

Primary Care Expenditures

Summary of current primary care expenditures
and investment in Washington

Report to the Legislature

As required by Chapter 415, Laws of 2019



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Executive summary

This is the first comprehensive analysis of annual primary care medical expenditures in Washington. In the 2019–21 biennial budget, the Legislature directed the Office of Financial Management to determine annual primary care medical expenditures as a percentage of total medical expenditures by carrier. This report summarizes the approach and data sets used to calculate these expenditures, compares and contrasts the methods and results with other state and national reports on primary care medical expenditures, and discusses limitations to current data sources.

OFM, working with key stakeholders representing different areas of primary care practitioners, created a definition for primary care providers and services that takes into account the range of interpretations of primary care. A narrow and broad definition of providers and services were created, and then claims meeting the service and provider definitions were used to calculate primary care expenditures. This approach ensured expenditures attributed to primary care services were incurred by primary care providers. Expenditures were calculated using cost information from the Washington All-Payer Health Care Claims Database.

In Washington for 2018, primary care expenditures as a percentage of total medical expenditures ranged from 4.4% (about \$838 million) to 5.6% (about \$1 billion) based on either a narrow or broad definition, respectively, of primary care. Primary care spending as a percentage of total spending was highest for people under 18 years and lowest in people 65 years and older.

With respect to market sector: Similar percentages of primary care spending were seen in public employee, Medicaid managed care and commercial coverage. Medicare Advantage had the lowest percentage, reflecting differences already seen by age. Differences in primary care spending by health care company and market sector vary considerably and could be influenced by the needs of the population covered (average age, sex, comorbidity and geography).

This report's estimates for the proportion of medical expenditures attributable to primary care appears smaller than estimates calculated in other reports. Because there is no national standard for how to measure primary care expenditures, however, these estimates cannot be compared directly because of differences in data sets, methodologies and definitions of primary care. When comparing Washington's proportion of primary care spending with reports from Oregon and Rhode Island, the differences in approaches and definitions of primary care make these types of comparisons challenging. For instance, Washington included pharmacy claims in its total medical expenditures while Oregon did not. Washington and Oregon also differed in their methods for capturing costs of primary care services. Oregon and Rhode Island included non-claims-based expenditures in their total primary care spending which are not included in Washington's estimates. An overview of the non-claims-based expenditures collected by Oregon and Rhode Island is included in this report, in addition to examples for future consideration in data collection efforts for Washington.

This report highlights a low rate of investment in primary care in Washington and, as a baseline, can be used to monitor future spending. Research has shown health care systems with higher proportions of investments oriented toward primary care have better health outcomes and lower costs. Monitoring the impact of policies and system performance will be key to successfully strengthening Washington's primary care system.

Background

In the 2019–21 biennial operating budget, Chapter 415, Laws of 2019,¹ the Legislature directed the Office of Financial Management to conduct a study to determine annual primary care medical expenditures as a percentage of total medical expenditures in Washington (Appendix A). Having an estimate of primary care expenditures, in addition to reports on the primary care workforce, enhances the state’s understanding of the current level of investment in primary care (Yen, 2018). With a baseline of primary care spending, the state will have better:

- Benchmarking of spending and investments on primary care;
- Tracking of efforts to increase primary care spending;
- Measurement of the impacts of payment reform;
- Focus of interventions to increase patient access to primary care; and
- Information to compare to other states’ efforts to increase primary care spending.

Similar reports have been completed in Oregon and Rhode Island; efforts are underway in other states to understand primary care spending levels to guide new investments.

As required in the proviso, OFM convened a group of stakeholders (Appendix B) representing family practice, general internal medicine, general pediatrics and the state Health Care Authority to advise on the parameters for estimating primary care expenditures for the state.

The stakeholder group worked with OFM to answer the following questions:

- Who are primary care providers?
- What are primary care services?
- What percentage of total health care expenditures is currently allocated to primary care?
- How does this percentage differ by health insurance carrier?
- What information about primary care is not captured by current data sources?

OFM also contacted researchers in Oregon and Rhode Island, and from other institutions who worked on similar primary care expenditure reports, to discuss methodology and gather advice for pursuing the Washington report.

The goals for Washington’s primary care expenditure report are to:

- Conduct a transparent process for determining what providers and services are considered primary care;
- Develop a transparent and detailed methodology that can be replicated to measure trends and changes in primary care spending in future years;
- Discuss differences between Washington’s methodology and results compared with other estimates and reports;
- Identify barriers to accurately estimating primary care expenditures; and
- Provide suggestions and guidance for future tracking of primary care spending and iterations of this type of report.

OFM intends for this report to be the baseline for tracking and monitoring new investments and initiatives to increase primary care spending in Washington. This report can help frame discussions

¹ <http://lawfilesexst.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1109-S.SL.pdf>

on what additional information will be beneficial for understanding primary care needs and how to measure outcomes of increasing primary care spending.

But first, we must start with a definition of primary care.

What is primary care?

Primary care as defined by the National Academy of Medicine (formerly the Institute of Medicine): “... is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs including physical, mental, emotional, and social concerns, developing a sustained partnership with patients, and practicing in the context of family and community (Donaldson, M.S., Yordy, K.D., Lohr, K.N., & Vanselow, N.A., 1996).”

This definition has been used to measure how well four main features of primary care services are fulfilled (Starfield, B., Shi, L., Macinko, J., 2005):

- First-contact access (into the health care system) for each new need
- Long-term person- (not disease-) focused care (also referred to as continuous care)
- Comprehensive care for most health needs
- Coordinated care when it must be sought elsewhere

Investing in primary care and ensuring access to primary care can reduce health care costs by lowering rates of preventable emergency department visits, hospital admissions and specialist visits (Friedberg, Hussey, & Schneider, 2010; Glass, Kanter, Jacobsen, & Minardi, 2017; Starfield, B., Shi, L., Macinko, J., 2005). Primary care helps to achieve health equity by providing access to health services and promotes care at the most appropriate level (Starfield, 1998) and, as a result, can reduce premature mortality (Basu et al., 2019; Starfield, B., Shi, L., Macinko, J., 2005). Internationally, health systems with higher proportions of health care spending on primary care have better health outcomes and lower health care costs (Friedberg et al., 2010; Jabbarpour, Y., Greiner, A., Jetty, A., Coffman, M., Jose, C., Petterson, S., 2019; OECD, 2017).

Many states are implementing strategies to improve primary care investment by adopting patient-centered medical home incentives or other value-based care models; focusing on social determinants of health; expanding the primary care workforce and infrastructure; or increasing rates for primary care providers.

Approach to estimate primary care spending

OFM contracted with Onpoint Health Data to estimate primary care expenditures using the state-run Washington All-Payer Health Care Claims Database, or WA-APCD. Onpoint Health Data is the data vendor for the WA-APCD, which was established by OFM through legislation passed in 2014. Launched in the summer of 2018, the WA-APCD contains pharmacy, medical and dental claims along with eligibility information. It is the most comprehensive source of claims data in the state with more than 6 million covered lives from more than 50 commercial, Medicaid and Medicare payers. Self-insured (not covered by state public employee benefits), federal insurance and Veterans Benefits Administration claims are not included in the database. The WA-APCD contains cost information, including billed, allowed and paid amounts that allow for calculations of total and primary care expenditures. Data from 2014 through the third quarter of 2019 are included in the database; submissions from carriers are completed on a quarterly basis and validated on a yearly basis. Data from calendar year 2018 were used for this report.

Inclusion and exclusion criteria

As per the budget proviso, total medical expenditures excluded dental care, but included costs of prescription drugs. The proviso also called for vision care to be excluded, but it was unclear what types of vision services should be excluded (e.g., eyeglasses, cataract surgery, glaucoma testing). Many commercial insurance plans lack vision coverage, but because vision services are not submitted separately from medical claims to the WA-APCD (unlike dental claims that are a separate submission), it was determined for this report to leave vision services as part of total medical expenditures.

Only claims paid using the member's primary insurance are included in the calculations for expenditures. Claims paid using a secondary insurance or payer were not included to avoid double counting expenditures. Only members who had a medical or pharmacy claim paid in 2018 are included in the analysis, limiting the members who are included. According to the National Health Interview Survey, about 16% of adults did not have contact with a doctor or other health care professional in the past year (Centers for Disease Control and Prevention, 2019).

Additionally, Medicare fee-for-service data were excluded from this report because the 2018 data will not be available until 2020. Medicaid fee-for-service data were excluded due to errors in submission to the WA-APCD, and health care claims from Coordinated Care for Medicaid managed care were excluded because labeling of its claims in the submission process made it difficult to distinguish if claims were paid as a primary or secondary payer.

Oregon and Rhode Island included estimates of non-claims-based expenditures for primary care, which are usually self-reported by the individual insurance carriers in the state, in their reports on primary care spending. Currently, there is no process in Washington to collect this type of information from all commercial carriers. The Health Care Authority collects information from the Medicaid managed care organizations and the public employee benefits carriers for managed care rate development, and is developing processes to collect non-claims information for future contracts. OFM was unable to access this information for this report. Suggestions for future data collection of non-claims-based expenditures are outlined later in this report.

Defining primary care claims

Identifying primary care services in claims data is not straightforward. Most analyses of primary care expenditures using claims data must construct a definition for primary care provider and primary care services. There are several reasons for this approach:

- Identifying primary care clinics or offices in claims data is difficult because there is no field or value that indicates primary care as a setting of care.
- Providers who list primary care as their specialty may work in a variety of places, some of which would not be considered a traditional primary care setting (e.g., hospitalists in inpatient settings or nurse practitioners working in a specialist's office) or may be delivering nonprimary care services.
- Some primary care services may be delivered by specialists or others who would not be defined as a primary care provider (e.g., a cardiologist ordering a basic lab test).
- Some institutions (e.g., Federally Qualified Health Center) may submit both a facility and professional claim for primary care services depending on the health insurance company, and the provider identification on these types of claims may be different.

As a first step for this analysis, separate definitions of primary care provider and primary care services were determined and then claims meeting both definitions were included as primary care expenditures. This approach follows the concepts of the Primary Care Spend Model to narrow primary care services to those that are performed specifically by primary care providers (Baillieu et al., 2019).

Primary care providers

Washington does not have a roster or other data source identifying individual providers who are practicing in primary care settings. Some health insurance companies may have a listing of providers delivering primary care, but it is not included in claims submissions to the WA-APCD. There is also no agreed-upon definition used in the literature to define primary care providers. Some of the variation in definition is due to the availability of different data sources that may or may not include certain types of providers (e.g., homeopaths).

The stakeholder group began by reviewing taxonomy codes, which are used to categorize health care providers by their specialization, and descriptions included in the 2019 Primary Care Spending in Oregon report (Oregon Health Authority and the Department of Consumer and Business Services, 2019). The stakeholder group decided upon two groups of providers (Appendix C):

- Narrow definition: representing providers who traditionally perform roles contained within strict definitions of primary care
- Broad definition: representing providers who perform roles not traditionally contained within a strict definition of primary care (e.g., obstetricians)

This approach is similar to other reports on primary care expenditures (Bailit, Friedberg, & Houy, 2017; Jabbarpour, Y., Greiner, A., Jetty, A., Coffman, M., Jose, C., Petterson, S., et al., 2019; Reid, Damberg, & Friedberg, 2019), but was not the approach taken in the Oregon report. Results for both the narrow and broad definitions of primary care providers are included in this report.

Taxonomy codes for the narrow definition of primary care provider are family medicine, internal medicine, Federally Qualified Health Center, general practice, naturopath, pediatrics, preventive medicine, nurse practitioner, physician assistant, primary care clinic and rural health clinic. The broad definition of providers included behavioral health providers, clinical nurse specialist, registered nurse, midwives, obstetrics and gynecology, family medicine and pediatric subspecialties, homeopath, psychiatry and neurology, psychologist, registered nurse and social worker.

