Primary Care Spending in Oregon

A report to the Oregon Legislature

Oregon Health Authority

February 2019

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Executive summary

Senate Bill 231 (2015) and House Bill 4017 (2016) require the Oregon Health Authority (OHA) and the Department of Consumer and Business Services (DCBS) to report the percentage of medical spending allocated to primary care by the following health care payers:

- Prominent carriers, defined as health insurance carriers with annual health premium income of $200 million or more. These carriers may offer commercial or Medicare Advantage plans.
- Health insurance plans contracted by the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB)
- Medicaid coordinated care organizations (CCOs)

In addition to reporting on spending allocated to primary care, SB 231 requires OHA to convene a Primary Care Payment Reform Collaborative. The collaborative is an advisory group tasked with helping OHA develop and implement the Primary Care Transformation Initiative to strengthen Oregon's primary care system. Senate Bill 934 (2017) extends the collaborative through 2027.

SB 934 also requires health insurance carriers and CCOs to allocate at least 12 percent of their health care expenditures to primary care, by 2023.

This document is an OHA and DCBS report to the Legislature on medical spending allocated to primary care. It presents information about primary care spending in calendar year 2017.

It excludes:

- ERISA self-insured plans
- Prescription drug claims
- Health care payers not covered by SB 231, and
- Health care spending by people who pay out-of-pocket including people without insurance.

The health care payers in this report provided health coverage for 2.5 million Oregonians. This represents 61 percent of Oregon's population in 2017.

Multiple factors can affect primary care spending by health care payers. These include:

- Health plan members' age
- Health status
- Distance from primary care providers
- Other demographic factors that can affect use of primary care and other services, and
- Carriers' spending decisions, provider networks and other policy decisions.

This report will help policymakers and the public assess resources allocated to primary care in Oregon. It will also help to develop proposals to improve primary care. Specifically, it will inform the work of the Primary Care Payment Reform Collaborative.

Executive summary (cont.)

This year's report uses an updated methodology for measuring primary care

See section titled "What's new in this report."

Coordinated care organizations (CCOs) and prominent carriers listed in this report spent $1.4 billion on primary care in 2017. On average, CCOs allocated a greater percentage of total medical spending to primary care than any other type of health care.

Prominent carriers spent $991 million on primary care. Commercial carriers' primary care spending averaged 13.4 percent of total medical spending. Medicare Advantage, PEBB and OEBB plans' primary care spending averaged 10.6 percent and 12.2 percent, respectively. CCOs spent $433 million on primary care. This represents 16.5 percent of total medical spending.

Total medical spending percentage to primary care varied.

Commercial carriers allocated from 6.7 to 16.9 percent of medical spending to primary care. Medicare Advantage plans allocated from 4.1 to 23.3 percent to primary care. PEBB and OEBB plans allocated from 11.1 to 16.3 percent to primary care. CCOs allocated from 9.2 to 23.8 percent to primary care.

On average, non-claims-based payments made up a greater percentage of primary care spending by Medicare Advantage plans than by other payer types.

Non-claims-based payments are payments to a health care provider intended to:

- Motivate efficient care delivery
- Reward achievement of quality or cost-savings goals, and
- Build health care infrastructure and capacity.

In total, more than 65 percent of primary care spending by Medicare Advantage plans was non-claims-based. More than 60 percent of primary care spending by CCOs was non-claims-based. By contrast, non-claims-based payments made up 45 and 36 percent of primary care spending for commercial carriers and PEBB and OEBB plans, respectively.

Of non-claims-based primary care spending, most carriers and CCOs use provider incentives and capitated payments.

Most prominent carriers and CCOs reported some primary care spending in the form of provider incentives. Many reported capitated or salaried provider payments. Other non-claims-based categories were less common.

Background

Primary care is the front line of Oregon's health care system. Primary care providers:

- Deliver preventive services such as flu shots and cancer screenings
- Respond to new patient needs and undiagnosed conditions
- Identify health problems before they become serious
- Help patients navigate an increasingly complex health care system
- Coordinate care with specialists and other providers, and
- Maintain relationships with patients over time.

Primary care providers include:

- Physicians
- Physicians' assistants
- Nurse practitioners, and
- Naturopathic health care providers.

Research indicates that availability of primary care providers is associated with improved health outcomes, including reduced mortality rates, reduced rates of low birth weight and preventable hospitalizations, and increased self-rated health status.

The Oregon Legislature enacted Senate Bill 231 (2015) and House Bill 4017 (2016) to provide information about primary care in Oregon and strengthen Oregon's primary care infrastructure. SB 231 and HB 4017 require OHA and DCBS to report the percentage of medical spending allocated to primary care by the following health care payers:

- Prominent carriers. These are defined as health insurance carriers with annual health premium income of $200 million or more that may offer commercial or Medicare Advantage plans
- Health insurance plans contracted by the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB)
- Medicaid coordinated care organizations (CCOs)

In addition to reporting on spending allocated to primary care, these bills require OHA to convene a Primary Care Payment Reform Collaborative (collaborative) made up of more than 40 members representing a broad range of provider, payer and other primary care stakeholder perspectives. The collaborative advises and assists OHA in the implementation of the Primary Care Transformation Initiative (initiative). The purpose of the initiative is to develop and share best practices in technical assistance and payment arrangements that direct more resources to support innovation and care improvement in primary care. Senate Bill 934 (2017) extends the collaborative through 2027. The bill requires the collaborative to submit an annual report on the initiative's progress to the Oregon Health Policy Board and the Legislature. Further, SB 934 (2017) requires health insurance carriers and CCOs to allocate at least 12 percent of their health care expenditures to primary care, by 2023. Commercial carriers that do not meet the 12 percent target, will be required to submit a plan to OHA and DCBS to increase the carrier's primary care spending by 1 percentage point each year. This includes PEBB and OEBB plans, as well as CCOs.

Background

OHA and DCBS made a significant effort to collect complete information on primary care spending and total medical spending by the health care payers covered in SB 231. This effort ensured the report includes the following types of payments used to pay for health care services:

- Claims-based payments:
  Payments to health care providers for services reported on health care claims. As reflected in statute, OHA uses claims based on specific provider types and for specific services related to primary care. Information about claims-based payments made by Oregon's major health care payers is available from OHA's All Payer All Claims Data Reporting Program (APAC).
- Non-claims-based payments:
  Payments to health care providers intended to:
  - Motivate efficient care delivery
  - Reward achievement of quality or cost-savings goals, and
  - Build primary care infrastructure and capacity.

To collect information about non-claims-based payments for this report, OHA and DCBS aligned with the following administrative rules (OARs):

- OAR 836-053-1500 through 836-053-1510:
  - These rules define prominent carriers and require carriers to report non-claims-based primary care spending and total medical spending.
- OAR 409-027-0010 through 409-027-0030:
  - These rules require CCOs to report non-claims-based primary care spending and total medical spending.

The rules define non-claims-based spending that prominent carriers and CCOs must report. Prominent carriers and CCOs must use a special report template to provide the report.

Primary care spending: What's included?

The Primary Care Spending Report defines primary care based on the **health care provider** and **what service is given**. In other words, primary care in this report is defined by specific types of health care professionals who provide a specific set of services to patients. The definition of primary care includes certain provider organizations. However, it excludes specific health care settings. Costs associated with services provided in hospital and ambulatory surgical center settings do not count toward primary care spending.

Who are primary care providers?

For this report, primary care providers are defined as:

- Physicians specializing in primary care including:
  - Family medicine
  - General medicine
  - Obstetrics and gynecology
  - Pediatrics
  - General psychiatry, and
  - Geriatric medicine
- Naturopathic providers
- Physicians' assistants
- Nurse practitioners
- Primary care clinics
- Federally qualified health centers (FQHCs)
- Rural health centers.

What are primary care services?

For this report, primary care services are:

- Office or home visits
- General medical exams
- Routine medical and child health exams
- Preventive medicine evaluation or counseling
- Health risk assessments
- Routine obstetric care, excluding delivery, and
- Other primary care procedures.

A complete list of procedure codes and specialty taxonomy codes are at the end of this report.

How are provider data and procedure codes used to determine primary care?

For example, claims paid for a patient wellness exam by a family physician in a clinic is considered primary care spending. However, if a physician performs a primary care service in an emergency department, it is not be considered primary care spending. This is because emergency department visits are excluded from the definition of primary care spending. Primary care is defined as a set of procedures and activities performed by certain types of providers. However, procedures administered in hospital and ambulatory surgical center settings are excluded.

