Nevada Health Care Cost Growth Benchmark Program

Data Specifications Manual

Version 1.1

Version History

Version Number	Date Released	Description of Change(s)
1.0	May 13, 2022	
1.1	May 17, 2022	• Clarified that Insurers should submit TME data by Large Provider Entity and for the Insurer overall by Insurance Category Code. • Updated list of Large Provider Entities.

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I. Introduction

On December 27th, 2021, Governor Sisolak signed Executive Order Number 2021-29, directing the establishment of a statewide health care cost growth benchmark. A health care cost growth benchmark is a targeted annual per capita rate of spending growth that Insurers, Large Provider Entities, and the State should endeavor to stay below to make health care more affordable. Benchmarks were established for calendar years (CY) 2022-2026. Governor Sisolak signed this Executive Order during the COVID-19 pandemic, recognizing that the work to keep health care affordable for Nevada citizens continues.

This manual outlines the technical specifications to assist Insurers in preparing the annual Health Care Cost Growth Benchmark data submission. This manual accompanies the cost growth benchmark data submission template.

This document is organized as follows:

- **Section I:** An overview of the cost growth benchmark and how it will be reported.
- **Section II:** A brief description of how performance against the benchmark will be calculated.
- **Section III:** A list of Insurers that will be requested to report, and the data they will be required to submit.
- **Section IV:** The timeline and process for submitting data.
- **Section V:** A description of the data submission template, and specifications for how to calculate data elements.
- **Section VI:** Appendices including definitions of key terms and a data dictionary for each tab in the data submission template.

For more information contact Malinda Southard, Executive Director, Nevada Patient Protection Commission (PPC) at m.southard@dhhs.nv.gov.

Additional information about Nevada's Health Care Cost Growth Benchmark program is available online at: https://ppc.nv.gov/.

II. Cost Growth Benchmark

In 2019, Governor Sisolak signed Senate Bill 544, creating the Patient Protection Commission (PPC). The PPC includes health care experts, advocates, providers, and industry professionals and has been charged with systematically reviewing issues related to Nevada residents' health care needs, and the quality, accessibility, and affordability with which health care is delivered. Most notably, the review must include examining the cost of health care and the primary factors impacting those costs.

In March 2021, Governor Sisolak requested the PPC's assistance with Nevada's participation in the Peterson-Milbank Program for Sustainable Health Care Costs to develop a statewide health care cost growth benchmark, calculate and analyze statewide health care cost growth, and analyze drivers of health care cost growth. Assembly Bill 348 modified the PPC's charge in June 2021, designating the PPC as the sole state agency responsible for administering and coordinating matters relating to Nevada's participation in the Peterson-Milbank Program.

On December 27th, 2021, Governor Sisolak signed Executive Order Number 2021-29, directing the establishment of a statewide health care cost growth benchmark for calendar years (CY) 2022-2026. Governor Sisolak signed this Executive Order during the COVID-19 pandemic, recognizing that the work to keep health care affordable for Nevada citizens continues.

A. Cost Growth Benchmark Definition

The Nevada Health Care Cost Growth Benchmark is a targeted annual per capita rate of spending growth for total health care spending in the state that Insurers, Large Provider Entities, and the State should endeavor to stay below to make health care more affordable. The cost growth benchmark is not a mandatory cap or index, but reflects a shared goal for stakeholders and the State to work toward constraining the growth of health care costs.

The cost growth benchmark program will assess health care cost growth for all Nevada residents with commercial (insured and self-insured), Medicaid and Medicare coverage, or who receive care through the Veterans Health Administration and the state correctional system. If feasible, the State will also include spending for Nevada residents who received care through the Indian Health Service. Health care cost growth at the State level is measured using Total Health Care Expenditures (THCE), which includes claims spending; non-claims-based spending; consumer cost sharing; and Insurer administrative costs.

B. Methodology for Calculating the Cost Growth Benchmark

To derive the cost growth benchmark values, the PPC recommended a methodology that blends the growth rate of forecasted median wage and gross state product, with increasing emphasis given to forecasted median wage over time.

Table 1 shows the varying weights of each economic indicator applied to calculate each year’s benchmark value, and the resulting values for the benchmark.

Table 1. Health Care Cost Growth Benchmark Values 2022-2026

Calendar Year	Weighting of Median Wage and Gross State Product	Cost Growth Benchmark Values
2022	20% / 80%	3.19%
2023	35% / 65%	2.98%
2024	50% / 50%	2.78%
2025	65% /35%	2.58%
2026	80% / 20%	2.37%

C. Calculating Performance against the Cost Growth Benchmark

Health care spending growth will be measured annually using THCE or total medical expenses (TME), in aggregate dollars and on a per member per year (PMPY) or per member per month (PMPM) basis. The aggregate dollar figure will be for informational purposes only. The percentage change in THCE/TME on a PMPY/PMPM basis between the Performance year and the prior calendar year will be used to assess performance against the benchmark applicable to the specific Performance Year. The year over year PMPY/PMPM rate of growth is calculated at the state, market, Insurer and Large Provider Entity levels as follows:

- **State:** PMPY using unadjusted, non-truncated THCE
- **Market (Medicare, Medicaid, commercial):** PMPY using unadjusted, non-truncated TME
- **Insurer, stratified by market:** PMPM using truncated TME
- **Large Provider Entity stratified by market:** PMPM using truncated TME[1]

All spending data at the state, market, and Insurer reported levels are net of pharmacy rebates. Spending data at the Large Provider Entity TME are reported gross of pharmacy rebates since Insurers provide rebate data in the aggregate, and the State cannot attribute rebates to Large Provider Entities.

Detailed formulas for calculating cost growth are outlined in the Nevada Health Care Cost Growth Benchmark Program State Implementation Manual.

D. Public Reporting of Cost Growth Benchmark Performance Results

Performance relative to the Health Care Cost Growth Benchmark will be reported annually at four levels:

1. State
2. Insurance market (i.e., commercial, Medicaid, and Medicare)
3. Insurer, stratified by market

[1] Benchmark performance reporting of performance at the provider level is limited to organizations with primary care providers that are large enough to enter into total cost of care contracts.

4. Large Provider Entity, stratified by market[2]

The Nevada cost growth benchmark program will analyze 2018-2021 health care spending data to establish a baseline, which will be reported at the state and market levels. For calendar year 2022 and future years when the benchmark is in effect, the State will report performance at all four levels.

Table 2 identifies the cost growth benchmark Performance Year, the source data year, the level of public reporting of performance and the timeframe for publicly reporting performance.

Table 2. Health Care Cost Growth Benchmark Performance Reporting Timeline

Performance Year	Benchmark	Data to be Collected	Level of Public Reporting	Public Reporting Date
Pre-Benchmark	No benchmark	2018-2021	State & Market	Q1 2023
Performance Year 1 (CY 2022)	3.19%	2021-2022	State, Market, Insurer & Provider	Q1 2024
Performance Year 2 (CY 2023)	2.98%	2022-2023	State, Market, Insurer & Provider	Q1 2025
Performance Year 3 (CY 2024)	2.78%	2023-2024	State, Market, Insurer & Provider	Q1 2026
Performance Year 4 (CY 2025)	2.58%	2024-2025	State, Market, Insurer & Provider	Q1 2027
Performance Year 5 (CY 2026)	2.37%	2025-2026	State, Market, Insurer & Provider	Q1 2028

[2] Benchmark performance reporting of performance at the provider level is limited to organizations with primary care providers that are large enough to enter into total cost of care contracts.

III. Reporting Requirements

This section contains information on the Cost Growth Benchmark Program's reporting requirements.

A. Insurers Required to Submit

Table 3 below lists which Insurers are required to report for their commercial, Medicare managed care, and Medicaid managed care markets.

Table 3. Insurers Required to Report TME Data by Market

Insurer	Commercial Fully and Self-Insured	Medicare Managed Care	Medicaid Managed Care
Aetna	X	X	
Anthem	X	X	X
Centene[3]	X		X
Cigna	X		
Humana	X	X	
Molina Healthcare[4]	X		X
Renown Health	X		
UnitedHealthcare[5]	X	X	X

B. Included Populations

The populations for whom TME should be reported include Nevada residents who have **comprehensive** health care coverage through Medicare, Medicaid, or a commercial insurance product, or who receive care through the Veterans Health Administration and the state correctional system. If feasible, the State will also include spending for Nevada residents who received care through the Indian Health Service.

1. Required Markets

Insurers must report TME for their Commercial, Medicare and Medicaid members. The commercial market includes the following lines of business:

- self-insured plans
- short-term health plans

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[3] SilverSummit Healthplan is the name of Centene's Nevada health plan subsidiary.

[4] Molina Healthcare's new four-year Medicaid contract commenced on January 1, 2022, so any data requests to insurers that predate Molina Healthcare's contract start date should exclude Molina Healthcare.

[5] Health Plan of Nevada is the name of UnitedHealthcare's Nevada health plan subsidiary.

- student health plans
- fully insured individual and group plans
- the Nevada Public Employees' Benefits Program (PEBP)
- the Federal Employee Health Benefits Program (FEHB)

The Medicare market includes the following types of plans:

- Medicare Advantage Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- HMO Point of Service (HMOPOS)
- Medicare Medical Savings Account (MSA)
- Private Fee-for-Service (PFFS)
- Special Needs Plans (SNPs)

The Medicaid market includes Medicaid and CHIP contracts with the Nevada Department of Health and Human Services, Division of Health Care Financing and Policy.

2. Excluded Types of Coverage

Insurers should **not** report TME for plans that offer limited benefits, including the following:

- accident policy
- disability policy
- hospital indemnity policy
- long-term care insurance
- Medicare supplemental insurance (AKA Medigap)
- stand-alone prescription drug plans
- specific disease policy
- stop-loss plans
- supplemental insurance that pays deductibles, copays, or coinsurance
- vision-only insurance
- workers compensation
- dental-only insurance

C. Reporting of TME

Insurers should report both Claims and Non-Claims Payments made **directly to providers** using the categories outlined below and detailed in the Data Submission Template section. To avoid double counting, all categories must be mutually exclusive. OOA may request additional information regarding how Insurers mapped their data into these categories to improve consistency in reporting across all Insurers. Payments should be reported:

- on an incurred basis, not paid basis; and
- for members for whom the Insurer is the primary Insurer on a claim (exclude any paid claims for which the Insurer is the secondary or tertiary payer; however, do not exclude spending for a member solely because they have additional coverage).