Primary care services

Primary care procedures or services were defined using the American Medical Association's Current Procedure Terminology, or CPT, and the Healthcare Common Procedure Coding System, or HCPCS. For this report, the stakeholder group began by reviewing the list of primary care procedure codes included in the Oregon report and added services (e.g., additional preventive medicine screenings) based on various works stakeholders had completed in other areas. Both a narrow and broad list of services were considered for estimating primary care. Many of the services included in the broad definition reflected services that were specific to provider taxonomies included in the broad definition of primary care provider (e.g., obstetricians and care following a cesarean delivery). Inpatient visits billed by primary care providers using a CPT or HCPC inpatient code were not included in either the broad or narrow definition of primary care services. The stakeholder group did not feel that these types of visits represented traditional primary care (e.g., first-contact access, continuous, comprehensive, coordinated) or getting people the right care in the right setting. In many instances, it's difficult to identify which services on claims were performed by a primary

care provider in inpatient hospital settings. Emergency department visits billed by a primary care practitioner were also not included for similar reasons.

Other reports on primary care expenditures have used one definition for primary care services cross-walked with different definitions for primary care providers (Bailit et al., 2017; Jabbarpour, Y., Greiner, A., Jetty, A., Coffman, M., Jose, C., Petterson, S., 2019). Reid et al (Reid et al., 2019) used both a narrow and broad definition for primary care providers in combination with a narrow definition for primary care services and then again with all professional services.

This report contains the results from both the narrow and broad definition of primary care services. Examples of primary care procedure codes are those for routine medical exams, preventive medicine services, screening for diseases, vaccine administration and newborn care services (Appendix D).

Expenditure calculations

Expenditures for health care services were calculated using the total allowed amount submitted on claims to the WA-APCD. The total allowed amount includes the health insurance plan paid amount plus any deductibles, coinsurance or copays paid by the patient. For insurance companies that pay providers using capitated payment arrangements (e.g., a per-member per-month payment), the fee-for-service equivalent amount is submitted to the WA-APCD and used as the paid amount for that health care service.

Total health care expenditures comprised all medical claims (including in-patient hospitalizations) and pharmacy claims. With respect to immunizations: Although vaccines are included in the total health care expenditures calculations, only the costs associated with administering the vaccine, if administered by a primary care provider, were included in primary care expenditures. Expenditures for primary care services provided by primary care providers were aggregated by provider specialty and then summed across all provider groupings to estimate total primary care expenditures. Although Appendix C (List of Providers) lists a large number of behavioral health specialist taxonomy codes, when primary care service codes were applied, most claims and associated expenditures for these providers were not included in primary care expenditures.

All nurse practitioner and physician assistant taxonomy codes were included in this report. Adjustments were made to the total primary care expenditures calculated for these providers. These adjustments (41% for nurse practitioners and 34% for physician assistants) were needed because many nurse practitioners and physician assistants may have a provider taxonomy code included in the definition for a primary care provider, but actually provide care in other settings (e.g., surgical). Because claims data do not indicate if a health care setting is primary care, the adjustment factors were needed to avoid overestimating primary care expenditures by counting services for nurse practitioners or physician assistants that were not conducted in primary care settings. These adjustments were based on recommendations from the stakeholder group and studies conducted by the Washington State University College of Nursing (Kaplan & Gill, 2018) and the Washington Medical Commission (Washington Medical Commission, 2019).

Primary care services for people without insurance and services paid with cash by patients who did not file an insurance claim were not included in the analyses.

Calculations for carriers

More than 50 commercial, Medicare and Medicaid data suppliers submit claims data to the WA-APCD. Data are submitted either at the company level or at the individual health insurance plan level, depending upon how the company's claims processing system is set up and the number of

health insurance plans issued in the state. Plans were first grouped by market sector (commercial, public employee benefits, Medicaid managed care organizations and Medicare Advantage) and then rolled up to the company level. Primary care and total expenditures were calculated at the company level within each market sector. Companies that had fewer than 1,000 covered persons were excluded from analyses. Dental companies were also excluded, and only medical and pharmacy claims from 2018 were used.

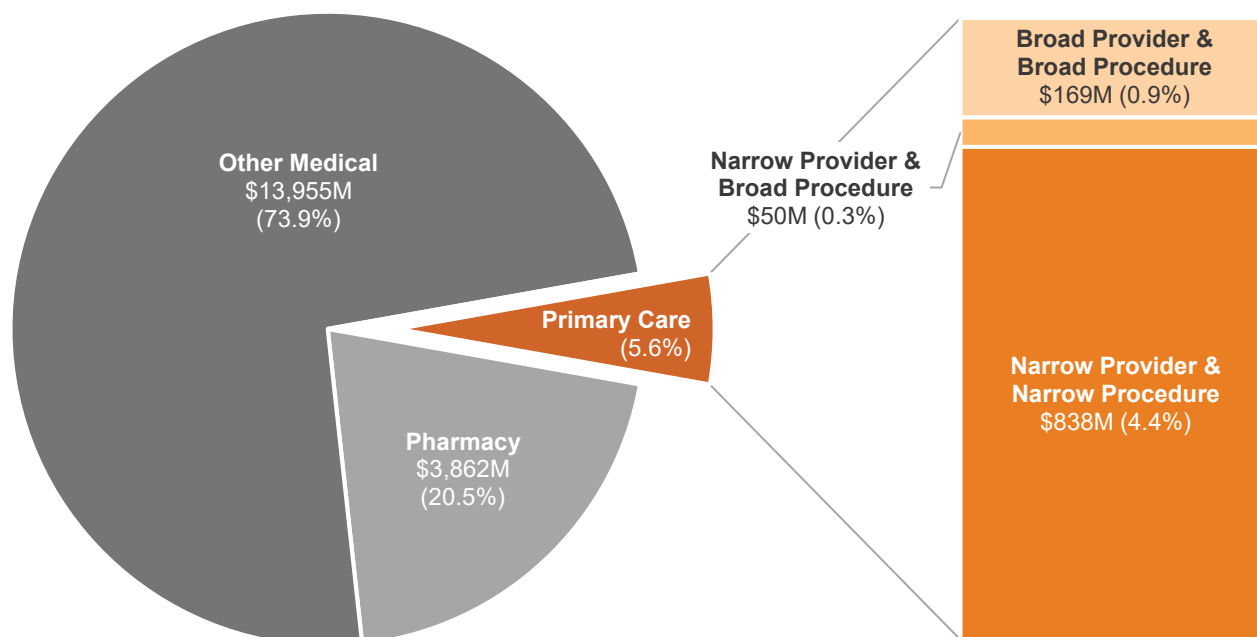
Results

Monthly enrollment

Included in this report is claims information for more than 1.2 million Medicaid managed care organization members, more than 1.1 million commercial members, and more than 300,000 public employees and 300,000 Medicare Advantage members. The total amount of health care spending captured in the WA-APCD for this report for 2018 was almost \$19 billion, 21% of which was for pharmacy claims.

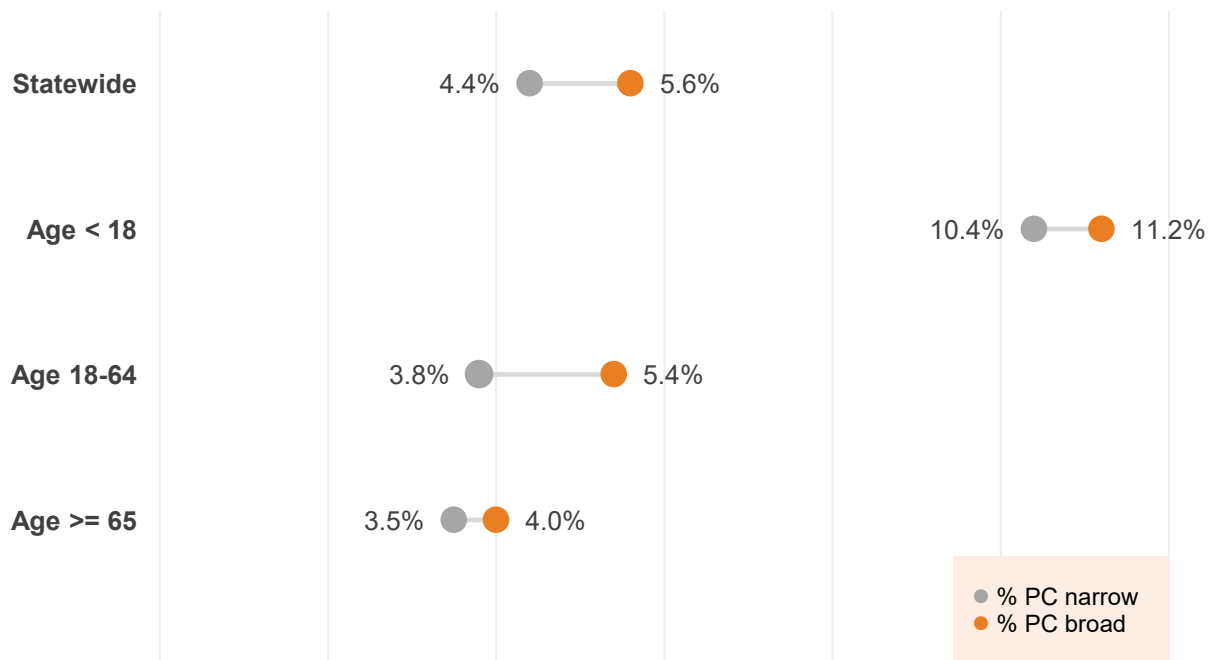
In 2018, overall investments in primary care as a total of all medical expenditures for Washington ranged from 4.4% to 5.6%, depending on whether a narrow or broad definition of providers and services were used (Figure 1). Limiting the definition of primary care providers and procedures to narrow definitions each resulted in approximately \$838 million in claims. Including the broad category of procedures resulted in about \$50 million more and an increase in the primary care share to 4.7% of total medical expenditures. Including a broad definition of providers, in addition to a broad definition of procedures, increased primary care expenditures by about \$169 million and resulted in a 19% increase in primary care expenditures, but overall, the total percentage of all health care expenditures specific to primary care was only 5.6%.

