeles—San Marino	91108
SPA3	Los Angeles—Pasadena	91109

Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
SPA3	Los Angeles—Pasadena	91110
SPA3	Los Angeles—Pasadena	91114
SPA3	Los Angeles—Pasadena	91115
SPA3	Los Angeles—Pasadena	91116
SPA3	Los Angeles—Pasadena	91117
SPA3	Los Angeles—San Marino	91118
SPA3	Los Angeles—Pasadena	91121
SPA3	Los Angeles—Pasadena	91123
SPA3	Los Angeles—Pasadena	91124
SPA3	Los Angeles—Pasadena	91125
SPA3	Los Angeles—Pasadena	91126
SPA3	Los Angeles—Pasadena	91129
SPA3	Los Angeles—Pasadena	91182
SPA3	Los Angeles—Pasadena	91184
SPA3	Los Angeles—Pasadena	91185
SPA3	Los Angeles—Pasadena	91188
SPA3	Los Angeles—Pasadena	91189
SPA3	Los Angeles—Pasadena	91199
SPA3	Los Angeles—Sylmar LA	91342
SPA3	Los Angeles—Azusa	91702
SPA3	Los Angeles—Baldwin Park	91706
SPA3	Los Angeles—Claremont	91711
SPA3	Los Angeles—City of Industry	91714
SPA3	Los Angeles—City of Industry	91715
SPA3	Los Angeles—City of Industry	91716
SPA3	Los Angeles—Covina	91722
SPA3	Los Angeles—Covina	91723
SPA3	Los Angeles—Covina	91724
SPA3	Los Angeles—El Monte	91731
SPA3	Los Angeles—El Monte	91732
SPA3	Los Angeles—El Monte	91733
SPA3	Los Angeles—El Monte	91734
SPA3	Los Angeles—El Monte	91735
SPA3	Los Angeles—Glendora	91740
SPA3	Los Angeles—Glendora	91741
SPA3	Los Angeles—La Puente	91744
SPA3	Los Angeles—Hacienda-Rowland Heights	91745
SPA3	Los Angeles—La Puente	91746
SPA3	Los Angeles—La Puente	91747

Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
SPA3	Los Angeles—Hacienda Rowland Heights	91748
SPA3	Los Angeles—La Puente	91749
SPA3	Los Angeles—La Verne	91750
SPA3	Los Angeles—Monterey Park	91754
SPA3	Los Angeles—Monterey Park	91755
SPA3	Los Angeles—Monterey Park	91756
SPA3	Los Angeles—Diamond Bar	91765
SPA3	Los Angeles—Pomona	91766
SPA3	Los Angeles—Pomona	91767
SPA3	Los Angeles—Pomona	91768
SPA3	Los Angeles—Pomona	91769
SPA3	Los Angeles—Rosemead	91770
SPA3	Los Angeles—Rosemead	91771
SPA3	Los Angeles—Rosemead	91772
SPA3	Los Angeles—San Dimas	91773
SPA3	Los Angeles—San Gabriel	91775
SPA3	Los Angeles—San Gabriel	91776
SPA3	Los Angeles—San Gabriel	91778
SPA3	Los Angeles—Temple City	91780
SPA3	Los Angeles—Walnut	91788
SPA3	Los Angeles—Walnut	91789
SPA3	Los Angeles—West Covina	91790
SPA3	Los Angeles—West Covina	91791
SPA3	Los Angeles—West Covina	91792
SPA3	Los Angeles—West Covina	91793
SPA3	Los Angeles—Walnut	91795
SPA3	Los Angeles—Alhambra	91801
SPA3	Los Angeles—Alhambra	91802
SPA3	Los Angeles—Alhambra	91803
SPA3	Los Angeles—Alhambra	91804
SPA3	Los Angeles—Alhambra	91896
SPA3	Los Angeles—Alhambra	91899
SPA3	Los Angeles—Pearblossom	93553
SPA3	Los Angeles—Valyermo	93563
SPA4	Los Angeles—Wilshire LA	90004
SPA4	Los Angeles—Wilshire LA	90005
SPA4	Los Angeles—Wilshire LA	90006
SPA4	Los Angeles—Wilshire LA	90010
SPA4	Los Angeles—Central LA	90012

Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
SPA4	Los Angeles—Central LA	90013
SPA4	Los Angeles—Central LA	90014
SPA4	Los Angeles—Central LA	90015
SPA4	Los Angeles—Central LA	90017
SPA4	Los Angeles—Wilshire LA	90019
SPA4	Los Angeles—Wilshire LA	90020
SPA4	Los Angeles—Central LA	90021
SPA4	Los Angeles—East LA	90023
SPA4	Los Angeles—Central LA	90026
SPA4	Los Angeles—Hollywood LA	90027
SPA4	Los Angeles—Hollywood LA	90028
SPA4	Los Angeles—Hollywood LA	90029
SPA4	Los Angeles—Chinatown	90030
SPA4	Los Angeles—Northeast LA	90031
SPA4	Los Angeles—Northeast LA	90032
SPA4	Los Angeles—East LA	90033
SPA4	Los Angeles—West Wilshire LA	90036
SPA4	Los Angeles—Hollywood LA	90038
SPA4	Los Angeles—Northeast LA	90039
SPA4	Los Angeles—Northeast LA	90041
SPA4	Los Angeles—Northeast LA	90042
SPA4	Los Angeles—West Hollywood	90046
SPA4	Los Angeles—West Wilshire LA	90048
SPA4	Los Angeles—Highland Park	90050
SPA4	Los Angeles—South Los Angeles	90051
SPA4	Los Angeles—Downtown Civic Center	90053
SPA4	Los Angeles—South Los Angeles	90054
SPA4	Los Angeles—Downtown Fashion District	90055
SPA4	Los Angeles—Wilshire LA	90057
SPA4	Los Angeles—Northeast LA	90065
SPA4	Los Angeles—Hollywood LA	90068
SPA4	Los Angeles—West Hollywood	90069
SPA4	Los Angeles—Wilshire Center	90070
SPA4	Los Angeles—Central LA	90071
SPA4	Los Angeles—Hollywood	90072
SPA4	Los Angeles—Bank of America	90074
SPA4	Los Angeles—Wilshire Center	90075
SPA4	Los Angeles—Wilshire Center	90076

Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
<del>SPA4</del>	<del>Los Angeles—Hollywood</del>	<del>90078</del>
<del>SPA4</del>	<del>Los Angeles—Downtown Central, Downtown Fashion District</del>	<del>90079</del>
<del>SPA4</del>	<del>Los Angeles—Downtown Bunker Hill</del>	<del>90081</del>
<del>SPA4</del>	<del>Los Angeles—Wells Fargo</del>	<del>90084</del>
<del>SPA4</del>	<del>Los Angeles—Downtown Terminal Annex</del>	<del>90086</del>
<del>SPA4</del>	<del>Los Angeles—South Los Angeles</del>	<del>90087</del>
<del>SPA4</del>	<del>Los Angeles—Wells Fargo</del>	<del>90088</del>
<del>SPA4</del>	<del>Los Angeles—Dodgertown</del>	<del>90090</del>
<del>SPA4</del>	<del>Los Angeles—Hollywood</del>	<del>90093</del>
<del>SPA4</del>	<del>Los Angeles—Bar Code Terminal Annex</del>	<del>90099</del>
<del>SPA4</del>	<del>Los Angeles—Citibank</del>	<del>90189</del>
<del>SPA4</del>	<del>Los Angeles—North Hollywood</del>	<del>91618</del>
<del>SPA5</del>	<del>Los Angeles—Los Angeles International Airport</del>	<del>90009</del>
<del>SPA5</del>	<del>Los Angeles—Westwood</del>	<del>90024</del>
<del>SPA5</del>	<del>Los Angeles—West LA</del>	<del>90025</del>
<del>SPA5</del>	<del>Los Angeles—West LA</del>	<del>90034</del>
<del>SPA5</del>	<del>Los Angeles—West LA</del>	<del>90035</del>
<del>SPA5</del>	<del>Los Angeles—Westchester LA</del>	<del>90045</del>
<del>SPA5</del>	<del>Los Angeles—Brentwood LA</del>	<del>90049</del>
<del>SPA5</del>	<del>Los Angeles—Culver City/Ladera</del>	<del>90056</del>
<del>SPA5</del>	<del>Los Angeles—Watts</del>	<del>90060</del>
<del>SPA5</del>	<del>Los Angeles—West LA</del>	<del>90064</del>
<del>SPA5</del>	<del>Los Angeles—Venice/Mar Vista LA</del>	<del>90066</del>
<del>SPA5</del>	<del>Los Angeles—Westwood LA</del>	<del>90067</del>
<del>SPA5</del>	<del>Los Angeles—Veterans Administration LA</del>	<del>90073</del>
<del>SPA5</del>	<del>Los Angeles—Bel Air LA</del>	<del>90077</del>
<del>SPA5</del>	<del>Los Angeles—Los Angeles International Airport</del>	<del>90080</del>
<del>SPA5</del>	<del>Los Angeles—Westchester</del>	<del>90083</del>
<del>SPA5</del>	<del>Los Angeles—Playa del Ray LA</del>	<del>90094</del>
<del>SPA5</del>	<del>Los Angeles—University of California Los Angeles</del>	<del>90095</del>
<del>SPA5</del>	<del>Los Angeles—Los Angeles</del>	<del>90134</del>



Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
SPA5	<del>Los Angeles—Beverly Hills—</del>	90209
SPA5	<del>Los Angeles—Beverly Hills</del>	90210
SPA5	<del>Los Angeles—Beverly Hills</del>	90211
SPA5	<del>Los Angeles—Beverly Hills</del>	90212
SPA5	<del>Los Angeles—Beverly Hills—</del>	90213
SPA5	<del>Los Angeles—Culver City/Ladera</del>	90230
SPA5	<del>Los Angeles—Culver City—</del>	90231
SPA5	<del>Los Angeles—Culver City/Ladera</del>	90232
SPA5	<del>Los Angeles—Culver City—</del>	90233
SPA5	<del>Los Angeles—Malibu—</del>	90263
SPA5	<del>Los Angeles—Malibu—</del>	90264
SPA5	<del>Los Angeles—Malibu</del>	90265
SPA5	<del>Los Angeles—Pacific Palisades LA</del>	90272
SPA5	<del>Los Angeles—Venice/Mar Vista LA</del>	90291
SPA5	<del>Los Angeles—Venice/Mar Vista LA</del>	90292
SPA5	<del>Los Angeles—Playa del Rey LA</del>	90293
SPA5	<del>Los Angeles—Venice</del>	90294
SPA5	<del>Los Angeles—Marina del Rey—</del>	90295
SPA5	<del>Los Angeles—Playa del Rey</del>	90296
SPA5	<del>Los Angeles—Santa Monica</del>	90401
SPA5	<del>Los Angeles—Santa Monica</del>	90402
SPA5	<del>Los Angeles—Santa Monica</del>	90403
SPA5	<del>Los Angeles—Santa Monica</del>	90404
SPA5	<del>Los Angeles—Santa Monica—</del>	90405
SPA5	<del>Los Angeles—Santa Monica—</del>	90406
SPA5	<del>Los Angeles—Santa Monica—</del>	90407
SPA5	<del>Los Angeles—Santa Monica—</del>	90408
SPA5	<del>Los Angeles—Santa Monica—</del>	90409
SPA5	<del>Los Angeles—Santa Monica—</del>	90410
SPA5	<del>Los Angeles—Santa Monica—</del>	90411
SPA6	<del>Los Angeles—South Central LA</del>	90001
SPA6	<del>Los Angeles—South Central LA</del>	90002
SPA6	<del>Los Angeles—South Central LA</del>	90003
SPA6	<del>Los Angeles—University LA</del>	90007
SPA6	<del>Los Angeles—Crenshaw LA</del>	90008
SPA6	<del>Los Angeles—University LA</del>	90011
SPA6	<del>Los Angeles—Crenshaw LA</del>	90016

Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
SPA6	Los Angeles—University LA	90018
SPA6	Los Angeles—University LA	90037
SPA6	Los Angeles—Crenshaw LA	90043
SPA6	Los Angeles—South Central LA	90047
SPA6	Los Angeles—South Los Angeles	90052
SPA6	Los Angeles—South Central LA	90059
SPA6	Los Angeles—West Compton LA	90061
SPA6	Los Angeles—University LA	90062
SPA6	Los Angeles—South Los Angeles	90082
SPA6	Los Angeles—University of Southern California	90089
SPA6	Los Angeles—Compton	90220
SPA6	Los Angeles—Compton	90221
SPA6	Los Angeles—Compton	90222
SPA6	Los Angeles—Compton	90223
SPA6	Los Angeles—Lynwood	90262
SPA6	Los Angeles—Paramount	90723
SPA7	Los Angeles—East LA	90022
SPA7	Los Angeles—Commerce	90040
SPA7	Los Angeles—Huntington Park/Vernon	90058
SPA7	Los Angeles—East LA	90063
SPA7	Los Angeles—Commerce	90091
SPA7	Los Angeles—Bell	90096
SPA7	Los Angeles—Rodale Press	90103
SPA7	Los Angeles—Bell	90201
SPA7	Los Angeles—Bell, Bell Gardens	90202
SPA7	Los Angeles—Downey	90239
SPA7	Los Angeles—Downey	90240
SPA7	Los Angeles—Downey	90241
SPA7	Los Angeles—Downey	90242
SPA7	Los Angeles—Huntington Park	90255
SPA7	Los Angeles—Maywood	90270
SPA7	Los Angeles—South Gate	90280
SPA7	Los Angeles—Whittier	90601
SPA7	Los Angeles—Whittier	90602
SPA7	Los Angeles—Whittier	90603
SPA7	Los Angeles—Whittier	90604
SPA7	Los Angeles—Whittier	90605
SPA7	Los Angeles—Whittier	90606

Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
SPA7	Los Angeles—Whittier	90607
SPA7	Los Angeles—Whittier	90608
SPA7	Los Angeles—Whittier	90609
SPA7	Los Angeles—Whittier	90610
SPA7	Los Angeles—La Habra	90631
SPA7	Los Angeles—La Mirada	90637
SPA7	Los Angeles—La Mirada	90638
SPA7	Los Angeles—La Mirada	90639
SPA7	Los Angeles—Montebello	90640
SPA7	Los Angeles—Norwalk	90650
SPA7	Los Angeles—Norwalk	90651
SPA7	Los Angeles—Norwalk	90652
SPA7	Los Angeles—Pico Rivera	90660
SPA7	Los Angeles—Pico Rivera	90661
SPA7	Los Angeles—Pico Rivera	90662
SPA7	Los Angeles—Santa Fe Springs	90670
SPA7	Los Angeles—Santa Fe Springs	90671
SPA7	Los Angeles—Artesia	90701
SPA7	Los Angeles—Artesia	90702
SPA7	Los Angeles—Cerritos	90703
SPA7	Los Angeles—Bellflower	90706
SPA7	Los Angeles—Bellflower	90707
SPA7	Los Angeles—Lakewood	90711
SPA7	Los Angeles—Lakewood	90712
SPA7	Los Angeles—Lakewood	90713
SPA7	Los Angeles—Lakewood	90714
SPA7	Los Angeles—Lakewood	90715
SPA7	Los Angeles—Hawaiian Gardens	90716
SPA7	Los Angeles—Signal Hill	90755
SPA8	Los Angeles—South Central LA	90044
SPA8	Los Angeles—Compton, Rancho Dominguez	90224
SPA8	Los Angeles—El Segundo	90245
SPA8	Los Angeles—Gardena	90247
SPA8	Los Angeles—Gardena	90248
SPA8	Los Angeles—Gardena	90249
SPA8	Los Angeles—Hawthorne	90250
SPA8	Los Angeles—Hawthorne	90251
SPA8	Los Angeles—Beach Cities	90254
SPA8	Los Angeles—Lawndale	90260

Rating Region / Service Planning Area	County Name	3-Digit ZIP Code (Los Angeles County only)
SPA8	Los Angeles—Lawndale Federal Bldg	90261
SPA8	Los Angeles—Beach Cities	90266
SPA8	Los Angeles—Manhattan Beach	90267
SPA8	Los Angeles—Palos Verdes	90274
SPA8	Los Angeles—Palos Verdes	90275
SPA8	Los Angeles—Beach Cities	90277
SPA8	Los Angeles—Beach Cities	90278
SPA8	Los Angeles—Inglewood	90301
SPA8	Los Angeles—Inglewood	90302
SPA8	Los Angeles—Inglewood	90303
SPA8	Los Angeles—Inglewood	90304
SPA8	Los Angeles—Inglewood	90305
SPA8	Los Angeles—Inglewood	90306
SPA8	Los Angeles—Inglewood	90307
SPA8	Los Angeles—Inglewood	90308
SPA8	Los Angeles—Inglewood	90309
SPA8	Los Angeles—Inglewood	90310
SPA8	Los Angeles—Inglewood	90311
SPA8	Los Angeles—Inglewood	90312
SPA8	Los Angeles—Torrance	90501
SPA8	Los Angeles—Torrance	90502
SPA8	Los Angeles—Torrance	90503
SPA8	Los Angeles—Torrance	90504
SPA8	Los Angeles—Torrance	90505
SPA8	Los Angeles—Torrance	90506
SPA8	Los Angeles—Torrance	90507
SPA8	Los Angeles—Torrance	90508
SPA8	Los Angeles—Torrance	90509
SPA8	Los Angeles—Torrance	90510
SPA8	Los Angeles—Avalon	90704
SPA8	Los Angeles—Harbor City LA	90710
SPA8	Los Angeles—Lomita	90717
SPA8	Los Angeles—San Pedro LA	90731
SPA8	Los Angeles—San Pedro LA	90732
SPA8	Los Angeles—San Pedro	90733
SPA8	Los Angeles—San Pedro	90734
SPA8	Los Angeles—Wilmington LA	90744
SPA8	Los Angeles—Carson	90745
SPA8	Los Angeles—Carson	90746

Rating Region / <del>Service Planning Area</del>	County Name	<del>3-Digit</del> ZIP Code (Los Angeles County only)
SPA8	<del>Los Angeles – Carson</del>	90747
SPA8	<del>Los Angeles – Wilmington</del>	90748
SPA8	<del>Los Angeles – Carson</del>	90749
SPA8	<del>Los Angeles – Long Beach</del>	90801
SPA8	<del>Los Angeles – Long Beach</del>	90802
SPA8	<del>Los Angeles – Long Beach</del>	90803
SPA8	<del>Los Angeles – Long Beach</del>	90804
SPA8	<del>Los Angeles – Long Beach</del>	90805
SPA8	<del>Los Angeles – Long Beach</del>	90806
SPA8	<del>Los Angeles – Long Beach</del>	90807
SPA8	<del>Los Angeles – Long Beach</del>	90808
SPA8	<del>Los Angeles – Long Beach</del>	90809
SPA8	<del>Los Angeles – Long Beach</del>	90810
SPA8	<del>Los Angeles – Long Beach</del>	90813
SPA8	<del>Los Angeles – Long Beach</del>	90814
SPA8	<del>Los Angeles – Long Beach</del>	90815
SPA8	<del>Los Angeles – Long Beach</del>	90822
SPA8	<del>Los Angeles – Long Beach</del>	90831
SPA8	<del>Los Angeles – Long Beach</del>	90832
SPA8	<del>Los Angeles – Long Beach</del>	90833
SPA8	<del>Los Angeles – Long Beach</del>	90834
SPA8	<del>Los Angeles – Long Beach</del>	90835
SPA8	<del>Los Angeles – Long Beach</del>	90840
SPA8	<del>Los Angeles – Long Beach</del>	90842
SPA8	<del>Los Angeles – Long Beach</del>	90844
SPA8	<del>Los Angeles – Long Beach</del>	90846
SPA8	<del>Los Angeles – Long Beach</del>	90847
SPA8	<del>Los Angeles – Long Beach</del>	90848
SPA8	<del>Los Angeles – Long Beach</del>	90853
SPA8	<del>Los Angeles – Carson</del>	90895
SPA8	<del>Los Angeles – Long Beach</del>	90899

## Appendix D: Condition and Procedure Types

The tables below describe how submitters shall categorize episode-based payments in the Submission Questionnaire File into their respective payment subcategories and procedure or condition type.

### Procedure-related, Episode-based Payments

These shared savings payments or payments with risk of recoupments are built on a fee-for-service architecture with a retrospective reconciliation to determine the shared savings payment or recoupment. When Payment Subcategory (APM006) is 'C1' or 'C2', use the procedure types in the table below.

#	Type	Description	Examples of Procedures
<u>1</u>	<u>Cardiovascular</u>	<u>Procedures involving the heart and blood vessels.</u>	<ul style="list-style-type: none"> <li>• <u>Coronary artery bypass graft surgery</u></li> <li>• <u>Percutaneous coronary intervention</u></li> <li>• <u>Automatic cardiac defibrillator implant</u></li> </ul>
<u>2</u>	<u>Gastrointestinal</u>	<u>Procedures and surgeries involving the gastrointestinal tract.</u>	<ul style="list-style-type: none"> <li>• <u>Colonoscopy</u></li> <li>• <u>Upper gastrointestinal tract endoscopy</u></li> <li>• <u>Major bowel procedures</u></li> </ul>
<u>3</u>	<u>Orthopedic</u>	<u>Procedures and surgeries involving the musculoskeletal system, including muscles, joints, and the spine.</u>	<ul style="list-style-type: none"> <li>• <u>Hip replacement</u></li> <li>• <u>Knee arthroscopy</u></li> <li>• <u>Spinal fusion</u></li> <li>• <u>Amputation</u></li> <li>• <u>Removal of orthopedic devices</u></li> </ul>
<u>4</u>	<u>Transplant</u>	<u>Transplantation procedures of solid organs and bone marrow.</u>	<ul style="list-style-type: none"> <li>• <u>Kidney transplant</u></li> <li>• <u>Bone marrow transplant</u></li> <li>• <u>Partial liver transplant</u></li> </ul>
<u>5</u>	<u>Other Procedures</u>	<u>Other procedure-specific, episode-based payments built on a fee-for-service architecture with a retrospective reconciliation to determine the shared savings payment or recoupment that do not fall into Types 1-4.</u>	<ul style="list-style-type: none"> <li>• <u>Cataract surgery</u></li> <li>• <u>Bariatric surgery</u></li> <li>• <u>Hysterectomy</u></li> </ul>

### Condition-related, Episode-based Payments

These shared savings payments or payments with risk of recoupments are built on a fee-for-service architecture with a retrospective reconciliation to determine the shared savings payment or recoupment. When Payment Subcategory (APM006) is 'C3' or 'C4', use the condition types in the table below.