1. Claims-Based Payments

Claims-based spending should be categorized using the following broad, mutually exclusive categories. See the Total Medical Expenses in the Data Submission Template section below for further definition.

- Hospital inpatient
- Hospital outpatient
- Professional, primary care
- Professional, specialty
- Professional, other providers
- Long-term care
- Retail pharmacy
- Other claims-based spending not categorized above

2. Non-Claims Payments

Non-Claims Payments are all of the payments that Insurers make to providers outside of the claims system, categorized using the following mutually exclusive categories. See the Total Medical Expenses in the Data Submission Template section below for further definition.

- Prospective payments
- Performance incentive payments
- Population health and practice infrastructure payments
- Provider salaries
- Recovery
- Other non-claims-based spending

3. Exclusions

Insurers should exclude from TME the following spending:

- Discounts and other member perks, such as gym membership benefits
- Insurer reinsurance recoveries or reinsurance premiums
- CMS reconciliation payments, such as Medicare sweep or Part D
- Premiums

This is a non-exhaustive list and if there are other items that Insurers are not sure about whether to include or exclude in the cost growth benchmark data submission, Insurers should contact Malinda Southard, Executive Director, Nevada Patient Protection Commission (PPC) at m.southard@dhhs.nv.gov.

4. Reporting on Large Provider Entities and Attribution

Insurers must report TME data for the Large Provider Entities listed in Table 4. The Large Provider Entity Codes Table lists the codes that associated with each Large Provider Entity that Insurers must use in reporting TME. This list of Large Provider Entities may be updated from time to time as the health care market changes.

Table 4. Large Provider Entities for Which Insurers Must Report TME Data

Large Provider Entity	
Bacchus Wakefield Kahan PC	Procare Medical Group
Community Care Services	Robert B McBeath MD II PC
First Person Care Clinic	Southwest Medical Associates
Intermountain Healthcare	St. Mary's Medical Group
NEM Medical Center	UNLV Medicine
Nevada Health Centers	

To report TME by Large Provider Entity, Insurers must attribute individual patients to a primary care provider, and attribute those primary care providers to a Large Provider Entity. Insurers should use their own primary care attribution methodology to attribute patients to a primary care provider and submit that methodology with their data submission to the OOA. Primary care provider attribution to a Large Provider Entity should be performed consistent with Insurers' contracts with the Large Provider Entity for financial and quality performance assessment purposes that were in place during the reporting periods.

Payments associated with members who could not be attributed to a primary care provider, or whose primary care provider could not be attributed to a Large Provider Entity should be reported in aggregate to Large Provider Entity Code 999, Unattributed.

The data reported for each Large Provider Entity must include all TME for all attributed members for each month a member was attributed, so long as the member was a Nevada resident at the time of attribution, even when care was provided outside of or not affiliated with the respective Large Provider Entity. Insurers may choose whether residency is established as of the first of the month, last of the month, or another day of the month, consistent with their monthly attribution methodology.

D. Data Completeness

1. Claims Run-Out Period

Insurers should allow for a claims run-out period of at least 180 days after December 31 of the Performance Year. Insurers should apply reasonable and appropriate incurred but not reported (IBNR)/incurred but not paid (IBNP) completion factors to each respective TME service category and will be required to attest that they are reasonable and appropriate.

2. Non-Claims Reconciliation Period

Insurers shall allow for a non-claims "run-out" period of at least 180 days after December 31 of the Performance Year to reconcile Non-Claims Payments, including incentives, capitation and risk-settlements, or other non-claims-based payments. Non-Claims Payments should be reported on an incurred basis, not paid basis. For example, if a provider is eligible for a pay for performance bonus, the non-claims spending should be included in the year for which the bonus was earned (i.e., the Performance Year) rather than the year the bonus was paid. Insurers should apply reasonable and

appropriate estimations of non-claims liability to each Large Provider Entity (including payments expected to be made to organizations not separately identified for TME reporting purposes) that are expected to be reconciled after the 180-day review period.

E. Adjustments to Spending Data

1. Vendors and Carved-Out Services

Some Insurers carve-out services (e.g., pharmacy and behavioral health) and may not have access to the claims or encounter data for these services to accurately estimate or categorize claims-based payments. In such cases, Insurers should estimate spending for these carved-out services. The goal of making such adjustments is to estimate what total spending might be for those members without having to collect claims data from the vendors of the carved-out services, such as pharmacy benefit managers or behavioral health vendors.

Insurers should follow the general parameters below but are given flexibility in how they account for these costs because of the different approaches in how Insurers identify and allocate these costs.

- Payments for covered benefits should be included in the TME calculation, regardless of how the Insurer is delivering the benefit. If an Insurer is unable to determine the total spending by service category for carved-out benefits, and:
  - has encounter data, the Insurer should estimate payments and include them in the TME calculation allocated to the appropriate service category.
  - does not have access to claims or encounter data for carved-out services, the Insurer should apply a reasonable estimate of spending per member per service category and describe how they calculated the estimate in Tab 1 of their data submission.
- Spending for contracts and vendors that provide strictly administrative functions for health plan operations should not be included in the TME calculation.

Sample Methodology for Estimating Spending on Carved-Out Services

For an Insurer that has pharmacy services carved out, the Insurer could estimate pharmacy spending based on pharmacy spending on commercial members for which the Insurer has full claims information. The Insurer could calculate the per member per month spending on members who had pharmacy coverage and apply that amount to members for whom pharmacy services were carved out. Estimates should be developed on a per member per month basis.

2. Truncation

To minimize the impact of high-cost outliers on Insurer and provider cost growth, the State will not include member level spending above certain dollar amounts in the calculation of cost growth. As a component of TME submission, Insurers will be asked to submit truncated claims spending and the count of members with claims truncated.

The per member truncation points are listed in Table 5 below and in the Data Submission Template section of this manual. The Data Submission Template section of this manual also contains detailed instructions for how to truncate spending.

Table 5. Truncation Points

Insurance Category Code	Definition	Per Member Truncation Point
1	Medicare Expenses for Non-Dual Eligible Members	$150,000
2	Medicaid Expenses for Non-Dual Eligible Members	$100,000
3	Commercial: Full Claims	$175,000
4	Commercial: Partial Claims	$175,000
5	Medicare Expenses for Medicare/Medicaid Dual Eligible	$150,000
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible	$100,000

F. Statistical Testing

The State will conduct statistical significance testing to assess Insurers' and Large Provider Entities' performance against the cost growth benchmark. This will involve developing confidence intervals around each Insurer's and Large Provider Entity's cost growth and determining whether the confidence interval intersects with the benchmark.

To support the development of confidence intervals, OOA asks that Insurers provide standard deviation information on TME data after truncating spending for high-cost outliers. Insurers will need to provide standard deviation information for:

- Each market (Commercial, Medicaid, and Medicare) for the Insurer overall; and
- Each provider entity by market (Commercial, Medicaid, and Medicare).

Instructions for how to calculate standard deviation are included under Standard Deviation in the Data Submission Template section of this manual.

IV. Data Submission Process

This section details when and how Insurers should submit their Cost Growth Benchmark data. It also summarizes the data validation process Insurers should expect to go through with the State following data submission and before any data are publicly reported.

A. Data Submission Schedule

Insurers will submit TME data to OOA according to the schedule outlined in Table 6 below.

Table 6. Data Submission Schedule

Performance Year	Date	Files Due
Pre-Benchmark	August 30, 2022	CY 2018, CY 2019, CY 2020 and CY 2021 TME
Performance Year 1 (CY 2022)	August 30, 2023	CY 2021 and CY 2022 TME
Performance Year 2 (CY 2023)	August 30, 2024	CY 2022 and CY 2023 TME
Performance Year 3 (CY 2024)	August 30, 2025	CY 2023 and CY 2024 TME
Performance Year 4 (CY 2025)	August 30, 2026	CY 2024 and CY 2025 TME
Performance Year 5 (CY 2026)	August 30, 2027	CY 2025 and CY 2026 TME

B. File Specifications

Insurers will submit data using the Excel template provided by the Division of Insurance (DOI). The file extension must be .xls or .xlsx. Files should follow the following naming conventions:

Insurer Name_TME_YYYY_Version.xls

YYYY is the four-digit year of submission (which will generally be one year later than the year of the data reflected in the report).

Version is optional and indicates the submission number.

Below are examples of valid file names:

TME_2020_01.xlsx or TME_2020_1.xlsx or TME_2020.xlsx.

C. How to Submit Files

Electronic files are to be submitted to the DHHS Office of Analytics. To set up secure file sharing, please send a request via email to data@dhhs.nv.gov with the subject line: "COST GROWTH BASELINE DATA REQUEST – INSERT AGENCY NAME", and CC Kyra Morgan, State Biostatistician, at kmorgan@health.nv.gov.

D. Submission Attestation

The data submission template contains a field in the Cover Page where Insurers will attest that the information in the data submission is current, complete and accurate. Failure to attest will result in OOA's non-acceptance of the data submission.

E. Validation Process

Insurer Validation: After Insurers submit their data according to the filing schedule, the State will validate the data to ensure the data were submitted using the specifications outlined in this manual and appear reasonable compared to external sources. The State will engage with Insurers one-on-one to discuss any questions about the data that are identified during the initial validation. Insurers will be asked to resubmit data if the initial submission does not follow the specifications in this manual. After the initial analysis is complete, the State will share with Insurers their cost trends by market and give Insurers an opportunity to review their final data before it is published.

Large Provider Entity Validation: In addition to sharing Insurer-level trends, the State will be sharing trends at the provider level with each Large Provider Entity. Large Provider Entity performance will be published by market, but also shared with providers broken down by Insurer. Large Provider Entities will have an opportunity to review their performance by market and by Insurer in advance of public reporting. OOA will request that Large Provider Entities direct any questions about their data to Insurers.

V. Data Submission Template

This section describes in detail each of the tabs in the data submission template, and provides more detailed specifications for data to submitted in the template. The template is organized into 11 tabs as follows:

- Reference Tabs to orient Insurers to the data submission template and codes used to categorize certain data:
  - Contents
  - Reference Tables
- Data Tabs where Insurers must enter required data elements:
  - Cover Page
  - Total Medical Expenses
  - Standard Deviation
  - Line of Business Enrollment
  - Pharmacy Rebate Data
  - Mandatory Questions
- Validation Tabs that Insurers can use to check the accuracy and reasonability of their data submission:
  - Data Validation Checks
  - Validation by Market
  - Validation by Provider

Data dictionaries are included in **APPENDIX B.**

A. Contents Tab

This tab lists and provides a high-level summary of each tab in the data submission to template.