Figure 1. Summary of Medical Expenditures in Washington State, 2018



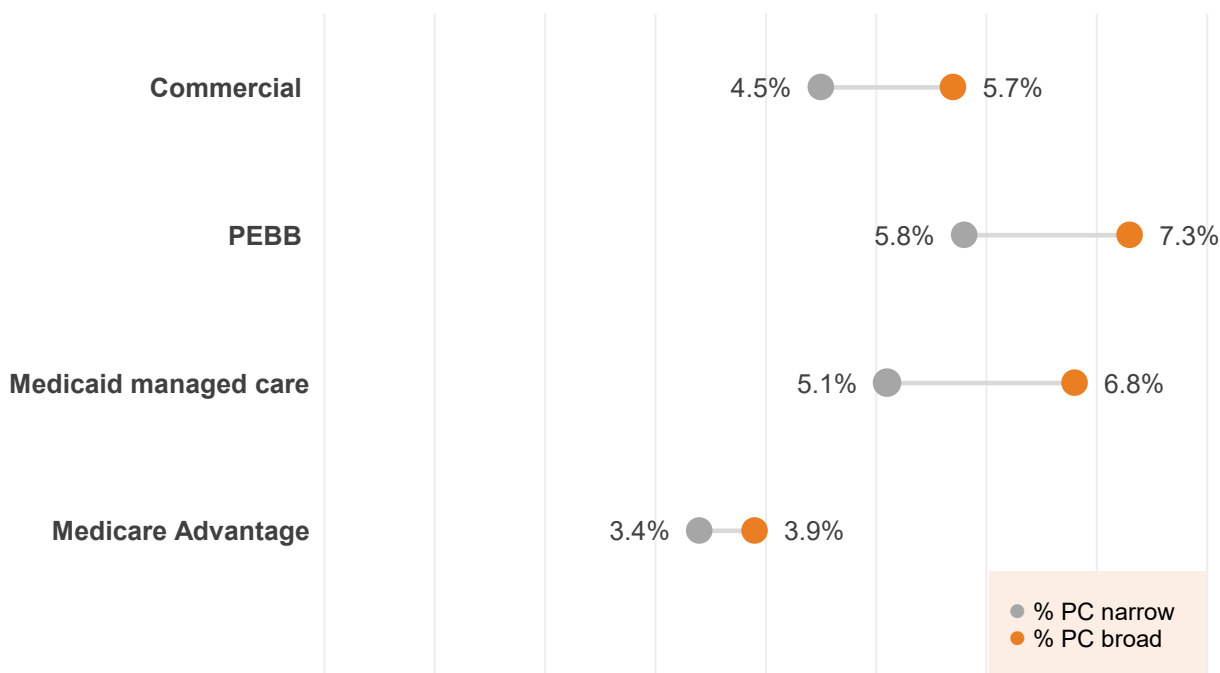
This highest percentage of primary care spending was for individuals younger than 18 years, ranging from 10.4% to 11.2% of about \$2 billion in total medical expenditures for the narrow (narrow definition of providers and narrow definition of procedures) and broad (broad definition of providers and broad definition of procedures) definitions of primary care, respectively (Figure 2). Of working age adults aged 18 to 64 years, the percentage of primary care spending ranged from 3.8% to 5.4% of about \$11 billion in total medical expenditures. It should be noted that this age group could be affected the most by the inclusion of obstetrics in the broad definition of primary care. For adults aged 65 and older, primary care spending was 3.5% to 4.0% of about \$5.5 billion in total medical spending. Older adults have a higher rate of hospital inpatient stays and other costs outside of primary care because of the higher prevalence of chronic and comorbid conditions and greater use of specialists.

Figure 2. Primary Care as Percentage of Total Expenditures by Age



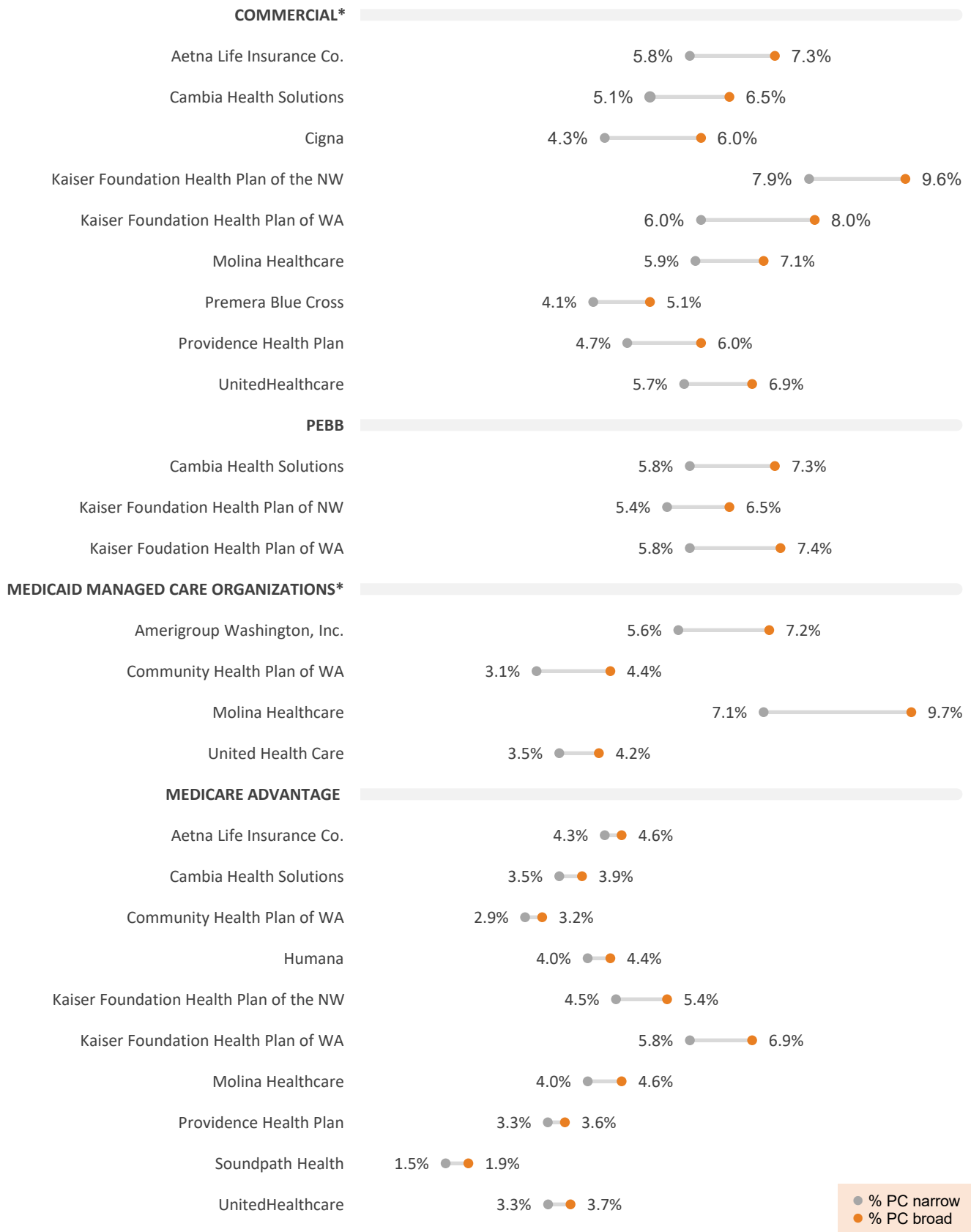
Considering primary care expenditures by market sector, public employee coverage had the highest percentage of primary care spending, ranging from 5.8% to 7.3% of about \$1.8 billion in 2018 (Figure 3). Medicaid managed care organizations ranged between 5.1% to 6.8% of about \$4 billion in 2018; commercial plans ranged between 4.5% and 5.7% of about \$8 billion; and Medicare Advantage plans ranged from 3.4% to 3.9% of about \$5 billion in total claims. Some of these differences in primary care spending reflect differences in patient characteristics between market sectors. Additionally, primary care spending for public employee coverage may be overestimated because many of the pharmacy claims were not designated for public employees when submitted to the WA-APCD. This would result in lower total expenditures for this group.

Figure 3. Primary Care as Percentage of Total Expenditures by Market Sector



Of commercial plans, the percentage of primary care investment as a total of all medical expenditures ranged from 4.1% to 5.1% for Premera Blue Cross to 7.9% to 9.6% for Kaiser Foundation Health Plan of the Northwest. For public employee plans in the Public Employee Benefits Board program, the range of primary care spending was very similar among the three companies. For Medicaid managed care plans, the percentage of primary care spending as a total of all medical expenditures ranged from 3.1% to 4.4% for Community Health Plan of Washington to 7.1% to 9.7% for Molina Healthcare. For Medicare Advantage plans, the percentage of primary care investment was less than 7% for all plans (Figure 4). Even within market sector, caution should be exercised in comparing expenditures by health plan or company because of differences in characteristics of enrollees that are not adjusted for in these analyses.

Figure 4. Primary Care as Percentage of Total Expenditures by Carrier or Company



* Data for Coordinated Care are not listed due to data issues.

Previous research on primary care

There have been a number of efforts to estimate primary care spending as a proportion of total health care spending. While Washington's estimates might appear low, these estimates cannot be compared directly with other published studies. Indeed, there is no national standard for how to measure primary care expenditures. As a result, estimates between reports may differ as a result of different definitions of primary care, different data sets used in analyses, different populations included in data sets and different methodologies to estimate primary care spending.

The Robert Graham Center, using survey data from the Medical Expenditure Panel Survey, or MEPS, estimated that Washington spends between 5.9% and 10.1% of health care expenditures on primary care (depending on whether a narrow or broad definition of primary care provider is used) (Jabbarpour, Y., Greiner, A., Jetty, A., Coffman, M., Jose, C., Petterson, S., 2019). While this study used a standardized measure (MEPS data) to compare primary care spending across states, it does have some limitations. The definition of primary care used in the analysis was based only on the taxonomy of the provider without taking into account the particular health care services performed, which may have resulted in an overestimate of actual primary care spending. Furthermore, nurses, nurse practitioners and physician assistants were included as primary care providers irrespective of whether they practiced in primary care settings because that information cannot be ascertained in the MEPS data. In addition, some MEPS data is self-reported and may be subject to recall bias.

The Milbank Memorial Fund undertook a proof-of-concept study to assess the feasibility of calculating primary care spending using commercial claims data (Bailit et al., 2017). The study used national data and found that 7.1% to 8.6% of total health care spending was specifically primary care-related. Differing interpretations of how to calculate primary care spending may have occurred, however, because each health insurance carrier calculated and submitted its data independently.

A recent report in the Journal of the American Medical Association Internal Medicine using claims data estimated about 2% to 4% of total medical and prescription drug spending for Medicare fee-for-service beneficiaries was for primary care (Reid et al., 2019). In comparison, while this report does not include Medicare fee-for-service beneficiaries, it does include Medicare Advantage members; these estimates as a market sector were between 3.4% and 3.9%.

Oregon and Rhode Island routinely produce reports estimating primary care spending. For 2017, Oregon estimated the percentage of total medical spending for primary care was:

- 16.5% for coordinated care organizations
- 13.4% for commercial carriers
- 12.2% for Medicare Advantage
- 10.6% for public employees and educators benefits

Rhode Island estimated primary care spending for its commercial plans to be close to 9.1% (in 2012), an increase of 3.5% from 2008.

It is difficult to compare Washington's proportion of primary care spending to Oregon's or Rhode Island's estimates due to differences in approaches and definitions of primary care. For example, Oregon did not include any health care spending by patients such as copay, coinsurance or deductibles while these were included in Washington's estimates. Oregon also excluded prescription drugs from its estimates of total claims-based payments or total medical expenditures. Per the budget proviso, this report included all pharmacy claims costs in total medical expenditures, which would make the percentage of primary care spending in Washington appear smaller than if these

claims had been excluded. For this report, only claims paid by the primary payer are included in the calculations to avoid any duplications of cost. It is not clear whether Oregon and Rhode Island employed this same strategy.

Additionally, Washington's estimates do not include non-claims-based expenditures, which are included in estimates for Oregon and Rhode Island. When limiting Oregon's primary care spending to just claims-based, the estimated percentage of total medical spending for primary care for 2017 was closer to Washington's estimates:

- 6.6% for coordinated care organizations
- 7.3% for commercial carriers
- 3.6% for Medicare Advantage
- 8% for public employees and educators benefits

Excluding non-claims-based estimates from this report produces a smaller overall estimate for Washington, although some of these included in other states may not be exclusive to primary care. For Oregon, many of the non-claims-based expenditures were capitated salaries for primary care or provider incentive payments. Because Washington uses a fee-for-service equivalent for capitated payments, the methods used in this report could be capturing some of the non-claims-based payments that Oregon reported separately in its total.

Non-claims-based expenditures

Many services and activities are needed to fulfill the four main features of primary care services (first-contact, continuous, comprehensive and coordinated care). These activities are not always captured in fee-for-service expenditures submitted on health care claims. Non-claims-based expenditures may occur in a provider's office, be delivered by health care companies or be part of government initiatives. Because of the broad nature of these types of activities, these investments may not be specific to primary care (e.g., health information technology) or may be unique to certain health care systems and populations. Collecting non-claims-based primary care expenditure information in a standard way across payers will be difficult with current data sources. Clear guidelines, definitions and reporting requirements, along with a critical examination of what non-claims-based investments will benefit the delivery of primary care specifically (versus the cost of business), should be included in future discussions on primary care expenditures.

