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What’s included in total medical spending and primary care spending?
Medical and primary care spending in this report are calculated from claims-based and non-claims-based payments to health care providers and provider organizations.

Claims-based payments
These include payments to health care providers and organizations as reported by health care claims data. Total medical spending and primary care spending from claims-based payments were identified using information about the rendering or billing provider and the service rendered on the claim.

Information about claims-based payments was obtained from OHA’s All Payer All Claims (APAC) Data Reporting Program. APAC collects information about health care claims and encounters from all health care payers covered by SB 231 and HB 4017. This includes:
• Prominent carriers
• CCOs, and
• PEBB and OEBB plans.
APAC also collects information from the below, which are not covered by SB 231:
• Medicaid fee-for-service, and
• Medicare fee-for-service programs.
APAC does not collect information from:
• Carriers with fewer than 5,000 members in Oregon
• ERISA self-insured employers
• Some types of commercial health plans, and
• Some types of public health care coverage.

In addition, APAC does not collect information about health care received by people who pay out-of-pocket. This includes people without insurance.

APAC data are refreshed quarterly so carriers and CCOs can adjust and finalize claims. The first three quarters of the annual data in this report have been refreshed four times, which is the maximum. The last quarter has been refreshed three times. In other words, there has been ample time to adjust any claims data used to generate this report.

Non-claims-based payments
These payments go to health care providers and provider organizations to:
• Motivate efficient care delivery
• Reward achievement of quality or cost-savings goals, and
• Build health care capacity.
Non-claims-based payments are separate from payments made using claims. However, some types of non-claims-based payments may be based on analysis of claims data (e.g., payments to reward providers for achieving quality or cost savings based on quality measures calculated from claims data).
Information about non-claims-based payments is gathered from a reporting template completed by carriers and CCOs. Carriers and CCOs receive instructions in the template to report total health care spending and primary care spending in the following categories as defined by Oregon Administrative Rules 836-053-1500 through 836-053-1510 and 409-027-0010 through 409-027-0030:

- Capitation payments and provider salaries
- Risk-based payments
- Payments to patient-centered primary care homes or other patient-centered medical homes
- Payments to reward achievement of performance goals, such as quality or cost-savings goals
- Payments to help providers adopt health information technology, and
- Payments for workforce expenditures, such as practice coaches, patient educators, patient navigators or nurse care managers.

Carriers and CCOs were instructed to report spending on the template for services implemented or incurred in calendar year 2019. Carriers and CCOs received instructions in the template to include behavioral health expenditures provided at the primary care clinic level and exclude dental spending. This is consistent with criteria to identify total medical spending and primary care spending from claims-based payments.

In addition to non-claims-based spending, carriers and CCOs were required to report total months of enrollment in 2019. This allows for calculation of non-claims-based spending per-member per-month. Carriers also received instructions to report non-claims-based spending and enrollment separately for commercial, Medicare Advantage, and PEBB and OEBB plans.

**Limitations**
Prominent carriers and CCOs vary in organizational size, composition of network providers and unique arrangements. Moreover, CCOs are required to provide services, such as non-emergent medical transportation, that commercial carriers do not commonly provide. These differences may affect the results presented in this report.

CCOs vary in organizational size, populations and geographic regions served, demographics, available providers, types of providers, plan type and other factors that may influence primary care and total medical spending. In some cases, spending amounts for certain services may be outside the control of the CCO. The dataset used by OHA to determine primary care spending may exclude some primary care spending due to how hospital-affiliated primary care providers bill for services.

Claims-based data for Kaiser Foundation Health Plan of the Northwest are self-reported expenditures. These data are not from APAC.
What’s not included in this report?
This report includes total health care spending and primary care spending of plans offered by prominent carriers and by CCOs:
- Commercial
- Medicare Advantage, and
- PEBB and OEBB.
The report excludes spending by the following health care payers:
- Health insurance carriers with annual health premium income of less than $200 million in 2019
- ERISA self-insured employers
- Medicare fee-for-service
- Medicaid fee-for-service
- TRICARE
- Veterans Health Administration, and
- Indian Health Service.
In addition, the report excludes information about health care received by people who pay out-of-pocket. This includes people without insurance.