B. Reference Tables Tab

The data submission template uses various codes to categorize spending. The codes are listed in the References Tables tab of the data submission template, and includes the following:

- Insurance category codes
- Market codes
- Line of business codes
- Large Provider Entity codes
- Insurer Codes

C. Cover Page Tab

This tab collects the following information about the data submission:

- **Insurer Name**

- **Contact Name** (the name of the individual who should be contacted with data validation questions)
- **Contact Email** (email of the individual listed above)

The cover page also asks the Insurer to attest that the information submitted in the template is current, complete, and accurate to the best of their knowledge. OOA asks Insurers to submit the following information:

- **Authorized Signatory**
- **Date**

D. Total Medical Expenses Tab

This tab is for Insurers to report TME, which the State will use to compute performance against the benchmark. Each Insurer must report TME and other data using the insurer codes listed in Table 7 below.

Table 7. Insurer Codes

Insurer Code	Description
201	Aetna
202	Anthem
203	Centene
204	Cigna
205	Humana
206	Molina Healthcare
207	Renown Health
208	UnitedHealthcare

1. Reporting by Insurance Category Codes

Insurers will report TME by insurance category. Insurers shall report for all insurance categories for which they have business. There are six insurance categories for cost growth benchmark reporting as outlined in **Error! Reference source not found.**.

Table 8. Insurance Category Codes

Insurance Category Code	Description
1	Medicare Expenses for Non-Dual Eligible Members
2	Medicaid Expenses for Non-Dual Eligible Members
3	Commercial: Full Claims
4	Commercial: Partial Claims
5	Medicare Expenses for Medicare/Medicaid Dual Eligible
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible

All data reported by Insurance Category Code should be mutually exclusive. Commercial claims should be separated into two categories: Commercial self-insured or fully insured data for Large Provider Entities for which the Insurer can collect information on all direct medical claims and any claims paid by a delegated entity should be reported in the "Full Claims" category; Commercial self-insured or fully insured data that does not include all medical and subcarrier claims should be reported in the "Partial Claims," category. An adjustment should be made to "Partial Claims" to allow for them to be comparable to full claims. Such an adjustment must be reviewed with the State before the adjustment is made. The goal of the adjustment is to estimate what total spending might be for those members without having to collect claims data from carve-out vendors, such as pharmacy benefit managers (PBMs) or behavioral health vendors. For example, for those members for whom pharmacy benefits are carved out, the Insurer might include its commercial market book of business average pharmacy spending per-member per-month for the same year, calculated on members who had pharmacy coverage, and applied to all member months for which the carve out applied.

If an Insurer enrolls Medicare/Medicaid dual eligibles, OOA requires the Insurer to report Medicare-related expenditures under insurance category code 5 and Medicaid-related expenditures under Insurance Category Code 6. For example, if an Insurer covers Medicare/Medicaid dual eligibles, but is only responsible for Medicaid services, expenditures for those dual eligibles are reported under Insurance Category Code 6.

2. Reporting by Large Provider Entity and for the Insurer Overall

Insurers will report TME by Large Provider Entity and for the Insurer overall by Insurance Category using the codes listed in **Error! Reference source not found.** below. TME data for members who cannot be attributed to a primary care provider or whose primary care provider cannot be unattributed to a Large Provider Entity should be reported in aggregate as "999 - Unattributed."

Table 9. Large Provider Entity Codes

Large Provider Entity Code	Description
100	Insurer Overall
101	Bacchus Wakefield Kahan PC
102	Community Care Services
103	First Person Care Clinic
104	Intermountain Healthcare
105	NEM Medical Center
106	Nevada Health Centers
107	Procare Medical Group
108	Robert B McBeath MD II PC
109	Southwest Medical Associates
110	St. Mary's Medical Group
111	UNLV Medicine
999	Members Not Attributed to a Large Provider Entity

3. Reporting by Service Categories

Insurers are also to report TME data using the claims and non-claims categories listed below. To avoid double counting, all categories must be mutually exclusive. The State may request additional information regarding how Insurers mapped their data into these categories to improve consistency in reporting across all insurance carriers.

Claims Payment Categories

- **Claims: Hospital Inpatient:** The TME paid to hospitals for inpatient services generated from claims. Include all room and board and ancillary payments. Include all hospital types. Include payments for emergency room services when the member is admitted to the hospital, in accordance with the specific Insurer's payment rules. Do not include payments made for observation services. Do not include payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician. Do not include inpatient services at non-hospital facilities.

- **Claims: Hospital Outpatient**: The TME paid to hospitals for outpatient services generated from claims. Include all hospital types and includes payments made for hospital-licensed satellite clinics. Include emergency room services not resulting in admittance. Include observation services. Do not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

- **Claims: Professional, Primary Care Providers**: The TME paid to primary care providers delivering care at a primary care site of care generated from claims using the code-level definition in APPENDIX C**.**

  Primary care services include care management; care planning; consultation services; health risk assessments, screenings and counseling; home visits; hospice/home health services; immunization administrations; office visits and preventive medicine visits. They do not include prescription drugs (including those covered by both medical and pharmacy benefits), laboratory, x-ray and imaging services.

  Primary care providers include family practice, geriatric, internal medicine and pediatric providers. Insurers should identify primary care providers first by searching for relevant provider taxonomy codes in the rendering provider field and then the billing provider field. If the Insurer does not utilize the provider taxonomy codes in the file above, it may apply its provider codes to match the description of the provider taxonomy codes included.

  A primary care site of care is defined as a primary care outpatient setting (e.g., office, clinic or center), federally qualified health center, school-based health center, or via telehealth. It does not include stand-alone telehealth vendors, i.e., a third-party telehealth vendor. It does not include urgent care centers or retail pharmacy clinics. Insurers should use the place of service and modifier codes in APPENDIX C to identify primary care services delivered via telehealth.

- **Claims: Professional, Specialty Providers**: The TME paid to physicians or physician group practices generated from claims. Include services provided by a doctor of medicine or osteopathy in clinical areas other than the family practice, geriatric, internal medicine and pediatrics as described above.

- **Claims: Professional, Other Providers**: The TME paid from claims to health care providers for services provided by a licensed practitioner other than a physician or identified as a PCP. This includes, but is not limited to, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors and any professional fees that do not fit other categories. Include services delivered through third-party telehealth vendors contracted directly through the health plan to offer a subset of services.

- **Claims: Long-Term Care**: All TME data from claims to providers for: (1) nursing homes and skilled nursing facilities; (2) intermediate care facilities for individuals with intellectual disability (ICF/ID) and assisted living facilities; and (3) providers of home- and community-based services, including personal care (e.g., assistance with dressing, bathing, eating, etc.), homemaker and chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services (e.g., assistance with grocery shopping, etc.), and programs designed to assist individuals with long-term care needs who receive care in their home and community. Do not include payments made for professional services rendered during a facility stay that have been billed directly by a physician group practice or an individual practitioner.

- **Claims: Retail Pharmacy**: The TME paid from claims to health care providers for prescription drugs, biological products or vaccines as defined by the Insurer's prescription drug benefit. This

category should not include claims paid for pharmaceuticals under the Insurer's medical benefit. Pharmacy payments made under the medical benefit should be attributed to the setting in which it was delivered (e.g., pharmaceuticals delivered in a hospital inpatient setting should be attributed to Claims: Hospital Inpatient). Do not include the cost of vaccines administered in the primary care setting. Medicare managed care, i.e., Medicare Advantage, Insurers that offer stand-alone prescription drug plans (PDPs) should exclude stand-alone PDP data from their TME. Pharmacy data should be reported gross of applicable rebates.

- **Claims: Other**: All TME paid from claims to health care providers for medical services not otherwise included in other categories. This includes, but is not limited to durable medical equipment, freestanding fees of community health center services, free standing ambulatory surgical center services, hospice facility, freestanding diagnostic facility services, hospice, hearing aid services and optical services. It also includes the cost of vaccines administered in the primary care setting. Payments made to members for direct reimbursement of health care benefits/services may be reported in "Claims: Other" if the Insurer is unable to classify the service. If this is the case, the Insurer should consult with the State about the appropriate placement of the service prior to categorizing it as "Claims: Other." However, TME data for non-health care benefits/services, such as fitness club reimbursements, should not be reported in any category. Payments for fitness club membership discounts – whether given to the provider or given in the form of a capitated payment to an organization that assists the Insurer with enrolling members in gyms – are not valid payments to include.

Non-Claims Payment Service Categories

- **Non-Claims: Capitation or Bundled Payments**: All non-claims based payments for services delivered under the following payment arrangements: (1) capitation payments, i.e., per capita payments to providers to provide healthcare services over a defined period of time; (2) global budget payments, i.e., prospective payments made to providers for a comprehensive set of services for a designated patient population or a more narrowly defined set of services where certain benefits (e.g., behavioral health, pharmacy) are carved out; (3) case rate payments, i.e., prospective payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific period of time and (4) prospective episode-based payments, i.e., payments received by providers (which can span multiple provider organizations) for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period.
- **Non-Claims: Performance Incentive Payments**: All payments to reward providers for achieving quality or cost-savings goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target. Include pay-for-performance, i.e., payments to reward providers for achieving a set target (absolute, relative or improvement-based) for quality or efficiency metrics, and pay-for-reporting, i.e., payments to providers for reporting on a set of quality or efficiency metrics, usually to build capacity for pay-for-performance, payments. Include shared savings distributions, i.e., payments received by providers if costs of services are below a pre-determined, risk-adjusted target, and shared risk recoupments, i.e., payments providers must recoup if costs of services are above a pre-determined, risk-adjusted target.

- **Non-Claims: Population Health and Practice Infrastructure Payments:** All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs. This includes, but is not limited to payments that support care management, care coordination and population health; I/HIT infrastructure payments and other data analytics payments; HIE payments; patient-centered medical home (PCMH) administration payments; PCMH recognition payments and behavioral health integration that are not reimbursable through claims.

- **Non-Claims: Provider Salaries**: All payments for salaries of providers who provide health care services not otherwise included in other claims and non-claims categories. This category typically only applies to closed delivery systems.

- **Non-Claims: Recovery**: All payments received from a provider, member/beneficiary or other Insurer, which were distributed by an Insurer and then later recouped due to a review, audit or investigation. This can include infrastructure payments that are recouped under total cost of care arrangements if a provider does not generate savings. This field should be reported as a negative number. Only report data in this category not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recovery amount in this category).