Oregon and Rhode Island included a variety of non-claims-based expenditures in their primary care spending estimates. Originally, Rhode Island had a requirement from its Office of the Health Insurance Commissioner's Affordability Standards that all commercial insurers allocate at least 35% of their total spending on primary care to non-claims-based (Rhode Island referred to these as non-fee-for-service) payments increasing to 40% in 2014. While these targets were retired in 2015, the aggregate value of non-fee-for-service investments in primary care has continued to increase (King, 2019).

Non-claims-based expenditures included incentive payments to providers or practices, health information technology investments such as health insurance exchanges, expansion of primary care workforce with supplemental staff and other investments. Oregon and Rhode Island collected this information directly from their health plans using Excel templates. Oregon included in rule the definitions for non-claims-based primary care expenditures² and gave additional guidance in its

² <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=260735> Accessed Oct 2019.

reporting templates on how to consider what expenditures to report. Rhode Island's Office of the Health Commissioner collects the non-claims-based information through its Affordability Standards program, which aims to lower costs and improve quality. This program includes investment requirements like patient-centered medical homes, but also allows for insurance companies to submit expenditures for other types of investments for primary care (e.g., loan repayment).

Washington has no process to collect non-claims-based information from all plans that submit claims to the WA-APCD, nor has the state developed any universal guidance or definitions of non-claims-based expenditures. Some information outside of fee-for-service payments is submitted through the Medicaid managed care rate development process for Medicaid and the Public Employees Benefit Board. The Health Care Authority is developing a process to collect information related to primary care for these programs, but OFM was not able to obtain this information for this report.

For future primary care expenditures reports, Washington may want to consider developing a standardized process to collect, across payers, a variety of non-claims-based investments. Outlined below are several such areas and examples.

Provider incentives

Provider incentives such as those to encourage providers to adopt certain behaviors or pay providers based on performance are often included in non-claims-based investments in primary care. Oregon includes retrospective incentive payments “to primary care providers or practices based on their performance at decreasing cost or improving value for a defined population” and prospective incentive payments “to providers or practices aimed at developing capacity for improving care for a defined population of patients.”³ For example, Oregon collects information on bonus payments to providers when they meet a target for vaccination rates. Rhode Island collects information on incentive distributions under shared savings contracts.

Washington should consider how to collect information on provider incentives, including:

- Carrier-specific quality improvement programs aimed at specific in-network providers.
- State-sponsored quality improvement initiatives such as pay for performance metrics or other bonus payments to providers.
- Federal quality improvement initiatives such as the Centers for Medicare and Medicaid Services Merit-Based Incentive Payment System.

Patient-Centered Medical Home Models

According to the American College of Physicians, a Patient-Centered Medical Home, or PCMH, is a care delivery model whereby treatment is coordinated through the patient's primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand. The Agency for Healthcare Research and Quality defines the core functions of the medical home as follows:⁴

- comprehensive care
- patient-centered
- coordinated care

³ Ibid.

⁴ <https://pcmh.ahrq.gov/page/defining-pcmh> Accessed Oct 2019.

- accessible services
- quality and safety

Oregon and Rhode Island collect information from carriers on investments in PCMH models (in addition to provider incentives). Oregon has a Patient-Centered Primary Care Home program that allows for the inclusion of the per-member per-month payment based upon a practice's tier level. Rhode Island hosts a Care Transformation Collaborative, called CTC-RI, which brings together key care stakeholders to promote care for patients with chronic disease through the PCMH model. Rhode Island's only multi-payer PCMH initiative, it helps practices apply for national PCMH recognition, hire on-site care management/coordination to improve the health of patients with the highest needs, and enhance data capabilities to manage and improve population health.⁵ Additionally, Oregon and Rhode Island collect information on investments from carriers on other PCMH initiatives.

Washington should consider how to collect information on practice and provider PCMH payments and how to include this information in future reports, e.g., carrier-specific investments or aggregated payments at the state level.

Investments in technology

Oregon and Rhode Island collect information on investments in primary care related to health information technology. These investments include payments to providers to adopt electronic medical records or payments for providers' license fees. Additionally, Rhode Island, which requires health insurance companies to invest in the state health information exchange called CurrentCare, includes this investment in insurers' non-claims-based expenditures.

In deciding which technology to include in primary care investments, Washington stakeholders should consider not only the four main features of primary care (first-contact, continuous, comprehensive and coordinated), but also technology advances that improve health equity. Below are ideas for the types of technology investments that stakeholders in Washington may want to consider:

- Technology to promote interoperability of electronic health records between providers and facilities.
- Telehealth services including secure online chat tools for members to speak with primary care providers and for video visits with providers.
- Texting services for reminders of appointments, lab test results or provider communication.
- Mobile applications to access medical records, pay bills or order refills on medications.
- E-consults between providers through electronic medical record platforms.
- Transcription services or talk-to-text services to help input information directly into electronic medical records.
- Investments in OneHealthPort to improve the state's health information exchange.
- Grants from state programs or federal programs to promote the exchange of health information.

⁵ <https://www.ctc-ri.org/about-us/what-ctc-ri> Accessed Oct 2019.

Many of the investments in technology previously mentioned may not be exclusive to primary care, and care should be taken if these types of investments are counted toward future primary care investments.

Workforce expenditures

In addition to typical staffing of primary care offices for administrative roles or billing, many of the non-claims-based initiatives already mentioned — investments in technology, provider incentives and PCMH models — require supplemental primary care staff and activities. Oregon and Rhode Island collect non-claims-based primary care expenditures for certain workforce investments such as practice coaches, patient educators, patient navigators and nurse case managers. Embedding supplemental staff, including registered nurses and practice coaches, in primary care supports the “whole person” model, will be in greater demand as the prevalence of multiple chronic conditions increases and can improve patient health outcomes (Bauer & Bodenheimer, 2017; Grumbach, K., Bainbridge, E., and Bodenheimer, T., 2012).

Examples of how supplemental staff can benefit a primary care setting are:

- Implementing electronic medical records or a health information exchange.
- Providing technical support for technology enhancements in care delivery.
- Supporting adoption of new models of care delivery and continuous quality improvement.
- Helping patients change or adapt unhealthy behaviors (e.g., weight loss or smoking cessation).
- Improving care of chronic conditions, including medication adherence.
- Connecting patients with social services.
- Improving cultural competence among clinic staff.
- Integrating behavioral health services.
- Managing continuity of care.

In addition to investments in supplemental staff, investments in primary care providers is needed to maintain enough providers to support Washington’s growing population. Baicker and Chandra (2004) found that states where more physicians are general practitioners have greater use of high-quality care and lower cost per beneficiary (among Medicare patients).

Although there are numerous ways to increase and maintain the primary care provider workforce in Washington — preventing provider burnout, increasing the number of residency slots in primary care, increasing the funding for primary care provider education — this report will focus only on one area, loan repayment, because Rhode Island has useful experience from which Washington can draw information.

The Washington Student Achievement Council and the Department of Health administer two programs to help health professionals pay back student loan debt. The median amount of that debt is about:

- \$200,000 for medical school (for class of 2018) (American Association of Medical Colleges, 2018)
- \$112,500 for physician assistants (for class of 2018) (National Commission on Certification of Physician Assistants, 2019)
- \$40,000 to \$55,000 for graduate nursing education (class of 2016, most recent year available) (American Association of Colleges of Nursing, 2017)

The Federal-State Loan Repayment Program, or FSLRP, awards \$70,000 for loan reimbursement with federal and state funds in return for two years of full-time work at an approved site. The Health Professional Loan Repayment Program, or HPLRP, is a state-funded award that reimburses \$75,000 of loans for three years of full-time employment (or five years for less than full-time employment). This program requires the approved site to meet the definition of providing comprehensive primary care services: comprehensive outpatient, ambulatory and primary health care services. This definition includes critical access or rural hospitals but excludes all other hospitals. (Program-specific criteria are available from the WSAC website.⁶) In the last cycle (funds obligated in fiscal year 2015–16 and disbursed in fiscal years 2016–18 for FSLRP and fiscal years 2016–19 for HPLRP), 72 primary care providers (who also matched the definition of primary care used in this study) were awarded more than \$4.4 million in student loan debt relief.

Other investments

Additional types of investments that Oregon or Rhode Island collected and included in its non-claims (or non-fee-for-service) primary care expenditure calculations included:

- Vaccine clinics (specifically for influenza vaccines)
- Integration of behavioral health services (outside of supplemental staff)
- Risk-based reconciliation
- Capitated or salaried expenditures not captured in claims

In considering the broad context of primary care, investments in evaluation and research on primary care services, community-based programs to address social determinants of health and activities undertaken by community health workers could all be counted as primary care expenditures although they may not be part of the direct delivery of primary care services. Understanding and defining the sphere in which primary care is taking place outside of the fee-for-service system is essential for capturing non-claims-based investments in primary care (Baillieu et al., 2019). In addition to what has already been mentioned about caveats to collecting non-claims-based investments or expenditures for primary care, future reports will want to consider mechanisms to evaluate these types of expenditures and how to allow for their inclusion over time.

Limitations of current report

This is the first comprehensive analysis of annual primary care expenditures in Washington using claims data from the WA-APCD. Although future reports may continue to use claims data extracted from the WA-APCD or other sources, there are inherent limitations to health care claims data from any data source. The gaps in data identified during the study included the following:

Procedure codes

The stakeholder group conducted an extensive review of primary care procedure codes. This report included all procedures from various reports on primary care (Bailit et al., 2017; Oregon Health Authority and the Department of Consumer and Business Services, 2019; Reid et al., 2019) and additional codes the stakeholder group identified as services performed in primary care settings by primary care providers. Even with the exhaustive list of codes, there could still be procedures that were not included in this report, but are billed for by primary care providers (e.g., hospice visits,

⁶ <https://wsac.wa.gov/sites/default/files/2019.FSLRP.HPLRP.Guide.pdf> Accessed Sept 2019.

charges for vaccines). Caution should be used when comparing this report to other reports that do not use the same codes.

No primary care location indicator

We were not able to identify if the setting for the primary care service was a primary care clinic or other type of health care setting; this information is not captured on claims submitted to the WA-APCD. It is unclear if this underestimated or overestimated the true level of primary care expenditures for the state. OFM is working on solutions to gather the primary care location information for future reports.

No primary care provider roster or consensus on definition

Without a roster or other continually updated source for primary care providers for Washington, stakeholder groups will need to determine and define who is a primary care provider outside of relying on just the taxonomy code. This is especially important for nurse practitioners and physician assistants: It is unclear from the methods used to define primary care and the adjustment used for nurse practitioners and physician assistants if we over- or under-estimated primary care providers for the state. Additionally, not all reports have included obstetrics and behavioral health as primary care providers. Without a national standard or consensus on definition of primary care providers, it will continue to be difficult to compare estimates between reports.

Bundled payment services

As health care services move to bundled payments for services (e.g., obstetrics), it becomes difficult to carve out which services are attributable or defined as primary care (e.g., prenatal visits). Future reports should consider possible adjustments to methodology to identify and capture primary care services within bundled payments.

Federally Qualified Health Centers and rural health centers

Claims submitted by Federally Qualified Health Centers or rural health centers may be submitted by the facility or by the individual provider. Because this practice varies by location, an accurate estimate of primary care services delivered at or by these facilities cannot be determined.

Integrated delivery systems

Some health insurance carriers are part of integrated delivery systems or use capitated payments. These type of systems do not follow the traditional fee-for-service model when paying for health care services. Although the methodology in this report used the fee-for-service equivalent in claims data for capitated payments, there could still be an underestimate of primary care expenditures for these services that could result in an underestimate of the true primary care investment by these health insurance carriers.