Primary care spending: What's included?

Primary care data:
Consistent with the definition of primary care in SB 231, this report includes the following types of primary care spending:

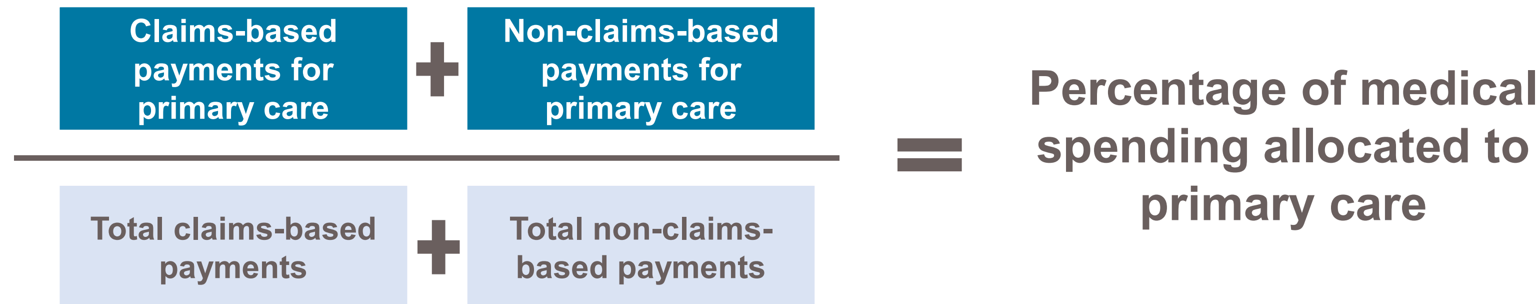
1. Claims-based payments: Payments to primary care providers or provider organizations for primary care services rendered to health plan members. These payments are based on paid medical claims reported by carriers and CCOs. Prescription drug payments are not included in the analysis. These data come from the All Payer All Claims Data Reporting Program and include the criteria outlined above.

2. Non-claims-based payments: Payments to primary care providers or provider organizations intended to:
   - Motivate efficient care delivery
   - Reward achievement of quality or cost-savings goals, and
   - Build primary care infrastructure and capacity.

   These data come from a data template that carriers and CCOs complete.

Primary care spending: What's included?

To calculate the percentage of total medical spending allocated to primary care, the sum of claims-based and non-claims-based payments to primary care providers is divided by the sum of total claims-based and non-claims-based payments to all providers (illustrated below). As the denominator, total payments include all payments for members including specialty care, mental health care, hospitalizations and more. However, total payments do not include prescription drugs.



Claims-based payments

Payments to primary care providers and practices:

Primary care providers

- Physicians specializing in primary care, including family medicine, general medicine, obstetrics and gynecology, pediatrics, general psychiatry, and geriatric medicine
- Naturopathic providers
- Physicians' assistants, and
- Nurse practitioners

Primary care practices

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

For primary care services:

- Office or home visits
- General medical exams
- Routine medical and child health exams
- Preventive medicine evaluation or counseling
- Health risk assessments
- Routine obstetric care, including delivery, and
- Other preventive medicine

Non-claims-based payments

Payments to primary care providers and practices:

- Capitation payments and provider salaries
- Risk-based payments
- Payments for patient-centered primary care home or patient-centered medical home recognition
- Payments to reward achievement of quality or cost-savings goals
- Payments aimed at developing capacity to improve care for a defined population of patients, such as patients with chronic conditions
- Payments to help providers adopt health information technology, such as electronic health records
- Payments or expenses for supplemental staff or activities, such as practice coaches, patient educators, patient navigators or nurse care managers

Data and limitations

Health care spending information in this report was obtained from two sources:

Claims-based payment information is from the All Payer All Claims Data Reporting Program (APAC).

APAC collects information about health care claims and encounters from:

- Health insurance carriers with more than 5,000 Oregon members
- All CCOs, and
- All OEBB and PEBB plans.

This information includes:

- Services rendered by health care providers
- Amounts paid to providers, and
- Provider attributes such as specialty and practice address.

APAC began collecting non-claims-based payments to providers in September 2017. OHA continues to analyze these data for use in future reports.

Non-claims-based payment information is from a reporting template completed by carriers and CCOs.

OHA and DCBS rely on a non-claims-based reporting template to collect this information. The template requires carriers and CCOs to report non-claims-based primary care spending and total spending in six categories. See page 32 for a list of the six categories. In addition, the template requires carriers and CCOs to report total months of enrollment for the calendar year, allowing for calculation of spending per member per month. Reporting requirements in the template were incorporated into Oregon Administrative Rules 836-053-1500 through 836-053-1510. Also, OAR 409-027-0010 through 409-027-0030.

The following limitations should be noted when interpreting this report:

This report excludes primary care spending by some health care payers.

The report excludes:

- Health insurance carriers with annual health premium income of less than $200 million in the calendar year
- Self-insured employers
- Medicaid fee-for-service
- Medicare fee-for-service, and
- Other federal health insurance programs.

In addition, the report excludes primary care spending by people who pay out-of-pocket. This includes people without insurance.

Multiple factors can affect primary care spending by carriers and CCOs.

The following can affect spending allocated to primary care:

- Health plan members' age
- Health status
- Distance from primary care providers
- Other demographic factors that can affect use of primary care and other services, and
- Carriers' spending decisions, provider networks and other policy decisions.

See page 30 for a complete list of carriers and CCOs included in this report.

See "Methodology" starting on page 31 for additional information about data collection and analysis.

What's new in this report?

This 2019 Primary Care Spending Report differs from the 2018 report. As a result of discussions with stakeholders, providers, carriers, CCOs and the public, the methodology has been updated to more accurately reflect primary care spending.

Change #1: Updating codes that expired

Occasionally procedure codes are replaced with different codes. The code for the administration and interpretation of health risk assessment (CPT® 99420) was replaced with 96160 and 96161.

Change #2: Costs associated with vaccines are no longer included

Costs associated with a vaccine are excluded from the definition of primary care. The costs to administer vaccines continues to be included in the definition of primary care.

Change #3: Including related codes

Previous reports included procedure codes. However, the reports did not include related codes in the definition of primary care. For example, smoking cessation counseling for up to 10 minutes was included. However, smoking cessation counseling for greater than 10 minutes was not included. Previous reports included annual depression screening. However, reports did not include alcohol misuse screening. The 2019 report includes all of these related codes to more accurately reflect primary care spending.

Change #4: Including additional primary care codes

New codes were added this year to better capture primary care activities. Examples include:

- Alcohol and substance abuse structured screenings
- Physician visits provided in rest homes (such as assisted living facilities), and
- Annual wellness visits that include personalized prevention plans.

Moving forward

Trending primary care spending over time is important to this analysis.
If there are no significant methodological changes to this report, future reports will show year-to-year trends in primary care spending.

See pages 40 through 42 for the specific codes included in the definition of primary care. Please email PC.ServicesReport@dhsoha.state.or.us with any other questions.

Health care payers in this report

A health care payer is an organization that pays doctors, hospitals and other health care providers for care and services received by a person with health care coverage. This report provides information about primary care spending by two types of health care payers:

1. Prominent carriers, and
2. Coordinated care organizations (CCOs).

The report presents information separately for three types of health insurance plans offered by prominent carriers:

1. Commercial plans
2. Medicare Advantage plans, and
3. PEBB and OEBB plans.

Prominent carriers

For the purpose of reporting on spending allocated to primary care, prominent carriers were defined by OAR 836-053-1505 as health insurance carriers with annual health premium income of $200 million or more. According to this definition, there were 11 prominent carriers in 2017. Prominent carriers offer the following types of health plans:

- Commercial health plans:
  Group plans for employers and individual plans for people without employer-sponsored health insurance.
- Medicare Advantage plans:
  Plans where the federal Medicare program pays part of the premium. The overwhelming majority of people covered by Medicare Advantage plans are age 65 and older.
- PEBB and OEBB plans:
  Health plans offered to public employees and educators. The Public Employees' Benefit Board and Oregon Educators Benefit Board contract with insurance companies to offer these plans.

