Data Specification Manual

957 CMR 2.00:

Payer Reporting of Primary Care and Behavioral Health Expenses

September 8, 2022

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1. Summary of Changes

- Updated code lists to capture primary care and behavioral health spending. Behavioral health sections include a service subtype column to differentiate between Behavioral Health (BH) and Substance Use Disorder (SUD)
- Updated code lists to add taxonomy codes for both behavioral health and primary care providers
- Added a Substance Use Disorder (SUD) aggregate expenditures by insurance category table on the front tab (required for CY2021), please see section 4b of the data specifications manual and the accompanying code list for guidance
- Added a supplemental telehealth collection by service category (requested for CY2020, required for CY2021), please see section 4c of the data specifications manual and the accompanying code list for guidance
- Moved member months by managing physician group into a separate data tab in the data collection template.

2. Introduction

There is emerging interest in the Commonwealth to better measure expenditures on primary care and behavioral health services, as reflected in recent legislative proposals, findings, and recommendations from state agencies, as well as support from patient advocates. These spending categories comprise an array of vital services that can meaningfully shape patient outcomes and are often associated with lower costs and higher quality.

Consistent with CHIA's mission to create and curate data assets that support evidence-based policy making and program oversight, the agency is collecting more detailed information about primary care and behavioral health spending in the Commonwealth. The data specifications outlined below will provide a foundational data set that can be leveraged and adapted to support future initiatives and policies related to primary care and behavioral health.

Regulation 957 CMR 2.00 governs the methodology and filing requirements for health care payers to calculate and report this data to CHIA. The Data Specification Manual provides additional technical details to assist payers in reporting and filing this data.

Payers are required to submit one Primary Care & Behavioral Health Expenditures (PCBH) file to CHIA annually: the file must include final data for the prior calendar year. **In the 2021 collection year, payers are required to submit final data for calendar year 2021**. **Payers may resubmit data for calendar year 2020 for run out or nonclaims adjustments.** Files will contain different tabs, including:

- Front page, including data confirmation and payer comments
- Supplemental telehealth collection by service category
- Primary Care & Behavioral Health expenses by managing physician group
- Member months by managing physician group
- Summary tab, which automatically calculates totals with inputted data from the data entry tab

3. File Submission Instructions and Schedule

Payers will submit data using the excel template provided using CHIA's online submission platform at https://chiasubmissions.chia.state.ma.us. Data submitters with an existing username and password will login to the submission platform and upload the completed excel file. The file name will be automatically generated by the "Save and Submit" button on the Front Page tab. If this format is not used, the file will not be accepted for submission.

If data submitters require a new username and password, please complete a User Agreement for Insurance Carriers and email the completed form to CHIA-DL-Data-Submitter-HelpDesk@chiamass.gov. For technical issues, please email CHIA-DL-Data-Submitter-HelpDesk@chiamass.gov. For additional questions about timelines or data submission requirements, please reach out to Erin Bonney at Erin.Bonney@chiamass.gov.

Payers will submit PCBH information in accordance with regulation 957 CMR 2.00 on the following schedule:

Date	Files Due
October 12, 2022	• CY 2021 Final PCBH

Data Validation and Verification
Within the template, Tab E automatically calculates totals with data entered in Tabs C and D. It is the responsibility of the data submitter to review this summarized information for accuracy before submitting the data to CHIA. In addition, the total expenditures for a given physician group should equal the total expenditures for that same physician group as reported in the Total Medical Expenses/Alternative Payment Methods (TME-APM) submission. CHIA will compare the totals reported in the PCBH data file and the TME-APM data file to confirm consistency.

4. Data Submission Guidelines

4a. Overview

In accordance with 957 CMR 2.00, payers must report expenditures, including claims and non-claims based payments, made to providers for their member populations. These expenditures will be reported by mutually-exclusive behavioral health, primary care, or other service categories using the detailed code sets provided by CHIA. Expenditures will be attributed to the member's managing physician group, as applicable, regardless of whether that physician group delivered the services.

Expenses in the PCBH data submission should separately include incurred amount and member cost-sharing. For claims based spending, the sum of the total payer liability and member cost share columns should equal allowed claims. Payers should include only information pertaining to Massachusetts residents, members for which they are the primary payer, and exclude any paid claims for which

it was the secondary or tertiary payer. Allowed claims should not be capped or truncated and should represent claims prior to the impact of any reinsurance.

When reporting non-claims payments by the behavioral health, primary care, or all other services categories, payers should make determinations based on their contracts to report non-claims payments into the appropriate service area and non-claims specific category. For payments that are unable to be separated out into behavioral health or primary care, the "all other services" category should be used. For payments that may combine or be related to the provision of both primary care and behavioral health services, payers may apportion or allocate payments into the primary care and behavioral health service types; these payments should not be double counted. Alternately, the "all other services" categories may be used.

When reporting capitation arrangements, payers should use fee-for-service (FFS) equivalents rather than reporting the arrangements within the Non-Claims categories. Any balance can be included in the Non-Claims field.

Physician Group Guidelines

- Payers shall report Primary Care & Behavioral Health expenditures by Physician Group according to the following categorization of Massachusetts resident members as of December 31st of the reporting year. Member months for members who were attributed to more than one PCP in a calendar year should be allocated based on the number of months associated with each PCP:
    1. Massachusetts members required to select a primary care provider (PCP) by plan design (as reported in all previous TME filings)
    2. Members not included in (1) who were attributed during the reporting year to a PCP, pursuant to a risk contract between the payer and provider.
    3. Members not included in (1) or (2), attributed to a PCP by the payer's own attribution methodology[1]
    4. Members not attributable to a PCP (aggregate line)
- Payers must calculate and report Primary Care & Behavioral Health expenses by Physician Group for any Physician Group for which the payer has 36,000 Massachusetts resident member months or more for the specified reporting period. The number of member months is determined by summing the total member months for a given product type and insurance category for the

[1] Chapter 224 of the Acts of 2012 amended chapters 175 and 176 of the Massachusetts General Laws (M.G.L.) to stipulate that "to the maximum extent possible [carriers] shall attribute every member to a primary care provider." Please see M.G.L. C. 175 §108L, C. 176A §36, C. 176B §23, C. 176G §31 , and C. 176J §16.

Physician Group. Payers must report the CHIA numeric identifier, the "OrgID," for all Physician Groups. Refer to Appendix A, Physician Group OrgID List, for this identifier.

- Data must be reported in aggregate for all practices in which the Physician Group's member months are below 36,000. This group is to be identified as "Groups below minimum threshold" with an OrgID of 999996.
- Payers must report all incurred and cost-sharing amounts for members regardless of whether services are provided by providers located in Massachusetts.

4b. Capturing Aggregate Spending for Substance Use Disorder Services

For reporting purposes on data tab C, substance use disorder spending continues to be reported within the behavioral health service type. Table A.3 on tab A captures aggregate substance use disorder spending by insurance category. Substance use disorder spending criteria is identified in the code list by the 'BH or SUD Service Subset' column on the applicable behavioral health tabs: POS, CPT BH & SUD, and ICD-10 Codes. Substance use disorder spending is identified following the same methodology as capturing behavioral health spending, a primary ICD-10 SUD diagnosis in combination with SUD specific CPT, revenue, DRG, or NDC codes.