Medicaid fee-for-service and Medicare fee-for-service claims

Neither Oregon nor Rhode Island, nor the current report for Washington include Medicaid fee-for-service or Medicare fee-for-service primary care expenditures. These results could be inferred from results calculated for Medicare Advantage and Medicaid managed care organizations, but these results would not take into account differences in population characteristics, health status or reimbursement rates between the fee-for-service groups and the managed care groups. Future reports may want to consider including these health insurance claims to better understand how investments in primary care differ among these populations.

Non-claims-based expenditures

As discussed previously in this report, there is no standardized statewide system in place to collect non-claims-based expenditures from health insurance carriers in Washington. Although not all primary care reports have used this type of data, Oregon and Rhode Island used it in their reports. Without non-claims-based expenditures, estimates of primary care spending will appear lower in Washington compared with states that collect these data.

Future considerations

This report provides a baseline estimate of primary care spending in Washington. This estimate can be used to monitor primary care spending and to compare the impacts of new investments and initiatives. Future reports should continue to evaluate limitations to evolving methodology and measurements. However, if future iterations of this report update or add codes or services, any changes in spending results could be due to these changes in methodology and may not be the result of any policy or behavior change. Oregon updated its inclusion of costs and primary care service codes between its reports released in 2018 and 2019 (Oregon Health Authority and the Department of Consumer and Business Services, 2019). There was no discussion on how this may have influenced its primary care expenditure results between reports.

Because primary care utilization is heavily influenced by needs of the population, future reports may include more detailed stratifications of population characteristics (e.g., sex, comorbidity, geography) to better understand variations in primary care spending. These population characteristics could help explain differences in primary care spending by market sector and by carriers outside of provider networks and business agreements.

This report cannot differentiate how spending among carriers in different market sectors correlates with quality of services, patient and provider satisfaction, or population health outcomes. If additional population characteristics are included in future reports, additional indicators previously mentioned should also be considered for collection.

If non-claims-based expenditures are to be collected and included in future iterations of this report, care should be given on whether to consider these types of investments as spending in addition to what is identified from claims and fee-for-service expenditures.

Conclusion

This primary care spending report provides not only a baseline to compare new investments or initiatives, but also caveats and considerations for how to continue to measure primary care expenditures.

The results in this report highlight a low rate of investment in primary care in Washington. Based on current research, the health care system would benefit from increased primary care investments. To ensure the best results, decisions should be guided by additional research into best practices based on current evidence, available data and broad stakeholder input. Monitoring the impact of policies and system performance will be key to successfully strengthening Washington's primary care system (Center for Health Care Strategies and State Health Access Data Assistance Center, 2014).

Future stakeholders should pose the following questions suggested by Koller et al (Koller, C.F., Khullar, 2017):

- What is the right level of primary care spending based on evidence?
- How large of an improvement in care outcomes could be expected with a unit increase in primary care spending?
- How does the effect of additional spending on primary care vary with the patient population being served?

State-level efforts to control costs and increase primary care spending are possible. Rhode Island's efforts to control costs have resulted in decreased overall spending among commercial insurers through lower prices while increasing primary care spending without affecting quality or utilization (Baum et al., 2019).

References

- American Association of Colleges of Nursing. (2017). *The Numbers Behind the Degree: Financing Graduate Nursing Education*. Retrieved from <https://www.aacnursing.org/Policy-Advocacy/View/ArticleId/20715/AACN-Releases-2017-Graduate-Nursing-Student-Debt-Report>
- American Association of Medical Colleges. (2018). October 2018 Medical Student Education: Debt, Costs, and Loan Repayment Fact Card. Retrieved October 17, 2019, from https://store.aamc.org/downloadable/download/sample/sample_id/240/
- Baicker, K., & Chandra, A. (2004). Medicare spending, the physician workforce, and beneficiaries' quality of care. *Health Affairs*, 23(SUPPL.), 184–197. <https://doi.org/10.1377/hlthaff.W4.184>
- Bailit, M. H., Friedberg, M. W., & Houy, M. L. (2017). *Standardizing the Measurement of Commercial Health Plan Primary Care Spending*. Retrieved from www.milbank.org
- Baillieu, R., Kidd, M., Phillips, R., Roland, M., Mueller, M., Morgan, D., ... Bazemore, A. (2019). The Primary Care Spend Model: A systems approach to measuring investment in primary care. *BMJ Global Health*, 4(4). <https://doi.org/10.1136/bmjgh-2019-001601>
- Basu, S., Berkowitz, S. A., Phillips, R. L., Bitton, A., Landon, B. E., & Phillips, R. S. (2019). Association of Primary Care Physician Supply With Population Mortality in the United States, 2005–2015. *JAMA Internal Medicine*, 179(4), 506–514. <https://doi.org/10.1001/jamainternmed.2018.7624>
- Bauer, L., & Bodenheimer, T. (2017). Expanded roles of registered nurses in primary care delivery of the future. *Nursing Outlook*, 65(5), 624–632. <https://doi.org/10.1016/j.outlook.2017.03.011>
- Baum, A., Song, Z., Landon, B. E., Phillips, R. S., Bitton, A., & Basu, S. (2019). Health care spending slowed after Rhode Island applied affordability standards to commercial insurers. *Health Affairs*, 38(2), 237–245. <https://doi.org/10.1377/hlthaff.2018.05164>
- Center for Health Care Strategies & State Health Access Data Assistance Center. (2014). *Multi-Payer Investments in Primary Care: Policy and Measurement Strategies*. Trenton, NJ.
- Centers for Disease Control and Prevention. (2019). *Tables of Summary Health Statistics for U.S. Adults: 2018 National Health Interview* (Vol. 0). Retrieved from <http://www.cdc.gov/nchs/nhs/SHS/tables.htm>
- Donaldson, M.S., Yordy, K.D., Lohr, K.N., & Vanselow, N. A. (Ed.). (1996). *Primary Care: America's Health in a New Era*. <https://doi.org/10.1002/clc.4960190202>
- Friedberg, M. W., Hussey, P. S., & Schneider, E. C. (2010). Primary care: A critical review of the evidence on quality and costs of health care. *Health Affairs*, 29(5), 766–772. <https://doi.org/10.1377/hlthaff.2010.0025>
- Glass, D. P., Kanter, M. H., Jacobsen, S. J., & Minardi, P. M. (2017). The impact of improving access to primary care. *Journal of Evaluation in Clinical Practice*, 23(6), 1451–1458. <https://doi.org/10.1111/jep.12821>

- Grumbach, K., Bainbridge, E., and Bodenheimer, T. (2012). Facilitating Improvement in Primary Care: The Promise of Practice Coaching. *Commonwealth Fund*, 15 (pub. 1605). Retrieved from https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2012_jun_1605_grumbach_facilitating_improvement_primary_care_practice_coaching.pdf
- Jabbarpour, Y., Greiner, A., Jetty, A., Coffman, M., Jose, C., Petterson, S. et al. (2019). *Investing in primary care: A state-level analysis*. Retrieved from <https://www.pcpcc.org/resource/evidence2019>
- Kaplan, L., & Gill, J. (2018). *2018 Washington State Advanced Registered Nurse Practitioner Survey Data Report*. Vancouver, WA.
- King, C. (2019). *Email Communication*.
- Koller, C.F., Khullar, D. (2017). Primary Care Spending Rate – A Lever for Encouraging Investment in Primary Care. *New England Journal of Medicine*, 377(18), 1709–1711.
- National Commission on Certification of Physician Assistants. (2019). *2018 Statistical Profile of Recently Certified Physician Assistants: An Annual Report of the National Commission on Certification of Physician Assistants*. Retrieved from <http://www.nccpa.net>
- OECD. (2017). *Health at a Glance 2017: OECD Indicators*. Retrieved from http://dx.doi.org/10.1787/health_glance-2017-en
- Oregon Health Authority and the Department of Consumer and Business Services. (2019). *Primary Care Spending in Oregon: A Report to the Oregon Legislature*. Retrieved from <https://www.oregon.gov/oha/HPA/ANALYTICS/Documents/SB-231-Report-2019.pdf>
- Reid, R., Damberg, C., & Friedberg, M. W. (2019, July 1). Primary Care Spending in the Fee-for-Service Medicare Population. *JAMA Internal Medicine*, Vol. 179, pp. 977–980. <https://doi.org/10.1001/jamainternmed.2018.8747>
- Starfield, B., Shi, L., Macinko, J. (2005). Contribution of primary care to health systems and health. *Milbank Quarterly*, 83(3), 457–502.
- Starfield, B. (1998). *Primary Care: Balancing Health Needs, Services, and Technology*. New York, NY: Oxford University Press.
- Washington Medical Commission. (2019). *Physician Assistant Demographic Census Aggregate Report*. Retrieved from <https://wmc.wa.gov/sites/default/files/public/PARReportOctober2019.pdf>
- Yen, W. (2018). *2016 Physician Supply*. Retrieved from https://www.ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/workforce/physician_supply_2016.pdf

Appendix A: Budget proviso

ESHB 1109, Section 131(9)

(9) \$110,000 of the general fund—state appropriation for fiscal year 2020 is provided solely for the office of financial management to determine annual primary care medical expenditures in Washington, by insurance carrier, in total and as a percentage of total medical expenditure. Where feasible, this determination must also be broken down by relevant characteristics such as whether expenditures were for in-patient or out-patient care, physical or mental health, by type of provider, and by payment mechanism.

(a) The determination must be made in consultation with statewide primary care provider organizations using the state's all payer claims database and other existing data.

(b) For purposes of this section:

(i) "Primary care" means family medicine, general internal medicine, and general pediatrics.

(ii) "Primary care provider" means a physician, naturopath, nurse practitioner, physician assistant, or other health professional licensed or certified in Washington state whose clinical practice is in the area of primary care.

(iii) "Primary care medical expenditures" means payments to reimburse the cost of physical and mental health care provided by a primary care provider, excluding prescription drugs, vision care, and dental care, whether paid on a fee-for-service basis or as a part of a capitated rate or other type of payment mechanism.

(iv) "Total medical expenditure" means payments to reimburse the cost of all health care and prescription drugs, excluding vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment mechanism.

(c) By December 1, 2019, the office of financial management shall report its findings to the legislature, including an explanation of its methodology and any limits or gaps in existing data which affected its determination.

Appendix B: Primary Care Expenditures Stakeholder Group

Office of Financial Management staff:

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Matthew Thompson

Washington Health Care Authority:

Rachel Quinn
Emily Transue
Judy Zerzan

Appendix C: List of providers

Narrow definition of primary care provider

Taxonomy Code	Description
207Q00000X	Family Medicine
207QA0000X	Family Medicine, Adolescent Medicine
207QA0505X	Family Medicine, Adult Medicine
207QG0300X	Family Medicine, Geriatric Medicine
261QF0400X	Federally Qualified Health Center
208D00000X	General Practice
207R00000X	Internal Medicine
207RG0300X	Internal Medicine, Geriatric Medicine
175F00000X	Naturopath
208000000X	Pediatrics
2080A0000X	Pediatrics, Adolescent Medicine
2083P0500X	Preventive Medicine, Preventive Medicine/Occupational Environmental Medicine
261QP2300X	Primary care clinic
261QR1300X	Rural health clinic

Nurse practitioner and physician assistant definitions

Taxonomy Code	Description
363L00000X	Nurse Practitioner
363LA2100X	Nurse Practitioner, Acute Care
363LA2200X	Nurse Practitioner, Adult Health
363LC1500X	Nurse Practitioner, Community Health
363LC0200X	Nurse Practitioner, Critical Care Medicine
363LF0000X	Nurse Practitioner, Family
363LG0600X	Nurse Practitioner, Gerontology
363LN0000X	Nurse Practitioner, Neonatal
363LN0005X	Nurse Practitioner, Neonatal, Critical Care
363LX0001X	Nurse Practitioner, Obstetrics & Gynecology
363LX0106X	Nurse Practitioner, Occupational Health
363LP0200X	Nurse Practitioner, Pediatrics
363LP0222X	Nurse Practitioner, Pediatrics, Critical Care
363LP1700X	Nurse Practitioner, Perinatal
363LP2300X	Nurse Practitioner, Primary Care
363LP0808X	Nurse Practitioner, Psychiatric/Mental Health
363LS0200X	Nurse Practitioner, School
363LW0102X	Nurse Practitioner, Women's Health
363A00000X	Physician Assistant
363AM0700X	Physician Assistant, Medical
363AS0400X	Physician Assistant, Surgical