Because commercial, Medicare Advantage, and PEBB and OEBB plans have very different benefit structures and member demographics, this report presents enrollment and spending separately for each type of plan.

Coordinated care organizations (CCOs)

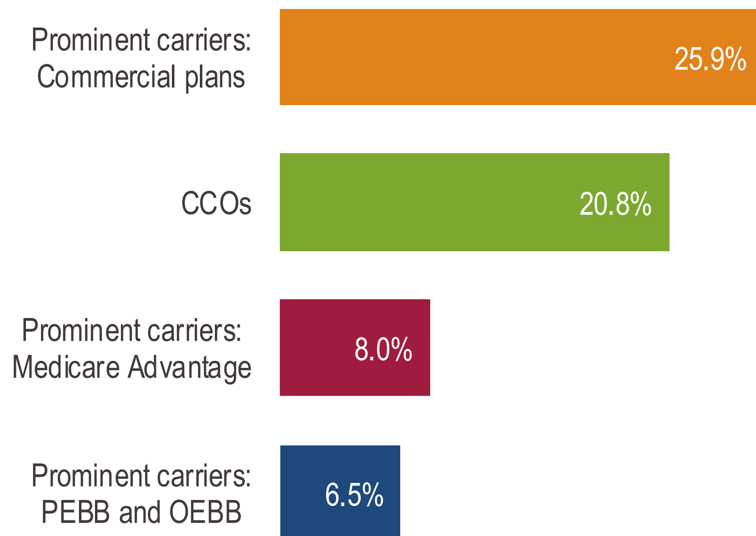
CCOs are local organizations that provide physical, mental and dental health care using global budgets that grow at a fixed rate. CCOs are accountable for the health outcomes of populations they serve. CCOs are part of Oregon's Medicaid program, which provides health coverage for Oregonians with incomes at or below 138 percent of the federal poverty level. There were 16 CCOs in 2017. However, Family Care's spending data are not included. Also, enrollment and spending for the two CCOs associated with Pacific Source Community Solutions are reported together.

See page 30 for the complete list of carriers and CCOs included in this report.

Health care payers in this report

Percentage of Oregon’s population covered by heath care payers included in this report:

In 2017, prominent carriers and CCOs provided coverage for nearly 2.5 million Oregonians, or more than 61 percent of Oregon’s population.*



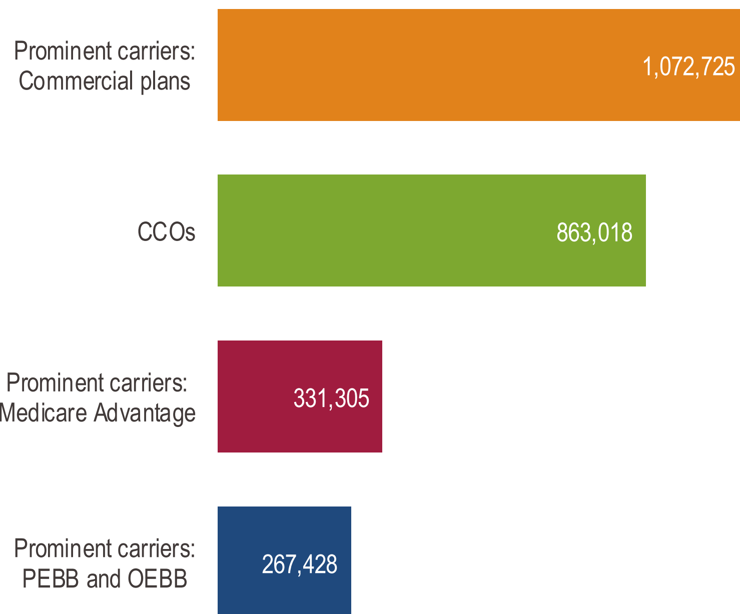
*Oregon’s estimated population was 4,141,100 as of July 1, 2017. Population Research Center, Portland State University.

Enrollment and total primary care spending

The graphs on this page show enrollment and total primary care spending by prominent carriers and CCOs in calendar year 2017. Enrollment is reported as the average number of unique people enrolled in a given month. On the graph on the right are total primary care spending and total spending broken out by payer category.

Monthly enrollment

In any given month of 2017, an average of 863,018 Oregonians were enrolled in CCOs. In the same year, 1.7 million Oregonians were enrolled in commercial, Medicare Advantage, and PEBB and OEBB plans offered by prominent carriers.



Total primary care spending in 2017

Commercial plans, CCOs, Medicare Advantage plans, and PEBB and OEBB plans spent $1.5 billion on primary care out of $11.0 billion of total spending.

Commercial
Primary care spending
$558 million
Total spending
$4.2 billion
Percent primary care
13.4 percent

CCOs
Primary care spending
$433 million
Total spending
$2.6 billion
Percent primary care
16.5 percent

Medicare Advantage
Primary care spending
$295 million
Total spending
$2.8 billion
Percent primary care
10.6 percent

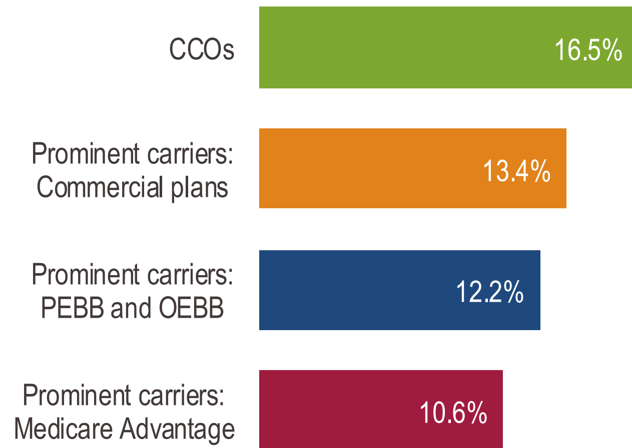
PEBB and OEBB
Primary care spending
$137 million
Total spending
$1.1 billion
Percent primary care
12.2 percent

Note: Enrollment data from all CCOs are included in the enrollment graphs. Spending data from Family Care CCO are not included in the spending graphs. As of January 2018, Family Care is no longer a CCO.

Primary care spending: Percentage of total medical spending and per member per month (PMPM)

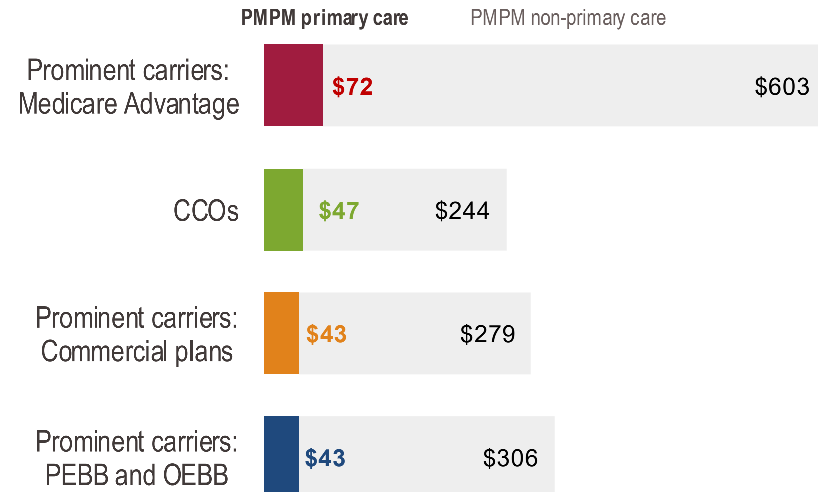
Percentage of total primary care medical spending

In 2017, CCOs allocated an average of 16.5 percent of total medical spending to primary care. Commercial, Medicare Advantage, and PEBB and OEBB plans allocated an average of 13.4 percent or less of total medical spending to primary care.



Per member per month (PMPM) primary care spending

In 2017, PMPM primary care spending ranged from $43 for PEBB and OEBB plans to $72 for Medicare Advantage plans on average. Non-primary care spending ranged from $244 PMPM for CCOs to $603 PMPM for Medicare Advantage plans on average.