4c. Capturing Telehealth Spending

The codes listed below are intended to be used as guides and may not be exhaustive of all codes related to telehealth. If additional codes are used by a payer to capture telehealth spending, these codes should be included in calculations for telehealth related spending in PCBH submissions. To ensure all spending related to telehealth is captured, please refer to your organization's internal methodology.

- Place of Service (POS) code 02
- Modifiers: 93, 95, GT, GQ, G0
- CPT codes: 98966-98972, 99091, 99201-99205, 99211-99215, 99421-99423, 99441-99443, 99453, 99454, 99457, 99458, 99473, 99474
- HCPCS codes: G0071, G0406, G0407, G0408, G0425, G0426, G0427, G0459, G0508, G0509, G2010, G2012, G2025, G2061, G2062, G2063, Q3014, T1014

5. Data Dictionary

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Front Page		Payer Name	Text	Text	Name of the Payer.
Front Page		Payer OrgId	Integer	########	This is the Payer's OrgID. This must match the Submitter's OrgID.
Front Page		Submission Year	Date	YYYY	Year in which the file is being submitted.
Front Page		Reporting Years	Date Period	YYYY	Year for which Behavioral Health and Primary Care data is being reported.
Front Page		Claims Paid Through Date	Date Period	MMDDYYYY	Date of claims data runout. At least 90 days of claims runout is required.
Front Page		MA residents only?	Text	Text	Confirm that the reported members are limited only to Massachusetts residents. Response must be 'yes' or 'no'.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Front Page		Primary Payer only?	Text	Text	Confirm that the reported members are limited only to members for whom the payer is the primary payer. Response must be 'yes' or 'no'.
Front Page		Comments	Text	Free Text Comments	Additional file comments.
Front Page		Substance Use Disorder Expenditures	Integer	#	Complete the table with an estimated spending for services related to Substance Use Disorder. Please list the insurance category for which SUD services are reported.
Supp Telehealth Data	A	Reporting Year	Integer	####	Year for which data is being reported.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Supp Telehealth Data	B	Insurance Category	Integer	#	Indicates the insurance category that is being reported: 1 = Medicare & Medicare Advantage 2 = Medicaid (e.g., MCO, ACO) 3 = Commercial: Full-Claim 4 = Commercial: Partial-Claim 5= SCO 6 = OneCare 7 = PACE 8 = Other Value must be an integer between '1' and '8'. For payers reporting in the "Other" category, payers should report in the comments field on the front tab what is included in the "Other" category.
Supp Telehealth Data	C	Service Category	Integer	##	Specific category of spending. See category descriptions for additional detail and Appendix B for applicable code lists 11= BH Inpatient 12= BH ED/Observation 13= BH Outpatient 21= PC Office Visit 22= PC Home/Nursing Facility Visit 23= PC Preventive Visit 24= PC Other Primary Care Visit 25= PC Immunization and Injection 26= PC Obstetric Visit 31=Other Medical 32= Other No negative values. For payers reporting in the "Other" category, payers should report in the comments field on the front tab what is included in the "Other" category.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Supp Telehealth Data	D	Telehealth Expenditures	Integer	#	Telehealth expenditures as defined in section 3c.
Expenditures Data	A	Submission Type	Text	Flag	F = Final
Expenditures Data	B	Reporting Year	Integer	####	Year for which data is being reported.
Expenditures Data	C	Physician Group OrgID	Integer	######	Physician Group OrgID. Must be a CHIA-issued OrgID. For aggregation of sites that fall below the threshold, use OrgID 999996.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Expenditures Data	D	Insurance Category	Integer	#	Indicates the insurance category that is being reported: 1 = Medicare & Medicare Advantage 2 = Medicaid (e.g., MCO, ACO) 3 = Commercial: Full-Claim 4 = Commercial: Partial-Claim 5= SCO 6 = OneCare 7 = PACE 8 = Other Value must be an integer between '1' and '8'. For payers reporting in the "Other" category, payers should report in the comments field on the front tab what is included in the "Other" category.
Expenditures Data	E	Product Type	Integer	#	Indicates the product type that is being reported: 1= HMO 2= PPO 3= Indemnity 4= Other (e.g. EPO) 5 = POS Value must be an integer between '1' and '5'.
Expenditures Data	F	PCP Type Indicator	Integer	#	Indicates Primary Care Physician attribution: 1 = Members required to select a PCP by plan design 2 = Members attributed to a PCP during reporting period pursuant to payer – provider risk contract 3 = Members attributed to PCP by payer's own attribution methodology 4 = Members not attributed to a PCP Value must be an integer between '1' and '4'.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Expenditures Data	G	Pediatric Indicator	Integer	#	Indicates if the physician group is a practice in which at least 75% of its patients are children up to the age of 18. 0 = No, 1 = Yes Value must be either a '0' or '1'.
Expenditures Data	H	MassHealth Accountable Care Organization (ACO) Indicator	Integer	#	Indicates provider is a MassHealth Accountable Care Organization (ACO). 0 = not an ACO or no Medicaid business, 1= ACO Value must be either a '0' or '1'.
Expenditures Data	I	Group Insurance Commission (GIC) Indicator	Integer	#	Indicates population in following columns reflects Group Insurance Commission (GIC) contract members. 0 = no GIC contract, 1= GIC contract Value must be either a '0' or '1'.
Expenditures Data	J	Service Type	Integer	#	Type of Service 1= Behavioral Health 2= Primary Care 3= All Other Services No negative values.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Expenditures Data	K	Spending Service Category	Integer	##	Specific category of spending. See category descriptions for additional detail and Appendix B for applicable code lists 11= BH Inpatient 12= BH ED/Observation 13= BH Outpatient 14= BH Prescription Drugs 21= PC Office Visit 22= PC Home/Nursing Facility Visit 23= PC Preventive Visit 24= PC Other Primary Care Visit 25= PC Immunization and Injection 26= PC Obstetric Visit 31=Other Medical 32= Other 33= Other Prescription Drugs 41= Non-Claims: Incentive Payments 42= Non-Claims: Capitation 43= Non-Claims: Risk Settlements 44= Non-Claims: Care Management 45= Non-Claims: Other No negative values. For payers reporting in the "Other" category, payers should report in the comments field on the front tab what is included in the "Other" category.
Expenditures Data	L	Provider Type	Integer	#	Type of Provider rendering services reflected in columns K and L. See provider descriptions for additional detail, and Appendix B for specific code sets 1= Facility 2= Professional: Physician 3= Professional: Other 4= No Provider No negative values.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Expenditures Data	M	Expenditures: Incurred Expenses (Payer Liability)	Integer	#######	Total incurred expenses/ payer paid amounts for service category spending by a particular type of provider by service type as designated in columns L-N No negative values for claims-based expenses. Negative values allowed for non-claims spending service categories only.
Expenditures Data	N	Expenditures: Member Cost Share	Integer	#######	Total member cost share/member paid amounts for service category spending by a particular type of provider by service type as designated in columns L-N No negative values.
Member Months Data	A	Submission Type	Text	Flag	F = Final
Member Months Data	B	Reporting Year	Integer	####	Year for which data is being reported.
Member Months Data	C	Physician Group OrgID	Integer	######	Physician Group OrgID. Must be a CHIA-issued OrgID. For aggregation of sites that fall below the threshold, use OrgID 999996.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Member Months Data	D	Insurance Category	Integer	#	Indicates the insurance category that is being reported: 1 = Medicare & Medicare Advantage 2 = Medicaid (e.g., MCO, ACO) 3 = Commercial: Full-Claim 4 = Commercial: Partial-Claim 5= SCO 6 = OneCare 7 = PACE 8 = Other Value must be an integer between '1' and '8'. For payers reporting in the "Other" category, payers should report in the comments field on the front tab what is included in the "Other" category.
Member Months Data	E	Product Type	Integer	#	Indicates the product type that is being reported: 1= HMO 2= PPO 3= Indemnity 4= Other (e.g. EPO) 5 = POS Value must be an integer between '1' and '5'.
Member Months Data	F	PCP Type Indicator	Integer	#	Indicates Primary Care Physician attribution: 1 = Members required to select a PCP by plan design 2 = Members attributed to a PCP during reporting period pursuant to payer – provider risk contract 3 = Members attributed to PCP by payer's own attribution methodology 4 = Members not attributed to a PCP Value must be an integer between '1' and '4'.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Member Months Data	G	Pediatric Indicator	Integer	#	Indicates if the physician group is a practice in which at least 75% of its patients are children up to the age of 18. 0 = No, 1 = Yes Value must be either a '0' or '1'.
Member Months Data	H	MassHealth Accountable Care Organization (ACO) Indicator	Integer	#	Indicates provider is a MassHealth Accountable Care Organization (ACO). 0 = not an ACO or no Medicaid business, 1= ACO Value must be either a '0' or '1'.
Member Months Data	I	Group Insurance Commission (GIC) Indicator	Integer	#	Indicates population in following columns reflects Group Insurance Commission (GIC) contract members. 0 = no GIC contract, 1= GIC contract Value must be either a '0' or '1'.
Member Months Data	J	Member Months	Integer	#########	The number of members participating in a plan over a specified period of time expressed in months of membership. No negative values.
Member Months Data	K	BH Member Months	Integer	#########	The number of members participating in a plan over a specified period of time expressed in months of membership, that had a Behavioral Health principal diagnosis at any point during the reporting year. No negative values.
Summary	-	No payer data entry needed	-	-	The summary tab will automatically populate with data from data entry for Expenditures Data and Member Months Data. Please review this tab prior to submitting data to CHIA to confirm that totals and trends are correct.