- **Non-Claims: Other**: All other payments made pursuant to the Insurer's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere. This may include governmental Insurer shortfall payments, grants or other surplus payments. For CY 2020, this may also include supportive funds made to providers to support clinical and business operations during the global COVID 19 pandemic. Only payments made to providers are to be reported; Insurer administrative expenditures (including corporate allocations) are not included in TME.

Guidance for Medicaid Managed Care Organizations

Medicaid MCOs should include inpatient and practitioner qualified directed payments received from DHHS and paid to providers. These payments should be included as Non-Claims: Other

- **Non-Claims: Total Primary Care Non-Claims-Based Payments:** All non-claims-based payments included in the above six categories that are specifically made to a primary care provider or provider organization. Payments in this category should be a sub-set of payments reported in the other non-claims categories. *This category is the only category not mutually exclusive to the other non-claims categories.*

4. Truncation

In addition to spending by claims and non-claims categories above (which should not be truncated), Insurers will submit truncated claims spending and the count of members with claims truncated. Insurers should use the per member truncation points for each Insurance Category Code listed in the Table 10 below. Insurers will submit truncated claims spending and the count of members with claims truncated by Large Provider Entity and for the Insurer Overall by Insurance Category Code.

Table 10. Truncation Points

Insurance Category Code	Definition	Per Member Truncation Point
1	Medicare Expenses for Non-Dual Eligible Members	$150,000
2	Medicaid Expenses for Non-Dual Eligible Members	$100,000
3	Commercial: Full Claims	$175,000
4	Commercial: Partial Claims	$175,000
5	Medicare Expenses for Medicare/Medicaid Dual Eligible	$150,000
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible	$100,000

While OOA recognizes that some Insurers separately truncate medical and pharmacy spending in their total cost of care contracts, OOA requests that truncation be applied to individuals' total spending, inclusive of all medical and pharmacy spending.

For Insurers reporting Insurance Category Code 4 (Commercial: Partial Claims), the member level truncation should be applied *after* estimates of carve-out spending have been made, so that truncation is being applied to an estimate of individual members' total claims spending (see inset below for an explanation of how to truncate partial claims spending).

How to Apply Truncation to Insurance Category Code 4 (Commercial: Partial Claims)

- An Insurer reporting Insurance Category Code 4 (Commercial: Partial Claims) data has carved-out its pharmacy benefit to a PBM and does not have access to claims level spending.
- The Insurer would develop an estimate for what Insurance Category Code 4's PMPM spending on pharmacy would have been using its Insurance Category Code 3 (Commercial: Full Claims) population experience as a benchmark.
    - For example, for those members for whom pharmacy benefits are carved out, the Insurer might include its commercial market book of business average pharmacy spending per-member per-month for the same year, calculated on members who had pharmacy coverage, and applied to all member months for which the carve out applied. **Note: Such an adjustment must be reviewed with the State before the adjustment is made.**
- The Insurer would add this PMPM estimate to member level spending by multiplying the estimated Insurance Category 4 Rx PMPM by the number of member months in Insurance Category Code 4.
- The Insurer would then apply the per-member truncation to Insurance Category Code 4.

In addition, for members who are attributed to more than one Large Provider Entity during the year, Insurers should "reset the clock" and calculate truncated spending for the member for each of the Large Provider Entities, and for the Insurer as a whole. This is done by first calculating the member's total spending that is attributed to each Large Provider Entity, and separately applying truncation to the

member's spending that is attributed to each Large Provider Entity (see inset below for how to apply truncation in this case).

How to Handle Truncation When Members Are Attributed to More than One Large Provider Entity During the Calendar Year

Example with a $150,000 truncation point:

- A member in Insurance Category Code 1 was attributed to Provider X for 8 months with $200,000 in claims.
- The member is then attributed to Provider Y for 4 months with $175,000 in claims.
- Provider X's spending above the truncation would be $50,000 while Provider Y's spending above the truncation would be $25,000.
- Since the member cost the payer $375,000 in total, the total dollars above the truncation point for the payer would be $225,000.

E. Standard Deviation Tab

This tab is for Insurers to submit standard deviation, so that that the State can calculate confidence intervals for year-to-year cost growth. Insurers must calculate and submit standard deviation data as follows

- For each Large Provider Entity, by market
- For the Insurer, by market

Market should be defined and submitted using the market codes in Table 11 below.

Table 11. Market Codes

Market Code	Description
1	Medicare (Insurance Category Codes 1 and 5)
2	Medicaid (Insurance Category Codes 2 and 6)
3	Commercial (Insurance Category Codes 3 and 4)

The following steps detail how Insurers can calculate standard deviation values for the data submission:

- **Step 1:** Attribute members to the appropriate Large Provider Entity (see Reporting on Large Provider Entities and Attribution for how to perform the attribution). Insurers should include all members attributed to a Large Provider Entity, ***including members with no utilization***.

- **Step 2**: For each market, for each Large Provider Entity, the Insurer must calculate the average monthly spending amount of each member using claims-based allowed amounts. Insurers should calculate the average claims-based allowed amount ***after partial claims adjustments and after truncation of member level spending***. Non-claims expenditures should be *excluded* from this average.

- **Step 3**: Use the per-month average for each individual and multiply that value by the number of enrolled member months for that member. Sum the values for all members and divide by the total number of member months to produce a per member per month dollar amount that is specific to a given market and Large Provider Entity. Note that when calculating the standard deviation of the population for the cost growth benchmark program, Insurers must use each member's average cost applied to ***each month they were enrolled***, instead of the actual utilization each month.

- **Step 4**: With the average claims expenses value for each Large Provider Entity, Insurers can now calculate the standard deviation. The formula is:

$$SD = \sqrt{\frac{\sum_i (X_i - \bar{X})^2}{N}}$$

  Using the Excel function STDEV.P() or other standard deviation commands in any other statistical software program, Insurers can calculate the risk-adjusted standard deviation of the PMPM costs for a given market.

  Note that when calculating standard deviation, Insurers should use the formula for ***population standard deviation*** (divided by N). Insurers should NOT use the formula for sample standard deviation (divided by N-1).

- **Step 5**: Report the standard deviation values in the data submission template in Tab 3. Each row should correspond to either a Large Provider Entity or the market for the Insurer overall.

F. Line of Business Enrollment Tab

This tab is for Insurers to report member months by Line of Business.

Member Months (annual) are the number of unique members participating in a plan each month with at least a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by taking the number of members with a medical benefit and multiplying that sum by the number of months in the member's policy. Member months should be reported for the line of business using the codes and definitions in

Table 12.

Note that Insurers should not include Medigap members but should include members in Dual Special Needs Plans (D-SNPs).

Table 12. Line of Business Codes

Line of Business Categories	Description
1	Large group (51 + employees), fully insured
2	Small group (2-50 employees), fully insured
3	Self-insured
4	Individual (buy coverage on their own)
5	Student plans
6	Medicare Advantage for Non-Dual Eligible Members
7	Medicaid Managed Care for Non-Dual Eligible Members
8	Medicare Dual Eligible Members
9	Medicaid Dual Eligible Members

G. Pharmacy Rebate Data Tab

This tab is for Insurers to report pharmacy rebates data by Insurance Category Code. Insurers should not try to allocate pharmacy rebates at the member or provider level.

Total rebates should be reported without regard to how they are paid to the Insurer (e.g., through regular aggregate payments, on a claim-by-claim basis, etc.). The only exception is for Medicaid managed care Insurers which should not report pharmacy rebates that are passed to the State. They should only report those rebates below and beyond the state-negotiated rebates.

Insurers should report both retail pharmacy rebates and medical pharmacy rebates. Pharmacy rebates should be reported as a negative number.

1. Retail Pharmacy Rebates

Pharmacy rebates for retail pharmacy are reported as the estimated value of rebates attributed to Nevada residents provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill corresponding with the reporting period, excluding manufacturer-provided fair market value bona fide service fees for retail prescription drugs.

This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM.

2. Medical Pharmacy Rebates

Pharmacy rebates for medical pharmacy are reported as the estimated value of rebates attributed to Nevada residents provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill corresponding with the reporting period, excluding manufacturer-provided fair market value bona fide service fees for pharmaceuticals that are paid for under the member's medical benefit. These drugs may be included in the professional claims category with J codes or part of facility fees for drug infusions administered in the outpatient setting.

This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM.

If Insurers are unable to separate out retail and medical pharmacy rebates for reporting, all pharmacy rebates should be reported in aggregate in the optional field RXR06 in Tab 5 of the data submission template.

3. Estimating Pharmacy Rebates

Pharmacy rebates may have long tails (e.g., 12 or more months) and Insurers may not have complete pharmacy rebate data for a measurement period in time for the annual cost growth benchmark data submission.

Insurers should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the reporting period.

If Insurers are unable to report rebates specifically for Nevada residents, Insurers should report estimated rebates attributed to Nevada residents in a proportion equal to the proportion of pharmacy spending for Nevada residents compared to pharmacy spending for total members, by Insurance Category Code. For example, if Nevada commercial member spending represents 10% of an Insurer's total commercial members, then 10% of the total pharmacy rebates for its commercial book of business should be reported.

If Insurers are unable to identify the percentage of pharmacy spending for Nevada residents, then the Insurer should calculate the pharmacy rebates attributable to Nevada residents using percentage of membership.

4. Pharmacy Rebates Passed Back to Employers

Some self-funded employer groups ask for portions of the rebates to be passed along to them. Insurers should report any rebates they receive, regardless of whether they are passed along to employers.

H. Mandatory Questions Tab

This tab asks the Insurer to answer a series of questions to confirm that their data submission follows the specifications and that their data are sound and correct.

This tab also includes space for Insurers with self-insured lines of business to provide income from fees of uninsured plans (in aggregate). This information is used to calculate the Net Cost of Private Health Insurance (NCPHI). Insurers must follow the instructions from the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE), Part 1, Line 12, Income from Fees of Uninsured Plans.

I. Data Validation Checks Tab

This tab uses Insurer-provided information from other tabs within the Excel workbook to conduct checks of data consistency and reasonableness. These checks are intended to help Insurers flag potential errors

in their data submission. Insurers are not required to input any data in this tab, but must review it prior to submitting to ensure the data are correct.

J. Validation by Market Tab

This tab uses Insurer-provided information from other tabs within the Excel workbook to calculate spend and trend by market and service category. These summary tables are intended to help Insurers validate their own data prior to submission to OOA. Insurers are not required to input any data in this tab, but must review it prior to submitting to ensure the data are correct.