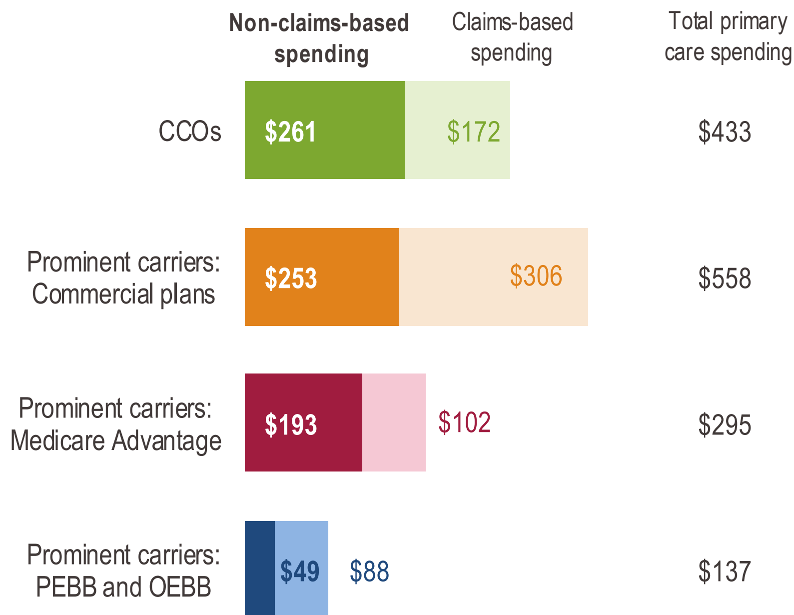
The graphs on this page show two measures of medical spending allocated to primary care by prominent carriers and CCOs:

- Percentage of total medical spending allocated to primary care. This measure allows for comparison of spending allocated to primary care as a share of total medical spending, regardless of total dollars spent.
- Per member per month (PMPM) primary care spending compared with PMPM non-primary care spending. This measure represents the average amount paid to health care providers in a month for each member with coverage. Total PMPM spending is defined as (primary care spending + non-primary care spending) ÷ total months of enrollment in the calendar year. It allows for comparison of dollars per person spent on primary care and other types of care. On the graph at right, the colored part of each bar shows PMPM primary care spending. The gray part of each bar shows PMPM non-primary-care spending. The graph is sorted by highest to lowest PMPM primary care spending.

Primary care spending: Claims-based and non-claims-based spending

Total claims-based and non-claims-based primary care spending ($ Million)

In 2017, CCOs spent $261 million on primary care through non-claims-based payments. Commercial, Medicare Advantage, and PEBB and OEBB plans spent $253, $193 and $49 million respectively on primary care through non-claims-based payments.

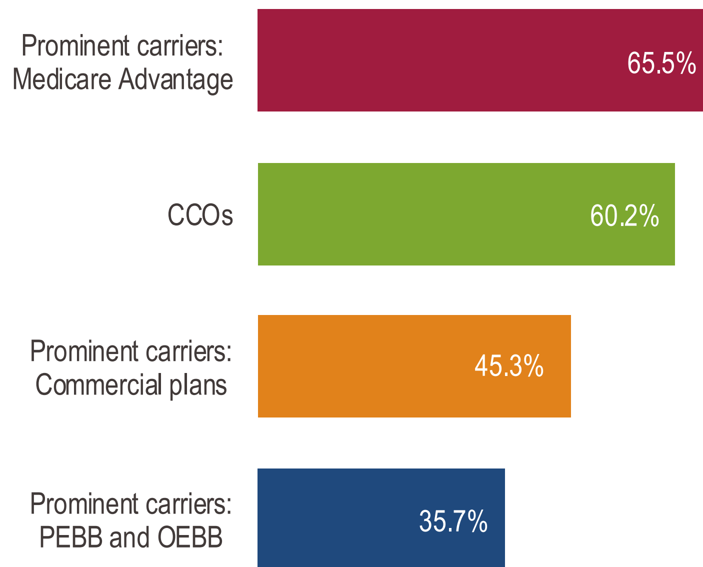


The graph on this page show claims-based primary care spending in dollars and percentages of total primary care spending. In this graph the dark part of each bar shows non-claims-based primary care spending. The light part of each bar shows total claims-based primary care spending.

Primary care spending: Non-claims-based spending

Non-claims-based spending as a percentage of total primary care spending

In 2017, more than 65 percent of primary care spending by Medicare Advantage was non-claims-based. The averages presented below for commercial, Medicare Advantage and PEBB and OEBB plans are heavily influenced by one or two carriers that allocate nearly all primary care spending as non-claims-based. See pages 19 to 26 for more detail.



The graphs on this page show non-claims-based primary care spending in dollars and percentages of total primary care spending. Non-claims-based payments are payments to health care providers intended to:

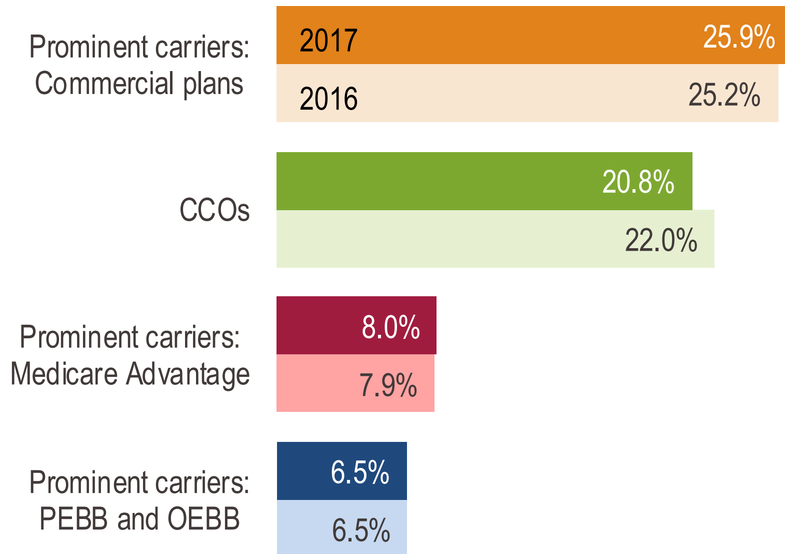
- Motivate efficient care delivery
- Reward achievement of quality or cost-savings goals, and
- Build primary care infrastructure and capacity.

This graph shows non-claims-based primary care spending as a proportion of total primary care spending.

Compared to last year: Enrollment

Percentage of Oregon's population covered by heath care payers:

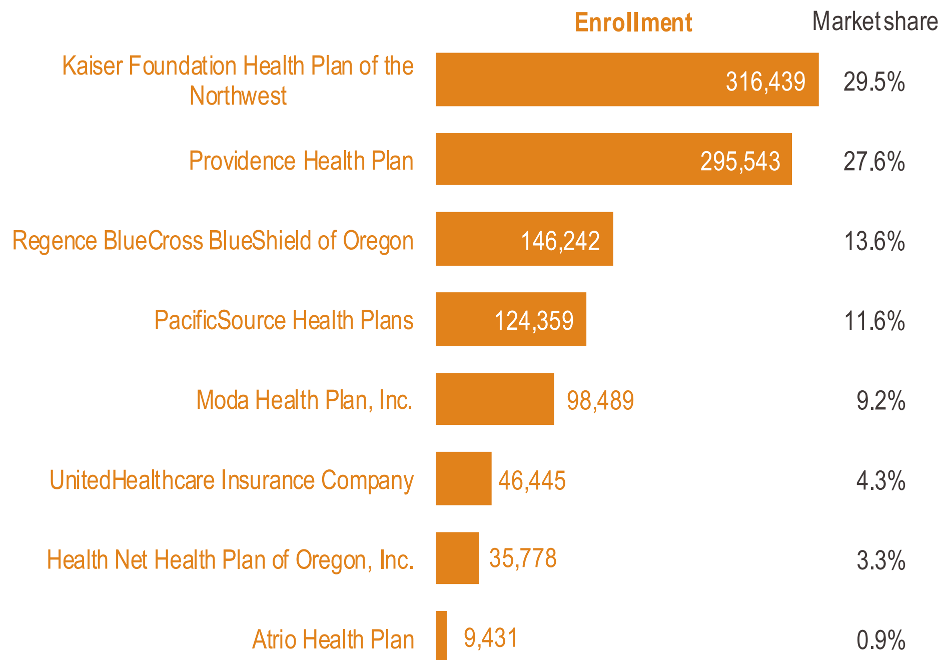
In 2017, the percentage of Oregon's population covered by Commercial carriers increased slightly. The percentage covered by CCOs decreased slightly.