Broad definition of primary care provider

Taxonomy Code	Description
367A00000X	Advanced Practice Midwife
106E00000X	Assistant Behavior Analyst
106S00000X	Behavior Technician
103K00000X	Behavioral Analyst
103G00000X	Clinical Neuropsychologist
364S00000X	Clinical Nurse Specialist
163W00000X	Registered Nurse
101Y00000X	Counselor
101YA0400X	Counselor, Addiction (Substance Use Disorder)
101YM0800X	Counselor, Mental Health
101YP1600X	Counselor, Pastoral
101YP2500X	Counselor, Professional
101YS0200X	Counselor, School
207QA0401X	Family Medicine, Addiction Medicine
207QB0002X	Family Medicine, Bariatric Medicine
207QH0002X	Family Medicine, Hospice and Palliative Medicine
207QS1201X	Family Medicine, Sleep Medicine
207QS0010X	Family Medicine, Sports Medicine
175L00000X	Homeopath
207RA0401X	Internal Medicine, Addiction Medicine
106H00000X	Marriage & Family Therapist
176B00000X	Midwife
207V00000X	Obstetrics & Gynecology
207VG0400X	Obstetrics & Gynecology, Gynecology
2080P0006X	Pediatrics, Developmental – Behavioral Pediatrics
2080P0008X	Pediatrics, Neurodevelopmental Disabilities
2084A0401X	Psychiatry & Neurology, Addiction Medicine
2084P0802X	Psychiatry & Neurology, Addiction Psychiatry

Broad definition of primary care provider

Taxonomy Code	Description
2084P0804X	Psychiatry & Neurology, Child & Adolescent Psychiatry
2084F0202X	Psychiatry & Neurology, Forensic Psychiatry
2084P0805X	Psychiatry & Neurology, Geriatric Psychiatry
2084P0005X	Psychiatry & Neurology, Neurodevelopmental Disabilities
2084P0800X	Psychiatry & Neurology, Psychiatry
2084P0015X	Psychiatry & Neurology, Psychosomatic Medicine
102L00000X	Psychoanalyst
103T00000X	Psychologist
103TA0400X	Psychologist, Addiction (Substance Use Disorder)
103TA0700X	Psychologist, Adult Development & Aging
103TC0700X	Psychologist, Clinical
103TC2200X	Psychologist, Clinical Child & Adolescent
103TB0200X	Psychologist, Cognitive & Behavioral
103TC1900X	Psychologist, Counseling
103TE1000X	Psychologist, Educational
103TE1100X	Psychologist, Exercise & Sports
103TF0000X	Psychologist, Family
103TF0200X	Psychologist, Forensic
103TP2701X	Psychologist, Group Psychotherapy
103TH0004X	Psychologist, Health
103TH0100X	Psychologist, Health Service
103TM1700X	Psychologist, Men & Masculinity
103TM1800X	Psychologist, Mental Retardation & Developmental Disabilities
103TP0016X	Psychologist, Prescribing (Medical)
103TP0814X	Psychologist, Psychoanalysis
103TP2700X	Psychologist, Psychotherapy
103TR0400X	Psychologist, Rehabilitation

Broad definition of primary care provider

Taxonomy Code	Description
103TS0200X	Psychologist, School
103TW0100X	Psychologist, Women
104100000X	Social Worker
1041C0700X	Social Worker, Clinical
1041S0200X	Social Worker, School

Appendix D: Procedure codes

Narrow definition of procedures

HCPCs or CPT codes	Procedure Category	Procedure Long Description
99497	Advance Care Planning Evaluation & Management Services	ADVANCE CARE PLANNING FIRST 30 MINS
99498	Advance Care Planning Evaluation & Management Services	ADVANCE CARE PLANNING EA ADDL 30 MINS
99450	Basic Life and/or Disability Exam	BASIC LIFE AND/OR DISABILITY EXAMINATION
99455	Basic Life and/or Disability Exam	WORK RELATED/MED DBLT XM TREATING PHYS
99456	Basic Life and/or Disability Exam	WORK RELATED/MED DBLT XM OTH/THN TREATING PHYS
99366	Case Management Services	TEAM CONFERENCE FACE-TO-FACE NONPHYSICIAN
99367	Case Management Services	TEAM CONFERENCE NON-FACE-TO-FACE PHYSICIAN
99368	Case Management Services	TEAM CONFERENCE NON-FACE-TO-FACE NONPHYSICIAN
99487	Chronic Care Management Services	CMPLX CHRON CARE MGMT W/O PT VST 1ST HR PER MO
99489	Chronic Care Management Services	CMPLX CHRON CARE MGMT EA ADDL 30 MIN PER MONTH
99490	Chronic Care Management Services	CHRON CARE MANAGEMENT SRVC 20 MIN PER MONTH
G0506	Chronic Care Management Services	COMP ASMT OF & CARE PLNG PT RQR CC MGMT SRVC
99241	Consultation Services	OFFICE CONSULTATION NEW/ESTAB PATIENT 15 MIN
99242	Consultation Services	OFFICE CONSULTATION NEW/ESTAB PATIENT 30 MIN
99243	Consultation Services	OFFICE CONSULTATION NEW/ESTAB PATIENT 40 MIN
99244	Consultation Services	OFFICE CONSULTATION NEW/ESTAB PATIENT 60 MIN
G0438	Counseling, Screening, & Prevention Services	ANNUAL WELLNESS VISIT; PERSONALIZ PPS INIT VISIT
G0439	Counseling, Screening, & Prevention Services	ANNUAL WELLNESS VST; PERSONALIZED PPS SUBSQVT VST
G0442	Counseling, Screening, & Prevention Services	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES
G0443	Counseling, Screening, & Prevention Services	BRIEF FACE-FACE BEHAV CNSL ALCOHL MISUSE 15 MIN
99324	Domiciliary, Rest Home or Custodial Care	DOMICIL/REST HOME NEW PT VISIT LOW SEVER 20 MIN
99325	Domiciliary, Rest Home or Custodial Care	DOMICIL/REST HOME NEW PT VISIT MOD SEVER 30 MIN
99326	Domiciliary, Rest Home or Custodial Care	DOMICIL/REST HOME NEW PT HI-MOD SEVER 45 MINUTES
99327	Domiciliary, Rest Home or Custodial Care	DOMICIL/REST HOME NEW PT VISIT HI SEVER 60 MIN

Narrow definition of procedures

HCPCs or CPT codes	Procedure Category	Procedure Long Description
99328	Domiciliary, Rest Home or Custodial Care	DOM/R-HOME E/M NEW PT SIGNIF NEW PROB 75 MINUTES
99334	Domiciliary, Rest Home or Custodial Care	DOM/R-HOME E/M EST PT SELF-LMTD/MINOR 15 MINUTES
99335	Domiciliary, Rest Home or Custodial Care	DOM/R-HOME E/M EST PT LW MOD SEVERITY 25 MINUTES
99336	Domiciliary, Rest Home or Custodial Care	DOM/R-HOME E/M EST PT MOD HI SEVERITY 40 MINUTES
99337	Domiciliary, Rest Home or Custodial Care	DOM/R-HOME E/M EST PT SIGNIF NEW PROB 60 MINUTES
99078	Educational Service Group Setting	PHYS/QHP EDUCATION SVCS RENDERED PTS GRP SETTING
G0466	FQHC Visits	FEDERALLY QUALIFIED HEALTH CENTER VISIT NEW PT
G0467	FQHC Visits	FEDERALLY QUALIFIED HEALTH CENTER VISIT ESTAB PT
G0468	FQHC Visits	FEDERALLY QUALIFIED HEALTH CENTER VISIT IPPE/AWV
G0469	FQHC Visits	FED QUAL HEALTH CNTR VISIT MENTAL HEALTH NEW PT
G0470	FQHC Visits	FED QUAL HEALTH CNTR VST MENTAL HEALTH ESTAB PT
T1015	FQHC Visits - T1015	CLINIC VISIT/ENCOUNTER ALL-INCLUSIVE
96160	Health Risk Assessment & Screenings	PT-FOCUSED HLTH RISK ASSMT SCORE DOC STND INSTRM
96161	Health Risk Assessment & Screenings	CAREGIVER HLTH RISK ASSMT SCORE DOC STND INSTRM
99339	Health Risk Assessment & Screenings	INDIV PHYS SUPVJ HOME/DOM/R-HOME MO 15-29 MIN
99340	Health Risk Assessment & Screenings	INDIV PHYS SUPVJ HOME/DOM/R-HOME MO 30 MIN/>
99483	Health Risk Assessment & Screenings	ASSMT & CARE PLANNING PT W/COGNITIVE IMPAIRMENT
G0396	Health Risk Assessment & Screenings	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT 15-30 MIN
G0397	Health Risk Assessment & Screenings	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT >30 MIN
G0444	Health Risk Assessment & Screenings	ANNUAL DEPRESSION SCREENING 15 MINUTES
G0505	Health Risk Assessment & Screenings	COGN & FUNCT ASMT USING STD INST OFF/OTH OP/HOME
99341	Home Health Services	HOME VISIT NEW PATIENT LOW SEVERITY 20 MINUTES
99342	Home Health Services	HOME VISIT NEW PATIENT MOD SEVERITY 30 MINUTES
99343	Home Health Services	HOME VST NEW PATIENT MOD-HI SEVERITY 45 MINUTES
99344	Home Health Services	HOME VISIT NEW PATIENT HI SEVERITY 60 MINUTES
99345	Home Health Services	HOME VISIT NEW PT UNSTABL/SIGNIF NEW PROB 75 MIN

Narrow definition of procedures

HCPs or CPT codes	Procedure Category	Procedure Long Description
99347	Home Health Services	HOME VISIT EST PT SELF LIMITED/MINOR 15 MINUTES
99348	Home Health Services	HOME VISIT EST PT LOW-MOD SEVERITY 25 MINUTES
99349	Home Health Services	HOME VISIT EST PT MOD-HI SEVERITY 40 MINUTES
99350	Home Health Services	HOME VST EST PT UNSTABLE/SIGNIF NEW PROB 60 MINS
99374	Home Health Services	SUPVJ PT HOME HEALTH AGENCY MO 15-29 MINUTES
99375	Home Health Services	SUPERVISION PT HOME HEALTH AGENCY MONTH 30 MIN/>
99376	Home Health Services	CARE PLAN OVERSIGHT/OVER
G0179	Home Health Services	PHYS RE-CERT MCR-COVR HOM HLTH SRVC RE-CERT PRD
G0180	Home Health Services	PHYS CERT MCR-COVR HOM HLTH SRVC PER CERT PRD
G0181	Home Health Services	PHYS SUPV PT RECV MCR-COVR SRVC HOM HLTH AGCY
G0463	Hospital Outpatient Clinic Visit	HOSPITAL OUTPATIENT CLIN VISIT ASSESS & MGMT PT
90460	Immunization Administration for Vaccines/Toxoids	IM ADM THRU 18YR ANY RTE 1ST/ONLY COMPT VAC/TOX
90461	Immunization Administration for Vaccines/Toxoids	IM ADM THRU 18YR ANY RTE ADDL VAC/TOX COMPT
90471	Immunization Administration for Vaccines/Toxoids	IM ADM PRQ ID SUBQ/IM NJXS 1 VACCINE
90472	Immunization Administration for Vaccines/Toxoids	IM ADM PRQ ID SUBQ/IM NJXS EA VACCINE
90473	Immunization Administration for Vaccines/Toxoids	IM ADM INTRANSL/ORAL 1 VACCINE
90474	Immunization Administration for Vaccines/Toxoids	IM ADM INTRANSL/ORAL EA VACCINE
G0402	Initial Services for Medicare Enrollment	INIT PREV PE LTD NEW BENEF DUR 1ST 12 MOS MCR
96372	Injections	THERAPEUTIC PROPHYLACTIC/DX INJECTION SUBQ/IM
11055	Minor Procedures and Tests	PARING/CUTTING BENIGN HYPERKERATOTIC LESION 1
11056	Minor Procedures and Tests	PARING/CUTTING BENIGN HYPERKERATOTIC LESION 2-4
11200	Minor Procedures and Tests	REMOVAL SKN TAGS MLT FIBRQ TAGS ANY AREA UPW/15
11201	Minor Procedures and Tests	REMOVAL SK TGS MLT FIBRQ TAGS ANY AREA EA 10

