Data Specification Manual

957 CMR 2.00:

Payer Reporting of Primary Care and Behavioral Health Expenses

July 1, 2024

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1. Summary of Changes

Updates to the code list for capturing primary care, mental health, and SUD spending has been made to this data specification manual in order to comply with Chapter 177 of the Acts of 2022: *An Act Addressing Barriers to Care for Mental Health*, which requires CHIA to publish information that separately measures mental health and substance use disorders across specific settings and populations.

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. Additionally, in 2022, Massachusetts enacted Chapter 177: *An Act Addressing Barriers to Care for Mental Health*, expanding access to behavioral health services, supporting the behavioral health workforce, and, among other initiatives, charging CHIA with monitoring "costs, cost trends, price, quality, utilization, and patient outcomes related to behavioral health service subcategories."[1] Behavioral health service subcategories include, but are not limited to: mental health, substance use disorder, outpatient, inpatient, services for children, services for adults, and provider types as defined in M.G.L. c. 12C, § 10 Section 21A.

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 supports directives in Chapter 177 and other 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. This 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 2024 collection year, CHIA is requesting payers to submit final data from CY2023 with the option to submit CY2022 and CY2021 to correct any previous data submission errors.** Files will contain different tabs, including:

- Front page, including data confirmation, payer comments, and supplemental data collection
- Supplemental telehealth collection by service type
- Primary Care & Behavioral Health expenses by managing physician group
- Member months by managing physician group

[1] Chapter 177 "An Act Addressing Barriers to Care for Mental Health." Available at https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter177.

- 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 DL-Data-Submitter-HelpDesk@chiamass.gov. For technical issues, please email 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**
September 25, 2024	Required • CY 2023 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 mental health, substance use disorders, 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 mental health, substance use disorders, 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 mental health and substance use disorders, payers should apportion or allocate payments into the primary care, mental health, and substance use disorders service types; these payments should not be double counted. For all other non-claims payments that do not fall into one of the aforementioned categories, the "all other services" category 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.

<u>Physician Group Guidelines</u>

- 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 and spending for members who were attributed to more than one physician group in a calendar year should be allocated based on the number of months associated with each physician group:

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[2]
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 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 member cost-sharing amounts for members regardless of whether services are provided by providers located in Massachusetts.

Mutually Exclusive Guidelines

As outlined on pages 35 to 36 of the data specification manual, there is an established hierarchical structure for the allocation of spending through the mental health, SUD, primary care, and all other service categories. **Allocation of spending should be distinct and mutually exclusive.** For example, claims marke as MH ED/Observation should not appear in the MH Outpatient category.

Facility Claims Guidelines

For claims categorized to the MH/SUD Inpatient, MH/SUD Emergency Department/Observation, and MH/SUD outpatient facility categories, the logic requires that the entire claim, including all claim lines, be attributed to the same service category. In the example provided below (sourced from CHIA's E-APCD data warehouse), although claim line 4 was the only claim line related with Emergency

[2] 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.

Department/Observation facility, spending for the entire claim should be reported in the Emergency Department/Observation service category.

Line	Year	PROCEDURE_CD	PROCEDURE_DS	PRIMARY_DIAGNOS	PARIMARY_DIAG_DESC	REVENUE_CD	REVENUE_CD_DS	POS_CD
1	2020	80307	DRUG TST PRSMV INSTRMNT CHEM ANALYZERS PR DATE	F331	Major depressive disorder, recurrent, moderate	300	Laboratory General Classification	22
2	2020	85025	BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC	F331	Major depressive disorder, recurrent, moderate	300	Laboratory General Classification	22
3	2020	80048	BASIC METABOLIC PANEL CALCIUM TOTAL	F331	Major depressive disorder, recurrent, moderate	301	Laboratory Chemistry	22
4	2020	99285	EMERGENCY DEPT VISIT HIGH SEVERITY&THREAT FUNCJ	F331	Major depressive disorder, recurrent, moderate	450	Emergency Room General Classification	22

4b. Capturing Behavioral Health Spending in Primary Care

CHIA has revised its logic for capturing behavioral health spending delivered in primary care settings. Payers shall report payments identified in the following three new categories:

- MH Outpatient: Primary Care Provider
- SUD Outpatient: Primary Care Provider
- Primary Care Behavioral Health Screening

Payments reported in each of these categories should be distinct from each other and not overlap. Payments should only include professional claims. Payments reported in each of these categories will be summed to calculate Behavioral Health Spending in Primary Care.