K. Validation by Provider Tab

This tab uses Insurer-provided information from other tabs within the Excel workbook to calculate spend and trend by Large Provider Entity and service category. These summary tables are intended to help Insurers validate their own data prior to submission to OOA. Insurers are not required to input any data in this tab, but must review it prior to submitting to ensure the data are correct.

APPENDIX A: Definition of Terms

Term	Definition
Claims Payments	The allowed amounts on provider claims to Insurers. This includes the amount Insurers paid to providers and any member cost sharing, such as copayments, deductibles, and co-insurance.
Health Care Cost Growth Benchmark	The targeted annual per member growth rate for total health care spending in the state. This is expressed as the percentage growth from the prior year's per member per year.
Performance Year	The calendar year (Jan 1 – Dec 31) for which performance is measured against the prior calendar year for purposes of calculating the growth in health care costs.
Net Cost of Private Health Insurance (NCPHI)	The cost to Nevada residents associated with the administration of private health insurance. It is the difference between health premiums earned and claims paid. It consists of Insurers' costs related to paying bills, advertising, sales commissions, other administrative costs, premium taxes, and other fees. It also includes Insurers' profits (contribution to margin) or losses.
Non-Claims Payments	All payments that Insurers make to providers other than providers' claims. This includes incentive payments, capitation or bundled payments, payments that support care transformation and infrastructure (e.g., care manager payments, lump sum investments, patient-centered medical home payments) and other payments that support provider services.
Insurer	A public or private organization or entity that offers one or more of the following: commercial insurance, benefit administration for self-insured employers, Medicaid managed care, or Medicare managed care. Also referred to as "insurance carriers" or "carriers."
Large Provider Entity	A term referring to an organization with primary care providers and that is large enough to enter into an accountable care organization total cost of care contract, for whom Insurers must report Total Medical Expense data.
Total Health Care Expenditures (THCE)	The Total Medical Expense incurred by Nevada residents for all health care services for all Insurers reporting to OOA, plus the Insurers' Net Cost of Private Health Insurance.
Total Medical Expenses (TME)	The sum of total Claims Payments and total Non-Claims Payments to providers for health care services delivered to Nevada residents.

APPENDIX B: Data Dictionaries

This appendix provides data dictionaries that list all of the data elements in tabs 2 through 6 of the data submission template, organized by tab. Insurers should reference the data dictionaries when completing each section of the data submission template to ensure they align with the data specifications.

Data Dictionary for Tab 2. TME

The "Data Element" column indicates the code associated with the data entry field in the data submission template and the "Name" column indicates the Data Element's name. The "Type" column indicates what type of data entry is required (e.g., text, percentage, non-negative number). The "Description" column provides additional details about the required data, including guidance for how insurers can confirm the data align with data specifications.

Data Element	Name	Type	Description
TME01	Insurer Code	Code	Code associated with the Insurer submitting the data. See Insurer Codes table in the Total Medical Expenses Tab section.
TME02	Reporting Year	Year	Year for which data are being reported.
TME03	Insurance Category Code	Code	Code associated with the insurance category being reported. See Insurance Category Codes table in the Total Medical Expenses Tab section.
TME04	Large Provider Entity Code	Code	Code associated with the Large Provider Entity whose spending is being reported. See Large Provider Entity Codes table in the Total Medical Expenses Tab section. For reporting the overall spending by Insurance Category Code, Insurers should use Large Provider Entity Code 100 for "Insurer Overall".
TME05	Member Months	Non-negative number	The number of members enrolled in a plan over the reporting year expressed in months of membership.
TME06	Claims: Hospital Inpatient	Non-negative number	Sum of the allowed amount from the claims for hospital inpatient services. See Claims Payments by Service Category for additional details. **Note that this is the unadjusted, non-truncated allowed amount.**
TME07	Claims: Hospital Outpatient	Non-negative number	Sum of the Claims Payments for hospital outpatient services. Insurers should report allowed amounts. See Claims Payments by Service Category for additional details. **Note that this is the unadjusted, non-truncated allowed amount.**

Data Element	Name	Type	Description
TME08	Claims: Professional, Primary Care Providers	Non-negative number	Sum of the Claims Payments for physicians or physician group practices that are defined as a primary care providers delivering care at a primary care site of care using the code-level definition in **Appendix C**. OB/GYNs are not considered a PCP for this purpose. Insurers should report allowed amounts. See Claims Payments by Service Category and **Appendix C** for additional details. **Note that this is the unadjusted, non-truncated allowed amount.**
TME09	Claims: Professional, Specialty Providers	Non-negative number	Sum of the allowed amount from the claims for physicians or physician group practices that are NOT defined as a PCP (using the Cost Growth Benchmark definition of primary care). See Claims Payments by Service Category for additional details. **Note that this is the unadjusted, non-truncated allowed amount.**
TME10	Claims: Professional, Other Providers	Non-negative number	Sum of the Claims Payments for health providers for services provided by a licensed practitioner other than a physician, a physician group, or identified as a PCP (using the Cost Growth Benchmark definition of primary care). Insurers should report allowed amounts. See Claims Payments by Service Category for additional details. **Note that this is the unadjusted, non-truncated allowed amount.**
TME11	Claims: Long-Term Care	Non-negative number	Sum of the Claims Payments for long-term care services. Insurers should report allowed amounts. See Claims Payments by Service Category for additional details. **Note that this is the unadjusted, non-truncated allowed amount.**
TME12	Claims: Retail Pharmacy	Non-negative number	Sum of the Claims Payments for the retail pharmacy services. This should not include claims paid for pharmaceuticals under the Insurer's medical benefit. Insurers should report allowed amounts See Claims Payments by Service Category for additional details. **Note that this is the unadjusted, non-truncated allowed amount.**

Data Element	Name	Type	Description
TME13	Claims: Other	Non-negative number	Sum of the Claims Payments for all other services not mentioned above. Insurers should report allowed amounts. See Claims Payments by Service Category for additional details. **Note that this is the unadjusted, non-truncated allowed amount.**
TME14	Non-Claims: Capitation or Bundled Pmts	Non-negative number	Sum of payments made outside of the claims system by the Insurer to Large Provider Entities to deliver covered services to members. These include capitated, global budget, case rate, or episode-based payments. See Non-Claims Payments by Service Category for additional details.
TME15	Non-Claims: Performance Incentive Pmts	Number	Sum of performance incentive payments made by the Insurer to Large Provider Entities. This includes pay-for-performance, pay-for-reporting, shared savings distributions, and shared risk recoupments. Note that shared risk recoupments are reported as a negative number, but all other incentive payments that Insurers make to Large Provider Entities are positive numbers. This field is the net payment amount and could be either a positive or negative number. See Non-Claims Payments by Service Category for additional details.
TME16	Non-Claims: Pop Health and Practice Infrastructure Pmts	Non-negative number	Sum of the payments made by the Insurer to Large Provider Entities to support population health and practice infrastructure. See Non-Claims Payments by Service Category for additional details.
TME17	Non-Claims: Provider Salaries	Non-negative number	Sum of the payments made by the Insurer to Large Provider Entities for provider salaries. See Non-Claims Payments by Service Category for additional details.
TME18	Non-Claims: Recovery	Non-positive number	Sum of the payments received by the Insurer from a provider, member/beneficiary and/or other Insurer because of a review, audit, or investigation. This field should be reported as a **negative number**. See Non-Claims Payments by Service Category for additional details.

Data Element	Name	Type	Description
TME19	Non-Claims: Other	Non-negative number	Sum of the payments made outside of the claims system by the Insurer to Large Provider Entities that cannot be properly classified elsewhere. See Non-Claims Payments by Service Category for additional details.
TME20	Non-Claims: Total Primary Care Non-Claims-Based Payments	Non-negative number	Sum of all non-claims-based primary care spending made to a primary care provider or provider organization. **This is the only category not mutually exclusive to other non-claims categories.** See Non-Claims Payments by Service Category for additional details.
TME21	Total Claims Excluded because of Truncation	Non-negative number	The total claims-based spending truncated using the truncation points listed in the Truncation Points table in the Truncation section. This variable is collected by Insurance Category Code for each Large Provider Entity and for the Insurer Overall.
TME22	Count of Members with Claims Truncated	Non-negative integer	The number of members who had spending above the truncation threshold applicable to the Insurance Category Code and Large Provider Entity to which the member was attributed. This variable is collected by Insurance Category Code for each Large Provider Entity and for the Insurer Overall.
TME23	Total Non-Truncated Claims Spending	NA	**This is a calculated field, no Insurer data entry needed.** Sum of all non-truncated claims spending, i.e., the sum of TME06 through TME13. Insurers should review for reasonableness
TME24	Total Non-Claims Spending	NA	**This is a calculated field, no Insurer data entry needed.** Sum of all non-claims spending, i.e., the sum of TME14 through TME19. Insurers should review for reasonableness.
TME25	Total Non-Truncated Claims and Non-Claims Spending	NA	**This is a calculated field, no Insurer data entry needed.** The sum of all non-truncated spending (claims and non-claims), i.e., the sum of TME23 and TME24. Insurers should review for reasonableness.

Data Element	Name	Type	Description
TME26	Total Truncated Claims Spending	NA	**This is a calculated field, no Insurer data entry needed.** The sum of all truncated claims spending, i.e., TME23 less TME21. Insurers should review for reasonableness.
TME27	Truncated Total Expenses (Total Truncated Claims Expenses + Non-Claims Expenses)	NA	**This is a calculated field, no Insurer data entry needed.** The sum of all truncated total spending (claims and non-claims), i.e., the sum of TME26 and TME24. Insurers should review for reasonableness.
TME28	Non-Truncated TME PMPM	NA	**This is a calculated field, no Insurer data entry needed.** The non-truncated TME PMPM, i.e., TME25 divided by TME05. Insurers should review for reasonableness.
TME29	Truncated TME PMPM	NA	**This is a calculated field, no Insurer data entry needed.** The truncated TME PMPM, i.e., TME27 divided by TME05. Insurers should review for reasonableness.

Data Dictionary for Tab 3. SD

The “Data Element” column indicates the code associated with the data entry field in the data submission template and the “Name” column indicates the Data Element’s name. The “Type” column indicates what type of data entry is required (e.g. text, percentage, non-negative number). The “Description” column provides additional details about the required data, including guidance for how insurers can confirm the data align with data specifications.