Identifying total medical spending and primary care spending from claims-based payments

Total medical spending: Claims that met the following criteria were used to calculate total medical spending:
- Claims for medical services rendered in calendar year 2019. Prescription drug claims were excluded.
- Services rendered by health care providers or provider organizations with a practice address in Oregon or one of the following border areas:
  - In Washington
    - Longview
    - Vancouver
    - Battle Ground, or
    - Walla Walla
  - In Idaho
    - Emmett
    - Fruitland
    - Payette
    - New Plymouth, or
    - Weiser
- Claims not denied by health care payers.

Spending was calculated as the sum of dollars paid to health care providers by carriers or CCOs. Dollars paid to providers by patients in the forms of a copay, coinsurance or deductible were excluded.
Primary care spending: Primary care spending is a subset of total medical spending. To calculate primary care spending, claims that met the following criteria were selected from claims used to calculate total medical spending:

- Providers or provider organizations that rendered services as primary care providers. A list of provider taxonomy codes used to identify primary care providers was established through review of:
  - SB 231
  - The National Uniform Claim Committee’s Health Care Provider Taxonomy code set, and
  - The Health Cost Guidelines medical code set, which is used to identify primary care claims in APAC.

The complete list of taxonomy codes is on page 13 of this report.

The following types of individual providers were included in the code list:

- Physicians specializing in:
  - Child and adolescent psychiatry
  - Family medicine
  - General medicine
  - General psychiatry
  - Geriatric medicine
  - Obstetrics and gynecology
  - Pediatrics or preventive medicine
- Nurses
  - Nurse practitioners
  - Nurse non-practitioners
  - Certified clinical nurse specialists
- Physicians’ assistants
- Naturopathic medicine providers

The following types of provider organizations were included in the code list:

- Primary care clinics
- Federally qualified health centers (FQHCs), and
- Rural health centers.

- The claims were for primary care services. A list of Current Procedural Terminology (CPT®) codes used to identify primary care providers was established:
  - Through review of:
    - CPT® codes, and
    - The National Committee on Quality Assurance’s Healthcare Effectiveness Data and Information Set
  - Through consultation with:
    - OHA’s Actuarial Services Unit, and
    - Oregon Health & Science University’s Center for Health Systems Effectiveness.

The complete list of CPT® is on page 12 of this report.

The following types of services were included:

- Office or home visits
- General medical exams
- Routine medical and child health exams
- Preventive medicine evaluation or counseling
- Administration and interpretation of health risk assessments
- Routine obstetric care excluding delivery (60 percent of payment amount reported on claims is included to represent non-delivery services), and
- Other preventive medicine.
Claims were grouped by carrier and CCO to report primary care spending as a percentage of total medical spending for each. For carriers, claims were further grouped to report results separately for each type of coverage by:
- Commercial
- Medicare Advantage, and
- PEBB and OEBB.

Calculating total medical spending and primary care spending by payer type and payer
To calculate total medical and primary care spending by prominent carriers and CCOs, the following were summed from the reporting template:
- Claims-based payments from APAC, and
- Non-claims-based payments.
For prominent carriers, payments by the following plans were summed to report results separately for each type of coverage:
- Commercial
- Medicare Advantage, and
- PEBB and OEBB.

Calculating per-member per-month (PMPM) spending
PMPM spending is defined as total paid by payer divided by member months. To calculate PMPM primary care spending and non-primary-care spending, calculations were made separately for claims-based and non-claims-based payments and summed:
- For claims-based payments, spending by carriers and CCOs were divided by total member months for each payer type from APAC.
- For non-claims-based payments, spending by carriers and CCOs from the specialized reporting template were divided by member months from the template.

Results from the above steps were summed to calculate PMPM total medical spending and PMPM primary care spending. PMPM primary care spending was subtracted from PMPM total medical spending to calculate PMPM non-primary-care spending.

These steps were used to calculate PMPM spending by all CCOs and prominent carriers offering:
- Commercial
- Medicare Advantage, and
- PEBB and OEBB plans.
These steps were also used to calculate PMPM spending for each carrier and CCO.

Enrollment
Enrollment is reported as number of unique people with health care coverage in 2019 as reported in APAC. Enrollment is calculated by taking the total member months and dividing by 12. This number is used as the annual enrollment number. A person may be enrolled with more than one health plan at the same time. This means the number of people enrolled with all carriers in this report may sum to more than the total number of actual people enrolled.
Calculating primary care non-claims-based spending as a percent of total primary care spending
Primary care spending by most prominent carriers and CCOs consists of both claims-based and non-claims-based spending. The proportion of primary care spending that a prominent carrier or CCO allocates to non-claims-based spending is calculated by dividing primary care non-claims-based spending by total primary care spending.
**Glossary**

**Capitation payment**: Single payment to a health care provider to provide health care services to a health plan member over a defined period of time. Services covered by capitation payments may be broad, such as all outpatient and inpatient services. Conversely, they may be narrow, such as primary care or mental health only. Capitation payments are a type of non-claims-based payment. They provide financial incentives for providers to manage care efficiently. They also avoid costly complications or expensive services such as emergency department or inpatient admissions.