Narrow definition of procedures

HCCPs or CPT codes	Procedure Category	Procedure Long Description
11719	Minor Procedures and Tests	TRIMMING NONDYSTROPHIC NAILS ANY NUMBER
11720	Minor Procedures and Tests	DEBRIDEMENT NAIL ANY METHOD 1-5
11721	Minor Procedures and Tests	DEBRIDEMENT NAIL ANY METHOD 6/>
11740	Minor Procedures and Tests	EVACUATION SUBUNGUAL HEMATOMA
11900	Minor Procedures and Tests	INJECTION INTRALESIONAL UP TO & INCLUD 7 LESIONS
11901	Minor Procedures and Tests	INJECTION INTRALESIONAL >7 LESIONS
15851	Minor Procedures and Tests	REMOVAL SUTURES UNDER ANESTHESIA OTHER SURGEON
16020	Minor Procedures and Tests	DRS&/DBRDMT PRTL-THKNS BURNS 1ST/SBSQ SMALL
17110	Minor Procedures and Tests	DESTRUCTION BENIGN LESIONS UP TO 14
17111	Minor Procedures and Tests	DESTRUCTION BENIGN LESIONS 15/>
24640	Minor Procedures and Tests	CLTX RDL HEAD SUBLXTJ CHLD NURSEMAID ELBW W/MANJ
30300	Minor Procedures and Tests	REMOVAL FOREIGN BODY INTRANASAL OFFICE PROCEDURE
36415	Minor Procedures and Tests	COLLECTION VENOUS BLOOD VENIPUNCTURE
36416	Minor Procedures and Tests	COLLECTION CAPELLARY BLOOD SPECIMEN
43760	Minor Procedures and Tests	CHANGE GASTROSTOMY TUBE PERCUTANEOUS W/O GDNCE
51702	Minor Procedures and Tests	INSJ TEMP NDWELLG BLADDER CATHETER SIMPLE
54150	Minor Procedures and Tests	CIRCUMCISION W/CLAMP/OTH DEV W/BLOCK
57170	Minor Procedures and Tests	DIAPHRAGM/CERVICAL CAP FITTING W/INSTRUCTIONS
69200	Minor Procedures and Tests	RMVL FB XTRNL AUDITORY CANAL W/O ANES
69210	Minor Procedures and Tests	REMOVAL IMPACTED CERUMEN INSTRUMENTATION UNILAT
81000	Minor Procedures and Tests	URINLS DIP STICK/TABLET REAGNT NON-AUTO MICRSCP
81001	Minor Procedures and Tests	URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY
81002	Minor Procedures and Tests	URNLS DIP STICK/TABLET RGNT NON-AUTO W/O MICRSCP
81025	Minor Procedures and Tests	URINE PREGNANCY TEST VISUAL COLOR CMPRSN METHS
82044	Minor Procedures and Tests	URINE ALBUMIN SEMIQUANTITATIVE
82270	Minor Procedures and Tests	BLOOD OCCULT PEROXIDASE ACTV QUAL FECES 1 DETER

Narrow definition of procedures

HCPs or CPT codes	Procedure Category	Procedure Long Description
82272	Minor Procedures and Tests	BLOOD OCCULT PEROXIDASE ACTV QUAL FECES 1-3 SPEC
82465	Minor Procedures and Tests	CHOLESTEROL SERUM/WHOLE BLOOD TOTAL
82947	Minor Procedures and Tests	GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP
82948	Minor Procedures and Tests	GLUCOSE BLOOD REAGENT STRIP
82950	Minor Procedures and Tests	GLUCOSE POST GLUCOSE DOSE
82962	Minor Procedures and Tests	GLUC BLD GLUC MNTR DEV CLEARED FDA SPEC HOME USE
83718	Minor Procedures and Tests	LIPOPROTEIN DIR MEAS HIGH DENSITY CHOLESTEROL
85013	Minor Procedures and Tests	BLOOD COUNT SPUN MICROHEMATOCRIT
85014	Minor Procedures and Tests	BLOOD COUNT HEMATOCRIT
85018	Minor Procedures and Tests	BLOOD COUNT HEMOGLOBIN
86580	Minor Procedures and Tests	SKIN TEST TUBERCULOSIS INTRADERMAL
87205	Minor Procedures and Tests	SMR PRIM SRC GRAM/GIEMSA STAIN BCT FUNGI/CELL
87880	Minor Procedures and Tests	IAADIADOO STREPTOCOCCUS GROUP A
92551	Minor Procedures and Tests	SCREENING TEST PURE TONE AIR ONLY
92567	Minor Procedures and Tests	TYMPANOMETRY
93000	Minor Procedures and Tests	ECG ROUTINE ECG W/LEAST 12 LDS W/I&R
93005	Minor Procedures and Tests	ECG ROUTINE ECG W/LEAST 12 LDS TRCG ONLY W/O I&R
93010	Minor Procedures and Tests	ECG ROUTINE ECG W/LEAST 12 LDS I&R ONLY
93040	Minor Procedures and Tests	RHYTHM ECG 1-3 LEADS W/INTERPRETATION & REPORT
93268	Minor Procedures and Tests	XTRNL PT ACTIV ECG TRANSMIS W/R&I </30 DAYS
93270	Minor Procedures and Tests	XTRNL PT ACTIVATED ECG RECORD MONITOR 30 DAYS
93272	Minor Procedures and Tests	XTRNL PT ACTIVTD ECG DWNLD W/R&I </30 DAYS
93784	Minor Procedures and Tests	AMBL BLD PRESS W/TAPE&/DISK 24/> HR ALYS I&R
94010	Minor Procedures and Tests	SPMTRY W/VC EXPIRATORY FLO W/WO MXML VOL VNTJ
94060	Minor Procedures and Tests	BRNCDILAT RSPSE SPMTRY PRE&POST-BRNCDILAT ADMN
94640	Minor Procedures and Tests	PRESSURIZED/NONPRESSURIZED INHALATION TREATMENT

Narrow definition of procedures

HCPs or CPT codes	Procedure Category	Procedure Long Description
94664	Minor Procedures and Tests	DEMO&/EVAL OF PT UTILIZ AERSL GEN/NEB/INHLR/IP
94760	Minor Procedures and Tests	NONINVASIVE EAR/PULSE OXIMETRY SINGLE DETER
94761	Minor Procedures and Tests	NONINVASIVE EAR/PULSE OXIMETRY MULTIPLE DETER
95115	Minor Procedures and Tests	PROF SVCS ALLG IMMNTX X W/PRV ALLGIC XTRCS 1 NJX
95117	Minor Procedures and Tests	PROF SVCS ALLG IMMNTX X W/PRV ALLGIC XTRCS NJXS
97597	Minor Procedures and Tests	DEBRIDEMENT OPEN WOUND 20 SQ CM/<
97602	Minor Procedures and Tests	RMVL DEVITAL TISS N-SLCTV DBRDMT W/O ANES 1 SESS
99000	Minor Procedures and Tests	HANDLG&/OR CONVEY OF SPEC FOR TR OFFICE TO LAB
99050	Minor Procedures and Tests	SERVICES PROVIDED OFFICE OTH/THN REG SCHED HOURS
99051	Minor Procedures and Tests	SVC PRV OFFICE REG SCHEDD EVN WKEND/HOLIDAY HRS
99058	Minor Procedures and Tests	SVC PRV EMER BASIS IN OFFICE DISRUPTING SVCS
A4627	Minor Procedures and Tests	SPACR BAG/RESRVOR W/WO MASK W/METRD DOSE INHAL
A6448	Minor Procedures and Tests	LT COMPRS BANDGE ELAST WIDTH < 3 IN PER YARD
A6449	Minor Procedures and Tests	LT COMPRS BANDGE ELAST WIDTH >= 3 & <5 IN PER YD
A7003	Minor Procedures and Tests	ADMN SET SM VOL NONFILTR PNEUMAT NEBULIZR DISPBL
A7015	Minor Procedures and Tests	AREO MASK USED W/ DME NEB
G0403	Minor Procedures and Tests	ECG RTN ECG W/12 LEADS SCR INIT PREVNTV PE W/I&R
G0404	Minor Procedures and Tests	ECG RTN ECG W/12 LEADS TRACING ONLY W/O I&R
G0405	Minor Procedures and Tests	ECG RTN ECG W/12 LEADS INTERPR & REPORT ONLY
S8100	Minor Procedures and Tests	HOLDING CHAMB/SPACR W/INHAL/NEBULIZR; W/O MASK
S8101	Minor Procedures and Tests	HOLDING CHAMB/SPACR W/AN INHAL/NEBULIZR; W/MASK
99460	Newborn Care Services	1ST HOSP/BIRTHING CENTER CARE PER DAY NML NB
99461	Newborn Care Services	1ST CARE PR DAY NML NB XCPT HOSP/BIRTHING CENTER
99462	Newborn Care Services	SUBQ HOSPITAL CARE PER DAY E/M NORMAL NEWBORN
99463	Newborn Care Services	1ST HOSP/BIRTHING CENTER NB ADMIT & DSCHG SM DAT
98969	Non-Face-to-Face Non-Physician Services	NONPHYSICIAN ONLINE ASSESSMENT AND MANAGEMENT

Narrow definition of procedures

HCPs or CPT codes	Procedure Category	Procedure Long Description
99441	Non-Face-to-Face Physician Services	PHYS/QHP TELEPHONE EVALUATION 5-10 MIN
99442	Non-Face-to-Face Physician Services	PHYS/QHP TELEPHONE EVALUATION 11-20 MIN
99443	Non-Face-to-Face Physician Services	PHYS/QHP TELEPHONE EVALUATION 21-30 MIN
99444	Non-Face-to-Face Physician Services	PHYS/QHP ONLINE EVALUATION & MANAGEMENT SERVICE
99446	Non-Face-to-Face Physician Services	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5-10 MIN
99447	Non-Face-to-Face Physician Services	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 11-20 MIN
99448	Non-Face-to-Face Physician Services	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 21-30 MIN
99449	Non-Face-to-Face Physician Services	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 31/> MIN
99451	Non-Face-to-Face Physician Services	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5/> MIN
99452	Non-Face-to-Face Physician Services	NTRPROF PHONE/NTRNET/EHR REFERRAL SVC 30 MIN
99453	Non-Face-to-Face Physician Services	REM MNTR PHYSIOL PARAM 1ST SET UP PT EDUCAJ EQP
99454	Non-Face-to-Face Physician Services	REM MNTR PHYSIOL PARAM 1ST DEV SUPPLY EA 30 D
99457	Non-Face-to-Face Physician Services	REMOTE PHYSIOLOGIC MONITORING 20 MIN+ PER MONTH
98966	Non-Physician Telephone Services	NONPHYSICIAN TELEPHONE ASSESSMENT 5-10 MIN
98967	Non-Physician Telephone Services	NONPHYSICIAN TELEPHONE ASSESSMENT 11-20 MIN
98968	Non-Physician Telephone Services	NONPHYSICIAN TELEPHONE ASSESSMENT 21-30 MIN
99201	Office/Other Outpatient Services	OFFICE OUTPATIENT NEW 10 MINUTES
99202	Office/Other Outpatient Services	OFFICE OUTPATIENT NEW 20 MINUTES
99203	Office/Other Outpatient Services	OFFICE OUTPATIENT NEW 30 MINUTES
99204	Office/Other Outpatient Services	OFFICE OUTPATIENT NEW 45 MINUTES
99205	Office/Other Outpatient Services	OFFICE OUTPATIENT NEW 60 MINUTES
99211	Office/Other Outpatient Services	OFFICE OUTPATIENT VISIT 5 MINUTES
99212	Office/Other Outpatient Services	OFFICE OUTPATIENT VISIT 10 MINUTES
99213	Office/Other Outpatient Services	OFFICE OUTPATIENT VISIT 15 MINUTES
99214	Office/Other Outpatient Services	OFFICE OUTPATIENT VISIT 25 MINUTES
99215	Office/Other Outpatient Services	OFFICE OUTPATIENT VISIT 40 MINUTES