<u>#</u>	<u>Type</u>	<u>Description</u>	<u>Examples of Conditions</u>
<u>6</u>	<u>Chronic/Outpatient-Based</u>	<u>Care to treat chronic conditions primarily managed in an outpatient setting, over a defined period of time. Note: chronic care for cancer should be included in Type 8.</u>	<ul style="list-style-type: none"> <li><u>• Diabetes</u></li> <li><u>• Asthma</u></li> <li><u>• Chronic kidney disease</u></li> </ul>
<u>7</u>	<u>Acute/Hospitalization-Based</u>	<u>Episodes initiated by an inpatient stay, which may be limited to inpatient treatment or may extend into the post-hospitalization period or may include only post-hospitalization care.</u>	<ul style="list-style-type: none"> <li><u>• Stroke</u></li> <li><u>• Cardiac arrhythmia</u></li> <li><u>• Sepsis</u></li> </ul>
<u>8</u>	<u>Oncology</u>	<u>Diagnosis, treatment, and/or prevention of cancer.</u>	<ul style="list-style-type: none"> <li><u>• High-risk breast cancer</u></li> <li><u>• Lymphoma</u></li> <li><u>• Colorectal cancer</u></li> </ul>
<u>9</u>	<u>Pregnancy</u>	<u>Care to support health during pregnancy, childbirth, and/or the postpartum period.</u>	<u>N/A</u>
<u>10</u>	<u>Other Conditions</u>	<u>Other condition-specific, episode-based payments built on a fee-for-service architecture with a retrospective reconciliation to determine the shared savings payment or recoupment that do not fall into Types 6-9.</u>	<u>N/A</u>

## Appendix E: Primary Care Code Sets

### Primary Care Providers Taxonomy List

Primary care providers are defined by National Uniform Claim Committee (NUCC) taxonomy codes on claims.<sup>8</sup> The taxonomies listed, in combination with service and place of service criteria, are included in the claims-based definition of primary care.<sup>9</sup> Rows with an asterisk (\*) indicate taxonomies for physicians, physician assistants, and nurse practitioners.

<u>Taxonomy</u>	<u>NUCC Name</u>
<u>163W00000X</u>	<u>Nurse, non-practitioner</u>
<u>172V00000X</u>	<u>Community Health Worker</u>
<u>183500000X</u>	<u>Pharmacist</u>
<u>1835G0303X</u>	<u>Geriatric Pharmacist</u>
<u>1835P0018X</u>	<u>Pharmacist Clinician (PhC)/ Clinical Pharmacy Specialist</u>
<u>1835P0200X</u>	<u>Pediatric Pharmacist</u>
<u>207Q00000X</u>	<u>Family Medicine*</u>
<u>207QA0000X</u>	<u>Family Medicine, Adolescent Medicine*</u>
<u>207QA0505X</u>	<u>Family Medicine, Adult Medicine*</u>
<u>207QG0300X</u>	<u>Family Medicine- Geriatric Medicine*</u>
<u>207R00000X</u>	<u>Internal Medicine*</u>
<u>207RA0000X</u>	<u>Internal Medicine, Adolescent Medicine*</u>
<u>207RG0300X</u>	<u>Internal Medicine- Geriatric Medicine*</u>
<u>208000000X</u>	<u>Pediatrics*</u>
<u>2080A0000X</u>	<u>Pediatrics, Adolescent Medicine*</u>
<u>208D00000X</u>	<u>General Practice*</u>
<u>261QC0050X</u>	<u>Critical Access Hospital Clinic/Center</u>
<u>261QF0400X</u>	<u>Federally Qualified Health Center</u>
<u>261QP2300X</u>	<u>Clinic/Center- Primary Care</u>
<u>261QR1300X</u>	<u>Clinic/Center- Rural Health</u>
<u>363AM0700X</u>	<u>Physician Assistant, Medical*</u>
<u>363L00000X</u>	<u>Nurse Practitioner*</u>
<u>363LA2200X</u>	<u>Nurse Practitioner- Adult Health*</u>
<u>363LC1500X</u>	<u>Nurse Practitioner, Community Health*</u>

<sup>8</sup> National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy:  
<https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40>

<sup>9</sup> Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Primary Care Investment Benchmark.  
[https://hcai.ca.gov/wp-content/uploads/2024/04/OHCA-Recommendations-to-Board\\_Proposed-Primary-Care-Investment-Benchmark.pdf](https://hcai.ca.gov/wp-content/uploads/2024/04/OHCA-Recommendations-to-Board_Proposed-Primary-Care-Investment-Benchmark.pdf)



<b>Taxonomy</b>	<b>NUCC Name</b>
<a href="#"><u>363LF0000X</u></a>	<a href="#"><u>Nurse Practitioner- Family*</u></a>
<a href="#"><u>363LG0600X</u></a>	<a href="#"><u>Nurse Practitioner, Gerontology*</u></a>
<a href="#"><u>363LP0200X</u></a>	<a href="#"><u>Nurse Practitioner- Pediatrics*</u></a>
<a href="#"><u>363LP2300X</u></a>	<a href="#"><u>Nurse Practitioner- Primary Care*</u></a>
<a href="#"><u>363LS0200X</u></a>	<a href="#"><u>Nurse Practitioner, School*</u></a>
<a href="#"><u>364SA2200X</u></a>	<a href="#"><u>Certified clinical nurse specialist- adult health</u></a>
<a href="#"><u>364SC1501X</u></a>	<a href="#"><u>Certified clinical nurse specialist- community health/public health</u></a>
<a href="#"><u>364SC2300X</u></a>	<a href="#"><u>Certified clinical nurse specialist- chronic health</u></a>
<a href="#"><u>364SF0001X</u></a>	<a href="#"><u>Certified clinical nurse specialist- family health</u></a>
<a href="#"><u>364SG0600X</u></a>	<a href="#"><u>Certified clinical nurse specialist- gerontology</u></a>
<a href="#"><u>364SP0200X</u></a>	<a href="#"><u>Certified clinical nurse specialist- pediatrics</u></a>

### Primary Care CMS Places of Service

Primary care places of service are defined by the Centers for Medicare and Medicaid Services (CMS) Place of Service (POS) codes on claims.<sup>10</sup> The listed POS codes, in combination with service and provider criteria, are included in the claims-based definition of primary care.<sup>11</sup>

<b>POS Code</b>	<b>Place of Service</b>
<a href="#"><u>02</u></a>	<a href="#"><u>Telehealth Provided Other than in Patient's Home</u></a>
<a href="#"><u>03</u></a>	<a href="#"><u>School</u></a>
<a href="#"><u>04</u></a>	<a href="#"><u>Homeless Shelter</u></a>
<a href="#"><u>05</u></a>	<a href="#"><u>Indian Health Service Free-Standing Facility</u></a>
<a href="#"><u>07</u></a>	<a href="#"><u>Tribal 638 Free-standing Facility</u></a>
<a href="#"><u>09</u></a>	<a href="#"><u>Prison/ Correctional Facility</u></a>
<a href="#"><u>10</u></a>	<a href="#"><u>Telehealth Provided in Patient's Home</u></a>
<a href="#"><u>11</u></a>	<a href="#"><u>Office</u></a>
<a href="#"><u>12</u></a>	<a href="#"><u>Home</u></a>
<a href="#"><u>13</u></a>	<a href="#"><u>Assisted Living Facility</u></a>
<a href="#"><u>14</u></a>	<a href="#"><u>Group Home</u></a>
<a href="#"><u>15</u></a>	<a href="#"><u>Mobile Unit</u></a>
<a href="#"><u>18</u></a>	<a href="#"><u>Place of Employment- Worksite</u></a>

<sup>10</sup> CMS Place of Service Code Set: <https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets>

<sup>11</sup> Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Primary Care Investment Benchmark. [https://hcai.ca.gov/wp-content/uploads/2024/04/OHCA-Recommendations-to-Board\\_Proposed-Primary-Care-Investment-Benchmark.pdf](https://hcai.ca.gov/wp-content/uploads/2024/04/OHCA-Recommendations-to-Board_Proposed-Primary-Care-Investment-Benchmark.pdf)

<b>POS Code</b>	<b>Place of Service</b>
<u>19</u>	<u>Off Campus- Outpatient Hospital</u>
<u>22</u>	<u>On Campus- Outpatient Hospital</u>
<u>26</u>	<u>Military Treatment Facility</u>
<u>27</u>	<u>Outreach Site/ Street</u>
<u>49</u>	<u>Independent Clinic</u>
<u>50</u>	<u>Federally Qualified Health Center</u>
<u>66</u>	<u>Programs of All-Inclusive Care for the Elderly (PACE) Center</u>
<u>71</u>	<u>Public Health Clinic</u>
<u>72</u>	<u>Rural Health Clinic</u>

### HCPCS/CPT Primary Care Services

Primary care services are defined by Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes on claims.<sup>12</sup> The listed service codes, in combination with provider taxonomy and place of service, are included in the claims-based definition of primary care.<sup>13</sup>

<b>HCPCS/CPT Code</b>	<b>Description</b>
<u>10040</u>	<u>Acne surgery</u>
<u>10060</u>	<u>Drainage Of Skin Abscess Simple</u>
<u>10061</u>	<u>Drainage Of Skin Abscess Complicated</u>
<u>10080</u>	<u>Drainage Of Pilonidal Cyst Simple</u>
<u>10081</u>	<u>Drainage of pilonidal cyst</u>
<u>10120</u>	<u>Remove Foreign Body Simple</u>
<u>10121</u>	<u>Remove Foreign Body Complicated</u>
<u>10140</u>	<u>Drainage of hematoma/fluid</u>
<u>10160</u>	<u>Puncture Drainage Of Lesion</u>
<u>10180</u>	<u>Complex drainage wound</u>
<u>11000</u>	<u>Debride Infected Skin</u>
<u>11055</u>	<u>Trim Skin Lesion Single</u>
<u>11056</u>	<u>Trim Skin Lesions 2 To 4</u>
<u>11102</u>	<u>Tangntl bx skin single les</u>
<u>11103</u>	<u>Tangntl bx skin ea sep/addl</u>

<sup>12</sup> HCPCS and CPT codes are maintained by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA):

<https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system>

<sup>13</sup> Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Primary Care Investment Benchmark.