**Claims**: Communications from health care providers to health care payers requesting payments for services rendered by providers. Claims include information about patient diagnoses, procedures performed by providers, amount payers and patients will pay for services under health insurance plans, and — in cases of paid claims — amounts paid by payers.

**Claims-based payment**: Payments to health care providers for specific services or sets of services rendered by providers and documented on health care claims. This is also known as fee-for-service. Claims-based payment systems may motivate providers to bill health care payers for a high volume of services rather than providing efficient care.

**Commercial health plans**: Group or individual health insurance plans offered by health insurance carriers.

**Coordinated care organizations (CCOs)**: Local organizations that provide physical, mental and dental health care using global budgets that grow at a fixed rate. CCOs are accountable for the health outcomes of populations they serve. CCOs are part of Oregon’s Medicaid program, which provides health coverage for low-income Oregonians.

**Health care payers**: Health insurance plans or health coverage programs that pay doctors, hospitals and other health care providers for care and services received by people with health care coverage. Health care payers include:
- Commercial health insurance plans
- Medicare Advantage plans
- PEBB and OEBB plans offered by health insurance carriers
- CCOs that provide and pay for care for Medicaid members, and
- Public programs, such as:
  - Medicaid fee-for-service
  - Medicare fee-for-service, and
  - Other state and federal programs that pay claims for members.
Medicaid: Health coverage for low-income Oregonians. Medicaid coverage includes:
• CCOs
• Other Medicaid managed care, and
• Medicaid fee-for-service (FFS).
Medicaid is funded by a mix of state and federal funds. Since 2014, Oregonians with incomes at or below 138 percent of the federal poverty level have been Medicaid-eligible. The waiting list for the Medicaid program has been eliminated.

Medicaid fee-for-service: A payment methodology by which the state directly pays health care providers for services delivered to individuals with Medicaid coverage. Payments are based on claims. Primary care spending by Medicaid fee-for-service is not included in this report.

Medicare Advantage: Health insurance plans offered by health insurance carriers where the federal Medicare program pays part of the premium. This is also known as Medicare Part C. The overwhelming majority of people in Medicare Advantage are age 65 and older.

Medicare fee-for-service: A payment methodology by which the federal Medicare program directly pays health care providers for services to individuals with Medicare coverage. Payments are based on claims. Primary care spending by Medicare fee-for-service is not included in this report.

Member months: Total number of months in a given calendar year that the enrolled health insurance plan members have coverage. For example, if one member was enrolled in a plan for all 12 months of 2019 and another member was enrolled for only 10 months, total member months equal 22. To provide a standard measure of spending across types of coverage or insurance plans, total spending is often divided by member months in order to report per-member per-month (PMPM) spending.

Non-claims-based payment: Payments to health care providers intended to:
• Motivate efficient care delivery
• Reward achievement of quality or cost-savings goals, and
• Build health care infrastructure and capacity.
Non-claims-based payments are not payments for specific services rendered by providers and reported on health care claims. However, they may be awarded based on information reported on claims. Oregon Administrative Rules 836-053-1500 through 836-053-1510 and 409-027-0010 through 409-027-0030 define seven types of non-claims-based payments for purposes of reporting on medical spending allocated to primary care under Senate Bill 231 (2015). See page 4 for a list of the categories.
**Patient-centered medical homes (PCMHs):** Health care clinics that:
- Are accountable for the large majority of each patient's physical and mental health care needs
- Are patient-centered and oriented toward the whole person, and
- Coordinate care with specialists, hospitals and other elements of the broader health care system.
PCMHs include patient-centered primary care homes and clinics recognized by other primary care initiatives.

**Patient-centered primary care homes (PCPCHs):** Health care clinics recognized by the Oregon Health Authority for the clinics' commitment to providing high-quality, patient-centered care. A PCPCH must meet quality measures in six core attributes to receive recognition.