Payments reported in these categories also should be distinct from and not overlap other MH, SUD, or Primary Care categories. Payments reported as MH Primary Care will be summed with other MH payments to calculate total spending on Mental Health services. Payments reported as SUD Primary Care will be summed with other SUD payments to calculate total spending on Substance Use Disorder services.

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, 10

- Modifiers: 93, 95, GT, GQ, G0

- CPT codes: 98966-98968, 98970-98972, 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.
Supp Telehealth Data	A	Reporting Year	Integer	####	Year for which data is being reported.
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-A) 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.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Supp Telehealth Data	C	Service Type	Integer	#	Type of Service 1 = Mental Health 2 = Substance Use Disorders 3 = Primary Care 4 = All Other Services No negative values.
Supp Telehealth Data	D	Telehealth Expenditures	Integer	#	Telehealth expenditures as defined in section 4c.
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-A) 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	Age Group	Integer	#	Indicates the age group of the population. 1 = 0 – 17 2 = 18 – 64 3 = 65+ Value must be an integer between '1' and '3'.
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 = Mental Health 2 = Substance Use Disorders 3 = Primary Care 4 = 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 = MH Inpatient 12 = MH ED/Observation 13 = MH Outpatient: PC Provider 14 = MH Outpatient: Non-PC Provider 15 = MH Prescription Drugs 21 = SUD Inpatient 22 = SUD ED/Observation 23 = SUD Outpatient: PC Provider 24 = SUD Outpatient: Non-PC Provider 25 = SUD Prescription Drugs 31 = PC Office Visit 32 = PC Home/Nursing Facility Visit 33 = PC Behavioral Health Screening 34 = PC Preventive Visit 35 = PC Other Primary Care Visit 36 = PC Immunization and Injection 37 = PC Obstetric Visit 41 = Other Medical 42 = Other Prescription Drugs 51 = Non-Claims: Incentive Payments 52 = Non-Claims: Capitation 53 = Non-Claims: Risk Settlements 54 = Non-Claims: Care Management 55 = Non-Claims: Other No negative values. For payers reporting in the "Other Medical" or "Non-Claims: Other" categories, payers should report in the comments field on the front tab what is included in these categories.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
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.
Expenditures Data	M	Expenditures: Incurred Expenses (Payer Liability)	Number	#######	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, for all allowed claims and non-claims. This should include (be gross of) CSR subsidies for ConnectorCare members. No negative values for claims-based expenses. Negative values allowed for non-claims spending service categories only.
Expenditures Data	N	Expenditures: Member Cost Share	Number	#######	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.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
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.
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-A) 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'.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
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'.
Member Months Data	G	Age Group	Integer	#	Indicates the age group of the population. 1 = 0-17 2 = 18-64 3 = 65+ Value must be an integer between '1' and '3'.
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.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Member Months Data	K	MH 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 Mental Health principal diagnosis at any point during the reporting year. No negative values.
Member Months Data	L	SUD 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 Substance Use Disorder 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 OrgID: The CHIA-assigned organization ID for the payer or carrier submitting the file.
- Submission Year: Year in which the data is submitted (e.g., 2023)
- Reporting Year: Year for which Primary Care & Behavioral Health data is being reported (e.g., 2022)
- 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.

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-A)
3	Commercial – Full Claims
4	Commercial – Partial Claims
5	SCO
6	OneCare
7	PACE
8	Other

- Service Type: A number that reflects the category of services being reported

Service Type	Definition
1	Mental Health
2	Substance Use Disorders
3	Primary Care
4	All Other Services

- Telehealth Expenditures: Telehealth expenditures as defined in section 4c.

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
Product Type Code	**Definition**
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

- Age Group: Indicates the age of the population reported.