5a. Field Definitions

Tab A: Front Page

Table A.1: File Overview

- Payer Name: The name of the reporting payer
- Payer Org ID: The CHIA-assigned organization ID for the payer or carrier submitting the file.
- Submission Year: Year in which the data is submitted (e.g., 2021)
- Reporting Year: Year for which Primary Care & Behavioral Health data is being reported (e.g., 2021)
- Claims Paid Through Date: Date for which Primary Care & Behavioral Health claims data is paid through.

Table A.2: Additional Data Confirmation

- Massachusetts residents only? Confirm that the reported data include Massachusetts residents only.
- Primary payer only? Confirm that the reported data include only claims data for which the payer was the primary payer, exclude any paid claims for which they were the secondary or tertiary payer.
- Comments: Payers may use this field to provide any additional information or describe any data caveats for the PCBH file.

Table A.3: Aggregate Substance Use Disorder Expenditures by Insurance Category

For each Calendar Year, complete table with an estimated total spending for Substance Use Disorder services, as outlined in section 4b and as defined in the accompanying code list. Please list the insurance category in which SUD services are reported.

Tab B: Supplemental Telehealth Data

- Reporting Year: Indicates the year for which the data is being reported.
- Insurance Category: A number that indicates the insurance category being reported.

Insurance Category Code	Definition
1	Medicare & Medicare Advantage
2	Medicaid (e.g., MCO, ACO)
3	Commercial – Full Claims

4	Commercial – Partial Claims
5	SCO
6	OneCare
7	PACE
8	Other

- Service Category: A number that indicates the service category being reported.

Service Category Code	**Service Category Definition**
11	BH Inpatient
12	BH Emergency Department-Observation
13	BH Outpatient
21	Office Type Visits
22	Home-Nursing Facility Visits
23	Preventive Visits
24	Other Primary Care Visits
25	Immunizations and Injections
26	Obstetric Visits
31	Other Medical
32	Other

- Telehealth Expenditures: Telehealth expenditures as defined in section 3c.

Tab C: Expenditures Data Tab

- Submission Type: Indicates that the file contains final PCBH reporting period.
- Reporting Year: Indicates the year for which the data is being reported.
- Physician Group OrgID: The CHIA-assigned OrgID of the Physician Group. This may be the parent organization of one or more Local Practice Groups. For "Groups below minimum threshold", data should be reported using aggregate OrgID 999996

- Insurance Category: A number that indicates the insurance category that is being reported. Commercial claims should be separated into two categories, as shown below. Commercial self-insured or fully insured data for physicians' groups for which the payer is able to collect information on all direct medical claims and subcarrier claims should be reported in the "Full Claims" category. Commercial data that does not include all medical and subcarrier claims should be reported in the "Partial Claims" category. Payers shall report for all insurance categories for which they have business, even if those categories do not meet the member month threshold. *Stand-alone Medicare Part D Prescription Drug Plan members and payments should not be reported in the data.* For payers reporting in the "Other" category, payers should report in the comments field on the Front Tab what is included in the "Other" category.

Insurance Category Code	**Definition**
1	Medicare & Medicare Advantage
2	Medicaid (e.g., MCO, ACO)
3	Commercial – Full Claims
4	Commercial – Partial Claims
5	SCO
6	OneCare
7	PACE
8	Other

- Product Type: The product type under the insurance category reported.

Product Type Code	**Definition**
1	HMO
2	PPO
3	Indemnity
4	Other
5	POS

- PCP Type Indicator: The method used to attribute members to a specific physician group.

PCP Indicator	Definition
1	Data for members who select a PCP as part of plan design
2	Data for members who are attributed to a PCP during reporting period pursuant to payer-provider risk contract
3	Data for members who are attributed to a PCP by payer's own attribution methodology
4	Data for members who are not attributed to a PCP

- Pediatric Indicator: Indicates if the Physician Group is a practice in which at least 75% of its patients are children up to the age of 18. The pediatric indicator should be used to separately report pediatric *practices*, not the subset of pediatric patients within a non-pediatric practice

Pediatric Indicator	Definition
0	Not a pediatric practice
1	Pediatric practice

- MassHealth ACO Indicator: Indicates if the Local Practice Group is part of the MassHealth Accountable Care Organization (ACO) program. The ACO indicator should be used to report these groups. Medicaid payers should identify ACOs for the entirety of 2018, do not split data before and after the start of the program on 3/1/2018. Payers with no Medicaid business should report a "0" for all providers.

ACO Indicator	Definition
0	Not an ACO or no Medicaid business
1	ACO

- Group Insurance Commission (GIC) Indicator: Indicates the member population covered under a contract with the Group Insurance Commission. Payers with no GIC membership should report a "0" for all providers.

GIC Indicator	Definition
0	Non-GIC population
1	GIC population

Service Categories

General definitions of each service category are described below; however, payers should classify claims-based expenditures based on the standard code sets provided by CHIA; coding logic and summaries of these sets are included in Appendix D. A reference table of all codes is included in Appendix B. Expenditures shall be categorized into mutually-exclusive, hierarchal categories that distinguish: (1) Behavioral Health Services, (2) Primary Care, and (3) All Other Services. Note that not all categories will be applicable to each reported Physician Group; data submitters should only report lines for services categories that had expenditures. Service categories for non-claims payments are included in each service type. If non-claims base payments cannot be attributed to behavioral health or primary care service categories, all non-claims payments should be reported in the appropriate All Other Services non-claims categories.