Data Element	Name	Type	Description
SD01	Insurer Code	Code	Code associated with Insurer submitting data. See Insurer Codes table in the Total Medical Expenses Tab section.
SD02	Reporting Year	Year	Year for which data are being reported.
SD03	Market Code	Code	Code associated with the market being reported. See Market Codes Table in the Standard Deviation Tab section. **Note that each Market Code combines two Insurance Category Codes** (Medicare combines Insurance Category Codes 1 and 5, Medicaid combines Insurance Category Codes 2 and 6, Commercial combines Insurance Category Codes 3 and 4).
SD04	Large Provider Entity Code	Code	Code associated with the Large Provider Entity whose spending is being reported. See Large Provider Entity Codes table in the Total Medical Expenses Tab section. **When reporting standard deviation for each market for the Insurer overall, use the appropriate Insurer Code instead of the Large Provider Entity Code.**
SD05	Member Months	Non-negative number	The number of members enrolled in a plan over the reporting calendar year expressed in months of membership.
SD06	Total Truncated Claims Spending	Non-negative number	Total truncated claims spending associated with the Large Provider Entity and market.

Data Element	Name	Type	Description
SD07	Standard Deviation PMPM	Non-negative number	The calculated standard deviation for all members for the applicable market and Large Provider Entity, reported as a PMPM value. Insurers should include all members attributed to a Large Provider Entity, *including members with no utilization*. Standard deviation should be based on *per-member-per-month (PMPM) spending*. Insurers should calculate the standard deviation PMPM *after partial claims adjustments*. Non-claims expenditures should be *excluded* from the calculation.

Data Dictionary for Tab 4. LOB_ENROLL

The “Data Element” column indicates the code associated with the data entry field in the data submission template and the “Name” column indicates the Data Element’s name. The “Type” column indicates what type of data entry is required (e.g., text, percentage, non-negative number). The “Description” column provides additional details about the required data, including guidance for how insurers can confirm the data align with data specifications.

Data Element	Name	Type	Description
LOB01	Insurer Code	Code	Code associated with Insurer submitting data. See Insurer Codes table in the Total Medical Expenses Tab section.
LOB02	Line of Business Category	Code	Code associated with the line of business being reported. See Line of Business Category Codes table in the Line of Business Enrollment Tab section.
LOB03	Year 2018 Member Months	Non-negative number	In 2018, the number of members enrolled in a plan over the reporting calendar year expressed in months of membership.
LOB04	Year 2019 Member Months	Non-negative number	In 2019, the number of members enrolled in a plan over the reporting calendar year expressed in months of membership.
LOB05	Year 2020 Member Months	Non-negative number	In 2020, the number of members enrolled in a plan over the reporting calendar year expressed in months of membership.
LOB06	Year 2021 Member Months	Non-negative number	In 2021, the number of members enrolled in a plan over the reporting calendar year expressed in months of membership.

Data Dictionary for Tab 5. RX_REBATE

The "Data Element" column indicates the code associated with the data entry field in the data submission template and the "Name" column indicates the Data Element's name. The "Type" column indicates what type of data entry is required (e.g., text, percentage, non-negative number). The "Description" column provides additional details about the required data, including guidance for how insurers can confirm the data align with data specifications.

Data Element	Name	Type	Description
RXR01	Insurer Code	Code	Code associated with Insurer submitting data. See Insurer Codes table in the Total Medical Expenses Tab section.
RXR02	Reporting Year	Year	Year for which data are being reported.
RXR03	Insurance Category Code	Code	Code associated with the insurance category being reported. See Insurance Category Codes table in the Total Medical Expenses Tab section.
RXR04	Medical Pharmacy Rebate Amount	Negative number	The value of total federal and state supplemental rebates attributed to Nevada resident members provided by pharmaceutical manufacturers for prescription drugs that are administered *by medical providers*. This amount should include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. This field should be reported as a **negative number**.
RXR05	Retail Pharmacy Rebate Amount	Negative number	The value of total federal and state supplemental rebates attributed to Nevada resident members provided by pharmaceutical manufacturers for prescription drugs that are administered *by retail pharmacies*. This amount should include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. This field should be reported as a **negative number**.
RXR06	Total Pharmacy Rebate Amount (Optional)	Negative number	**This is an optional field.** The total pharmacy rebate amount reported *only if* Insurers are unable to separately report medical and retail pharmacy rebates in RXR04 and RXR05. If this field is used, RXR04 and RXR05 should be blank.

Data Element	Name	Type	Description
RXR07	Total Pharmacy Rebate Amount	NA	**This is a calculated field.** The total pharmacy rebate amount, i.e., the sum of RXR04 and RXR05. Insurers should review for reasonableness.

Data Dictionary for Tab 6. Mandatory Questions

The “Table #” column indicates in which Mandatory Questions table the data element appears and the “Data Element Name” column includes the question the Insurer is asked to answer. The “Data Element” column indicates the code associated with the data entry field in the data submission template and the “Name” column indicates the Data Element’s name. The “Type” column indicates what type of data entry is required (e.g., text, percentage, non-negative number). The “Description” column provides additional details about the required data, including guidance for how insurers can confirm the data align with data specifications.

Table #	Data Element Name	Type	Description
1.1	What is the overall completeness of the claims data (please report as %)?	Percentage	The overall completeness of the claims data that the Insurer reported in TME tabs. If completeness of the claims data drops below a given threshold (98%), OOA reserves the right to request Insurers to calculate IBNR and/or provide supplemental information.
1.1	How long was the claims runout period for Claims Payments (please report as days)?	Integer	The runout period for the Claims Payments that the Insurer reported in the TME tab. Insurers shall allow for a run-out period of at least 180 days after December 31 of the Performance Year (i.e., Insurers should not pull the data until after June 30 of the year following the Performance Year).
1.1	How long was the runout period for Non-Claims Payments (please report as days)?	Integer	The runout period for the Non-Claims Payments that the Insurer reported in the TME tab. Insurers shall allow for a runout period of at least 180 days after December 31 of the Performance Year (i.e., Insurers should not pull the data until after June 30 of the year following the Performance Year).
1.1	Are IBNR/IBNP factors applied to the Claims Payments?	Drop-down list (Yes/No)	Confirm that IBNR/IBNP are not applied to Claims Payments.
1.1	Is pharmacy rebate data estimated? If yes, how?	Drop-down list (Yes/No)	Confirm whether pharmacy rebate data is estimated or not. If yes, please describe the method in the comment field.
1.1	What carve-out services are estimated?	Text	For commercial: partial claims only. Specify what carve-out services are estimated in the data reported in the data submission template.

Table #	Data Element Name	Type	Description
1.2	Are the Claims Payments reported as allowed amounts, including both payments that Insurers paid to providers and member cost sharing?	Drop-down list (Yes/No)	Confirm that the Claims Payments are reported using allowed amounts, which includes payments that Insurers paid to providers and member cost sharing.
1.2	Is the spending reported in a manner consistent with the service category definitions outlined in the Data Specifications Manual?	Drop-down list (Yes/No)	Confirm that the spending reported in the data submission template is consistent with the service category definitions outlined in the Data Specifications Manual.
1.2	Does the TME data include Nevada residents only?	Drop-down list (Yes/No)	Confirm that the data reported in the data submission template only includes Nevada residents. Confirm that out-of-state residents who receive care from Nevada providers are not included.
1.2	Does the TME include services rendered by providers, regardless of location of provider?	Drop-down list (Yes/No)	Confirm that the data in the data submission template includes all the providers providing care to Nevada residents, no matter the services are provided by the providers in or outside of Nevada.
1.2	Does the TME include services rendered by providers, regardless of the situs of the member's plan?	Drop-down list (Yes/No)	Confirm that the data reported in the data submission template includes all the providers providing care to Nevada residents, no matter the situ of the member's plan.
1.2	Are the data limited only to members for whom the Insurer is primary on the claim?	Drop-down list (Yes/No)	Confirm that the reported members are limited only to members for whom the Insurer is primary on the claim.

Table #	Data Element Name	Type	Description
1.2	Please describe your methodology for attributing members to a primary care provider.	Text	Describe the methodology used to attribute members to a primary care provider. Insurers may submit their methodology separately to DHHS if it does not fit in the allocated space in the template.
1.2	Please describe your methodology for attributing primary care providers to a Large Provider Entity.	Text	Describe the methodology used to attribute primary care providers to Large Provider Entities. Insurers may submit their methodology separately to DHHS if it does not fit in the allocated space in the template.
1.2	Are members attributed to provider organizations consistent with your contracts with each provider?	Drop-down list (Yes/No)	Confirm that the members attributed to provider organizations reported in the TME tab are consistent with the Insurer's contracts with each provider.
1.2	Are TME data submitted based on the incurred date/date of service?	Drop-down list (Yes/No)	Confirm that TME data reported in the data submission template are based on the date of service, not the paid or reconciled date.
1.2	Is truncation applied at the member level?	Drop-down list (Yes/No)	Confirm that truncation is applied to each member participating in a plan each month with a medical benefit consistent with the general cost growth benchmark specifications on how to calculate claims-based spending.
1.2	Does the truncated spending include only claims data?	Drop-down list (Yes/No)	Confirm that truncated spending only includes claims spending and **does not** include non-claims spending categories.
1.2	Is estimated spending on carved-out services included in the calculation of claims at the member level before applying truncation?	Drop-down list (Yes/No)	For commercial: partial claims only. Confirm that estimations for carved-out services are included in the calculation of claims at the member level before truncation is applied.

Table #	Data Element Name	Type	Description
1.3	Are the standard deviations calculated using the formula for population standard deviation?	Drop-down list (Yes/No)	Confirm that the standard deviations reported in the data submission template are calculated using the formula for population standard deviation. See Standard Deviation for additional details.
1.3	Are non-claims expenses excluded from the calculation of standard deviations?	Drop-down list (Yes/No)	Confirm that non-claims are excluded when calculating standard deviations. See Standard Deviation for additional details.
1.3	Is estimated spending on carved-out services at the member month level included in the calculation of standard deviation?	Drop-down list (Yes/No)	For commercial market only. Confirm that estimated spending on carved-out services at the member month level is included when calculating standard deviations.
1.3	When calculating the standard deviation, did you include all the member months, regardless of whether the member has paid claims for that month?	Drop-down list (Yes/No)	Confirm that when calculating the standard deviation, all the member months are included regardless of whether the member has paid claims for that month. See Standard Deviation for additional details.
1.3	When calculating the standard deviation, did you use each member's average cost per month applied to each month they were enrolled, instead of the actual utilization each month?	Drop-down list (Yes/No)	Confirm that when calculating the standard deviation, the Insurer uses each member's average cost per month applied to each month they were enrolled. Confirm that the Insurer did not use actual utilization of each month to calculate standard deviation. See Standard Deviation for additional details.
1.3	Is standard deviation calculated by market, which combines certain Insurance Category Codes?	Drop-down list (Yes/No)	Confirm that standard deviations are calculated by market, which combines Insurance Category Codes (Medicare combines Insurance Category Codes 1 and 5, Medicaid combines Insurance Category Codes 2 and 6, Commercial combines Insurance Category Codes 3 and 4).