Age Group	Definition

1	0-17
2	18-64
3	65+

- 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
ACO Indicator	**Definition**
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) Mental Health Services, (2) Substance Use Disorder Services, (3) Primary Care Services and (4) All Other Services. Note that not all categories will be applicable to each reported Physician Group; data submitters should only report lines for service categories that had expenditures.

Service categories for non-claims payments are included in each service type. If non-claims based payments cannot be attributed to mental health, substance use disorders, or primary care service categories, all non-claims payments should be reported in the appropriate All Other Services non-claims categories.

Mental Health (MH): Mental health services are classified based on ICD-10-CM Principal Diagnosis Code and *combinations of* Current Procedure Terminology (CPT) Codes, Revenue Codes and Place of Service (POS) Codes. The logic for classifying MH services delivered in a Primary Care (PC) setting also includes restriction by Provider Type. Data submitters will report expenses within the following mutually exclusive spending service categories, based on logic outlined in **Appendix D**.

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

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

- **MH Outpatient: Primary Care Provider**: Payments for outpatient MH face-to-face and telehealth services, including evaluation and management and integrated mental health primary care services, with a mental health diagnosis **and delivered by a primary care provider included in Appendix D**. **Ancillary services should be excluded**.

- **MH Outpatient: Non-Primary Care Provider:** Payments for outpatient MH specific services, including evaluation and management, intensive outpatient services, and other diversionary care and residential treatment with a mental health principal diagnosis, not included in MH Emergency Department and Observation and delivered by any provider type except primary care. This category excludes care classified as MH Emergency Department and Observation and MH Primary Care. **Ancillary services should be excluded.**
- **MH Prescription Drugs:** All payments made for prescription drugs prescribed to address mental 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.

- **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	MH Inpatient
12	MH Emergency Department-Observation
13	MH Outpatient: PC Provider
14	MH Outpatient: Non-PC Provider
15	MH Prescription Drugs
51	Non-Claims: Incentive Programs
52	Non-Claims: Capitation

53	Non-Claims: Risk Settlements
54	Non-Claims: Care Management
55	Non-Claims: Other

Substance Use Disorders (SUD): SUD 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, based on logic outlined in **Appendix D**.

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

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

- **SUD Outpatient: Primary Care Provider:** Payments for certain outpatient face-to-face and telehealth services, including evaluation and management and integrated SUD primary care services, with a SUD diagnosis **and** delivered by a primary care provider included in Appendix D. **Ancillary services should not be included**.

- **SUD Outpatient: Non-Primary Care Provider:** Payments for SUD specific services, including evaluation and management, intensive outpatient services, medication assisted treatment, and other diversionary care and residential treatment with a SUD principal diagnosis, not included in SUD Emergency Department and Observation and delivered by any provider type except primary care. This category excludes care classified as SUD Emergency Department and Observation and SUD Primary Care. **Ancillary services should not be included**.

- **SUD Prescription Drugs:** All payments made for prescription drugs prescribed to address SUD 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.

- **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**
21	SUD Inpatient
22	SUD Emergency Department-Observation
23	SUD Outpatient: PC Provider
24	SUD Outpatient: Non-PC Provider

25	SUD Prescription Drugs
51	Non-Claims: Incentive Programs
52	Non-Claims: Capitation
53	Non-Claims: Risk Settlements
54	Non-Claims: Care Management
55	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, based on logic outlined in **Appendix D**. 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.

- **Behavioral Health Screening:** All payments made for behavioral health screenings 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. Excludes payments already allocated to Behavioral Health Screening.

- **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.

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

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

- **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
31	PC Office Type Visits
32	PC Home-Nursing Facility Visits
33	PC Behavioral Health Screening
34	PC Preventive Visit
35	PC Other Primary Care Visits
36	PC Immunizations and Injections
37	PC Obstetric Visits
51	Non-Claims: Incentive Programs
52	Non-Claims: Capitation
53	Non-Claims: Risk Settlements
54	Non-Claims: Care Management
55	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 Prescription Drugs:** All other payments made for prescription drugs not previously categorized as mental health or substance use disorders.

- **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**
41	Other Medical
42	Other Prescription Drugs

Service Category Code	Service Category Definition
51	Non-Claims: Incentive Programs
52	Non-Claims: Capitation
53	Non-Claims: Risk Settlements
54	Non-Claims: Care Management
55	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. Incurred Claims should reflect only those amounts that are the liability of the payer, including (gross of) payments from the federal or state governments (CSR Amounts) and excluding payments from the member (Cost-Sharing).