**Per-member per-month (PMPM):** Spending on care for members of a health plan divided by member months. Dividing spending by member months provides a comparable measure of spending across health plans and payers, regardless of the number of members enrolled.

**Primary care:** Health care that includes:
- General exams and assessments
- Preventive care, and
- Care coordination.

Primary care providers:
- Respond to new patient needs and undiagnosed conditions
- Help patients navigate the health system, and
- Maintain relationships over time.

For purposes of reporting on medical spending allocated to primary care under SB 231 and HB 4017, primary care is defined as a specific set of health care services delivered by specific types of health care providers and practices (see the “Methodology” section for details).

**Prominent carriers:** Health insurance carriers with annual premium incomes of $200 million or more. Prominent carriers were defined by Oregon Administrative Rules 836-053-1500 through 836-053-1510 for purposes of reporting on medical spending allocated to primary care under SB 231.

**Public Employees’ Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB):** Boards that contract with private health insurance companies to:
- Provide health insurance plans for educators and public employees, and
- Contribute the employer share of premiums for covered employees.
OEBB and PEBB became part of OHA in 2009.

**Risk-based payments:** Payments received by health care providers that may be reduced if costs exceed defined targets. In a risk-based payment system, providers may pay a penalty or share in costs that exceed the target.

**Self-insured employers:** Employers that set aside funds to pay for health care expenses of employees, rather than buy a group health insurance plan offered by a private insurance company. Primary care spending by ERISA self-insured employers is not included in this report.
# Codes used to define primary care

## CPT® codes and description

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Additional Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>59400</td>
<td>Routine obstetric care including vaginal delivery (global code) - 60 percent of payment for CCOs</td>
<td>99406-99407 Smoking and tobacco use cessation counseling visit</td>
</tr>
<tr>
<td>59510</td>
<td>Routine obstetric care including cesarean delivery (global code) - 60 percent of payment for CCOs</td>
<td>99408-99409 Alcohol or substance abuse screening and brief intervention</td>
</tr>
<tr>
<td>59610</td>
<td>Routine obstetric care including vaginal birth after C-section (VBAC) delivery (global code) - 60 percent of payment for CCOs</td>
<td>99411-99412 Group preventive medicine counseling or risk reduction intervention</td>
</tr>
<tr>
<td>59618</td>
<td>Routine obstetric care including attempted VBAC delivery (global code) - 60 percent of payment for CCOs</td>
<td>99412 Unlisted preventive medicine service</td>
</tr>
<tr>
<td>90460-90461</td>
<td>Immunization through age 18, including provider consult</td>
<td>99413 Telephone calls for patient management</td>
</tr>
<tr>
<td>90471-90472</td>
<td>Immunization by injection</td>
<td>99414 Non-face-to-face online medical evaluation</td>
</tr>
<tr>
<td>90473-90474</td>
<td>Immunization by oral or intranasal route</td>
<td>99483 Cognition and functional assessment</td>
</tr>
<tr>
<td>96160-96161</td>
<td>Administration of health risk assessment</td>
<td>99484 Care management services for behavioral health conditions</td>
</tr>
<tr>
<td>96372</td>
<td>Therapeutic, prophylactic or diagnostic injection</td>
<td>99492 Initial psychiatric collaborative care management</td>
</tr>
<tr>
<td>98966-98968</td>
<td>Non-physician telephone services</td>
<td>99493 Subsequent psychiatric collaborative care management</td>
</tr>
<tr>
<td>98969</td>
<td>Online assessment, management services by non-physician</td>
<td>99494 Initial or subsequent psychiatric collaborative care management</td>
</tr>
<tr>
<td>99201-99205</td>
<td>Office or outpatient visit for a new patient</td>
<td>99495-99496 Transitional care management services</td>
</tr>
<tr>
<td>99211-99215</td>
<td>Office or outpatient visit for an established patient</td>
<td>G0008-G0010 Administration of influenza virus, pneumococcal, hepatitis B vaccine</td>
</tr>
<tr>
<td>99241-99245</td>
<td>Office or other outpatient consultations</td>
<td>G0396-G0397 Alcohol or substance abuse assessment</td>
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<tr>
<td>99339-99340</td>
<td>Physician supervision of patient in home or rest home</td>
<td>G0438-G0439 Annual wellness visit, personalized prevention plan of service</td>
</tr>
<tr>
<td>99341-99345</td>
<td>Home visit for a new patient</td>
<td>G0442 Annual alcohol screening</td>
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<tr>
<td>99347-99350</td>
<td>Home visit for an established patient</td>
<td>G0443 Brief behavioral counseling for alcohol misuse</td>
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<tr>
<td>99381-99387</td>
<td>Preventive medicine initial evaluation</td>
<td>G0444 Annual depression screening</td>
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<tr>
<td>99391-99397</td>
<td>Preventive medicine periodic reevaluation</td>
<td>G0506 Comprehensive assessment of and care planning for patients requiring chronic care management services</td>
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<tr>
<td>99401-99404</td>
<td>Preventive medicine counseling or risk reduction intervention</td>
<td>G0513-G0514 Prolonged preventive service</td>
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### Specialty taxonomy code and description