Behavioral Health: Behavioral health services are classified based on ICD-10-CM Principal Diagnosis Code and *combinations of* Current Procedure Terminology (CPT) Codes, Revenue Codes, Place of Service (POS) Codes, and Provider Types. Data submitters will report expenses within the following mutually-exclusive spending service categories:

- **BH Inpatient**: All payments made for claims associated with services provided at an acute or non-acute inpatient facility with a behavioral health principle diagnosis.

- **BH Emergency Department and Observation:** All payments made for emergency or observation services in an acute or non-acute facility for claims with a behavioral health principal diagnosis.

- **BH Outpatient:** All payments for behavioral health specific services, including intensive outpatient services, medication assisted treatment, and other diversionary care and residential treatment with a behavioral health principal diagnosis, delivered by any provider type. Additionally includes outpatient face-to-face and telehealth services, including evaluation and management and integrated behavioral health primary care services, with a behavioral health diagnosis **and** delivered by a behavioral health provider. **Ancillary services should not be included**.

- **BH Prescription Drugs:** All payments made for prescription drugs prescribed to address behavioral health needs, based on the specified set of National Drug Codes (NDC) listed in Appendix B.

- **Non-Claims: Incentive Programs**: All payments made to providers for achievement in specific pre-defined goals for quality, cost reduction, or infrastructure development related to the provision of behavioral health care services. Examples include, but are not limited to, pay-for-performance payments, performance bonuses, and EMR/HIT adoption incentive payments related to the provision of behavioral health care services.

- **Non-Claims: Capitation:** All payments made to providers *not* on the basis of claims related to the provision of behavioral health care services. Capitation should not include payments to non-provider third party entities that manage behavioral health care services. Amounts reported as capitation should not include any incentives or performance bonuses.

- **Non-Claims: Risk Settlements:** All payments made to providers as a reconciliation of payments made for the provision of behavioral health care services. Amounts reported as Risk Settlement should not include any incentive or performance bonuses.

- **Non-Claims: Care Management:** All payments made to providers for providing care management, utilization review, discharge planning, and other care management programs related to behavioral health care.

- **Non-Claims: Other:** All other payments made pursuant to the payer's contract with a provider that were not made on the basis of a claim for medical services and that cannot be properly classified in other non-claims categories related to the provision of behavioral health care services. This may include governmental payer shortfall payments, grants, or other surplus payments. Only payments made to providers are to be reported. Payments to government entities, such as the Health Safety Net Surcharge, may not be included in any category

Service Category Code	**Service Category Definition**
11	BH Inpatient
12	BH Emergency Department-Observation
13	BH Outpatient
14	BH Prescription Drugs
41	Non-Claims: Incentive Programs
42	Non-Claims: Capitation
43	Non-Claims: Risk Settlements

Service Category Code	Service Category Definition
44	Non-Claims: Care Management
45	Non-Claims: Other

Primary Care: Primary care will be identified based on CPT codes and Provider Types. Data submitters will report expenses not included in the above behavioral health service categories within the following mutually-exclusive subcategories. All primary care spending categories should include only professional claims payments:

- **Office Type Visits[3]:** All payments made for professional evaluation and management services, delivered in an office or other outpatient setting, including telehealth delivered by a primary care provider type included in Appendix D.

- **Home/Nursing Facility Visits:** All payments made for professional evaluation and management services, delivered in the home, rest home, or nursing facility delivered by a primary care provider type included in Appendix D.

- **Preventive Visits[3]:** All payments made for professional preventive medicine services, including exams, screenings, and counseling delivered by a primary care provider type included in Appendix D.

- **Other Primary Care Visits:** All payments made for professional services, including initial Medicare enrollment visits, annual wellness visits, and chronic disease care delivered by a primary care provider type included in Appendix D.

- **Immunizations and Injections:** All payments made for the administration of injections, infusions, and vaccines by a primary care provider type included in Appendix D.

- **Obstetric Visits[2]:** All payments made for the professional components of routine obstetric care, as well as OB/GYN evaluation and management services.

[2] Services delivered by OB/GYN practitioners may be reported in this category only for procedure codes listed in the code set.

- **Non-Claims: Incentive Programs**: All payments made to providers for achievement in specific pre-defined goals for quality, cost reduction, or infrastructure development related to the provision of primary care services. Examples include, but are not limited to, pay-for-performance payments, performance bonuses, and EMR/HIT adoption incentive payments.

- **Non-Claims: Capitation:** All payments made to providers *not* on the basis of claims related to the provision of primary care services. Amounts reported as capitation should not include any incentives or performance bonuses.

- **Non-Claims: Risk Settlements:** All payments made to providers as a reconciliation of payments made for the provision of primary care services. Amounts reported as Risk Settlement should not include any incentive or performance bonuses.

- **Non-Claims: Care Management:** All payments made to providers for providing care management, utilization review, discharge planning, and other care management programs related to primary health care.

- **Non-Claims: Other:** All other payments made pursuant to the payer's contract with a provider that were not made on the basis of a claim for medical services and that cannot be properly classified in other non-claims categories, related to the provision of primary care services. This may include governmental payer shortfall payments, grants, or other surplus payments. Only payments made to providers are to be reported. Payments to government entities, such as the Health Safety Net Surcharge, may not be included in any category.

Service Category Code	**Service Category Definition**
21	Office Type Visits
22	Home-Nursing Facility Visits
23	Preventive Visits
24	Other Primary Care Visits
25	Immunizations and Injections
26	Obstetric Visits
41	Non-Claims: Incentive Programs
42	Non-Claims: Capitation

Service Category Code	Service Category Definition
43	Non-Claims: Risk Settlements
44	Non-Claims: Care Management
45	Non-Claims: Other

All Other Services: All other services paid for that are not classified as Behavioral Health or Primary Care. Data submitters will report expenses not included in the above behavioral health or primary care service categories within the following mutually-exclusive subcategories:

- **Other Medical:** All payments for claims based medical services, including facility and professional components not previously categorized as behavioral health or primary care.

- **Other:** All other claims based expenditures not previously categorized as behavioral health or primary care, or included in Other Medical expenses above.

- **Other Prescription Drugs:** All other payments made for prescription drugs not previously categorized as behavioral health.

- **Non-Claims: Incentive Programs**: All payments made to providers for achievement in specific pre-defined goals for quality, cost reduction, or infrastructure development not directly related to the provision of primary care or behavioral health services. Examples include, but are not limited to, pay-for-performance payments, performance bonuses, and EMR/HIT adoption incentive payments.

- **Non-Claims: Capitation:** All payments made to providers *not* on the basis of claims and not related to the provision of primary care or behavioral health services. Amounts reported as capitation should not include any incentives or performance bonuses.

- **Non-Claims: Risk Settlements:** All payments made to providers as a reconciliation of payments made for services other than for the provision of primary care and behavioral health services. Amounts reported as Risk Settlement should not include any incentive or performance bonuses.

- **Non-Claims: Care Management:** All payments made to providers for providing care management, utilization review, discharge planning, and other care management programs not related to primary care or behavioral health services.