Table #	Data Element Name	Type	Description
1.4	Did you have self-insured lines of business reported in Tab 4. LOB_ENROLL?	Drop-down list (Yes/No)	Should align with information reported in Tab 4. LOB_ENROLL.
1.4	If yes, please enter the income from fees of uninsured plans here.	Non-negative number	Enter Income from Fees of Uninsured Plans, NAIC SHCE Part 1, Line 12.
1.5	Any Medicare Managed Care Organization must submit all names for which it is “doing business” as in the state of Nevada.	Text	Medicare Managed Care Organizations should enter any names with which they are “doing business” in the state of Nevada.

APPENDIX C: Primary Care Code Level Definition

This appendix details how to define spending on primary care services for inclusion in the Claims: Professional, Primary Care service category. This category should include the TME paid to primary care providers delivering care at a primary care site of care generated from claims using provider taxonomy codes in Table 13, primary care payment codes in Table 14 and place of service and modifier codes in Table 15.[6]

For the purposes of reporting spending for the cost growth benchmark program, primary care providers include providers practicing in the following specialties: family practice; geriatrics; internal medicine; and pediatrics. Insurers should use the taxonomy codes in Table 13 to identify primary care providers.

Primary care services include care management; care planning; consultation services; health risk assessments, screenings and counseling; home visits; hospice/home health services; immunization administrations; office visits and preventive medicine visits. They do not include prescription drugs (including those covered by both medical and pharmacy benefits), laboratory, x-ray and imaging services. Insurers should use the primary care payment codes in Table 14 to identify the services to include.

A primary care site of care is defined as a primary care outpatient setting (e.g., office, clinic or center), federally qualified health center, school-based health center, or via telehealth. It does not include stand-alone telehealth vendors, i.e., a third-party telehealth vendor. It does not include urgent care centers or retail pharmacy clinics. Insurers should use either the telephone and internet services codes in Table 14 or another code in Table 14 with the place of service and/or modifier codes in Table 15 to identify primary care services delivered via telehealth.

Primary Care Specialties

Table 13 below lists select provider taxonomy codes for the four primary care specialties included in the State's definition of primary care providers (e.g., family practice, geriatrics, internal medicine and pediatrics) and certain provider organization taxonomy codes (e.g., federally qualified health centers). Insurers should identify primary care providers first by searching for provider taxonomy codes in Table 13 in the rendering provider field and then the billing provider field. If the Insurer does not use the provider taxonomy codes in Table 13, it may apply its provider codes to match the description of the provider taxonomy codes in Table 13.

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[6] This primary care definition and accompanying code lists are informed by the New England States Consortium Systems Organization's (NESCSO) definition of primary care spending.

Table 13. Primary Care Taxonomy Codes

Taxonomy	Description	Notes or restrictions
208D00000X	General Practice	
207Q00000X	Family Medicine	
207QA0000X	Family Medicine, Adolescent Medicine	
207QA0505X	Family Medicine, Adult Medicine	
207QG0300X	Family Medicine, Geriatric Medicine	
207QH0002X	Family Medicine, Hospice Palliative	Restrict to only home health and hospice procedure codes
208000000X	Pediatrics	
2080A0000X	Pediatrics, Adolescent Medicine	
2080H0002X	Pediatrics, Hospice and Palliative Medicine	Restrict to only home health and hospice procedure codes
207R00000X	Internal Medicine	
207RG0300X	Internal Medicine, Geriatric Medicine	
207RA0000X	Internal Medicine, Adolescent Medicine	
207RH0002X	Internal Medicine, Hospice and Palliative Medicine	Restrict to only home health and hospice procedure codes
363A00000X	Physician Assistant	
363AM0700X	Physician Assistant, Medical	
363L00000X	Nurse Practitioner	
363LA2200X	Nurse Practitioner, Adult Health	
363LF0000X	Nurse Practitioner, Family	
363LG0600X	Nurse Practitioner, Gerontology	
363LP0200X	Nurse Practitioner, Pediatrics	
363LP2300X	Nurse Practitioner, Primary Care	

Taxonomy	Description	Notes or restrictions
363LC1500X	Nurse Practitioner, Community Health	Always restrict on the procedure code list
363LS0200X	Nurse Practitioner, School	Always restrict on the procedure code list
261QF0400X	Federally Qualified Health Center (FQHC)	Restrict by procedure code list AND restrict on revenue codes for clinic and professional services 0510, 0515, 0517, 0520, 0521, 0523, 0960, 0983
261QR1300X	Clinic/Center, Rural Health	
261QP2300X	Clinic/Center, Primary Care	
282NR1301X	Rural Hospital	
261QC0050X	Critical Access Hospital	
282NC0060X	Critical Access Hospital	

Primary Care Procedures

Table 14 below contains payment codes for primary care services. Services must be performed by a primary care provider delivering care at a primary care site of care.

Table 14. Primary Care Payment Codes

Procedure Code	Description	Reporting Procedure Category
99201	OFFICE OUTPATIENT NEW 10 MINUTES	Office Visits
99202	OFFICE OUTPATIENT NEW 20 MINUTES	Office Visits
99203	OFFICE OUTPATIENT NEW 30 MINUTES	Office Visits
99204	OFFICE OUTPATIENT NEW 45 MINUTES	Office Visits
99205	OFFICE OUTPATIENT NEW 60 MINUTES	Office Visits
99211	OFFICE OUTPATIENT VISIT 5 MINUTES	Office Visits
99212	OFFICE OUTPATIENT VISIT 10 MINUTES	Office Visits
99213	OFFICE OUTPATIENT VISIT 15 MINUTES	Office Visits
99214	OFFICE OUTPATIENT VISIT 25 MINUTES	Office Visits

Procedure Code	Description	Reporting Procedure Category
99215	OFFICE OUTPATIENT VISIT 40 MINUTES	Office Visits
99381	INITIAL PREVENTIVE MEDICINE NEW PATIENT <1YEAR	Preventive Medicine Visits
99382	INITIAL PREVENTIVE MEDICINE NEW PT AGE 1-4 YRS	Preventive Medicine Visits
99383	INITIAL PREVENTIVE MEDICINE NEW PT AGE 5-11 YRS	Preventive Medicine Visits
99384	INITIAL PREVENTIVE MEDICINE NEW PT AGE 12-17 YR	Preventive Medicine Visits
99385	INITIAL PREVENTIVE MEDICINE NEW PT AGE 18-39YRS	Preventive Medicine Visits
99386	INITIAL PREVENTIVE MEDICINE NEW PATIENT 40-64YRS	Preventive Medicine Visits
99387	INITIAL PREVENTIVE MEDICINE NEW PATIENT 65YRS&>	Preventive Medicine Visits
99391	PERIODIC PREVENTIVE MED ESTABLISHED PATIENT <1Y	Preventive Medicine Visits
99392	PERIODIC PREVENTIVE MED EST PATIENT 1-4YRS	Preventive Medicine Visits
99393	PERIODIC PREVENTIVE MED EST PATIENT 5-11YRS	Preventive Medicine Visits
99394	PERIODIC PREVENTIVE MED EST PATIENT 12-17YRS	Preventive Medicine Visits
99395	PERIODIC PREVENTIVE MED EST PATIENT 18-39 YRS	Preventive Medicine Visits
99396	PERIODIC PREVENTIVE MED EST PATIENT 40-64YRS	Preventive Medicine Visits
99397	PERIODIC PREVENTIVE MED EST PATIENT 65YRS& OLDER	Preventive Medicine Visits
99241	OFFICE CONSULTATION NEW/ESTAB PATIENT 15 MIN	Consultation Services
99242	OFFICE CONSULTATION NEW/ESTAB PATIENT 30 MIN	Consultation Services
99243	OFFICE CONSULTATION NEW/ESTAB PATIENT 40 MIN	Consultation Services
99244	OFFICE CONSULTATION NEW/ESTAB PATIENT 60 MIN	Consultation Services
99245	OFFICE CONSULTATION NEW/ESTAB PATIENT LEVEL 5	Consultation Services
G0466	FEDERALLY QUALIFIED HEALTH CENTER VISIT NEW PT	HCPC Visit Codes
G0467	FEDERALLY QUALIFIED HEALTH CENTER VISIT ESTAB PT	HCPC Visit Codes
G0468	FEDERALLY QUALIFIED HEALTH CENTER VISIT IPPE/AWV	HCPC Visit Codes

Procedure Code	Description	Reporting Procedure Category
T1015	CLINIC VISIT/ENCOUNTER ALL-INCLUSIVE	HCPC Visit Codes
S9117	BACK SCHOOL VISIT	HCPC Visit Codes
G0402	INIT PREV PE LTD NEW BENEF DUR 1ST 12 MOS MCR	HCPC Visit Codes
G0438	ANNUAL WELLNESS VISIT; PERSONALIZ PPS INIT VISIT	HCPC Visit Codes
G0439	ANNUAL WELLNESS VST; PERSONALIZED PPS SUBSQT VST	HCPC Visit Codes
G0463	HOSPITAL OUTPATIENT CLIN VISIT ASSESS & MGMT PT	HCPC Visit Codes
99401	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 15 MIN	Preventive Medicine Services
99402	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 30 MIN	Preventive Medicine Services
99403	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 45 MIN	Preventive Medicine Services
99404	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 60 MIN	Preventive Medicine Services
99406	TOBACCO USE CESSATION INTERMEDIATE 3-10 MINUTES	Preventive Medicine Services
99407	TOBACCO USE CESSATION INTENSIVE >10 MINUTES	Preventive Medicine Services
99408	ALCOHOL/SUBSTANCE SCREEN & INTERVEN 15-30 MIN	Preventive Medicine Services
99409	ALCOHOL/SUBSTANCE SCREEN & INTERVENTION >30 MIN	Preventive Medicine Services
99411	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 30 M	Preventive Medicine Services
99412	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 60 M	Preventive Medicine Services
99420	ADMN & INTERPJ HEALTH RISK ASSESSMENT INSTRUMENT	Preventive Medicine Services
99429	UNLISTED PREVENTIVE MEDICINE SERVICE	Preventive Medicine Services
99341	HOME VISIT NEW PATIENT LOW SEVERITY 20 MINUTES	Home Visits
99342	HOME VISIT NEW PATIENT MOD SEVERITY 30 MINUTES	Home Visits
99343	HOME VST NEW PATIENT MOD-HI SEVERITY 45 MINUTES	Home Visits
99344	HOME VISIT NEW PATIENT HI SEVERITY 60 MINUTES	Home Visits