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>261QF0400X</td>
<td>Federally qualified health center</td>
</tr>
<tr>
<td>261QP2300X</td>
<td>Primary care clinic</td>
</tr>
<tr>
<td>261QR1300X</td>
<td>Rural health clinic</td>
</tr>
<tr>
<td>207Q00000X</td>
<td>Physician, family medicine</td>
</tr>
<tr>
<td>207R00000X</td>
<td>Physician, general internal medicine</td>
</tr>
<tr>
<td>175F00000X</td>
<td>Naturopathic medicine</td>
</tr>
<tr>
<td>2080000000X</td>
<td>Physician, pediatrics</td>
</tr>
<tr>
<td>2084P0800X</td>
<td>Physician, general psychiatry</td>
</tr>
<tr>
<td>2084P0804X</td>
<td>Physician, child and adolescent psychiatry</td>
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<tr>
<td>207V00000X</td>
<td>Physician, obstetrics and gynecology</td>
</tr>
<tr>
<td>207VG0400X</td>
<td>Physician, gynecology</td>
</tr>
<tr>
<td>208D00000X</td>
<td>Physician, general practice</td>
</tr>
<tr>
<td>363L00000X</td>
<td>Nurse practitioner</td>
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<tr>
<td>363LA2200X</td>
<td>Nurse practitioner, adult health</td>
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<tr>
<td>363LF0000X</td>
<td>Nurse practitioner, family</td>
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<tr>
<td>363LP0200X</td>
<td>Nurse practitioner, pediatrics</td>
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<tr>
<td>363LP0808X</td>
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<td>363LP2300X</td>
<td>Nurse practitioner, primary care</td>
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<td>363LW0102X</td>
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<tr>
<td>363LX0001X</td>
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<td>363AM0700X</td>
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<td>207RG0300X</td>
<td>Physician, geriatric medicine</td>
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<tr>
<td>175L00000X</td>
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<tr>
<td>2083P0500X</td>
<td>Physician, preventive medicine</td>
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<tr>
<td>364S00000X</td>
<td>Certified clinical nurse specialist</td>
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<tr>
<td>163W00000X</td>
<td>Nurse, non-practitioner</td>
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### ICD-10 codes and description

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z00</td>
<td>Encounter for general exam without complaint</td>
</tr>
<tr>
<td>Z000</td>
<td>Encounter for general adult medical examination</td>
</tr>
<tr>
<td>Z0000</td>
<td>Encounter for general adult medical exam without abnormal findings</td>
</tr>
<tr>
<td>Z0001</td>
<td>Encounter for general adult medical exam with abnormal findings</td>
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<tr>
<td>Z001</td>
<td>Encounter for newborn, infant and child health examinations</td>
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<tr>
<td>Z0011</td>
<td>Newborn health examination</td>
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<tr>
<td>Z00110</td>
<td>Health examination for newborn under 8 days old</td>
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<tr>
<td>Z00111</td>
<td>Health examination for newborn 8 to 28 days old</td>
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<tr>
<td>Z0012</td>
<td>Encounter for routine child health examination</td>
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<tr>
<td>Z00121</td>
<td>Encounter for routine child health exam with abnormal findings</td>
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<td>Encounter for routine child health exam without abnormal findings</td>
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<td>Z008</td>
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<td>Encounter for gynecological examination</td>
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<td>Z0141</td>
<td>Encounter for routine gynecological examination</td>
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<tr>
<td>Z01411</td>
<td>Encounter for gynecological exam, general, routine with abnormal findings</td>
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<tr>
<td>Z01419</td>
<td>Encounter for gynecological exam, general, routine without abnormal findings</td>
</tr>
</tbody>
</table>
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This document (“August 2021 v2”) was updated March 2022 to correct a formatting error on p. 6.