- **Non-Claims: Other:** All other payments made pursuant to the payer's contract with a provider that were not made on the basis of a claim for medical services and that cannot be properly classified in other non-claims categories, and are not related to the provision of primary care or behavioral health services. This may include governmental payer shortfall payments, grants, or other surplus payments. Only payments made to providers are to be reported. Payments to government entities, such as the Health Safety Net Surcharge, may not be included in any category.

Service Category Code	**Service Category Definition**
31	Other Medical
32	Other
33	Other Prescription Drugs
41	Non-Claims: Incentive Programs
42	Non-Claims: Capitation
43	Non-Claims: Risk Settlements
44	Non-Claims: Care Management
45	Non-Claims: Other

Provider Type: The type of provider rendering the services:

- Facility: The facility or non-professional component
- Professional: All professional services combined, including licensed physicians and other professional staff
- Professional- Physician: Services are provided by a doctor of medicine or osteopathy
- Professional- Other: Services are provided by a licensed practitioner other than a physician. This includes, but is not limited to, community health center services, freestanding ambulatory surgical center services, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, and chiropractors
- No Provider: No applicable facility or licensed practitioner

Provider Type Code	Provider Type Definition
1	Facility
2	Professional Physician
3	Professional Other
4	No Provider

Expenditures- Incurred Expenses (Payer Liability): The total incurred expenses/ payer paid amounts for claims-based services and non-claims payments to providers.

Expenditures- Member Cost Share: Total member cost share/member paid amounts for claims-based services.

Tab D: Member Months Data Tab

- Submission Type: Indicates that the file contains final PCBH reporting period.
- Reporting Year: Indicates the year for which the data is being reported.
- Physician Group OrgID: The CHIA-assigned OrgID of the Physician Group. This may be the parent organization of one or more Local Practice Groups. For "Groups below minimum threshold", data should be reported using aggregate OrgID 999996
- Insurance Category: A number that indicates the insurance category that is being reported. Commercial claims should be separated into two categories, as shown below. Commercial self-insured or fully insured data for physicians' groups for which the payer is able to collect information on all direct medical claims and subcarrier claims should be reported in the "Full Claims" category. Commercial data that does not include all medical and subcarrier claims should be reported in the "Partial Claims" category. Payers shall report for all insurance categories for which they have business, even if those categories do not meet the member month threshold. *Stand-alone Medicare Part D Prescription Drug Plan members and payments should not be reported in the data.* For payers reporting in the "Other" category, payers should report in the comments field on the Front Tab what is included in the "Other" category.

Insurance Category Code	Definition

1	Medicare & Medicare Advantage
2	Medicaid (e.g., MCO, ACO)
3	Commercial – Full Claims
4	Commercial – Partial Claims
5	SCO
6	OneCare
7	PACE
8	Other

- Product Type: The product type under the insurance category reported.

Product Type Code	**Definition**
1	HMO
2	PPO
3	Indemnity
4	Other
5	POS

- PCP Type Indicator: The method used to attribute members to a specific physician group.

PCP Indicator	**Definition**
1	Data for members who select a PCP as part of plan design
2	Data for members who are attributed to a PCP during reporting period pursuant to payer-provider risk contract
3	Data for members who are attributed to a PCP by payer's own attribution methodology
4	Data for members who are not attributed to a PCP

- Pediatric Indicator: Indicates if the Physician Group is a practice in which at least 75% of its patients are children up to the age of 18. The pediatric indicator should be used to separately report pediatric *practices*, not the subset of pediatric patients within a non-pediatric practice

Pediatric Indicator	**Definition**
0	Not a pediatric practice
1	Pediatric practice

- MassHealth ACO Indicator: Indicates if the Local Practice Group is part of the MassHealth Accountable Care Organization (ACO) program. The ACO indicator should be used to report these groups. Medicaid payers should identify ACOs for the entirety of 2018, do not split data before and after the start of the program on 3/1/2018. Payers with no Medicaid business should report a "0" for all providers.

ACO Indicator	**Definition**
0	Not an ACO or no Medicaid business
1	ACO

- Group Insurance Commission (GIC) Indicator: Indicates the member population covered under a contract with the Group Insurance Commission. Payers with no GIC membership should report a "0" for all providers.

GIC Indicator	**Definition**
0	Non-GIC population
1	GIC population

- Member Months (annual): The number of members participating in a plan over the specified period of time expressed in months of membership.

- BH Member Months (annual): The number of members participating in a plan over the specified period of time expressed in member months, who have a Behavioral Health principal diagnosis at any point during the reporting year.

Appendix A: Physician Group OrgIDs

Please visit: https://www.chiamass.gov/payer-data-reporting-primary-and-behavioral-health-care-expenditures

Payers should report physician group data based on their individual contracting structures with providers.

Appendix B: Service Categorization Code Lists

Please visit: http://chiamass.gov/reference-materials

Payers should use these lists as reference tables **in conjuction with the metholodogy and coding logic outlined in Appendices C and D**. Note, these reference tables separately identify service codes and provider types to facilitate data compilation; however, for categorization of claims, payers should follow the methodology outlined in Appendix D, in which claims are categorized by combinations of service codes and provider types.

Appendix C: Payment Allocation Methodology

Identify claims with a principal behavioral health diagnosis

Based on ICD-10 diagnosis code in excel reference file

Allocate spending for the claim **sequentially** through the Behavioral Health specific service categories based on code sets/logic in Appendices B & D:

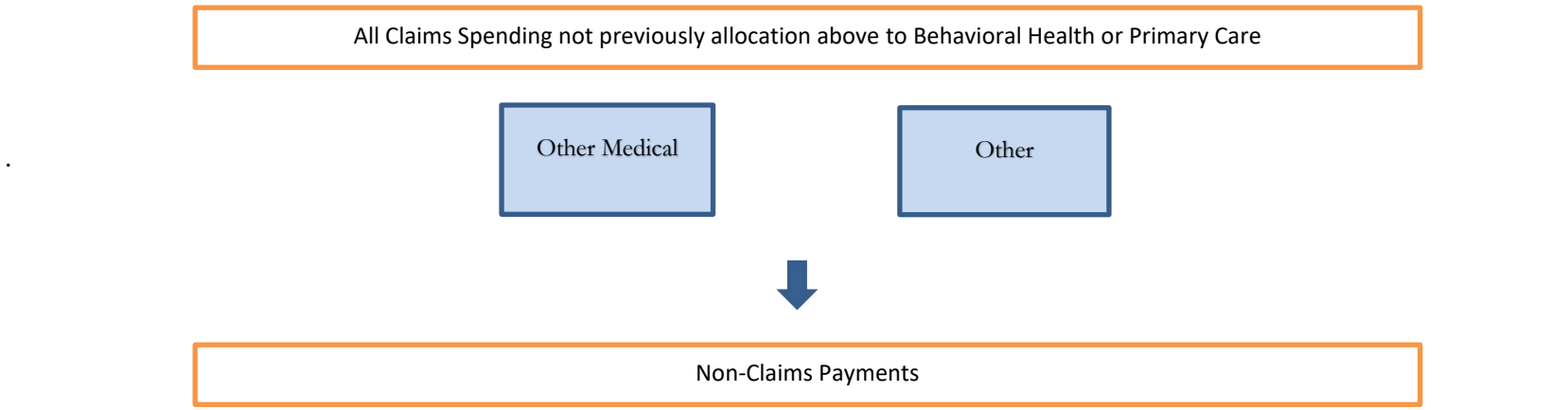
BH Inpatient → BH ED/Observation → BH Outpatient

Note: Behavioral Health allocations are based on combinations of CPT and Revenue codes, POS codes, as well as Provider Types.