Procedure Code	Description	Reporting Procedure Category
99345	HOME VISIT NEW PT UNSTABL/SIGNIF NEW PROB 75 MIN	Home Visits
99347	HOME VISIT EST PT SELF LIMITED/MINOR 15 MINUTES	Home Visits
99348	HOME VISIT EST PT LOW-MOD SEVERITY 25 MINUTES	Home Visits
99349	HOME VISIT EST PT MOD-HI SEVERITY 40 MINUTES	Home Visits
99350	HOME VST EST PT UNSTABLE/SIGNIF NEW PROB 60 MINS	Home Visits
99374	SUPVJ PT HOME HEALTH AGENCY MO 15-29 MINUTES	Hospice/Home Health Services
99375	SUPERVISION PT HOME HEALTH AGENCY MONTH 30 MIN/>	Hospice/Home Health Services
99376	CARE PLAN OVERSIGHT/OVER	Hospice/Home Health Services
99377	SUPERVISION HOSPICE PATIENT/MONTH 15-29 MIN	Hospice/Home Health Services
99378	SUPERVISION HOSPICE PATIENT/MONTH 30 MINUTES/>	Hospice/Home Health Services
G0179	PHYS RE-CERT MCR-COVR HOM HLTH SRVC RE-CERT PRD	Hospice/Home Health Services
G0180	PHYS CERT MCR-COVR HOM HLTH SRVC PER CERT PRD	Hospice/Home Health Services
G0181	PHYS SUPV PT RECV MCR-COVR SRVC HOM HLTH AGCY	Hospice/Home Health Services
G0182	PHYS SUPV PT UNDER MEDICARE-APPROVED HOSPICE	Hospice/Home Health Services
99339	INDIV PHYS SUPVJ HOME/DOM/R-HOME MO 15-29 MIN	Domiciliary, Rest Home Multidisciplinary care Planning
99340	INDIV PHYS SUPVJ HOME/DOM/R-HOME MO 30 MIN/>	Domiciliary, Rest Home Multidisciplinary care Planning
99495	TRANSITIONAL CARE MANAGE SRVC 14 DAY DISCHARGE	Transitional Care Management Services
99496	TRANSITIONAL CARE MANAGE SRVC 7 DAY DISCHARGE	Transitional Care Management Services
99497	ADVANCE CARE PLANNING FIRST 30 MINS	Advance Care Planning Evaluation & Management Services
99498	ADVANCE CARE PLANNING EA ADDL 30 MINS	Advance Care Planning Evaluation & Management Services
99366	TEAM CONFERENCE FACE-TO-FACE NONPHYSICIAN	Case Management Services
99367	TEAM CONFERENCE NON-FACE-TO-FACE PHYSICIAN	Case Management Services

Procedure Code	Description	Reporting Procedure Category
99368	TEAM CONFERENCE NON-FACE-TO-FACE NONPHYSICIAN	Case Management Services
99487	CMPLX CHRON CARE MGMT W/O PT VST 1ST HR PER MO	Chronic Care Management Services
99489	CMPLX CHRON CARE MGMT EA ADDL 30 MIN PER MONTH	Chronic Care Management Services
99490	CHRON CARE MANAGEMENT SRVC 20 MIN PER MONTH	Chronic Care Management Services
99491	CHRON CARE MANAGEMENT SRVC 30 MIN PER MONTH	Chronic Care Management Services
G0506	COMP ASMT OF & CARE PLNG PT RQR CC MGMT SRVC	Chronic Care Management Services
99358	PROLNG E/M SVC BEFORE&/AFTER DIR PT CARE 1ST HR	Prolonged Services
99359	PROLNG E/M BEFORE&/AFTER DIR CARE EA 30 MINUTES	Prolonged Services
99360	PHYS STANDBY SVC PROLNG PHYS ATTN EA 30 MINUTES	Prolonged Services
G0513	PRLNG PREV SRVC OFC/OTH O/P RQR DIR CTC;1ST 30 M	Prolonged Services
G0514	PRLNG PREV SRVC OFC/OTH O/P DIR CTC;EA ADD 30 M	Prolonged Services
99441	PHYS/QHP TELEPHONE EVALUATION 5-10 MIN	Telephone and Internet Services
99442	PHYS/QHP TELEPHONE EVALUATION 11-20 MIN	Telephone and Internet Services
99443	PHYS/QHP TELEPHONE EVALUATION 21-30 MIN	Telephone and Internet Services
99444	PHYS/QHP ONLINE EVALUATION & MANAGEMENT SERVICE	Telephone and Internet Services
99446	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5-10 MIN	Telephone and Internet Services
99447	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 11-20 MIN	Telephone and Internet Services
99448	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 21-30 MIN	Telephone and Internet Services
99449	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 31/> MIN	Telephone and Internet Services
99451	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5/> MIN	Telephone and Internet Services

Procedure Code	Description	Reporting Procedure Category
99452	NTRPROF PHONE/NTRNET/EHR REFERRAL SVC 30 MIN	Telephone and Internet Services
98966	NONPHYSICIAN TELEPHONE ASSESSMENT 5-10 MIN	Telephone and Internet Services
98967	NONPHYSICIAN TELEPHONE ASSESSMENT 11-20 MIN	Telephone and Internet Services
98968	NONPHYSICIAN TELEPHONE ASSESSMENT 21-30 MIN	Telephone and Internet Services
98969	NONPHYSICIAN ONLINE ASSESSMENT AND MANAGEMENT	Telephone and Internet Services
90460	IM ADM THRU 18YR ANY RTE 1ST/ONLY COMPT VAC/TOX	Immunization Administration for Vaccines/Toxoids
90461	IM ADM THRU 18YR ANY RTE ADDL VAC/TOX COMPT	Immunization Administration for Vaccines/Toxoids
90471	IM ADM PRQ ID SUBQ/IM NJXS 1 VACCINE	Immunization Administration for Vaccines/Toxoids
90472	IM ADM PRQ ID SUBQ/IM NJXS EA VACCINE	Immunization Administration for Vaccines/Toxoids
90473	IM ADM INTRANSL/ORAL 1 VACCINE	Immunization Administration for Vaccines/Toxoids
90474	IM ADM INTRANSL/ORAL EA VACCINE	Immunization Administration for Vaccines/Toxoids
G0008	ADMINISTRATION OF INFLUENZA VIRUS VACCINE	Immunization Administration for Vaccines/Toxoids
G0009	ADMINISTRATION OF PNEUMOCOCCAL VACCINE	Immunization Administration for Vaccines/Toxoids
G0010	ADMINISTRATION OF HEPATITIS B VACCINE	Immunization Administration for Vaccines/Toxoids
96160	PT-FOCUSED HLTH RISK ASSMT SCORE DOC STND INSTRM	Health Risk Assessment, Screenings, and Counselings
96161	CAREGIVER HLTH RISK ASSMT SCORE DOC STND INSTRM	Health Risk Assessment, Screenings, and Counselings
99078	PHYS/QHP EDUCATION SVCS RENDERED PTS GRP SETTING	Health Risk Assessment, Screenings, and Counselings
99483	ASSMT & CARE PLANNING PT W/COGNITIVE IMPAIRMENT	Health Risk Assessment, Screenings, and Counselings
G0396	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT 15-30 MIN	Health Risk Assessment, Screenings, and Counselings
G0397	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT >30 MIN	Health Risk Assessment, Screenings, and Counselings
G0442	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES	Health Risk Assessment, Screenings, and Counselings
G0443	BRIEF FACE-FACE BEHAV CNSL ALCOHL MISUSE 15 MIN	Health Risk Assessment, Screenings, and Counselings

Procedure Code	Description	Reporting Procedure Category
G0444	ANNUAL DEPRESSION SCREENING 15 MINUTES	Health Risk Assessment, Screenings, and Counselings
G0505	COGN & FUNCT ASMT USING STD INST OFF/OTH OP/HOME	Health Risk Assessment, Screenings, and Counselings
99173	SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT	Preventive Medicine Services
G0102	PROS CANCER SCREENING; DIGTL RECTAL EXAMINATION	Preventive Medicine Services
G0436	SMOKE TOB CESSATION CNSL AS PT; INTRMED 3-10 MIN	Preventive Medicine Services
G0437	SMOKING & TOB CESS CNSL AS PT; INTENSIVE >10 MIN	Preventive Medicine Services
58300	INSETION OF IUD	Contraceptive Insertion/Removal
58301	REMOVAL OF IUD	Contraceptive Insertion/Removal
57170	DIAPHRAGM OR CERVICAL CAP FITTING WITH INSTRUCTIONS	Contraceptive Insertion/Removal
S4981	INSERTION OF LEVONORGESTREL-RELEASING INTRAUTERINE SYSTEM	Contraceptive Insertion/Removal
11981	INSERTION, NON-BIODEGRADBLE DRUG DELIVERY IMPLANT	Contraceptive Insertion/Removal
11982	REMOVAL, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT	Contraceptive Insertion/Removal
11983	REMOVAL WITH REINSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT	Contraceptive Insertion/Removal
S0610	ANNUAL GYNECOLOGICAL EXAM, ESTABLISHED PATIENT	Gynecological Services
S0612	ANNUAL GYNECOLOGICAL EXAM, NEW PATIENT	Gynecological Services
S0613	ANNUAL GYNECOLOGICAL EXAM, BREAST EXAM W/O PELVIC	Gynecological Services
G0101	CERV/VAGINAL CANCER SCR; PELV&CLIN BREAST EXAM	Gynecological Services
Q0091	SCREEN PAP SMEAR; OBTAIN PREP &C ONVEY TO LAB	Gynecological Services

Place of Service and Modifier Codes

The codes in Table 15 below should be used in addition to the taxonomy and procedure codes in Table 13 and Table 14 so as to include primary care delivered via telehealth.

Table 15. Telehealth Place of Service and Modifier Codes

Place of Service/Modifier Code
02
10
95
GT