[https://hcai.ca.gov/wp-content/uploads/2024/04/OHCA-Recommendations-to-Board\\_Proposed-Primary-Care-Investment-Benchmark.pdf](https://hcai.ca.gov/wp-content/uploads/2024/04/OHCA-Recommendations-to-Board_Proposed-Primary-Care-Investment-Benchmark.pdf)

<b>HCP/CS/CPT Code</b>	<b>Description</b>
<u>11104</u>	<u>Punch bx skin single lesion</u>
<u>11105</u>	<u>Punch bx skin ea sep/addl</u>
<u>11106</u>	<u>Incal bx skn single les</u>
<u>11107</u>	<u>Incal bx skn ea sep/addl</u>
<u>11200</u>	<u>Removal Of Skin Tags &lt;W/15</u>
<u>11201</u>	<u>Remove Skin Tags Add-On</u>
<u>11300</u>	<u>Shave Skin Lesion 05 Cm/&lt;</u>
<u>11301</u>	<u>Shave Skin Lesion 06-10 Cm</u>
<u>11302</u>	<u>Shave Skin Lesion 11-20 Cm</u>
<u>11303</u>	<u>Shave Skin Lesion &gt;20 Cm</u>
<u>11305</u>	<u>Shave Skin Lesion 05 Cm/&lt;</u>
<u>11306</u>	<u>Shave Skin Lesion 06-10 Cm</u>
<u>11307</u>	<u>Shave Skin Lesion 11-20 Cm</u>
<u>11308</u>	<u>Shave skin lesion &gt;2.0 cm</u>
<u>11310</u>	<u>Shave Skin Lesion 05 Cm/&lt;</u>
<u>11311</u>	<u>Shave Skin Lesion 06-10 Cm</u>
<u>11312</u>	<u>Shave skin lesion 1.1-2.0 cm</u>
<u>11313</u>	<u>Shave skin lesion &gt;2.0 cm</u>
<u>11400</u>	<u>Exc Tr-Ext B9+Marg 05 Cm&lt;</u>
<u>11401</u>	<u>Exc Tr-Ext B9+Marg 06-1 Cm</u>
<u>11402</u>	<u>Exc Tr-Ext B9+Marg 11-2 Cm</u>
<u>11403</u>	<u>Exc Tr-Ext B9+Marg 21-3 Cm</u>
<u>11404</u>	<u>Exc tr-ext b9+marg 3.1-4 cm</u>
<u>11406</u>	<u>Exc tr-ext b9+marg &gt;4.0 cm</u>
<u>11420</u>	<u>Exc H-F-Nk-Sp B9+Marg 05/&lt; Cm</u>
<u>11421</u>	<u>Exc H-F-Nk-Sp B9+Marg 06-1 Cm</u>
<u>11422</u>	<u>Exc H-F-Nk-Sp B9+Marg 11-2 Cm</u>
<u>11423</u>	<u>Exc H-F-Nk-Sp B9+Marg 21-3 Cm</u>
<u>11424</u>	<u>Exc h-f-nk-sp b9+marg 3.1-4</u>
<u>11426</u>	<u>Exc h-f-nk-sp b9+marg &gt;4 cm</u>
<u>11440</u>	<u>Exc face-mm b9+marg 0.5 cm/&lt;</u>
<u>11441</u>	<u>Exc face-mm b9+marg 0.6-1 cm</u>
<u>11442</u>	<u>Exc face-mm b9+marg 1.1-2 cm</u>
<u>11443</u>	<u>Exc face-mm b9+marg 2.1-3 cm</u>
<u>11444</u>	<u>Exc face-mm b9+marg 3.1-4 cm</u>
<u>11446</u>	<u>Exc face-mm b9+marg &gt;4 cm</u>
<u>11719</u>	<u>Trimming Nondystrophic Nails Any Number</u>
<u>11720</u>	<u>Debride Nail 1-5</u>
<u>11721</u>	<u>Debride Nail 6+</u>
<u>11730</u>	<u>Removal Of Nail Plate Simple</u>
<u>11732</u>	<u>Remove nail plate add-on</u>

HCP/CS/CPT Code	Description
11740	Evacuation Subungual Hematoma
11750	Removal Of Nail Bed Partial/Complete
11765	Excision Of Nail Fold Toe
11900	Inject Skin Lesions </W 7
11901	Inject Skin >7 Lesions
11976	Remove Contraceptive Capsule
11980	Implant hormone pellet(s)
11981	Insert Drug Implant Device
11982	Remove Drug Implant Device
11983	Remove W/ Insert Drug Implant
12001	Simple Rpr S/N/Ax/Gen/Trnk 25Cm/<
12002	Rpr s/n/ax/gen/trnk2.6-7.5cm
12004	Rpr s/n/ax/gen/trk7.6-12.5cm
12005	Rpr s/n/a/gen/trk12.6-20.0cm
12006	Rpr s/n/a/gen/trk20.1-30.0cm
12007	Rpr s/n/ax/gen/trnk >30.0 cm
12011	Rpr f/e/e/n/l/m 2.5 cm/<
12013	Rpr f/e/e/n/l/m 2.6-5.0 cm
12014	Rpr f/e/e/n/l/m 5.1-7.5 cm
12015	Rpr f/e/e/n/l/m 7.6-12.5 cm
12016	Rpr fe/e/en/l/m 12.6-20.0 cm
12017	Rpr fe/e/en/l/m 20.1-30.0 cm
12018	Rpr f/e/e/n/l/m >30.0 cm
12020	Closure of split wound
12021	Closure of split wound
12031	Intmd rpr s/a/t/ext 2.5 cm/<
12032	Intmd rpr s/a/t/ext 2.6-7.5
12034	Intmd rpr s/tr/ext 7.6-12.5
12035	Intmd rpr s/a/t/ext 12.6-20
12036	Intmd rpr s/a/t/ext 20.1-30
12037	Intmd rpr s/tr/ext >30.0 cm
12041	Intmd rpr n-hf/genit 2.5cm/<
12042	Intmd Rpr N-Hf/Genit26-75
12044	Intmd rpr n-hf/genit7.6-12.5
12045	Intmd rpr n-hf/genit12.6-20
12046	Intmd rpr n-hf/genit20.1-30
12047	Intmd rpr n-hf/genit >30.0cm
12051	Intmd rpr face/mm 2.5 cm/<
12052	Intmd rpr face/mm 2.6-5.0 cm
12053	Intmd rpr face/mm 5.1-7.5 cm
12054	Intmd rpr face/mm 7.6-12.5cm

<b>HCP/CS/CPT Code</b>	<b>Description</b>
<a href="#"><u>12055</u></a>	<a href="#"><u>Intmd rpr face/mm 12.6-20 cm</u></a>
<a href="#"><u>12056</u></a>	<a href="#"><u>Intmd rpr face/mm 20.1-30.0</u></a>
<a href="#"><u>12057</u></a>	<a href="#"><u>Intmd rpr face/mm &gt;30.0 cm</u></a>
<a href="#"><u>13160</u></a>	<a href="#"><u>Late closure of wound</u></a>
<a href="#"><u>15839</u></a>	<a href="#"><u>Excise Excess Skin &amp; Tissue</u></a>
<a href="#"><u>16020</u></a>	<a href="#"><u>Dress/debrid p-thick burn s</u></a>
<a href="#"><u>17000</u></a>	<a href="#"><u>Destroy Premalg Lesion</u></a>
<a href="#"><u>17003</u></a>	<a href="#"><u>Destroy Premalg Lesion 2-14</u></a>
<a href="#"><u>17004</u></a>	<a href="#"><u>Destroy Premal Lesions 15/&gt;</u></a>
<a href="#"><u>17106</u></a>	<a href="#"><u>Destruction of skin lesions</u></a>
<a href="#"><u>17107</u></a>	<a href="#"><u>Destruction of skin lesions</u></a>
<a href="#"><u>17108</u></a>	<a href="#"><u>Destruction of skin lesions</u></a>
<a href="#"><u>17110</u></a>	<a href="#"><u>Destroy B9 Lesion 1-14</u></a>
<a href="#"><u>17111</u></a>	<a href="#"><u>Destroy B9 Lesion 15 Or More</u></a>
<a href="#"><u>17250</u></a>	<a href="#"><u>Chem Caut Of Granlt Tissue</u></a>
<a href="#"><u>17281</u></a>	<a href="#"><u>Destroy Malgnt Skin Lesions 06-1 Cm</u></a>
<a href="#"><u>17340</u></a>	<a href="#"><u>Cryotherapy For Acne</u></a>
<a href="#"><u>19000</u></a>	<a href="#"><u>Drainage Of Breast Lesion</u></a>
<a href="#"><u>20520</u></a>	<a href="#"><u>Removal Of Foreign Body Simple</u></a>
<a href="#"><u>20550</u></a>	<a href="#"><u>Inj Tendon Sheath/Ligament</u></a>
<a href="#"><u>20551</u></a>	<a href="#"><u>Inj Tendon Origin/Insertion</u></a>
<a href="#"><u>20552</u></a>	<a href="#"><u>Inj Trigger Point 1/2 Muscl</u></a>
<a href="#"><u>20553</u></a>	<a href="#"><u>Inject Trigger Points 3/&gt;</u></a>
<a href="#"><u>20600</u></a>	<a href="#"><u>Drain/Inj Joint/Bursa W/O Us Small</u></a>
<a href="#"><u>20604</u></a>	<a href="#"><u>Drain/inj joint/bursa w/us</u></a>
<a href="#"><u>20605</u></a>	<a href="#"><u>Drain/Inj Joint/Bursa W/O Us Intermediate</u></a>
<a href="#"><u>20606</u></a>	<a href="#"><u>Drain/inj joint/bursa w/us</u></a>
<a href="#"><u>20610</u></a>	<a href="#"><u>Drain/Inj Joint/Bursa W/O Us Major</u></a>
<a href="#"><u>20611</u></a>	<a href="#"><u>Drain/inj joint/bursa w/us</u></a>
<a href="#"><u>20612</u></a>	<a href="#"><u>Drain/Inj Ganglion Cyst</u></a>
<a href="#"><u>24640</u></a>	<a href="#"><u>Closed Treat Radial Head Sublx Child</u></a>
<a href="#"><u>27096</u></a>	<a href="#"><u>Inject sacroiliac joint</u></a>
<a href="#"><u>29105</u></a>	<a href="#"><u>Apply long arm splint</u></a>
<a href="#"><u>29125</u></a>	<a href="#"><u>Apply forearm splint</u></a>
<a href="#"><u>29126</u></a>	<a href="#"><u>Apply forearm splint</u></a>
<a href="#"><u>29130</u></a>	<a href="#"><u>Application of finger splint</u></a>
<a href="#"><u>29131</u></a>	<a href="#"><u>Application of finger splint</u></a>
<a href="#"><u>29200</u></a>	<a href="#"><u>Strapping of chest</u></a>
<a href="#"><u>29240</u></a>	<a href="#"><u>Strapping of shoulder</u></a>
<a href="#"><u>29260</u></a>	<a href="#"><u>Strapping of elbow or wrist</u></a>
<a href="#"><u>29280</u></a>	<a href="#"><u>Strapping of hand or finger</u></a>