Narrow definition of procedures

HPCPs or CPT codes	Procedure Category	Procedure Long Description
98925	Osteopathic Manipulation	OSTEOPATHIC MANIPULATIVE TX 1-2 BODY REGIONS
98926	Osteopathic Manipulation	OSTEOPATHIC MANIPULATIVE TX 3-4 BODY REGIONS
98927	Osteopathic Manipulation	OSTEOPATHIC MANIPULATIVE TX 5-6 BODY REGIONS
98928	Osteopathic Manipulation	OSTEOPATHIC MANIPULATIVE TX 7-8 BODY REGIONS
98929	Osteopathic Manipulation	OSTEOPATHIC MANIPULATIVE TX 9-10 BODY REGIONS
11981	Preventive Medicine Services	INSJ NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
11982	Preventive Medicine Services	REMOVAL NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
11983	Preventive Medicine Services	RMVL W/RINSJ NON-BIODEGRADABLE DRUG DLVR IMPLT
58300	Preventive Medicine Services	INSERTION INTRAUTERINE DEVICE IUD
83655	Preventive Medicine Services	ASSAY OF LEAD
99173	Preventive Medicine Services	SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT
99381	Preventive Medicine Services	INITIAL PREVENTIVE MEDICINE NEW PATIENT <1YEAR
99382	Preventive Medicine Services	INITIAL PREVENTIVE MEDICINE NEW PT AGE 1-4 YRS
99383	Preventive Medicine Services	INITIAL PREVENTIVE MEDICINE NEW PT AGE 5-11 YRS
99384	Preventive Medicine Services	INITIAL PREVENTIVE MEDICINE NEW PT AGE 12-17 YR
99385	Preventive Medicine Services	INITIAL PREVENTIVE MEDICINE NEW PT AGE 18-39YRS
99386	Preventive Medicine Services	INITIAL PREVENTIVE MEDICINE NEW PATIENT 40-64YRS
99387	Preventive Medicine Services	INITIAL PREVENTIVE MEDICINE NEW PATIENT 65YRS&>
99391	Preventive Medicine Services	PERIODIC PREVENTIVE MED ESTABLISHED PATIENT <1Y
99392	Preventive Medicine Services	PERIODIC PREVENTIVE MED EST PATIENT 1-4YRS
99393	Preventive Medicine Services	PERIODIC PREVENTIVE MED EST PATIENT 5-11YRS
99394	Preventive Medicine Services	PERIODIC PREVENTIVE MED EST PATIENT 12-17YRS
99395	Preventive Medicine Services	PERIODIC PREVENTIVE MED EST PATIENT 18-39 YRS
99396	Preventive Medicine Services	PERIODIC PREVENTIVE MED EST PATIENT 40-64YRS
99397	Preventive Medicine Services	PERIODIC PREVENTIVE MED EST PATIENT 65YRS& OLDER
99401	Preventive Medicine Services	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 15 MIN

Narrow definition of procedures

HCPs or CPT codes	Procedure Category	Procedure Long Description
99402	Preventive Medicine Services	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 30 MIN
99403	Preventive Medicine Services	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 45 MIN
99404	Preventive Medicine Services	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 60 MIN
99406	Preventive Medicine Services	TOBACCO USE CESSATION INTERMEDIATE 3-10 MINUTES
99407	Preventive Medicine Services	TOBACCO USE CESSATION INTENSIVE >10 MINUTES
99408	Preventive Medicine Services	ALCOHOL/SUBSTANCE SCREEN & INTERVEN 15-30 MIN
99409	Preventive Medicine Services	ALCOHOL/SUBSTANCE SCREEN & INTERVENTION >30 MIN
99411	Preventive Medicine Services	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 30 M
99412	Preventive Medicine Services	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 60 M
99420	Preventive Medicine Services	ADMN & INTERPJ HEALTH RISK ASSESSMENT INSTRUMENT
99429	Preventive Medicine Services	UNLISTED PREVENTIVE MEDICINE SERVICE
G0101	Preventive Medicine Services	CERV/VAGINAL CANCER SCR; PELV&CLIN BREAST EXAM
G0102	Preventive Medicine Services	PROS CANCER SCREENING; DIGTL RECTAL EXAMINATION
G0436	Preventive Medicine Services	SMOKE TOB CESSATION CNSL AS PT; INTRMED 3-10 MIN
G0437	Preventive Medicine Services	SMOKING & TOB CESS CNSL AS PT; INTENSIVE >10 MIN
J1050	Preventive Medicine Services	INJECTION MEDROXYPROGESTERONE ACETATE 1 MG
Q0091	Preventive Medicine Services	SCREEN PAP SMEAR; OBTAIN PREP & C ONVEY TO LAB
G0513	Prolonged Preventive Services	PRLNG PREV SRVC OFC/OTH O/P RQR DIR CTC;1ST 30 M
G0514	Prolonged Preventive Services	PRLNG PREV SRVC OFC/OTH O/P DIR CTC;EA ADD 30 M
99354	Prolonged Services	PROLNG E&M/PSYCTX SVC OFFICE O/P DIR CON 1ST HR
99355	Prolonged Services	PROLNG E&M/PSYCTX SVC OFFICE O/P DIR CON ADDL 30
99358	Prolonged Services	PROLNG E/M SVC BEFORE&/AFTER DIR PT CARE 1ST HR
99359	Prolonged Services	PROLNG E/M BEFORE&/AFTER DIR CARE EA 30 MINUTES
99360	Prolonged Services	PHYS STANDBY SVC PROLNG PHYS ATTN EA 30 MINUTES
99495	Transitional Care Management Services	TRANSITIONAL CARE MANAGE SRVC 14 DAY DISCHARGE
99496	Transitional Care Management Services	TRANSITIONAL CARE MANAGE SRVC 7 DAY DISCHARGE

Narrow definition of procedures

HCPs or CPT codes	Procedure Category	Procedure Long Description
G0008	Vaccine Administration	ADMINISTRATION OF INFLUENZA VIRUS VACCINE
G0009	Vaccine Administration	ADMINISTRATION OF PNEUMOCOCCAL VACCINE
G0010	Vaccine Administration	ADMINISTRATION OF HEPATITIS B VACCINE

Broad definition of procedure codes

HCPs or CPT codes	Procedure Category	Procedure Long Description
59510	Cesarean Delivery Procedures	OB ANTEPARTUM CARE CESAREAN DLVR & POSTPARTUM
59515	Cesarean Delivery Procedures	CESAREAN DELIVERY ONLY W/POSTPARTUM CARE
59610	Delivery Procedures After Previous Cesarean Delivery	ROUTINE OB CARE VAG DLVRY & POSTPARTUM CARE VB
59614	Delivery Procedures After Previous Cesarean Delivery	VAGINAL DELIVERY & POSTPARTUM CARE VBAC
59618	Delivery Procedures After Previous Cesarean Delivery	ROUTINE OBSTETRICAL CARE ATTEMPTED VBAC
59622	Delivery Procedures After Previous Cesarean Delivery	CESAREAN DLVRY & POSTPARTUM CARE ATTEMPTED VBA
99464	Delivery/Birthing Room Attendance & Resuscitation Services	ATTN AT DELIVERY 1ST STABILIZATION OF NEWBORN
99465	Delivery/Birthing Room Attendance & Resuscitation Services	DELIVERY/BIRTHING ROOM RESUSCITATION
99377	Hospice Services	SUPERVISION HOSPICE PATIENT/MONTH 15-29 MIN
99378	Hospice Services	SUPERVISION HOSPICE PATIENT/MONTH 30 MINUTES/>
G0182	Hospice Services	PHYS SUPV PT UNDER MEDICARE-APPROVED HOSPICE
99304	Nursing Facility Services	INITIAL NURSING FACILITY CARE/DAY 25 MINUTES
99305	Nursing Facility Services	INITIAL NURSING FACILITY CARE/DAY 35 MINUTES
99306	Nursing Facility Services	INITIAL NURSING FACILITY CARE/DAY 45 MINUTES
99307	Nursing Facility Services	SBSQ NURSING FACILITY CARE/DAY E/M STABLE 10 MIN
99308	Nursing Facility Services	SBSQ NURSING FACIL CARE/DAY MINOR COMPLJ 15 MIN
99309	Nursing Facility Services	SBSQ NURSING FACIL CARE/DAY NEW PROBLEM 25 MIN
99310	Nursing Facility Services	SBSQ NURS FACIL CARE/DAY UNSTABL/NEW PROB 35 MIN

Broad definition of procedure codes

HCPCs or CPT codes	Procedure Category	Procedure Long Description
99315	Nursing Facility Services	NURSING FACILITY DISCHARGE MANAGEMENT 30 MINUTES
99316	Nursing Facility Services	NURSING FACILITY DISCHARGE MANAGEMENT 30 MINUTES
99318	Nursing Facility Services	E/M ANNUAL NURSING FACILITY ASSESS STABLE 30 MIN
99379	Nursing Facility Services	SUPERVISION NURS FACILITY PATIENT MO 15-29 MIN
99380	Nursing Facility Services	SUPERVISION NURS FACILITY PATIENT MONTH 30 MIN/>
99484	Psychiatric Care Management	CARE MGMT SERVICES BEHAVIORAL HLTH COND 20 MINS
99492	Psychiatric Care Management	1ST PSYCHIATRIC COLLAB CARE MGMT 1ST 70 MINS
99493	Psychiatric Care Management	SBSQ PSYCHIATRIC COLLAB CARE MGMT 1ST 60 MINS
99494	Psychiatric Care Management	1ST/SBSQ PSYCH COLLAB CARE MGMT EA ADDL 30 MINS
G0502	Psychiatric Care Management	INIT PS CCM 1ST 70 MIN 1ST CAL MO BEH HC MGR AC
G0503	Psychiatric Care Management	SUBSQT PS CCM 1ST 60 MIN SUBSQT MO BEH HC MGR AC
G0504	Psychiatric Care Management	INIT/SUBSQ PS CCM EA ADD 30 MN CAL MO BHC MGR AC
G0507	Psychiatric Care Management	CARE MGMT BH COND AL 20 MIN CL STAFF TM P CAL MO
59400	Vaginal Delivery, Antepartum & Postpartum Care Procedures	OB CARE ANTEPARTUM VAG DLVR & POSTPARTUM
59410	Vaginal Delivery, Antepartum & Postpartum Care Procedures	VAGINAL DELIVERY ONLY W/POSTPARTUM CARE
59425	Vaginal Delivery, Antepartum & Postpartum Care Procedures	ANTEPARTUM CARE ONLY 4-6 VISITS
59426	Vaginal Delivery, Antepartum & Postpartum Care Procedures	ANTEPARTUM CARE ONLY 7/> VISITS
59430	Vaginal Delivery, Antepartum & Postpartum Care Procedures	POSTPARTUM CARE ONLY SEPARATE PROCEDURE

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