Expenditures- Member Cost Share: The sum of all member cost share/member paid amounts for claims-based services, including copays, coinsurance and deductible costs.

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-A)
3	Commercial – Full Claims
4	Commercial – Partial Claims
5	SCO

Insurance Category Code	Definition
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

- Age Group: Indicates the age of the population reported.

Age Group	Definition
1	0-17
2	18-64
3	65+

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

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

Appendix B: Service Categorization Code Lists

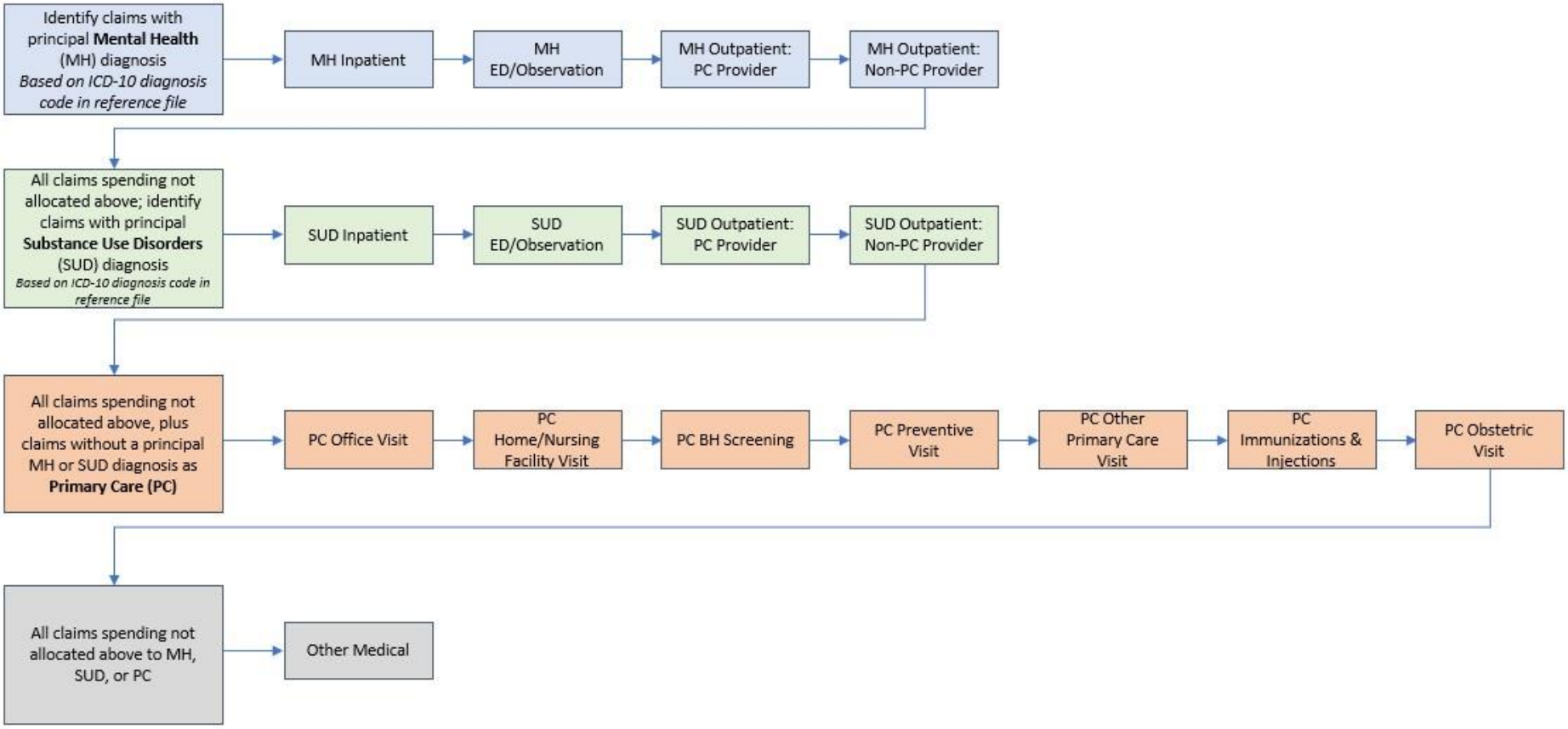
Please visit: https://www.chiamass.gov/payer-data-reporting-primary-and-behavioral-health-careexpenditures/