HCP/CS/CPT Code	Description
<a href="#">29505</a>	<a href="#">Application long leg splint</a>
<a href="#">29515</a>	<a href="#">Application lower leg splint</a>
<a href="#">29520</a>	<a href="#">Strapping of hip</a>
<a href="#">29530</a>	<a href="#">Strapping of knee</a>
<a href="#">29540</a>	<a href="#">Strapping of ankle and/or ft</a>
<a href="#">29550</a>	<a href="#">Strapping of toes</a>
<a href="#">29581</a>	<a href="#">Apply multilay comprs lwr leg</a>
<a href="#">29584</a>	<a href="#">Appl multilay comprs arm/hand</a>
<a href="#">30300</a>	<a href="#">Removal Foreign Body Intranasal Office Procedure</a>
<a href="#">30901</a>	<a href="#">Control of nosebleed</a>
<a href="#">30903</a>	<a href="#">Control of nosebleed</a>
<a href="#">30905</a>	<a href="#">Control of nosebleed</a>
<a href="#">30906</a>	<a href="#">Repeat control of nosebleed</a>
<a href="#">36410</a>	<a href="#">Non-routine bl draw 3/&gt; yrs</a>
<a href="#">36415</a>	<a href="#">Routine Venipuncture</a>
<a href="#">36416</a>	<a href="#">Capillary Blood Draw</a>
<a href="#">40804</a>	<a href="#">Removal foreign body mouth</a>
<a href="#">40805</a>	<a href="#">Removal foreign body mouth</a>
<a href="#">46600</a>	<a href="#">Diagnostic anoscopy spx</a>
<a href="#">51702</a>	<a href="#">Insert temp bladder cath</a>
<a href="#">51798</a>	<a href="#">Us urine capacity measure</a>
<a href="#">54050</a>	<a href="#">Destruction Penis Lesion Chem Simple</a>
<a href="#">54056</a>	<a href="#">Cryosurgery Penis Lesion Simple Cyro</a>
<a href="#">55250</a>	<a href="#">Removal Of Sperm Duct</a>
<a href="#">56405</a>	<a href="#">I &amp; d of vulva/perineum</a>
<a href="#">56420</a>	<a href="#">Drainage of gland abscess</a>
<a href="#">56605</a>	<a href="#">Biopsy of vulva/perineum</a>
<a href="#">56606</a>	<a href="#">Biopsy of vulva/perineum</a>
<a href="#">56820</a>	<a href="#">Exam of vulva w/scope</a>
<a href="#">56821</a>	<a href="#">Exam/biopsy of vulva w/scope</a>
<a href="#">57010</a>	<a href="#">Drainage of pelvic abscess</a>
<a href="#">57020</a>	<a href="#">Drainage of pelvic fluid</a>
<a href="#">57100</a>	<a href="#">Biopsy of vagina</a>
<a href="#">57105</a>	<a href="#">Biopsy of vagina</a>
<a href="#">57150</a>	<a href="#">Treat vagina infection</a>
<a href="#">57160</a>	<a href="#">Insert pessary/other device</a>
<a href="#">57170</a>	<a href="#">Fitting Of Diaphragm/Cap</a>
<a href="#">57180</a>	<a href="#">Treat vaginal bleeding</a>
<a href="#">57410</a>	<a href="#">Pelvic examination</a>
<a href="#">57420</a>	<a href="#">Exam of vagina w/scope</a>
<a href="#">57421</a>	<a href="#">Exam/biopsy of vag w/scope</a>

HCP/CS/CPT Code	Description
<a href="#">57452</a>	<a href="#">Exam of cervix w/scope</a>
<a href="#">57454</a>	<a href="#">Bx/curett of cervix w/scope</a>
<a href="#">57455</a>	<a href="#">Biopsy of cervix w/scope</a>
<a href="#">57456</a>	<a href="#">Endocerv curettage w/scope</a>
<a href="#">57500</a>	<a href="#">Biopsy of cervix</a>
<a href="#">58300</a>	<a href="#">Insert Intrauterine Device</a>
<a href="#">58301</a>	<a href="#">Remove Intrauterine Device</a>
<a href="#">59425</a>	<a href="#">Antepartum Care Only 4-6 Visits</a>
<a href="#">59426</a>	<a href="#">Antepartum Care Only 7&lt; Visits</a>
<a href="#">59430</a>	<a href="#">Postpartum Care Only</a>
<a href="#">59510</a>	<a href="#">Routine Ob Care</a>
<a href="#">59812</a>	<a href="#">Treatment of miscarriage</a>
<a href="#">59820</a>	<a href="#">Care of miscarriage</a>
<a href="#">59821</a>	<a href="#">Treatment of miscarriage</a>
<a href="#">59830</a>	<a href="#">Treat uterus infection</a>
<a href="#">69200</a>	<a href="#">Clear Outer Ear Canal W/Out Anesthesia</a>
<a href="#">69205</a>	<a href="#">Clear outer ear canal</a>
<a href="#">69209</a>	<a href="#">Remove Impacted Ear Wax Irrigation</a>
<a href="#">69210</a>	<a href="#">Remove Impacted Ear Wax Instruments</a>
<a href="#">81000</a>	<a href="#">Urinalysis Dip Stick/Tablet Reagnt Non-Auto Microscopy</a>
<a href="#">81001</a>	<a href="#">Urinalysis Dip Stick/Tablet Reagent Auto Microscopy</a>
<a href="#">81025</a>	<a href="#">Urine Pregnancy Test Visual Color Comparison</a>
<a href="#">82044</a>	<a href="#">Urine Albumin Semiquantitative</a>
<a href="#">82270</a>	<a href="#">Blood Occult Peroxidase Actv Qual Feces 1 Determination</a>
<a href="#">82272</a>	<a href="#">Blood Occult Peroxidase Actv Qual Feces 1-3 Spec Determination</a>
<a href="#">82465</a>	<a href="#">Cholesterol Serum/Whole Blood Total</a>
<a href="#">82947</a>	<a href="#">Glucose Quantitative Blood Xcpt Reagent Strip</a>
<a href="#">82948</a>	<a href="#">Glucose Blood Reagent Strip</a>
<a href="#">82950</a>	<a href="#">Glucose Post Glucose Dose</a>
<a href="#">83655</a>	<a href="#">Assay Of Lead</a>
<a href="#">83718</a>	<a href="#">Lipoprotein Dir Meas High Density Cholesterol</a>
<a href="#">85013</a>	<a href="#">Blood Count Spun Microhematocrit</a>
<a href="#">85014</a>	<a href="#">Blood Count Hematocrit</a>
<a href="#">85018</a>	<a href="#">Blood Count Hemoglobin</a>
<a href="#">86580</a>	<a href="#">Skin Test Tuberculosis Intradermal</a>
<a href="#">87205</a>	<a href="#">Smr Prim Src Gram/Giemsa Stain Bct Fungi/Cel</a>
<a href="#">90460</a>	<a href="#">Immunization Admin 1St/Only Component 18 Years&lt;</a>
<a href="#">90461</a>	<a href="#">Immunization Admin Each Addl Component 18 Years&lt;</a>
<a href="#">90471</a>	<a href="#">Immunization Admin 1 Vaccine Single/Combo</a>
<a href="#">90472</a>	<a href="#">Immunization Admin Each Add-On Single/Combo</a>



HCP/CS/CPT Code	Description
90473	Immunization Admin Oral/Nasal Single/Combo
90474	Immunization Admin Oral/Nasal Addl Single/Combo
90480	Admn Sarscov2 Vacc 1 Dose
90785	Psytx complex interactive
90791	Psych Diagnostic Evaluation
90792	Psych Diag Eval W/Med Services
90882	Envr Intrvt for Medical Mgmt on a Psycl Pts
90885	Psy evaluation of records
90887	Consultation with family
90889	Preparation of report
91065	Breath hydrogen/methane test
92502	Ear and throat examination
92551	Pure Tone Hearing Test Air
92552	Pure Tone Audiometry Air
92558	Evoked Auditory Test Qual
92567	Tympanometry
92587	Evoked auditory test limited
92625	Tinnitus assessment
93000	Ecq Routine Ecq W/Least 12 Lds W/I&R
93005	Ecq Routine Ecq W/Least 12 Lds Trcg Only W/O I&R
93010	Ecq Routine Ecq W/Least 12 Lds I&R Only
93015	Cardiovascular stress test
93016	Cardiovascular stress test
93017	Cardiovascular stress test
93018	Cardiovascular stress test
93040	Rhythm Ecq 1-3 Leads W/Interpretation & Report
93041	Rhythm ecg tracing
93042	Rhythm ecg report
93268	Xtrnl Pt Activ Ecq Transmis W/R&I </30 Days
93271	Ecq/monitoring and analysis
93272	Ecq/review interpret only
93784	Ambl Bld Press W/Tape&/Disk 24/> Hr Alys I&R
93786	Ambl bp mntr w/sw rec only
93788	Ambl bp mntr w/sw a/r
93790	Ambl bp mntr w/sw i&r
93793	Anticoag mgmt pt warfarin
94010	Spirometry
94011	Spirometry up to 2 yrs old
94012	Spirmetry w/brnchdil inf-2 yr
94014	Pt Recorded Spirometry Complex
94015	Pt Recorded Spirometry Simple



<b>HCP/CS/CPT Code</b>	<b>Description</b>
<a href="#">94016</a>	<a href="#">Review Pt Spirometry</a>
<a href="#">94060</a>	<a href="#">Bronchodilation Responsiveness</a>
<a href="#">94070</a>	<a href="#">Bronchodilation Provocation Evaluation</a>
<a href="#">94375</a>	<a href="#">Respiratory Flow Volume Loop</a>
<a href="#">94640</a>	<a href="#">Pressurized/Nonpressurized Inhalation Treatment</a>
<a href="#">94664</a>	<a href="#">Evaluate pt use of inhaler</a>
<a href="#">94760</a>	<a href="#">Noninvasive Ear/Pulse Oximetry Single Deter</a>
<a href="#">94761</a>	<a href="#">Noninvasive Ear/Pulse Oximetry Multiple Deter</a>
<a href="#">95004</a>	<a href="#">Percut allergy skin tests</a>
<a href="#">95017</a>	<a href="#">Perq &amp; icut allg test venoms</a>
<a href="#">95018</a>	<a href="#">Perq&amp;ic allg test drugs/biol</a>
<a href="#">95024</a>	<a href="#">Icut allergy test drug/bug</a>
<a href="#">95027</a>	<a href="#">Icut allergy titrate-airborn</a>
<a href="#">95028</a>	<a href="#">Icut allergy test-delayed</a>
<a href="#">95044</a>	<a href="#">Allergy patch tests</a>
<a href="#">95056</a>	<a href="#">Photosensitivity tests</a>
<a href="#">95060</a>	<a href="#">Eye allergy tests</a>
<a href="#">95065</a>	<a href="#">Nose allergy test</a>
<a href="#">95070</a>	<a href="#">Bronchial allergy tests</a>
<a href="#">95115</a>	<a href="#">Prof Services Allergen Immuthery Single Injection</a>
<a href="#">95117</a>	<a href="#">Prof Services Allergen Immuthery Multiple Injection</a>
<a href="#">95144</a>	<a href="#">Antigen therapy services</a>
<a href="#">95170</a>	<a href="#">Antigen therapy services</a>
<a href="#">95180</a>	<a href="#">Rapid desensitization</a>
<a href="#">95249</a>	<a href="#">Cont gluc mntr pt prov eqp</a>
<a href="#">95250</a>	<a href="#">Cont gluc mntr phys/qhp eqp</a>
<a href="#">95251</a>	<a href="#">Cont gluc mntr analysis i&amp;r</a>
<a href="#">95851</a>	<a href="#">Range of motion measurements</a>
<a href="#">95852</a>	<a href="#">Range of motion measurements</a>
<a href="#">95992</a>	<a href="#">Canalith repositioning proc</a>
<a href="#">96105</a>	<a href="#">Assessment of aphasia</a>
<a href="#">96110</a>	<a href="#">Developmental Screen W/Score</a>
<a href="#">96112</a>	<a href="#">Devel tst phys/qhp 1st hr</a>
<a href="#">96113</a>	<a href="#">Devel tst phys/qhp ea addl</a>
<a href="#">96116</a>	<a href="#">Nubhvl xm phys/qhp 1st hr</a>
<a href="#">96121</a>	<a href="#">Nubhvl xm phy/qhp ea addl hr</a>
<a href="#">96125</a>	<a href="#">Cognitive test by hc pro</a>
<a href="#">96127</a>	<a href="#">Brief Emotional/Behav Assmt</a>
<a href="#">96130</a>	<a href="#">Psycl tst eval phys/qhp 1st</a>
<a href="#">96131</a>	<a href="#">Psycl tst eval phys/qhp ea</a>
<a href="#">96132</a>	<a href="#">Nrpsyc tst eval phys/qhp 1st</a>