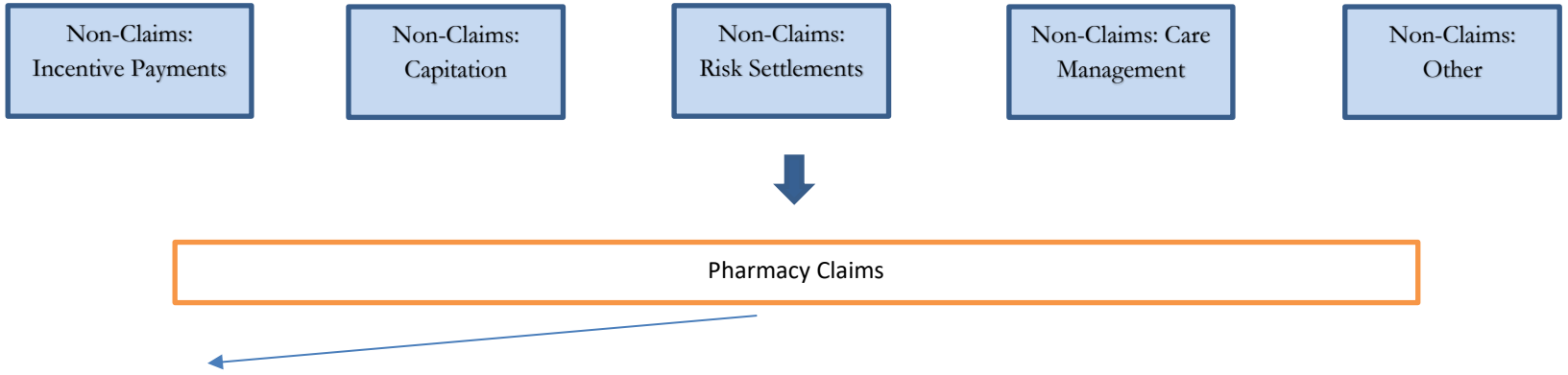
All Claims Spending not previously allocation above, plus claims without a principal behavioral health diagnosis

Allocate spending for the claim **sequentially** through the Primary Care specific service categories base on code sets/logic in Appendices B&D:

PC Office Visit → PC Home/Nursing Facility Visit → PC Preventive Visit → PC Other Primary Care Visit → PC Immunization and Injection → PC Obstetric Visit



Allocate non-claims payments into the below categories by service type. If non-claims cannot be separated into Behavioral Health or Primary Care, the "All Other" service type should be used in combination with the spending categories below. For payments that may combine or be related to the provision of both primary care and behavioral health services, payers may apportion or allocate payments into the primary care and behavioral health service types; these payments should not be double counted.



Allocate pharmacy claims spending base on the NDC codes provide in Appendix B:

Appendix D: Summary of Code Lists and Coding Logic

The tables below summarize the code lists found in Appendix B, and include the combinations of code type required for spending service categories within each Service Type. For "professional" measure categories below, it should be noted that physician and other professional types are reported separately using the provider type field outlined in the Data Dictionary.

Behavioral Health Diagnosis Codes

ICD-10 Code	Description	Notes and Exclusions
F0150 - F09	Mental Disorders Due to Known Physiological Conditions	Only include codes listed in the ICD-10 DX Codes tab in the excel reference file.
F1010 – F1999	Mental and Behavioral Disorders due to Psychoactive Substance Abuse	Only include codes listed in the ICD-10 DX Codes tab in the excel reference file.
F200 - F29	Schizophrenia, Schizotypal, Delusional and Other Non-Mood Psychotic Disorder	Only include codes listed in the ICD-10 DX Codes tab in the excel reference file.
F30010 – F39	Mood [Affective] Disorders	Only include codes listed in the ICD-10 DX Codes tab in the excel reference file. Excluding F38 Other mood [affective] disorders
F4000 - F489	Anxiety, Dissociative, Stress-Related, Somatoform and Other Nonpsychotic Mental Disorders	Only include codes listed in the ICD-10 DX Codes tab in the excel reference file.
F5000 - F59	Behavioral Syndromes Associated with Physiological Disturbances and Physical Factors	Only include codes listed in the ICD-10 DX Codes tab in the excel reference file. Excluding F54 (Psychological and behavioral factors associated with disorders or diseases classified elsewhere), F55 (Abuse of non-dependence-producing substances)
F60 -F69	Disorders of Adult Personality and Behavior	Only include codes listed in the ICD-10 DX Codes tab in the excel reference file.

ICD-10 Code	Description	Notes and Exclusions
		Excluding F61 (Mixed and other personality disorders) and F62 (Enduring personality changes, not attributable to brain damage and disease)
F800 - F89	Pervasive and Specific Developmental Disorders	Only include codes listed in the ICD-10 DX Codes tab in the excel reference file. Excluding F83 (Mixed specific developmental disorders)
F90 - F98	Behavioral and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence	Only include codes listed in the ICD-10 DX Codes tab in the excel reference file. Excluding F92 (Mixed disorders of conduct and emotions)
F99	Unspecified Mental Disorder	Only include codes listed in the ICD-10 DX Codes tab in the excel reference file.
R45851; R4588	Suicidal ideations & Nonsuicidal self-harm	Only include codes listed in the ICD-10 DX Codes tab in the excel reference file.
T149	Injury of Unspecified Body Region	Includes T14.91XA, T14.91XD, T14.91XS only Only include codes listed in the ICD-10 DX Codes tab in the excel reference file.
T400X1S – T887XXS	Injury, Poisoning and Certain Other Consequences of External Causes	Only include codes listed in the ICD-10 DX Codes tab in the excel reference file.

Behavioral Health Service Codes

Note: A principal diagnosis of BH from ICD-10 codes above is required for claims to be allocated through the categories below.