Payers should use these lists as reference tables **in conjunction with the methodology 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

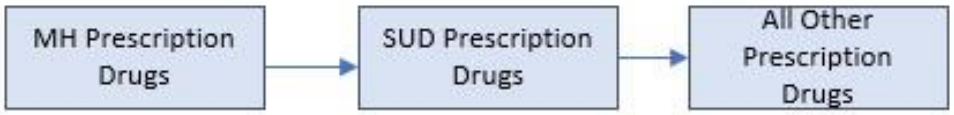
C.1: Medical Claims Allocation

Allocate spending sequentially through the specific service categories based on the code sets available in Appendices B&D



C.2: Pharmacy Claims Allocation

Allocate pharmacy claims spending based on the NDC codes provided in Appendix B.



C.3: Non-Claims Allocation

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. Alternately, the "all other services" categories may be used.

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.

Mental 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.
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.
F3010 – 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)
F600 -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 - F989	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.

Substance Use Diagnosis Codes

ICD-10 Code	Description	Notes and Exclusions
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.

Mental Health & SUD Service Codes

Note: A principal diagnosis of MH or SUD from ICD-10 codes above is required for claims to be allocated through the categories below. The service measure category, whether MH or SUD, is defined by the ICD-10 principal diagnosis category.

Measure Category	Specifications
Inpatient; Facility	Report payer paid and member cost-share for all claim lines across an entire claim when a Facility claim has one or more of the following Revenue codes: (0100, 0101, 0110-0119, 0120-0129, 0130-139, 0140-0149, 0150-0159, 0160-0161, 0164, 0167, 0169-0174, 0179-0183, 0185, 0189-0194, 0199-0204, 0206-0214, 0219, 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, 25, 31, 32, 34, 51, 54, 55, 56, 61) ***and*** CPT codes in (99221-99223, 99231-99236, 99238, 99239, 99251-99255, 99356, 99357, G0425, G0426, G0427, G0459)
Emergency Department / Observation; Facility (no inpatient admission)	Report payer paid and member cost-share amounts for all claim lines across an entire claim when a Facility claim has one or more of the following Revenue codes: (0450-0452, 0456, 0459, 0760-0762, 0769, 0981)
Emergency Department / Observation; Professional (no inpatient admission)	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, G0378-G0384, G0425 -G0427, G2213).