<b>HCP/CS/CPT Code</b>	<b>Description</b>
<a href="#"><u>96133</u></a>	<a href="#"><u>Nrpsyc tst eval phys/qhp ea</u></a>
<a href="#"><u>96136</u></a>	<a href="#"><u>Psycl/nrpsyc tst phy/qhp 1st</u></a>
<a href="#"><u>96137</u></a>	<a href="#"><u>Psycl/nrpsyc tst phy/qhp ea</u></a>
<a href="#"><u>96138</u></a>	<a href="#"><u>Psycl/nrpsyc tech 1st</u></a>
<a href="#"><u>96139</u></a>	<a href="#"><u>Psycl/nrpsyc tst tech ea</u></a>
<a href="#"><u>96146</u></a>	<a href="#"><u>Psycl/nrpsyc tst auto result</u></a>
<a href="#"><u>96151</u></a>	<a href="#"><u>Assessment Health/ Behavioral subsequent</u></a>
<a href="#"><u>96156</u></a>	<a href="#"><u>Health Behavior Assessment Or Re-Assessment</u></a>
<a href="#"><u>96158</u></a>	<a href="#"><u>Health Behavior Intervention, Individual Face-To-Face 30 Min</u></a>
<a href="#"><u>96159</u></a>	<a href="#"><u>Health Behavior Intervention, Individual Face-To-Face 15 Min</u></a>
<a href="#"><u>96160</u></a>	<a href="#"><u>Pt-Focused Hlth Risk Assmt</u></a>
<a href="#"><u>96161</u></a>	<a href="#"><u>Caregiver Health Risk Assmt</u></a>
<a href="#"><u>96164</u></a>	<a href="#"><u>Health Behavior Intervention, Group (2&lt;) Face-To-Face 30 Min</u></a>
<a href="#"><u>96165</u></a>	<a href="#"><u>Health Behavior Intervention, Group (2&lt;) Face-To-Face 15 Min</u></a>
<a href="#"><u>96167</u></a>	<a href="#"><u>Health Behavior Intervention, Family (W/ Pt) Face-To-Face 30 Min</u></a>
<a href="#"><u>96168</u></a>	<a href="#"><u>Health Behavior Intervention, Family (W/ Pt) Face-To-Face 15 Min</u></a>
<a href="#"><u>96170</u></a>	<a href="#"><u>Health Behavior Intervention, Family (W/Out Pt) Face-To-Face 30 Min</u></a>
<a href="#"><u>96171</u></a>	<a href="#"><u>Health Behavior Intervention, Family (W/Out Pt), Face-To-Face 15 Min</u></a>
<a href="#"><u>96202</u></a>	<a href="#"><u>Mlt fam grp bhv train 1st 60</u></a>
<a href="#"><u>96203</u></a>	<a href="#"><u>Mlt fam grp bhv train ea add</u></a>
<a href="#"><u>96372</u></a>	<a href="#"><u>Ther/Proph/Diag Inj Sc/Im</u></a>
<a href="#"><u>96373</u></a>	<a href="#"><u>Therapeutic, Prophylactic, Or Diagnostic Injection</u></a>
<a href="#"><u>96374</u></a>	<a href="#"><u>Therapeutic, Prophylactic, Or Diagnostic Injection Single</u></a>
<a href="#"><u>97151</u></a>	<a href="#"><u>Behavior Identification Assessment, Each 15 Min</u></a>
<a href="#"><u>97152</u></a>	<a href="#"><u>Behavior Identification-Supporting Assessment, Each 15 Min</u></a>
<a href="#"><u>97597</u></a>	<a href="#"><u>Debridement Open Wound 20 Sq Cm/&lt;</u></a>
<a href="#"><u>97598</u></a>	<a href="#"><u>Rmvl devital tis addl 20cm/&lt;</u></a>
<a href="#"><u>97802</u></a>	<a href="#"><u>Medical nutrition indiv in</u></a>
<a href="#"><u>97803</u></a>	<a href="#"><u>Med nutrition indiv subseq</u></a>
<a href="#"><u>97804</u></a>	<a href="#"><u>Medical Nutrition Group</u></a>
<a href="#"><u>98000</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98001</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98002</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>

<b>HCP/CS/CPT Code</b>	<b>Description</b>
<a href="#"><u>98003</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98004</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98005</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98006</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98007</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98008</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98009</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98010</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98011</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98012</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98013</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98014</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98015</u></a>	<a href="#"><u>Synchronous Audio-Video Evaluation and Management Services</u></a>
<a href="#"><u>98016</u></a>	<a href="#"><u>Brief communication technology-based service (eg, virtual check-in)</u></a>
<a href="#"><u>98925</u></a>	<a href="#"><u>Osteopath manj 1-2 regions</u></a>
<a href="#"><u>98926</u></a>	<a href="#"><u>Osteopath manj 3-4 regions</u></a>
<a href="#"><u>98927</u></a>	<a href="#"><u>Osteopath manj 5-6 regions</u></a>
<a href="#"><u>98928</u></a>	<a href="#"><u>Osteopath manj 7-8 regions</u></a>
<a href="#"><u>98929</u></a>	<a href="#"><u>Osteopath manj 9-10 regions</u></a>
<a href="#"><u>98960</u></a>	<a href="#"><u>Self-mgmt educ &amp; train 1 pt</u></a>
<a href="#"><u>98961</u></a>	<a href="#"><u>Self-mgmt educ/train 2-4 pt</u></a>
<a href="#"><u>98962</u></a>	<a href="#"><u>Self-mgmt educ/train 5-8 pt</u></a>
<a href="#"><u>98966</u></a>	<a href="#"><u>Hc Pro Phone Call 5-10 Min</u></a>
<a href="#"><u>98967</u></a>	<a href="#"><u>Non-Physician Telephone Services 11-20 Min</u></a>
<a href="#"><u>98968</u></a>	<a href="#"><u>Non-Physician Telephone Services 21-30 Min</u></a>
<a href="#"><u>98969</u></a>	<a href="#"><u>Online Service By Hc Pro</u></a>
<a href="#"><u>98970</u></a>	<a href="#"><u>NQHP ol dig assmt&amp;mgmt 5-10</u></a>

HCP/CS/CPT Code	Description
98971	NQHP ol dig assmt&mgmt 11-20
98972	NQHP ol dig assmt&mgmt 21+
99050	Medical Services After Hrs
99056	Med Service Out Of Office
99058	Office Emergency Care
99078	Phys/QHP Education Materials for Pts In Group Setting
99091	Colj & interpj data ea 30 d
99170	Anogenital exam child w imag
99173	Visual Acuity Screen
99174	Ocular Instrumnt Screen Bil Remote Analysis
99177	Ocular Instrumnt Screen Bil On Site Analysis
99188	App Topical Fluoride Varnish
99195	Phlebotomy
99201	Office/ outpatient visit new
99202	Office/OutPt Visit New 15-29 Min
99203	Office/OutPt Visit New 30-44 Min
99204	Office/OutPt Visit New 45-59 Min
99205	Office/OutPt Visit New 60-74 Min
99211	Office/OutPt Visit Est
99212	Office/OutPt Visit Est 10-19 Min
99213	Office/OutPt Visit Est 20-29 Min
99214	Office/OutPt Visit Est 30-39 Min
99215	Office/OutPt Visit Est 40-54 Min
99241	Office Or Other OutPt Consultations 15 Min
99242	Office Or Other OutPt Consultations 30 Min
99243	Office Or Other OutPt Consultations 40 Min
99244	Office Or Other OutPt Consultations 60 Min
99245	Office Or Other OutPt Consultations 80 Min
99339	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 15-29 Min
99340	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 30 Min
99341	Home Visit New Pt 20 Min
99342	Home Visit New Pt 30 Min
99343	Home Visit New Pt 45 Min
99344	Home Visit New Pt 60 Min
99345	Home Visit New Pt 75 Min
99346	Home Visit New Pt
99347	Home Visit Established Pt 15 Min
99348	Home Visit Established Pt 25 Min
99349	Home Visit Established Pt 40 Min