Measure Category	Specifications
Inpatient; Facility	Report payer paid and member cost-share amounts across all claims lines when a Facility claim has one or more of the following Revenue codes: (1000 - 1006)
Inpatient; Professional	Report payer paid and member cost-share amounts across all medical claim lines for Professional claims with the following Place of Service codes (02, 21, 31, 32, 35,51, 54, 55, 56, 61) ***and*** CPT codes in (99221-99223, 99231-99233, 99234-99236, 99238-99239, 99251-99255, 99356-99357, G0425-G0427, G0459)
Emergency Department / Observation; Facility (no inpatient admission)	Report payer paid and member cost-share amounts across all claim lines for Facility claims with one or more of the following Revenue codes: (0450-0452, 0456, 0459, 0760-0762, 0769, 0981)
Emergency Department / Observation; Professional (no inpatient admission; with a behavioral health provider)	Report payer paid and member cost-share amounts for only those claim lines on which a Professional claim has a POS code of 23 ***and*** CPT codes in (99217-99220, 99224-99226, 99234-99236, 99281-99285, 99291-99292, 99356-99357, G0425-G0427, G0378-G0384, G0427, G2213 with a behavioral health provider
Outpatient Professional: Behavioral Health Providers Only	Report payer paid and member cost-share amounts for only those claim lines on which a Professional claim has: POS codes in (02, 03, 04 05, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 57, 58, 71, 72, 99) ***and***, CPT/HCPCS Codes in (90901, 90912-90913, 99201-992015, 99211-99215, 99241-99245, 99304-99310, 99315-99316, 99318, 99324-99328, 99334-99337, 99339-99345, 99347-993350, 99354-993355, 99358-99359, 99366-99368, 99374-99375, 99378-99387, 99391-99397, 99401-99404, 99406-99407, 99411-99412, 99415-99417, 99421-99423, 99441-99444, 99446-99449, 99451-99452, 99483-99484, 99487, 99489, 99490, 99439, 99491, 99495-99496, 99510, 99605-99607, 96372-96376, 96379, 97110, 97112, 97530, 97535, 97537, 97802-97804, 97810-97811, 97813, 98960-98962, 98966-98972, 99050-99051, 99053, 99056, 99058, 99060, 99078, 99199, G0071, G0076-G0087, G0156, G0162, G0270-G0721, G0299-G0300, G0406-G0408, G0442, G0444, G0451, G0463, G0480-G0483, G0490, G0506, G0513-G0514, G2001-G2015, G2021, G2058, G2061-G2605, G2211-G2212, G2250-G2252, G8427 G9001-G9012, G9016, G9475, G9477-G9478, G9685, G9978-G9986, H0033-H0034, H0038-H0040, H2000-H2001, H2010, H2014-H2016, H2023-H2026, H2028-H2029, H2032-H2033, T100-T1005, T1015-T1021, T1023-T1028, T1502-T1503, T2024) with a behavioral health provider

Measure Category	Specifications
Outpatient Professional: **Any Provider Type**	Report payer paid and member cost-share amounts for only those claim lines when a Professional claim has: POS codes in (02, 03, 04, 05, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 57, 71, 72, 99) *and*, CPT/HCPCS codes (99408-99409, 99492-99494, 90785, 90791-90792, 90832-90840, 90845-90847, 90849, 90853, 90863, 90865, 90867-90870, 90875-90876, 90880, 90882, 90885, 90887, 90899, 96105, 96125, 96127, 96116, 96121, 96130-96133, 96136-96139, 96146, 96156, 96158-96159, 96164-96165, 96167-96168, 96170-96171, 96160-96161, 97129, 97151-97158, G0155, G0176-G0177, G0396-G0397, G0409-G0411, G0443, G0468-G0470, G0473, G0511-G0512, G2011, G2067-G2080, G2082-G2083, G2086-G2088, G2214, H0001-H0029)
Outpatient Facility: **Behavioral Health Providers Only**	Report payer paid and member cost-share amounts across all claim lines when a Facility claim has: Revenue codes in (0500, 0509, 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0525, 0526, 0527, 0528, 0529, 0780, 0790, 0940, 0941, 0942, 0943, 0944, 0945, 0946, 0947, 0948, 0949, 0951, 0952, 0953, 0960, 0961, 0962, 0964, 0969, 0982, 0983, 0984, 0985, 0986, 0987, 0988, 0989, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2109, 3101, 3102, 3103, 3104, 3105, 3106) with a behavioral health provider
Outpatient Facility: **Any Provider Type**	Report payer paid and member cost-share amounts across all claim lines when a Facility claim has: Revenue codes in (0900, 0901, 0902, 0903, 0904, 0905, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0918, 0919)

Behavioral Health Provider Types

Taxonomy	Practitioner Type	Provider Type
101YA0400X	Addiction (Substance Use Disorder) Counselor	Professional: Other
103TA0400X	Addiction (Substance Use Disorder) Psychologist	Professional: Other
163WA0400X	Addiction (Substance Use Disorder) Registered Nurse	Professional: Other

Taxonomy	Practitioner Type	Provider Type
207LA0401X	Addiction Medicine (Anesthesiology) Physician	Professional: Physician
207QA0401X	Addiction Medicine (Family Medicine) Physician	Professional: Physician
207RA0401X	Addiction Medicine (Internal Medicine) Physician	Professional: Physician
2083A0300X	Addiction Medicine (Preventive Medicine) Physician	Professional: Physician
2084A0401X	Addiction Medicine (Psychiatry & Neurology) Physician	Professional: Physician
2084P0802X	Addiction Psychiatry Physician	Professional: Physician
261QM0855X	Adolescent and Children Mental Health Clinic/Center	Facility
103TA0700X	Adult Development & Aging Psychologist	Professional: Other
261QM0850X	Adult Mental Health Clinic/Center	Facility
364SP0809X	Adult Psychiatric/Mental Health Clinical Nurse Specialist	Professional: Other
163WP0809X	Adult Psychiatric/Mental Health Registered Nurse	Professional: Other
106E00000X	Assistant Behavior Analyst	Professional: Other
3104A0630X	Assisted Living Facility (Behavioral Disturbances)	Facility
103K00000X	Behavior Analyst	Professional: Other
106S00000X	Behavior Technician	Professional: Other
2084B0040X	Behavioral Neurology & Neuropsychiatry Physician	Professional: Physician
171M00000X	Case Manager/Care Coordinator	Professional: Other
364SP0807X	Child & Adolescent Psychiatric/Mental Health Clinical Nurse Specialist	Professional: Other
163WP0807X	Child & Adolescent Psychiatric/Mental Health Registered Nurse	Professional: Other
2084P0804X	Child & Adolescent Psychiatry Physician	Facility
364SP0810X	Child & Family Psychiatric/Mental Health Clinical Nurse Specialist	Professional: Other
385HR2055X	Child Mental Illness Respite Care	Facility
3245S0500X	Children's Substance Abuse Rehabilitation Facility	Facility
364SP0811X	Chronically Ill Psychiatric/Mental Health Clinical Nurse Specialist	Professional: Other
103TC2200X	Clinical Child & Adolescent Psychologist	Professional: Other
103G00000X	Clinical Neuropsychologist	Professional: Other
103TC0700X	Clinical Psychologist	Professional: Other
1041C0700X	Clinical Social Worker	Professional: Other
103TB0200X	Cognitive & Behavioral Psychologist	Professional: Other
364SP0812X	Community Psychiatric/Mental Health Clinical Nurse Specialist	Professional: Other

Taxonomy	Practitioner Type	Provider Type
251S00000X	Community/Behavioral Health Agency	Facility
103TC1900X	Counseling Psychologist	Professional: Other
101Y00000X	Counselor	Professional: Other
2080P0006X	Developmental - Behavioral Pediatrics Physician	Professional: Physician
252Y00000X	Early Intervention Provider Agency	Facility
322D00000X	Emotionally Disturbed Children's' Residential Treatment Facility	Facility
103TF0000X	Family Psychologist	Professional: Other
2084P0805X	Geriatric Psychiatry Physician	Professional: Physician
364SP0813X	Geropsychiatric Psychiatric/Mental Health Clinical Nurse Specialist	Professional: Other
103TP2701X	Group Psychotherapy Psychologist	Professional: Other
103TH0004X	Health Psychologist	Professional: Other
103TH0100X	Health Service Psychologist	Professional: Other
167G00000X	Licensed Psychiatric Technician	Professional: Other
106H00000X	Marriage & Family Therapist	Professional: Other
261QM0801X	Mental Health Clinic/Center (Including Community Mental Health Center)	Facility
101YM0800X	Mental Health Counselor	Professional: Other
320800000X	Mental Illness Community Based Residential Treatment Facility	Facility
310500000X	Mental Illness Intermediate Care Facility	Facility
261QM2800X	Methadone Clinic	Facility
101YP1600X	Pastoral Counselor	Professional: Other
175T00000X	Peer Specialist	Professional: Other
103TP0016X	Prescribing (Medical) Psychologist	Professional: Other
101YP2500X	Professional Counselor	Professional: Other
283Q00000X	Psychiatric Hospital	Facility
273R00000X	Psychiatric Hospital Unit	Facility
323P00000X	Psychiatric Residential Treatment Facility	Facility
364SP0808X	Psychiatric/Mental Health Clinical Nurse Specialist	Professional: Other
363LP0808X	Psychiatric/Mental Health Nurse Practitioner	Professional: Other
163WP0808X	Psychiatric/Mental Health Registered Nurse	Professional: Other
2084P0800X	Psychiatry Physician	Professional: Physician