Commercial plans: Enrollment

Number of people enrolled

In 2017, an average of 1,072,725 people per month were enrolled in commercial plans offered by prominent carriers. More than two-thirds were enrolled in commercial plans offered by the three largest prominent carriers.



This graph shows the number of people enrolled in commercial plans offered by prominent carriers. Enrollment is reported as the number of total member months in the year divided by 12.

Note: See page 30 for a complete list of carriers included in this report. See page 31 for the methodology.

Commercial plans: Primary care spending

Per member per month (PMPM) primary care spending

In 2017, the average PMPM primary care spending for commercial plans was $43. Carriers' spending ranged from $25 PMPM to $68 PMPM. For most carriers, the proportion of total primary care that is non-claims-based is less than 6 percent.

	PMPM primary care	PMPM non-primary care	Primary care as %	Of primary care, % non-claims-based
Kaiser Foundation Health Plan of the Northwest	$68	$336	16.9%	93.4%
Moda Health Plan, Inc.	$40	$307	11.5%	5.6%
Providence Health Plan	$34	$247	12.0%	3.0%
PacificSource Health Plans	$33	$258	11.5%	5.9%
UnitedHealthcare Insurance Company	$30	$221	12.0%	0.0%
Regence BlueCross BlueShield of Oregon	$30	$252	10.5%	1.4%
Atrio Health Plan	$27	$379	6.7%	0.0%
Health Net Health Plan of Oregon, Inc.	$25	$240	9.3%	4.5%
All carriers	$43	$279	13.4%	45.3%

This graph shows the following for each prominent commercial carrier:

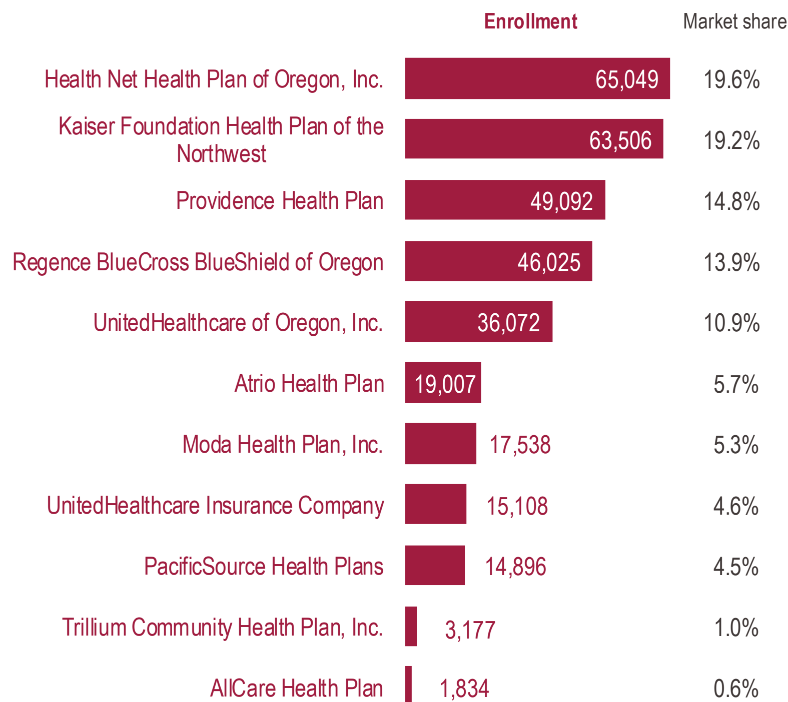
- Per member per month primary care spending
- Per member per month non-primary care spending
- Primary care spending as a percent of total medical spending, and
- The percent of primary care spending that was non-claims-based.

Note: See page 30 for a complete list of carriers included in this report. See page 31 for the methodology.

Medicare Advantage plans: Enrollment

Number of people enrolled

In 2017, an average of 331,305 people per month were enrolled in Medicare Advantage plans offered by prominent carriers. The three largest prominent carriers, those at the top of the graph, enrolled more than half of all Medicare Advantage enrollees reflected in this report.



This graph shows the number of people enrolled in Medicare Advantage plans offered by prominent carriers. Enrollment is reported as the number of total member months in the year divided by 12.

Note: See page 30 for a complete list of carriers included in this report. See page 31 for the methodology.

Medicare Advantage plans: Primary care spending

Per member per month (PMPM) primary care spending

In 2017, the average PMPM primary care spending for Medicare Advantage plans was $72. The plans' spending ranged from $30 to $183. Many carriers allocated more than a quarter of total primary care spending to non-claims-based spending, while some had less than 5 percent.

	PMPM primary care	PMPM non-primary care	Primary care as %	Of primary care, % non-claims-based
Kaiser Foundation Health Plan of the Northwest	$183	$860	17.6%	93.6%
UnitedHealthcare of Oregon, Inc.	$98	$322	23.3%	98.4%
Providence Health Plan	$64	$654	9.1%	39.3%
PacificSource Health Plans	$46	$634	6.8%	26.7%
AllCare Health Plan	$43	$670	6.1%	15.4%
Trillium Community Health Plan, Inc.	$37	$848	4.1%	0.0%
Regence BlueCross BlueShield of Oregon	$36	$573	5.9%	0.9%
UnitedHealthcare Insurance Company	$33	$572	5.3%	3.2%
Health Net Health Plan of Oregon, Inc.	$32	$566	5.3%	11.5%
Moda Health Plan, Inc.	$31	$607	4.8%	4.7%
Atrio Health Plan	$30	$652	4.4%	0.0%
All carriers	$72	$603	10.6%	65.5%

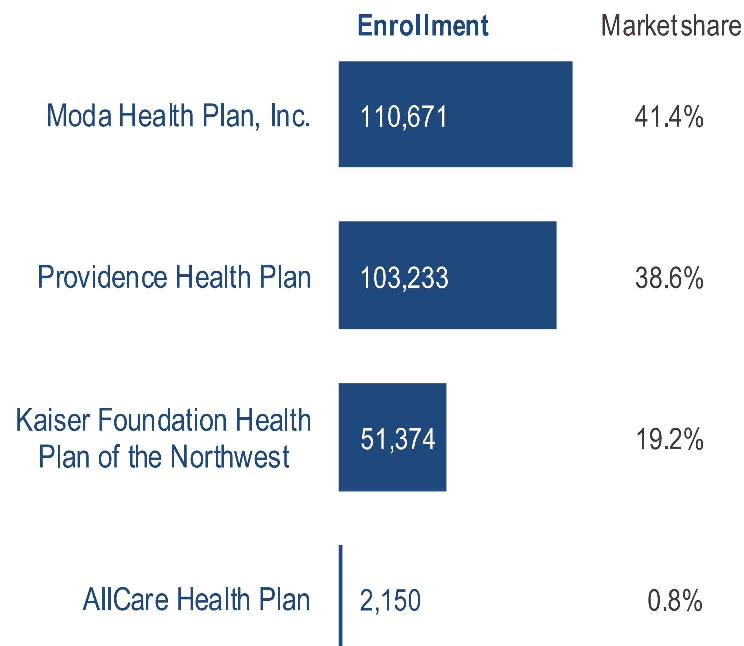
This graph shows the following for each prominent Medicare Advantage carrier:

- Per member per month primary care spending
- Per member per month non-primary care spending
- Primary care spending as a percent of total medical spending, and
- The percent of primary care spending that was non-claims-based.

Note: See page 30 for a complete list of carriers included in this report. See page 31 for the methodology.

PEBB and OEBB plans: Enrollment

Number of people enrolled
In 2017, an average of 267,428 people per month were enrolled in PEBB and OEBB plans offered by prominent carriers. Nearly 80 percent of PEBB and OEBB enrollees are enrolled in Moda Health Plan, Inc. and Providence Health Plan.