<b>HCP/CS/CPT Code</b>	<b>Description</b>
<a href="#"><u>99350</u></a>	<a href="#"><u>Home Visit Established Pt 60 Min</u></a>
<a href="#"><u>99354</u></a>	<a href="#"><u>Prolonged Service OutPt 60 Min</u></a>
<a href="#"><u>99355</u></a>	<a href="#"><u>Prolonged Service OutPt Add 30 Min</u></a>
<a href="#"><u>99358</u></a>	<a href="#"><u>Prolong Service W/O Contact</u></a>
<a href="#"><u>99359</u></a>	<a href="#"><u>Prolong Serv W/O Contact Add 30 Min</u></a>
<a href="#"><u>99366</u></a>	<a href="#"><u>Team Conf W/ Pt By Healthcare Prof 30 Min W/Physician</u></a>
<a href="#"><u>99367</u></a>	<a href="#"><u>Team Conf W/Out Pt By Healthcare Prof 30 Min W/Physician</u></a>
<a href="#"><u>99368</u></a>	<a href="#"><u>Team Conf W/Out Pt By Healthcare Prof 30 Min W/Out Physician</u></a>
<a href="#"><u>99374</u></a>	<a href="#"><u>Home/Nursing Facility Visits 15-29 Min</u></a>
<a href="#"><u>99375</u></a>	<a href="#"><u>Home/Nursing Facility Visits 30 Min</u></a>
<a href="#"><u>99376</u></a>	<a href="#"><u>Care Plan Oversight/Over</u></a>
<a href="#"><u>99379</u></a>	<a href="#"><u>Nursing fac care supervision</u></a>
<a href="#"><u>99380</u></a>	<a href="#"><u>Nursing fac care supervision</u></a>
<a href="#"><u>99381</u></a>	<a href="#"><u>Init Pm E/M New Pat Infant</u></a>
<a href="#"><u>99382</u></a>	<a href="#"><u>Init Pm E/M New Pat 1-4 Yrs</u></a>
<a href="#"><u>99383</u></a>	<a href="#"><u>Prev Visit New Age 5-11</u></a>
<a href="#"><u>99384</u></a>	<a href="#"><u>Prev Visit New Age 12-17</u></a>
<a href="#"><u>99385</u></a>	<a href="#"><u>Prev Visit New Age 18-39</u></a>
<a href="#"><u>99386</u></a>	<a href="#"><u>Prev Visit New Age 40-64</u></a>
<a href="#"><u>99387</u></a>	<a href="#"><u>Pre Visit New Age 65 or older</u></a>
<a href="#"><u>99391</u></a>	<a href="#"><u>Periodic Pm Reeval Est Pat Infant 1&gt;</u></a>
<a href="#"><u>99392</u></a>	<a href="#"><u>Prev Visit Est Age 1-4</u></a>
<a href="#"><u>99393</u></a>	<a href="#"><u>Prev Visit Est Age 5-11</u></a>
<a href="#"><u>99394</u></a>	<a href="#"><u>Prev Visit Est Age 12-17</u></a>
<a href="#"><u>99395</u></a>	<a href="#"><u>Prev Visit Est Age 18-39</u></a>
<a href="#"><u>99396</u></a>	<a href="#"><u>Prev Visit Est Age 40-64</u></a>
<a href="#"><u>99397</u></a>	<a href="#"><u>Per Pm Reeval Est Pat 65+ Yr</u></a>
<a href="#"><u>99401</u></a>	<a href="#"><u>Preventive Counseling Indiv 15 Min</u></a>
<a href="#"><u>99402</u></a>	<a href="#"><u>Preventive Counseling Indiv 30 Min</u></a>
<a href="#"><u>99403</u></a>	<a href="#"><u>Preventive Counseling Indiv 45 Min</u></a>
<a href="#"><u>99404</u></a>	<a href="#"><u>Preventive Counseling Indiv 60 Min</u></a>
<a href="#"><u>99406</u></a>	<a href="#"><u>Behav Chng Smoking 3-10 Min</u></a>
<a href="#"><u>99407</u></a>	<a href="#"><u>Behav Chng Smoking &gt; 10 Min</u></a>
<a href="#"><u>99408</u></a>	<a href="#"><u>Audit/Dast 15-30 Min</u></a>
<a href="#"><u>99409</u></a>	<a href="#"><u>Alcohol/Substance Screen &amp; Intervention &gt;30 Min</u></a>
<a href="#"><u>99411</u></a>	<a href="#"><u>Preventive Counseling Group 30 Min</u></a>
<a href="#"><u>99412</u></a>	<a href="#"><u>Preventive Counseling Group 60 Min</u></a>
<a href="#"><u>99415</u></a>	<a href="#"><u>Prolng clin staff svc 1st hr</u></a>
<a href="#"><u>99416</u></a>	<a href="#"><u>Prolng clin staff svc ea add</u></a>
<a href="#"><u>99417</u></a>	<a href="#"><u>Prolng op e/m each 15 min</u></a>

HCP/CS/CPT Code	Description
99420	Administration and interpretation of health risk assessments
99421	Ol dig e/m svc 5-10 min
99422	Ol dig e/m svc 11-20 min
99423	Ol dig e/m svc 21+ min
99424	Prin care mgmt phys 1st 30
99425	Prin care mgmt phys ea addl
99426	Prin care mgmt staff 1st 30
99427	Prin care mgmt staff ea addl
99429	Unlisted Preventive Service
99437	Chrc care mgmt phys ea addl
99439	Chrc care mgmt staf ea addl
99441	Phys/Qhp Telephone Evaluation 5-10 Min
99442	Phone E/M Phys/Qhp 11-20 Min
99443	Phys/Qhp Telephone Evaluation 21-30 Min
99444	Phys/Qhp Online Evaluation & Management Service
99446	Interprofessional Electronic Health Assessment 5-10 Min
99447	Interprofessional Electronic Health Assessment 11-20 Min
99448	Interprofessional Electronic Health Assessment 21-30 Min
99449	Interprofessional Electronic Health Assessment 31 Min <
99450	Basic Life And/Or Disability Exam
99451	Interprofessional Electronic Health Assessment 5 Min >
99452	Telephone or internet referral service, 30 minutes
99453	Remote Monitoring Physiologic Parameters Initial
99454	Remote Monitoring Physiologic Parameters Programed Transmission
99455	Work Related Disability Exam
99456	Disability Examination
99457	Remote Physiologic Monitoring Treatment Management Services, First 20 Min
99458	Remote Physiologic Monitoring Treatment Management Services, Additional 20 Min
99460	Initial Evaluation And Management Of Newborn At Hospital
99461	Initial Evaluation And Management Of Newborn Outside Of Hospital
99473	Self-meas bp pt educaj/train
99474	Self-meas bp 2 readg bid 30d
99483	Assmt & Care Planning Pt W/Cognitive Impairment
99484	Care Mgmt Svc Bhvl Health Conditions 20 Min
99487	Complex Care W/O Pt Vsit 60 Min
99489	Complex Chronic Care Addl 30 Min
99490	Chron Care Mgmt Srvs 20 Min

HCP/CS/CPT Code	Description
99491	Chronic Care Management Services At Least 30 Min
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
99499	<b>Unlisted e/m service</b>
99502	Home Visit For Newborn Care And Assessment
0001A	ADM SARSCOV2 30MCG/0.3ML 1ST
0002A	ADM SARSCOV2 30MCG/0.3ML 2ND
0003A	ADM SARSCOV2 30MCG/0.3ML 3RD
0004A	ADM SARSCOV2 30MCG/0.3ML BST
0011A	ADM SARSCOV2 100MCG/0.5ML1ST
0012A	ADM SARSCOV2 100MCG/0.5ML2ND
0013A	ADM SARSCOV2 100MCG/0.5ML3RD
0021A	ADM SARSCOV2 5X1010VP/.5ML 1ST
0022A	ADM SARSCOV2 5X1010VP/.5ML 2ND
0031A	ADM SARSCOV2 VAC AD26 .5ML
0034A	ADM SARSCOV2 VAC AD26 .5ML B
0041A	ADM SARSCOV2 5MCG/0.5ML 1ST
0042A	ADM SARSCOV2 5MCG/0.5ML 2ND
0044A	ADM SARSCOV2 5MCG/0.5ML BST
0051A	ADM SARSCV2 30MCG TRS-SUCR 1
0052A	ADM SARSCV2 30MCG TRS-SUCR 2
0053A	ADM SARSCV2 30MCG TRS-SUCR 3
0054A	ADM SARSCV2 30MCG TRS-SUCR B
0064A	ADM SARSCOV2 50MCG/0.25MLBST
0071A	ADM SARSCV2 10MCG TRS-SUCR 1
0072A	ADM SARSCV2 10MCG TRS-SUCR 2
0073A	ADM SARSCV2 10MCG TRS-SUCR 3
0074A	ADM SARSCV2 10MCG TRS-SUCR B
0081A	ADM SARSCOV2 3MCG TRS-SUCR 1
0082A	ADM SARSCOV2 3MCG TRS-SUCR 2
0083A	ADM SARSCOV2 3MCG TRS-SUCR 3
0091A	ADM SARSCOV2 50 MCG/.5 ML1ST
0092A	ADM SARSCOV2 50 MCG/.5 ML2ND
0093A	ADM SARSCOV2 50 MCG/.5 ML3RD
0094A	ADM SARSCOV2 50MCG/0.5 MLBST
0104A	ADM SARSCOV2 5MCG/.5ML AS03B



<b>HCP/CS/CPT Code</b>	<b>Description</b>
<u>0111A</u>	<u>ADM SARSCOV2 25MCG/0.25ML1ST</u>
<u>0112A</u>	<u>ADM SARSCOV2 25MCG/0.25ML2ND</u>
<u>0113A</u>	<u>ADM SARSCOV2 25MCG/0.25ML3RD</u>
<u>0121A</u>	<u>ADM SARSCV2 BVL 30MCG/.3ML 1</u>
<u>0124A</u>	<u>ADM SARSCV2 BVL 30MCG/.3ML B</u>
<u>0134A</u>	<u>ADM SARSCV2 BVL 50MCG/.5ML B</u>
<u>0141A</u>	<u>ADM SRSCV2 BVL 25MCG/.25ML 1</u>
<u>0142A</u>	<u>ADM SRSCV2 BVL 25MCG/.25ML 2</u>
<u>0144A</u>	<u>ADM SARSCV2 BVL 25MCG/.25ML B</u>
<u>0151A</u>	<u>ADM SARSCV2 BVL 10MCG/.2ML 1</u>
<u>0154A</u>	<u>ADM SARSCV2 BVL 10MCG/.2ML B</u>
<u>0164A</u>	<u>ADM SRSCV2 BVL 10MCG/0.2ML B</u>
<u>0171A</u>	<u>ADM SARSCV2 BVL 3MCG/0.2ML 1</u>
<u>0172A</u>	<u>ADM SARSCV2 BVL 3MCG/0.2ML 2</u>
<u>0173A</u>	<u>ADM SARSCV2 BVL 3MCG/0.2ML 3</u>
<u>0174A</u>	<u>ADM SARSCV2 BVL 3MCG/0.2ML B</u>
<u>0500F</u>	<u>Initial Prenatal Care Visit</u>
<u>0501F</u>	<u>Prenatal Flow Sheet</u>
<u>0502F</u>	<u>Subsequent Prenatal Care</u>
<u>0503F</u>	<u>Postpartum Care Visit</u>
<u>1000F</u>	<u>Tobacco Use Assessed</u>
<u>1031F</u>	<u>Smoking &amp; 2Nd Hand Assessed</u>
<u>1032F</u>	<u>Current Tobacco Smoker Or 2Nd Hand Exposed</u>
<u>1033F</u>	<u>Tobacco Nonsmoker Not Exposed 2Nd Hand</u>
<u>1034F</u>	<u>Current Tobacco Smoker</u>
<u>1035F</u>	<u>Current Smokeless Tobacco User</u>
<u>1036F</u>	<u>Current Tobacco Non-User</u>
<u>1220F</u>	<u>Pt Screened For Depression</u>
<u>3016F</u>	<u>Pt Screened For Unhlthy Alcohol Use</u>
<u>3085F</u>	<u>Suicide Risk Assessed</u>
<u>3351F</u>	<u>Neg Scrn Depression Symptoms By Dep Tool</u>
<u>3352F</u>	<u>No Sig Dep Symp By Dep Tool</u>
<u>3353F</u>	<u>Mild-Mod Dep Symp By Deptool</u>
<u>3354F</u>	<u>Clin Sig Dep Sym By Dep Tool</u>
<u>3355F</u>	<u>Clin Sig Dep Sym By Dep Tool</u>
<u>4000F</u>	<u>Tobacco Use Cessation Intervention Counseling</u>
<u>4001F</u>	<u>Tobacco Use Cessation Intervention Pharmacologic</u>
<u>4004F</u>	<u>Pt Tobacco Screen And Cessation Intervention</u>
<u>4290F</u>	<u>Pt Screened For Injection Drug Use (Hiv)</u>
<u>4293F</u>	<u>Pt Screened For High Risk Sexual Behavior (Hiv)</u>
<u>G0008</u>	<u>Admin Influenza Virus Vaccine</u>