Outpatient Professional PC	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, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 25, 26, 27, 33, 49, 50, 52, 53, 57, 58, 60, 62, 71, 72, 99) ***and***, CPT/HCPCS codes (90678, 90785, 90791, 90792, 90832-90840, 90845-90847, 90849, 90853, 90863, 90865, 90867-90870, 90875, 90876, 90880, 90882, 90885, 90887, 90899, 90901, 90912, 90913, 96105, 96116, 96121, 96125, 96127, 96130-96133, 96136-96139, 96146, 96156, 96158, 96159, 96160, 96161, 96164, 96165, 96167, 96168, 96170, 96171, 96202, 96203, 96372-96376, 96379, 97110, 97112, 97129, 97130, 97151-97158, 97530, 97535, 97537, 97802-97804, 97810, 97811, 97813, 98960-98962, 98966-98972, 99050, 99051, 99053, 99056, 99058, 99060, 99078, 99199, 99201-99205, 99211-99215, 99242-99245, 99304-99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99358, 99359, 99366-99368, 99374, 99375, 99377-99387, 99391-99397, 99401-99404, 99406-99409, 99411, 99412, 99415-99417, 99421-99423, 99439, 99441-99444, 99446-99449, 99451, 99452, 99483, 99484, 99487, 99489, 99490, 99491, 99492-99494, 99495, 99496, 99510, 99605-99607, 0362T, 0373T, G0032, G0033, G0071, G0076-G0087, G0155, G0156, G0162, G0176, G0177, G0270, G0271, G0299, G0300, G0396, G0397, G0406-G0408, G0409-G0411, G0442, G0444, G0451, G0463, G0468-G0470, G0473, G0480-G0483, G0490, G0506, G0511, G0512, G0513, G0514, G2001-G2015, G2021, G2058, G2061-G2065, G2067-G2080, G2082, G2083, G2086-G2088, G2211, G2212, G2214, G2250-G2252, G8427, G9001-G9012, G9016, G9475, G9477, G9478, G9685, G9903, G9978-G9986, H0001-H0029, H0031, H0032, H0033, H0034, H0035, H0036, H0037, H0038-H0040, H0046, H0047, H0048, H0049, H0050, H1000, H1001, H1002, H1003, H1004, H1005, H2000, H2001, H2010, H2011, H2012, H2013, H2014-H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2024, H2025, H2026, H2027, H2028, H2029, H2030, H2031, H2032, H2033, H2034, H2035, H2036, J0570, J0571, J0572, J0573, J0574, J0575, J0592, J1230, J2315, J3490, S0109, S0201, S9117, S9475, S9480, S9482, S9484, S9485, T1000, T1001, T1002, T1003, T1004, T1005, T1006, T1007, T1012, T1015, T1016, T1017, T1018, T1019, T1020, T1021, T1023, T1024, T1025, T1026, T1027, T1028, T1040, T1041, T1502, T1503, T2024, T2048) **with a primary care provider**

Measure Category	Specifications
Outpatient Professional Non-PC	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, 25, 26, 27, 33, 49, 50, 52, 53, 57, 58, 60, 62, 71, 72, 99) *and*, CPT/HCPCS codes (90678, 90785, 90791, 90792, 90832-90840, 90845-90847, 90849, 90853, 90863, 90865, 90867-90870, 90875, 90876, 90880, 90882, 90885, 90887, 90899, 90901, 90912, 90913, 96105, 96116, 96121, 96125, 96127, 96130-96133, 96136-96139, 96146, 96156, 96158, 96159, 96160, 96161, 96164, 96165, 96167, 96168, 96170, 96171, 96202, 96203, 96372-96376, 96379, 97110, 97112, 97129, 97130, 97151-97158, 97530, 97535, 97537, 97802-97804, 97810, 97811, 97813, 98960-98962, 98966-98972, 99050, 99051, 99053, 99056, 99058, 99060, 99078, 99199, 99201-99205, 99211-99215, 99242-99245, 99304-99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99358, 99359, 99366-99368, 99374, 99375, 99377-99387, 99391-99397, 99401-99404, 99406-99409, 99411, 99412, 99415-99417, 99421-99423, 99439, 99441-99444, 99446-99449, 99451, 99452, 99483, 99484, 99487, 99489, 99490, 99491, 99492-99494, 99495, 99496, 99510, 9960599607, 0362T, 0373T, G0032, G0033, G0071, G0076-G0087, G0155, G0156, G0162, G0176, G0177, G0270, G0271, G0299, G0300, G0396, G0397, G0406-G0408, G0409, G0411, G0442G0444, G0451, G0463, G0468-G0470, G0473, G0480-G0483, G0490, G0506, G0511, G0512, G0513, G0514, G2001-G2015, G2021, G2058, G2061-G2065, G2067-G2080, G2082, G2083, G2086-G2088, G2211, G2212, G2214, G2250-G2252, G8427, G9001-G9012, G9016, G9475, G9477, G9478, G9685, G9903, G9978-G9986, H0001-H0029, H0031, H0032, H0033, H0034, H0035, H0036, H0037, H0038-H0040, H0046, H0047, H0048, H0049, H0050, H1000, H1001, H1002, H1003, H1004, H1005, H2000, H2001, H2010, H2011, H2012, H2013, H2014-H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2024, H2025, H2026, H2027, H2028, H2029, H2030, H2031, H2032, H2033, H2034, H2035, H2036, J0570, J0571, J0572, J0573, J0574, J0575, J0592, J1230, J2315, J3490, S0109, S0201, S9117, S9475, S9480, S9482, S9484, S9485, T1000, T1001, T1002, T1003, T1004, T1005, T1006, T1007, T1012, T1015, T1016, T1017, T1018, T1019, T1020, T1021, T1023, T1024, T1025, T1026, T1027, T1028, T1040, T1041, T1502, T1503, T2024, T2048)