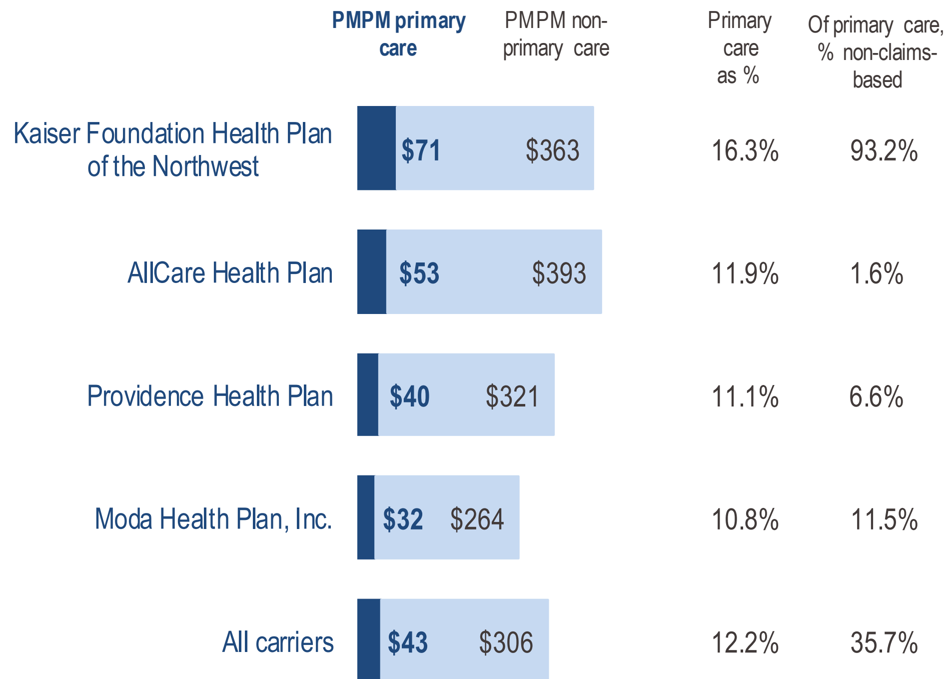


This graph shows the number of people enrolled in PEBB and OEBB plans offered by prominent carriers. Enrollment is reported as number of total member months in the year divided by 12.

Note: See page 30 for a complete list of carriers included in this report. See page 31 for the methodology.

PEBB and OEBB plans: Primary care spending

Per member per month (PMPM) primary care spending
In 2017, the average PMPM primary care spending for PEBB and OEBB plans was $43. The plans' spending ranged from $32 to $71. Three carriers allocated less then 12 percent of primary care spending to non-claims-based spending.



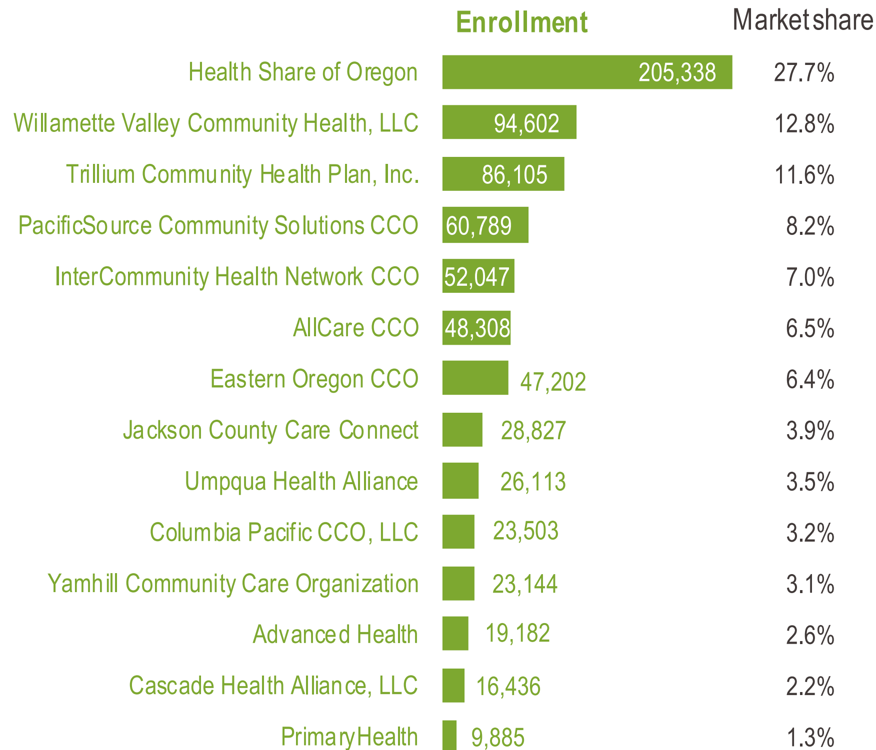
This graph shows the following for each prominent PEBB and OEBB carrier:
- Per member per month primary care spending
- Per member per month non-primary care spending
- Primary care spending as a percent of total medical spending, and
- The percent of primary care spending that was non-claims-based.

Note: See page 30 for a complete list of carriers included in this report. See page 31 for the methodology.

Coordinated care organizations: Enrollment

Number of people enrolled

In 2017, an average of 741,481 people per month were enrolled in CCOs. The three largest CCOs cover nearly half of all enrollees.



Note: There were 16 CCOs in 2017. However, Family Care's data are not included in the graph above. Enrollment for the two CCOs associated with Pacific Source Community Solutions are reported together.

Note: See page 30 for a complete list of carriers included in this report. See page 31 for the methodology.

Coordinated care organizations: Primary care spending

Per member per month (PMPM) primary care spending

In 2017, the average PMPM primary care spending for CCOs was $47. CCO spending ranged from $31 to $68. All CCOs allocated at least 35 percent of primary care spending to non-claims-based payments.

	PMPM primary care	PMPM non-primary care	Primary care as %	Of primary care, % non-claims-based
InterCommunity Health Network CCO	$68	$289	19.4%	70.5%
Willamette Valley Community Health, LLC	$67	$212	23.8%	71.6%
Eastern Oregon CCO	$66	$278	18.9%	76.2%
Advanced Health	$59	$276	17.9%	97.2%
Umpqua Health Alliance	$54	$247	17.8%	62.3%
PrimaryHealth	$53	$213	20.2%	83.3%
PacificSource Community Solutions CCO	$48	$241	16.6%	78.0%
Cascade Health Alliance, LLC	$47	$239	16.2%	86.1%
Trillium Community Health Plan, Inc.	$45	$252	15.2%	51.5%
Jackson County Care Connect	$44	$250	15.0%	40.9%
Yamhill Community Care Organization	$40	$259	13.4%	35.4%
Health Share of Oregon	$38	$249	13.3%	36.3%
AllCare CCO	$36	$176	17.0%	55.0%
Columbia Pacific CCO, LLC	$31	$308	9.2%	45.4%
All carriers	$47	$244	16.5%	60.2%

Note: 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 the OHA to determine primary care spending may exclude some primary care spending due to how hospital-affiliated primary care providers bill for services. There were 16 CCOs in 2017. However, Family Care's data are not included in the graphs above. Spending for the two CCOs associated with Pacific Source Community Solutions are reported together.

Note: See page 30 for a complete list of carriers included in this report. See page 31 for the methodology.

Non-claims-based spending: What's included?