<b>HCP/CS/CPT Code</b>	<b>Description</b>
<u>G0009</u>	<u>Admin Pneumococcal Vaccine</u>
<u>G0010</u>	<u>Admin Hepatitis B Vaccine</u>
<u>G0019</u>	<u>Comm hlth intq svcs sdoh 60mn</u>
<u>G0022</u>	<u>Comm hlth intq svcs add 30 m</u>
<u>G0023</u>	<u>Pin service 60m per month</u>
<u>G0024</u>	<u>Pin sv add 30 min pr m</u>
<u>G0101</u>	<u>Cancer Screen; Pelvic/Breast Exam</u>
<u>G0102</u>	<u>Prostate Cancer Screening; Digital Rectal Examination</u>
<u>G0103</u>	<u>PSA Screening</u>
<u>G0104</u>	<u>Colorectal cancer screening, flexible sigmoidoscopy</u>
<u>G0105</u>	<u>Colorectal cancer screening, colonoscopy on individual at high risk</u>
<u>G0106</u>	<u>Colorectal cancer screening, alternative to G0104</u>
<u>G0108</u>	<u>Diab manage trn per indiv</u>
<u>G0109</u>	<u>Diabetes OutPt Self-Management Training Services Group</u>
<u>G0120</u>	<u>Colorectal Cancer Screening, alternative to G0105, screening colonoscopy, barium enema</u>
<u>G0123</u>	<u>Screen Cerv/Vag Thin Layer</u>
<u>G0124</u>	<u>Screen c/v thin layer by md</u>
<u>G0140</u>	<u>Nav sv peer sup 60 min pr m</u>
<u>G0143</u>	<u>Scr c/v cyto,thinlayer,rescr</u>
<u>G0144</u>	<u>Scr c/v cyto,thinlayer,rescr</u>
<u>G0145</u>	<u>Scr C/V Cyto,Thinlayer,Rescr</u>
<u>G0146</u>	<u>Nav sv peer sup add 30 pr m</u>
<u>G0147</u>	<u>Scr c/v cyto, automated sys</u>
<u>G0148</u>	<u>Scr c/v cyto, autosys, rescr</u>
<u>G0179</u>	<u>Phys Re-Cert Mcr-Covr Hom Hlth Svc Re-Cert Prd</u>
<u>G0180</u>	<u>Phys Cert Mcr-Covr Hom Hlth Svc Per Cert Prd</u>
<u>G0181</u>	<u>Home/Nursing Facility Visits W/Out Pt Medicare Approved</u>
<u>G0202</u>	<u>Screening Mammography Digital</u>
<u>G0271</u>	<u>Medical Nutrition Therapy, Reassessment And Subsequent Intervention Group 30 Min</u>
<u>G0283</u>	<u>Therapy Electric Stimulation Other Than Wound</u>
<u>G0323</u>	<u>Care manage beh svcs 20mins</u>
<u>G0396</u>	<u>Alcohol/Subs Misuse Intervention 15-30 Min</u>
<u>G0397</u>	<u>Alcohol/Subs Misuse Intervention 30 Min &lt;</u>
<u>G0399</u>	<u>Home Sleep Test/Type 3 Porta</u>
<u>G0402</u>	<u>Welcome to Medicare visit</u>
<u>G0403</u>	<u>Ekg For Initial Prevent Exam</u>
<u>G0404</u>	<u>Ekg Tracing For Initial Prev</u>
<u>G0405</u>	<u>Ekg Interpret &amp; Report Prev</u>

<b>HCP/CS/CPT Code</b>	<b>Description</b>
<a href="#">G0436</a>	<a href="#">Smoke Tob Cessation Cnsl As Pt; Intrmed 3-10 Min</a>
<a href="#">G0437</a>	<a href="#">Smoking &amp; Tob Cess Cnsl As Pt; Intensive &gt;10 Min</a>
<a href="#">G0438</a>	<a href="#">Ppps, Initial Visit</a>
<a href="#">G0439</a>	<a href="#">Ppps, Subseq Visit</a>
<a href="#">G0442</a>	<a href="#">Annual Alcohol Screen 15 Min</a>
<a href="#">G0443</a>	<a href="#">Brief Alcohol Misuse Counsel</a>
<a href="#">G0444</a>	<a href="#">Depression Screen Annual 15 Min</a>
<a href="#">G0445</a>	<a href="#">High Intensity Behavioral Counseling Std 30 Min</a>
<a href="#">G0447</a>	<a href="#">Behavior counsel obesity 15m</a>
<a href="#">G0463</a>	<a href="#">Hospital Outpt Clinic Visit</a>
<a href="#">G0466</a>	<a href="#">FQHC Visit, New Pt</a>
<a href="#">G0467</a>	<a href="#">FQHC Visit, Established Pt</a>
<a href="#">G0468</a>	<a href="#">FQHC Preventive Visit</a>
<a href="#">G0472</a>	<a href="#">Hepatitis C Antibody Screening</a>
<a href="#">G0473</a>	<a href="#">Group behave couns 2-10</a>
<a href="#">G0475</a>	<a href="#">HIV Antigen/Antibody, Combination Assay, Screening</a>
<a href="#">G0476</a>	<a href="#">HPV Combo Assay Cancer Screen</a>
<a href="#">G0499</a>	<a href="#">Hepb screen high risk indiv</a>
<a href="#">G0505</a>	<a href="#">Cognition and functional assessment</a>
<a href="#">G0506</a>	<a href="#">Comprehensive Asses Care Plan Chronic Care Mgmt Services</a>
<a href="#">G0511</a>	<a href="#">Chronic Care Management Rural Health Clinic</a>
<a href="#">G0512</a>	<a href="#">Psych collab care rural health clinic or FQHC</a>
<a href="#">G0513</a>	<a href="#">Prolong Preventive Services, First 30 Min</a>
<a href="#">G0514</a>	<a href="#">Prolonged Preventive Service Addl 30 Min</a>
<a href="#">G0537</a>	<a href="#">Risk ascvd tst once pr 12 mo</a>
<a href="#">G0538</a>	<a href="#">Ascvd rsk mnq clin stf pr mo</a>
<a href="#">G0539</a>	<a href="#">Initial care training 30 m</a>
<a href="#">G0540</a>	<a href="#">Train for caregiver add 15</a>
<a href="#">G0541</a>	<a href="#">No pt prsnt train initial 30</a>
<a href="#">G0542</a>	<a href="#">No pt prsnt train add 15</a>
<a href="#">G0543</a>	<a href="#">Group train w/o patient</a>
<a href="#">G0546</a>	<a href="#">Phone/internet ehr assess</a>
<a href="#">G0547</a>	<a href="#">Phone/internet svs 11-20m</a>
<a href="#">G0548</a>	<a href="#">Phone/inter svs 21-30 m</a>
<a href="#">G0549</a>	<a href="#">Phone/inter for treat&gt;31m</a>
<a href="#">G0550</a>	<a href="#">Phone/inter for dx/treat &gt;5m</a>
<a href="#">G0551</a>	<a href="#">Phn/intr svs fr dx treat 30m</a>
<a href="#">G0556</a>	<a href="#">Adv prim care mgmt lvl 31</a>
<a href="#">G0557</a>	<a href="#">Adv prim care mgmt lvl 2</a>
<a href="#">G0558</a>	<a href="#">Adv prim care mgmt lvl 3</a>
<a href="#">G2010</a>	<a href="#">Remote Evaluation Of Recodred Video/Images</a>

<b>HCP/CS/CPT Code</b>	<b>Description</b>
<u>G2011</u>	<u>Alcohol/sub misuse assess</u>
<u>G2012</u>	<u>Brief check in by md/qhp</u>
<u>G2058</u>	<u>Ccm add 20min</u>
<u>G2086</u>	<u>Off base opioid tx 70min</u>
<u>G2087</u>	<u>Off base opioid tx, 60 m</u>
<u>G2088</u>	<u>Off base opioid tx, add30</u>
<u>G2211</u>	<u>Longitudinal care code</u>
<u>G2214</u>	<u>Initial or subsequent psych collab care mgmt</u>
<u>G2250</u>	<u>Remot img sub by pt, non e/m</u>
<u>G2251</u>	<u>Brief chkin, 5-10, non-e/m</u>
<u>G2252</u>	<u>Brief chkin by md/qhp, 11-20</u>
<u>G3002</u>	<u>Chronic pain mgmt 30 mins</u>
<u>G3003</u>	<u>Chronic pain mgmt addl 15m</u>
<u>G8431</u>	<u>Pos clin depres scrn f/u doc</u>
<u>G8482</u>	<u>Influenza Immunization Administered Or Previously Received</u>
<u>G8510</u>	<u>Scr dep neg, no plan reqd</u>
<u>G8731</u>	<u>Pain Assessment Documented</u>
<u>G9903</u>	<u>Pt Screened For Tobacco Use And Identified As A Non-User</u>
<u>H0001</u>	<u>Alcohol and/or drug assessment</u>
<u>H0002</u>	<u>Behavioral Health Screening To Admit To Treatment Program</u>
<u>H0031</u>	<u>Mental Health Assess By Non-MD</u>
<u>H0049</u>	<u>Alcohol/Drug Screening</u>
<u>H0050</u>	<u>Alcohol/drug service 15 min</u>
<u>H1011</u>	<u>Family assessment</u>
<u>H2015</u>	<u>Comp comm supp svc, 15 min</u>
<u>H2027</u>	<u>Psychoed svc, per 15 min</u>
<u>M0201</u>	<u>Covid-19 vaccine home admin</u>
<u>Q0091</u>	<u>Obtaining Screen Pap Smear</u>
<u>S0610</u>	<u>Annual Gynecological Examine New Pt</u>
<u>S0612</u>	<u>Annual Gynecological Examin Established Pt</u>
<u>S0613</u>	<u>Annual Breast Exam</u>
<u>S0622</u>	<u>Phys Exam For College</u>
<u>S4981</u>	<u>Insertion Of Levonorgestrel-Releasing Intrauterine Sys</u>
<u>S9117</u>	<u>Back To School Visits</u>
<u>S9446</u>	<u>Pt Education Not Classified Group</u>
<u>T1015</u>	<u>Clinic Service All-Inclusive</u>
<u>T1016</u>	<u>Case management</u>
<u>T1027</u>	<u>Family training &amp; counseling</u>
<u>Z1032</u>	<u>Initial Antepartum Office Visit</u>
<u>Z1034</u>	<u>Antepartum Follow-up Office Visit</u>
<u>Z1038</u>	<u>Postpartum Follow-up Office Visit</u>

HCPCS/CPT Code	Description
<u>GPCM1</u>	<u>APCM for pt w up to one chronic condition</u>
<u>GPCM2</u>	<u>APCM for pt with multiple chronic conditions</u>
<u>GPCM3</u>	<u>APCM for QMBs enrollees with multiple chronic conditions</u>