Taxonomy	Practitioner Type	Provider Type
103TP0814X	Psychoanalysis Psychologist	Professional: Other
102L00000X	Psychoanalyst	Professional: Other
103T00000X	Psychologist	Professional: Other
2084P0015X	Psychosomatic Medicine Physician	Professional: Physician
261QR0800X	Recovery Care Clinic/Center	Facility
103TR0400X	Rehabilitation Psychologist	Professional: Other
104100000X	Social Worker	Professional: Other
324500000X	Substance Abuse Rehabilitation Facility	Facility
261QR0405X	Substance Use Disorder Rehabilitation Clinic/Center	Facility
276400000X	Substance Use Disorder Rehabilitation Hospital Unit	Facility

Primary Care Service Codes

For claims not identified as Behavioral Health above

Measure Category	Specifications
Office Type Visits	Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (99201-99205, 99211-99215, 99241-99245, 99354-9935, 99358-99359, 99421-99423, 99441-99444, 99446-99449, 99451-99454, 99473, 99457-99458, 99474, 99483, 99487, 99489-99491, 99495-99498, 96110, 96112-96113, 96160-96161, 96372-96374, 98960-98962, 98966-98969, 99050-99051, 99056, 99058, 99078, 99173, 99366-99368, 99374-99375, 99377-99380, G0396-G0397, G0463, G0473, G0506, G2010, G2064-G2065, S9117) with a primary care provider
Home/Nursing Facility Visits	Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (99304-99310, 99315-99316, 99318, 99324-99328, 99334-99337, 99339-99345, 99347-99350, 99502, 99506, G0179-G0182) with a primary care provider

Measure Category	Specifications
Preventive Visits	Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (11976, 11981-11983; 57170; 58300-58301; 99173; 99381-99387; 99391-99397; 99401-99404; 99406-99409; 99411-99412; 99429; G0473; Q0091; S0610; S0612-S0613; S4981) with a primary care provider
Immunizations and Injections	Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (90281; 90283-90284; 90287-90288; 90291; 90296; 90371; 90375-90378; 90384-90386; 90389; 90393; 90396; 90399; 90460-90461; 90471-90474; 90746-90477; 90581; 90585-90587; 90619-90621; 90625; 90630; 90632; 90633-90634; 90636; 90644; 90647; 90648-90651; 90653-90658; 90660-90662; 90664; 90666-90668; 90670; 90672-90676; 90680-90682; 90685-90691; 90694; 90696-90698; 90700; 90702; 90707; 90710; 90713-90717; 90723; 90732-90734; 90736; 90738-90740; 90743-90744; 90745-90750; 90756; G008-G0010; Q2034-Q2039) with a primary care provider
Obstetric Visits	Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (59400; 59409-59410; 59425-59426; 59430; 59510; 59515; 59610; 59614-59515; 59610; 59612; 59614; 59618;59620; 59622; 99460-99465) with a primary care provider
Other Primary Care Visits	Report payer paid and member cost-share amounts only for claim lines for Professional claims with HCPCS codes in (G0101-G0106; G0117-G0118; G0120-G0124; G0141; G0143-G0145; G0147-G0148; G0327-G0328; G0402-G0405; G0433; G0435; G0438-G0439; G0442-G0444; G0447; G0466-G0468; G0472; G0475-G0476; G0499; G0511; G0513-G0514; T1015; T2024) with a primary care provider

Primary Care Provider Types

Taxonomy	Practitioner Type	Provider Type
207QA0000X	Adolescent Medicine (Family Medicine) Physician	Professional: Physician
207RA0000X	Adolescent Medicine (Internal Medicine) Physician	Professional: Physician
364SA2200X	Adult Health Clinical Nurse Specialist	Professional: Other
363LA2200X	Adult Health Nurse Practitioner	Professional: Other
207QA0505X	Adult Medicine Physician	Professional: Physician
367A00000X	Advanced Practice Midwife[1]	Professional: Other
261QB0400X	Birthing Clinic/Center[1]	Professional: Other
364S00000X	Clinical Nurse Specialist	Professional: Other
261QC1500X	Community Health Clinic/Center	Professional: Other
363LC1500X	Community Health Nurse Practitioner	Professional: Other
163WC1500X	Community Health Registered Nurse	Professional: Other
364SC1501X	Community Health/Public Health Clinical Nurse Specialist	Professional: Other
282NC0060X	Critical Access Hospital	Professional: Other
261QC0050X	Critical Access Hospital Clinic/Center	Professional: Other
207Q00000X	Family Medicine Physician	Professional: Physician
363LF0000X	Family Nurse Practitioner	Professional: Other
261QP0904X	Federal Public Health Clinic/Center	Professional: Other
261QF0400X	Federally Qualified Health Center (FQHC)	Professional: Other
208D00000X	General Practice Physician	Professional: Physician
163WG0000X	General Practice Registered Nurse	Professional: Other
207QG0300X	Geriatric Medicine (Family Medicine) Physician	Professional: Physician
207RG0300X	Geriatric Medicine (Internal Medicine) Physician	Professional: Physician
363LG0600X	Gerontology Nurse Practitioner	Professional: Other
207VG0400X	Gynecology Physician[1]	Professional: Physician
207R00000X	Internal Medicine Physician	Professional: Physician
363AM0700X	Medical Physician Assistant	Professional: Other
176B00000X	Midwife[1]	Professional: Other
363L00000X	Nurse Practitioner	Professional: Other
363LX0001X	Obstetrics & Gynecology Nurse Practitioner[1]	Professional: Other
207V00000X	Obstetrics & Gynecology Physician[1]	Professional: Physician

Taxonomy	Practitioner Type	Provider Type
207VX0000X	Obstetrics Physician[1]	Professional: Physician
2080A0000X	Pediatric Adolescent Medicine Physician	Professional: Physician
364SP0200X	Pediatric Clinical Nurse Specialist	Professional: Other
363LP0200X	Pediatric Nurse Practitioner	Professional: Other
208000000X	Pediatrics Physician	Professional: Physician
261QP2300X	Primary Care Clinic/Center	Professional: Other
363LP2300X	Primary Care Nurse Practitioner	Professional: Other
163W00000X	Registered Nurse	Professional: Other
282NR1301X	Rural Acute Care Hospital	Professional: Other
261QR1300X	Rural Health Clinic/Center	Professional: Other
261QP0905X	State or Local Public Health Clinic/Center	Professional: Other
364SW0102X	Women's Health Clinical Nurse Specialist	Professional: Other
363LW0102X	Women's Health Nurse Practitioner	Professional: Other