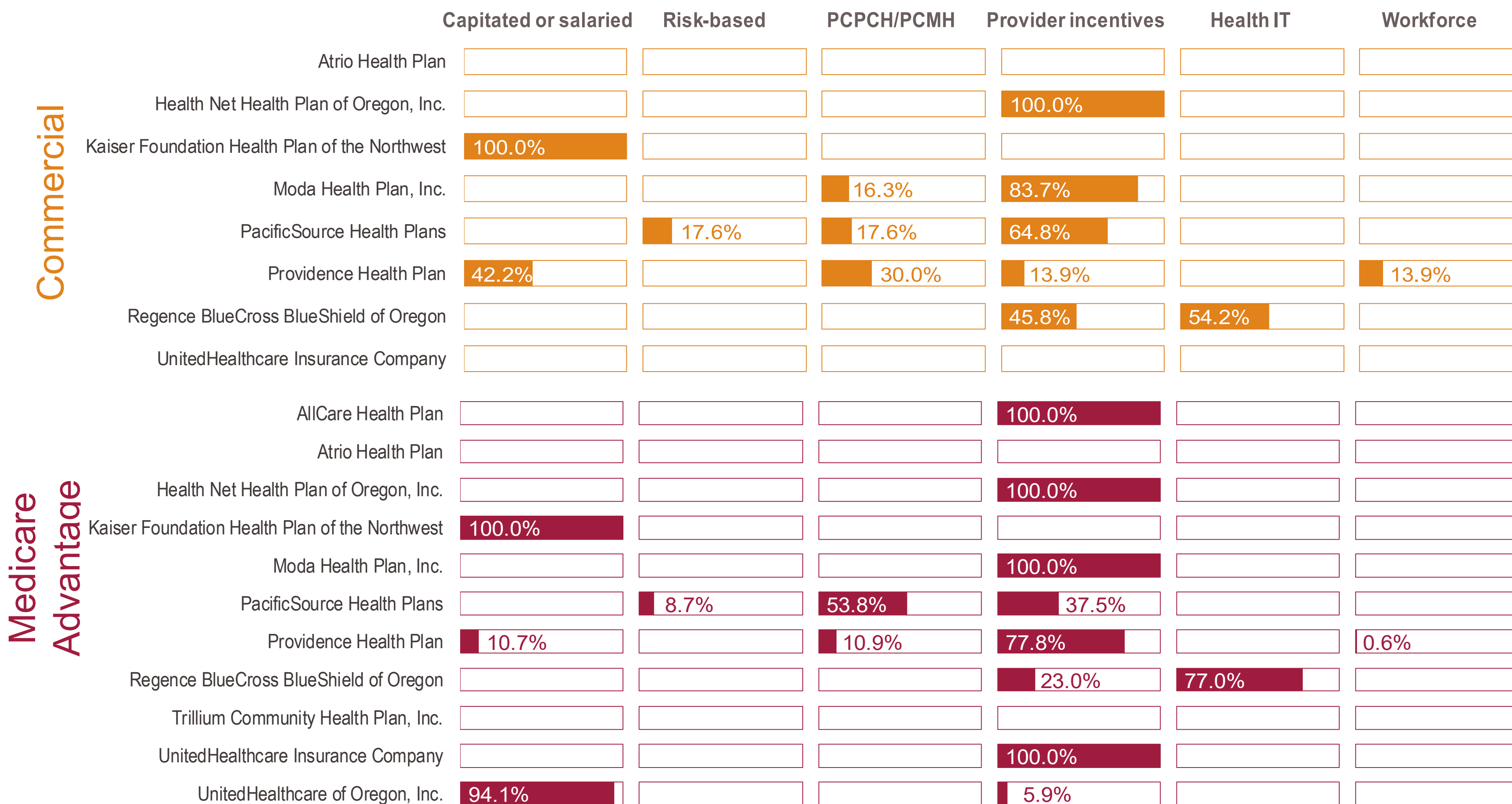
To report on primary care spending in Oregon, OHA and DCBS collected information about non-claims-based spending from prominent carriers and CCOs. OHA and DCBS adopted administrative rules defining non-claims-based spending. The rules define seven types of non-claims-based payments to primary care providers that carriers and CCOs were required to report. This section organizes the seven types of non-claims-based payments into three overall categories, shown in the table below. (Payments for recognition as a patient-centered medical home are broken out into payments for recognition by OHA's Patient-Centered Primary Care Home Program and recognition by other patient-centered medical home programs).

The adopted administrative rules 836-053-1500 to 836-053-1510 and 409-027-0010 through 409-027-0030 can be viewed here: http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_836/836_053.html and http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_409/409_027.html .

Non-claims-based payments	
Payments to motivate efficiency or quality	**Capitation or provider salary payments** • Capitation payment: Single payment to a health care provider to provide health care services needed by a health plan member over a defined period of time. Capitation payments can motivate providers to manage care efficiently and avoid costly complications or expensive services. • Salary payment: Payment for salaries of providers who provide the member's care. Like capitation payments, salary payments can motivate providers to manage care efficiently and avoid costly complications or expensive services.
	Risk-based payments: Payments received by providers that may be reduced if costs exceed a defined target. Risk-based payments can encourage providers to work on controlling costs.
	Retrospective incentive payments: Payments to reward providers for achieving quality or cost-savings goals. Retrospective incentive payments can encourage providers to work to improve quality and control costs.
Payments for patient-centered medical home recognition	**Patient-centered primary care home (PCPCH) recognition payments:** Payments to clinics recognized by OHA's PCPCH Program as providing good primary care.
	Other patient-centered medical home (PCMH) recognition payments: Payment to clinics recognized by other medical home programs as providing good primary care.
Payments to improve provider infrastructure and capacity	**Prospective incentive payments:** Payments aimed at developing provider capacity to improve care for a defined population of patients, such as patients with chronic conditions.
	Health information technology payments: Payments to help providers adopt health information technology, such as electronic medical records. Health information technology can help providers coordinate care, improve quality and control costs.
	Supplemental workforce payments: Payments for supplemental staff or activities. Examples are: Practice coaches, patient educators, patient navigators or nurse care managers. Supplemental staff can help doctors and other health care providers organize clinics to function better and help patients take charge of their health.

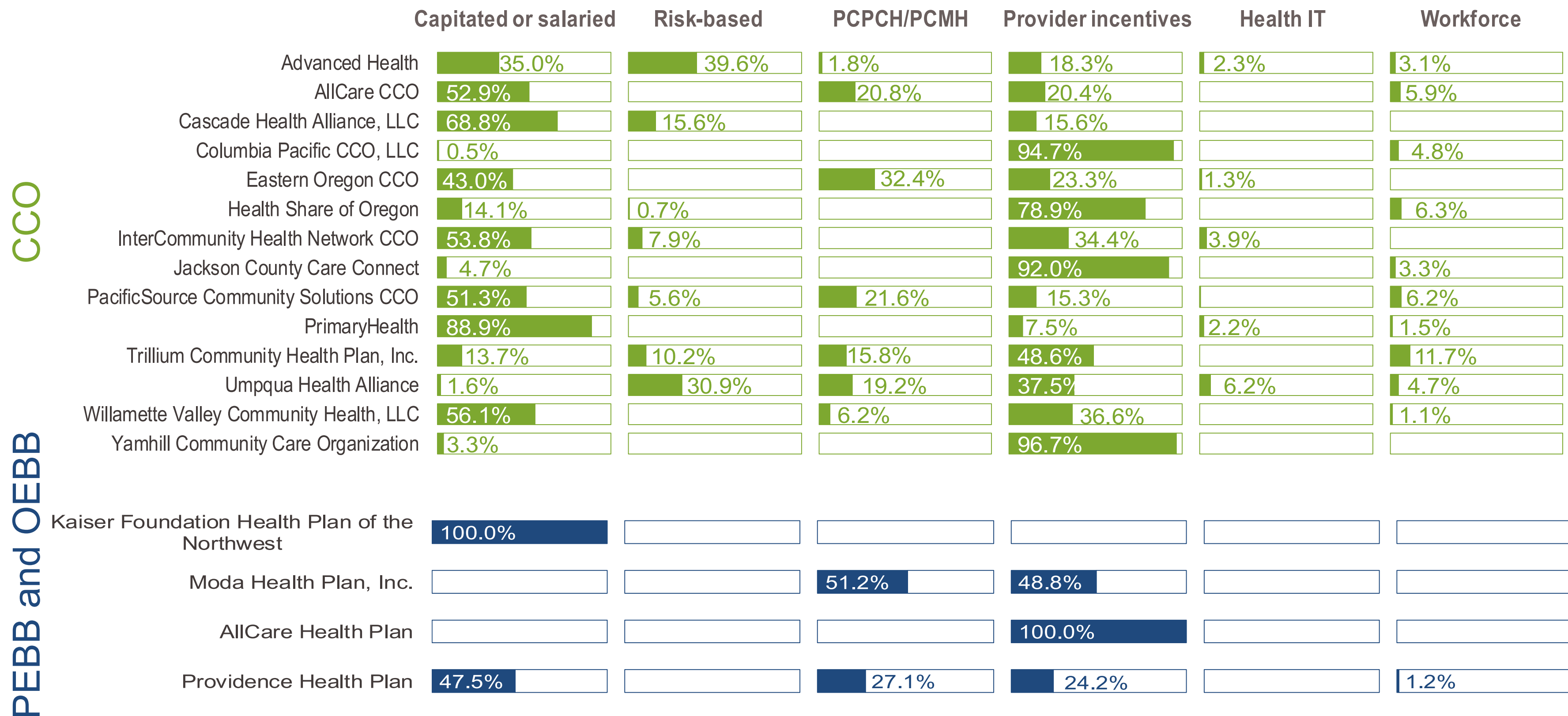
Commercial and Medicare Advantage plans: Non-claims-based spending

Primary care spending can be either claims-based or non-claims-based. The graphs below show only the non-claims-based primary care spending by each commercial and Medicare Advantage carrier. As shown below, some carriers focus on one or two categories of non-claims-based spending such as capitated payments or PCPCH. Other carriers spend in multiple categories. A minority of commercial and Medicare Advantage carriers have no non-claims-based primary care spending. Negative payments, or recoupments, are reflected as positive values. Because of this and rounding, all rows below may not sum to 100.0 percent.