Measure Category	Specifications
Outpatient Facility Non-PC	Report payer paid and member cost-share amounts for all claim lines across an entire claim when a Facility claim has: Revenue codes in (0500, 0509, 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0524, 0525, 0526, 0527, 0528, 0529, 0780, 0790, 0900, 0901, 0902, 0903, 0904, 0905, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0918, 0919, 0940, 0941, 0942, 0943, 0944, 0945, 0946, 0947, 0948, 0949, 0951, 0952, 0953, 0960, 0961, 0962, 0963, 0964, 0969, 0982, 0983, 0984, 0985, 0986, 0987, 0988, 0989, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2109, 3101, 3102, 3103, 3104, 3105, 3106)

Primary Care Service Codes

For claims not identified as Behavioral Health (MH or SUD) 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 (96110, 96112, 96113, 96160, 96161, 96372-96374, 98960-98962, 98966-98969, 99050, 99051, 99056, 99058, 99078, 99173, 99201-99205, 99211-99215, 99242-99245, 99358, 99359, 99360, 99366-99368, 99374, 99375, 99377-99380, 99421, 99422, 99423, 99424, 99425, 99426, 99427, 99437, 99439, 99441-99444, 99446-99449, 99451-99454, 99457, 99458, 99473, 99474, 99483, 99487, 99489-99491, 99495-99498, G0396, G0397, G0463, G0505, 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, 99341, 99342, 99344, 99345, 99347-99350, 99357, 99502, 99506, G0179-G0182) with a primary care provider
Behavioral Health Screening	Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (90865, 96127, 96136, 96137, 96138, 96139, 96146, 96156, 96202, 96203, 97151, 97152, 99408, 99409, G0442, G0444, G0480, G0481, G0482, G0483, G9903, H0001, H0002, H0031, H0049) 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, 99381-99387, 99391-99397, 99401-99404, 99406, 99407, 99411, 99412, 99420, 99429, G0028, G0029, G0030, G0202, G0436, G0437, 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, 90476, 90477, 90581, 90585-90587, 90619-90621, 90625, 90626, 90627, 90630, 90632, 90633,90634, 90636, 90644, 90647, 90648-90651, 90653-90658, 90660-90662, 90664, 90666-90668, 90670, 90671, 90672, 90673, 90674, 90675, 90676, 90677, 90678, 90680-90682, 90685-90691, 90694, 90696-90698, 90700, 90702, 90707, 90710, 90713-90717, 90723, 90732-90734, 90736, 90738-90740, 90743, 90744, 90746, 90747, 90748, 90749, 90750, 90756, 90758, 90759, 91300, 91301, 91303, 91304, 91305, 91306, 91307, 91308, 91309, 91311, 91312, 91313, 91314, 91315, 91316, 91317, 0001A, 0002A, 0003A, 0004A, 0011A, 0012A, 0013A, 0031A, 0034A, 0041A, 0042A, 0044A, 0051A, 0052A, 0053A, 0054A, 0064A, 0071A, 0072A, 0073A, 0074A, 0081A, 0082A, 0083A, 0091A, 0092A, 0093A, 0094A, 0111A, 0112A, 0113A, 0124A, 0134A, 0144A, 0154A, 0164A, 0173A, G0008, G0009, G0010, G9989, G9990, G9991, Q2034-Q2039) with a primary care provider

Measure Category	Specifications
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, 59514, 59515, 59610, 59612, 59614, 59618, 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 (98980, 98981, G0101, G0102, G0103, G0104, G0105, G0106, G0117, G0118, G0120, G0121, G0122, G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, G0327, G0328, G0402, G0403, G0404, G0405, G0433, G0435, G0438, G0439, G0443, G0447, G0466, G0467, G0468, G0472, G0475, G0476, G0499, G0511, G0513, G0514, G9998, G9999, 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

Taxonomy	Practitioner Type	Provider Type
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
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

Taxonomy	Practitioner Type	Provider Type
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