CCO and PEBB and OEBB: Non-claims-based spending

Primary care spending can be either claims-based or non-claims-based. The graphs below show only the non-claims-based primary care spending by each CCO and PEBB and OEBB carrier. As shown below, some carriers focus on one or two categories of non-claims-based spending such as capitated payments or PCPCH. Other carriers spend in multiple categories. Every CCO and PEBB and OEBB carrier has non-claims-based primary care spending. Negative payments, or recoupments, are reflected as positive values. Because of this and rounding, all rows below may not sum to 100.0 percent.



Prominent carriers and CCOs in this report

Prominent carriers

AllCare Health Plan

Atrio Health Plan

Health Net Health Plan of Oregon, Inc.

Kaiser Foundation Health Plan of the Northwest

Moda Health Plan, Inc.

PacificSource Health Plan

Providence Health Plan

Regence BlueCross BlueShield of Oregon

Trillium Community Health Plan, Inc.

UnitedHealthcare Insurance Company

UnitedHealthcare of Oregon, Inc.

CCOs

Advanced Health, LLC

AllCare CCO

Cascade Health Alliance

Columbia Pacific CCO

Eastern Oregon CCO

Health Share or Oregon

InterCommunity Health Network CCO

Jackson Care Connect

PacificSource Community Solutions CCOs

PrimaryHealth

Trillium Community Health Plan, Inc.

Umpqua Health Alliance

Willamette Valley Community Health, LLC

Yamhill Community Care

Methodology

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 Data Reporting Program (APAC). 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
- 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).

Methodology (continued)

Information about non-claims-based payments is 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 2017. Carriers and CCOs receive 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 2017. 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. It is not common for commercial carriers to provide these types of services. These differences may affect the results presented in this report.

Claims-based data for Kaiser Foundation Health Plan of the Northwest are self-reported expenditures. These data are not from the APAC.

Methodology (continued)

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.

As of 2017, these entities provided coverage for 2.5 million Oregonians. This represents 61 percent of Oregon's population. The report excludes spending by the following health care payers:

- Health insurance carriers with annual health premium income of less than $200 million in 2017
- 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 2017. Prescription drug claims were excluded.
- Services rendered by health care providers or provider organizations with a practice addresses 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.

Methodology (continued)

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 at the end 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® codes is at the end 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.

Methodology (continued)

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 2017 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 that the number of people enrolled with all carriers in this report may sum to more than the total number of actual people enrolled.

Methodology (continued)

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 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.

Glossary (continued)

Medicaid: Health coverage for low-income Oregonians. Medicaid coverage includes:

- Coordinated care organizations (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 2017 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 a 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 32 for a list of the categories.

Glossary (continued)

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 its 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. There were 11 prominent carriers in 2017.

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. These employers do this, rather than buy a group health insurance plan offered by a private insurance company. Primary care spending by self-insured employers is not included in this report.

Codes used to define primary care

CPT® Codes and Description

Code	Description
59400	Routine obstetric care including vaginal delivery (global code) *60 percent of payment
59510	Routine obstetric care including cesarean delivery (global code) *60 percent of payment
59610	Routine obstetric care including vaginal birth after C-section (VBAC) delivery (global code) *60 percent of payment
59618	Routine obstetric care including attempted VBAC delivery (global code) *60 percent of payment
90460-90461	Immunization through age 18, including provider consult
90471-90472	Immunization by injection
90473-90474	Immunization by oral or intranasal route
96160-96161	Administration of health risk assessment
96372	Therapeutic, prophylactic, or diagnostic injection
98966-98968	Non-physician telephone services
98969	Online assessment, management services by non-physician
99201-99205	Office or outpatient visit for a new patient
99211-99215	Office or outpatient visit for an established patient
99241-99245	Office or other outpatient consultations
99339-99340	Physician supervision of patient in home or rest home
99341-99345	Home visit for a new patient
99347-99350	Home visit for an established patient
99381-99387	Preventive medicine initial evaluation
99391-99397	Preventive medicine periodic reevaluation
99401-99404	Preventive medicine counseling or risk reduction intervention
99406-99407	Smoking and tobacco use cessation counseling visit
99408-99409	Alcohol or substance abuse screening and brief intervention
99411-99412	Group preventive medicine counseling or risk reduction intervention
99429	Unlisted preventive medicine service
99441-9944	Telephone calls for patient management
99444	Non-face-to-face on-line Medical Evaluation
99495-99496	Transitional Care Management Services

Code	Description
G0008-G0010	Administration of influenza virus, pneumococcal, hepatitis B vaccine
G0396-G0397	Alcohol or substance abuse assessment
G0438-G0439	Annual wellness visit, personalized prevention plan of service
G0442	Annual alcohol screening
G0443	Brief behavioral counseling for alcohol misuse
G0444	Annual depression screening
G0502	Initial psychiatric collaborative care management
G0503	Subsequent psychiatric collaborative care management
G0504	Initial or subsequent psychiatric collaborative care management
G0505	Cognition and functional assessment
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services
G0507	Care management services for behavioral health conditions
G0513-G0514	Prolonged preventive service

Codes used to define primary care (continued)

Specialty taxonomy code and description

Code	Description
261QF0400X	Federally Qualified Health Center
261QP2300X	Primary care clinic
261QR1300X	Rural Health Clinic
207Q00000X	Physician, family medicine
207R00000X	Physician, general internal medicine
175F00000X	Naturopathic medicine
208000000X	Physician, pediatrics
2084P0800X	Physician, general psychiatry
2084P0804X	Physician, child and adolescent psychiatry
207V00000X	Physician, obstetrics and gynecology
207VG0400X	Physician, gynecology
208D00000X	Physician, general practice
363L00000X	Nurse practitioner
363LA2200X	Nurse practitioner, adult health
363LF0000X	Nurse practitioner, family
363LP0200X	Nurse practitioner, pediatrics
363LP0808X	Nurse practitioner, psychiatric
363LP2300X	Nurse practitioner, primary care
363LW0102X	Nurse practitioner, women's health
363LX0001X	Nurse practitioner, obstetrics and gynecology
363A00000X	Physician's assistant
363AM0700X	Physician's assistant, medical
207RG0300X	Physician, geriatric medicine
175L00000X	Homeopathic medicine
2083P0500X	Physician, preventive medicine
364S00000X	Certified clinical nurse specialist
163W00000X	Nurse, non-practitioner

Codes used to define primary care (continued)

ICD-10 Codes and Description

Code	Description
Z00	Encounter for general exam without complaint
Z000	Encounter for general adult medical examination
Z0000	Encounter for general adult medical exam without abnormal findings
Z0001	Encounter for general adult medical exam with abnormal findings
Z001	Encounter for newborn, infant and child health examinations
Z0011	Newborn health examination
Z00110	Health examination for newborn under 8 days old
Z00111	Health examination for newborn 8 to 28 days old
Z0012	Encounter for routine child health examination
Z00121	Encounter for routine child health exam with abnormal findings
Z00129	Encounter for routine child health exam without abnormal findings
Z008	Encounter for other general examination
Z014	Encounter for gynecological examination
Z0141	Encounter for routine gynecological examination
Z01411	Encounter for gynecological exam, general, routine with abnormal findings
Z01419	Encounter for gynecological exam, general, routine, without abnormal findings

Endnotes

1. Rhode Island Department of Health. Impact of primary care on healthcare cost and population health: A literature review. 2012 Feb. 23 [cited 2017 Jan 23]; Available from: http://health.ri.gov/publications/literaturereviews/ImpactOfPrimaryCareOnHealthcareCostAndPopulationHealth.pdf

2. Center for Evidence-Based Policy, Oregon Health & Science University. Alternative payment methodologies in Oregon: The state of reform. 2014 [cited 2017 Jan 23]; Available from: https://www.ohsu.edu/xd/research/centers-institutes/evidence-based-policy-center/upload/APM-Report-123014.pdf.

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